SOUTH DAKOTA DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE		POLICY NUMBER 700-27	PAGE NUMBER 1 OF 5
		DISTRIBUTION:	Public
		SUBJECT:	Medical Decisions and Advance Directives
RELATED STANDARDS:	**None.**	EFFECTIVE DATE:	June 15, 2024
		SUPERSESSION:	New Policy
DESCRIPTION: Clinical Services	REVIEW MONTH: May	**KELLIE WASKO SECRETARY OF CORRECTIONS**	

I. POLICY

It is the policy of the South Dakota Department of Corrections (DOC) to provide offenders with the opportunity to anticipate future medical treatment decisions concerning critical care situations and to make informed decisions concerning future medical treatment.

II. PURPOSE

The purpose of this policy is to ensure that offenders are offered the opportunity to communicate their decisions regarding future medical treatment and to ensure that future medical treatment decisions are respected and performed in accordance with the offender's wishes.

III. DEFINITIONS

Advance Medical Directive:

A set of instructions written and agreed to by an offender concerning the use of life-sustaining and end-of-life medical treatments and procedures in the event the offender is incapacitated and/or lacks the decisional capacity to provide informed consent. Includes a durable power of attorney for healthcare (healthcare agent) and/or living will (providing treatment wishes).

Decisional Capacity:

The ability of an offender to provide informed consent to, or refusal of medical treatment, or the ability to make an informed health care decision.

Do Not Resuscitate Directive (DNR):

An offender's direction to refuse resuscitation and/or withhold CPR in certain situations.

Healthcare Proxy

An authorized person established to make health care decisions for an individual if they are determined to be unable to communicate or make decisions themself.

Life-Sustaining Treatment:

Any medical procedure or intervention that, when administered to a patient, will serve only to postpone the moment of death or to maintain the patient in a condition of permanent unconsciousness. The term does not include the provision of appropriate care to maintain comfort, hygiene, and human dignity, the oral administration of food and water, or the administration of any medication or other medical procedure deemed necessary to alleviate pain.

Living Will:

A document the offender signs informing the medical team of their desires regarding medical treatment in circumstances in which they are no longer able to express informed consent. to stop or not start life-sustaining treatments if they are in a terminal condition and cannot make decisions or if they are in a persistent vegetative state (PVS).

Medical Durable Power of Attorney (POA):
A document the offender signs, naming a healthcare proxy to make healthcare decisions for the offender when unable to do so.

Medical Orders for Scope of Treatment (MOST):
A document, other than an advance medical directive, executed by a patient who has been diagnosed with a terminal condition, or the patient's authorized representative, and the patient's medical provider and entered in the patient's medical record that provides direction to health care providers about the patient's goals and preferences regarding the use of medical interventions, including cardiopulmonary resuscitation and other life-sustaining treatment. A transportable medical order signed by a healthcare provider for individuals with a terminal illness. It informs and empowers patients to clearly state their end–of–life care wishes and authorize healthcare providers to carry out those wishes.

Terminal Condition:
An incurable and irreversible condition such that, in accordance with accepted medical standards, death is imminent if life-sustaining treatment is not administered, or a coma or other condition of permanent unconsciousness that, in accordance with accepted medical standards, will last indefinitely without significant improvement and in which the individual is unable to communicate verbally or nonverbally, demonstrates no purposeful movement or motor ability, and is unable to interact purposefully with environmental stimulation.

IV. PROCEDURES

1. Overview:

A. Medical decisions and advanced directives may be determined by an adult offender who has the decisional capacity to provide informed consent to or refuse medical treatment.
   1. Upon confirmation of DNR on file and practitioner order, Life-saving measures according to DNR will be discontinued.

B. Advanced Directive.
   1. A durable power of attorney executed under §§ 59-7-2.1 to 59-7-2.4, inclusive, a living will be executed under chapter 34-12D, or an EMS cardiopulmonary resuscitation directive executed pursuant to chapter 34-12F**.** The following forms are advance directives, and an offender may sign any one form, all of the forms, or none of the forms.
      a. *Medical Durable Power of Attorney and Living Will for Healthcare* (attachments #1 - English and #2 - Spanish).
         1) The Medical Durable Power of Attorney allows the offender to appoint a health care proxy for health care decisions for themselves if the offender is unable to do so.
         2) The Living Will is a declaration that allows the offender to document wishes for declaration of life-sustaining and end-of-life medical treatments which allows an offender to make a choice regarding the prolonged use of ventilator support, artificial nourishment, or any other life-prolonging treatment.
         3) This form includes both the Medical Durable Power of Attorney and Living Will for Healthcare, which will be completed and signed by the offender in the presence of a witness and verified by a notary. The signed form(s) will be scanned into the electronic health record (EHR).
      b. The Do Not Resuscitate directive allows an offender to decline the use of cardiopulmonary resuscitation in the event their heart or breathing stops or malfunctions. A *Do Not Resuscitate (DNR) Directive* (attachment #3) will be completed and signed by the offender and an attending physician. The completed form will be scanned into the EHR.

2. All advance directives are electronically generated as a component of the offender's EHR. At any time during their incarceration, offenders may submit a request to complete an advance directive regarding their future medical treatment.
3. An offender may request a clinical services employee or contract worker to obtain the necessary forms. The health care practitioner will be responsible for ensuring that the offender receives all health-related information needed to make an informed choice and that the electronically generated forms are complete with the proper signatures.
4. When an advance directive is electronically generated, an alert icon will display on the offender's electronic health record banner.
5. Advance directives completed before incarceration must be followed by DOC employees or medical contract workers if clinical services have been given a copy of the advance directive. The completed directives will be scanned into the EHR.
6. Advance directives do not apply when medical needs arise as a result of suicide attempts, homicide attempts, or hunger strikes.

C. Advanced Care Planning
   1. The *Medical Orders for Scope of Treatment (MOST) Form* (attachments #4 - English and #5 - Spanish).
      a. The MOST form is a portable, actionable medical order for a patient diagnosed with a terminal condition that helps ensure patient treatment wishes are known and honored and helps prevent the initiation of unwanted, disproportionately burdensome treatment.
      b. MOST outlines a plan of care through medical orders that outline the patient's wishes after being diagnosed with a terminal condition in the last year of life. A summary that allows for a timely discussion between the offender and their medical practitioner about choices to accept, withdraw, or refuse various components of end-of-life care and treatment through the use of standardized forms that will ensure the offender's preferences are clearly and unequivocally documented. This form must be completed, signed, and scanned into the EHR by the offender's medical practitioner.
      c. MOST is a medical order, not an advance directive.
      d. An advance directive is a legal document and mechanism for naming a durable power of attorney for healthcare (a healthcare proxy) and/or a living will (providing general treatment wishes). Patients diagnosed with a terminal condition should have both documents as a part of their advance care plan.
      e. MOST must be signed and dated by a healthcare practitioner and the patient or patient's authorized representative.

D. Qualifying witness to the offender's signature:
   1. The qualifying witness must be a clinical services or contract employee.
   2. The following people will NOT witness the offender's signature of the medical power of attorney or declaration as to medical treatment (Living Will):
      a. Any person who may have a claim, or believes they have a claim, against the offender's estate.
      b. Any other patient of the health care facility.
      c. Any offender currently incarcerated or under the supervision of the DOC.

E. Power of Attorney:
   1. Selection and use of a healthcare proxy in critical care situations: In the absence of an advance medical directive and the offender's inability to make medical treatment decisions, the medical practitioner may rely upon the medical treatment decision made by an established healthcare proxy. A healthcare proxy may be a guardian or agent appointed pursuant to a medical power of attorney, or an established healthcare proxy for medical treatment decisions.
      a. If the patient's attending physician deems the patient incompetent to make medical decisions and no POA is identified or guardian is in place, the family makes the medical decisions in the following order: spouse, adult child, parent, adult sibling, grandparent, adult grandchild, adult aunt/uncle, adult niece/ nephew.
   2. Healthcare Proxy.
      a. A person authorized to make health care decisions for a patient.

b. The following process will apply to the selection and use of a healthcare proxy.
   1) Before a healthcare proxy is used to make medical treatment decisions for the offender, the medical practitioner must determine and document in the offender's EHR-specific findings regarding the cause, nature, and projected duration of the offender's lack of decisional capacity. The medical practitioner will make reasonable efforts to communicate to the offender their inability to make medical decisions.
   2) Once the healthcare proxy has been identified, the medical practitioner will inform the person(s) of the offender's inability to make medical treatment decisions. This is a verbal agreement that will be documented in the EHR.
   3) In the event a healthcare proxy cannot be located, the medical practitioner will document that information in the EHR.
      a. For urgent decisions, care will be determined by the director of Clinical and Correctional Services, chief medical officer, chief of clinical operations, and the site medical practitioner.
      b. For nonurgent decisions, the chief of clinical operations will notify the director of Clinical and Correctional Services, who will be responsible for briefing executive staff. The director or chief of clinical operations and/or the chief medical officer will contact the Office of the Attorney General to petition the court to appoint a guardian for the offender for the purpose of medical decision-making, if necessary.
   4) If the healthcare proxy or the attending medical practitioner believes the offender has regained decision-making capability, then the attending medical practitioner will reexamine the offender and make such a determination. The provider will document in the offender's EHR and notify the offender and the person requesting re-examination of the decision regarding the offender's ability to make medical decisions. If the offender regains decision-making capability, the authority for health care consent/decision reverts back to the offender unless otherwise required by a court order.

2. Revocation or Revision of an Advance Directive:

A. An offender may revoke or revise an advance directive in the presence of clinical services staff in writing. The revocation or revision will be documented in the EHR, and the form will be marked as VOID, initialed, and dated.

B. A medical practitioner may revise the MOST form only if the offender or healthcare proxy is informed of the change and agrees with the change. In this instance, the offender or the healthcare proxy must sign and date the revision.

C. The medical practitioner or designee will notify the appropriate agencies in the event of the revocation of DNR status.

3. Assisted Death:

A. Healthcare practitioners are prohibited from prescribing medication to any offender within a DOC facility to assist the offender with medical aid in dying.

V. RESPONSIBILITY

The director of Clinical and Correctional Services is responsible for the annual review and maintenance of this policy.

VI. AUTHORITY

A. SDCL § **29A-5 South Dakota Guardianship and Conservatorship Act.**
B. SDCL §**34-12C Healthcare Consent Procedures.**
C. SDCL § **34-12D-1 Definition of terms.**
D. SDCL § **34-12F EMS Cardiopulmonary Resuscitation Directive**.

E. SDCL § 59-7-2.1 **Principal--Designation--Healthcare.**
F. SDCL § 59-7-2.4 **Nomination--Health care--Guardian--Conservator.**
G. Sdaho.org
H. Doh.sd.gov

VII. HISTORY

June 2024 - New Policy

ATTACHMENTS *(*INDICATES DOCUMENT OPENS EXTERNALLY)*

1. Medical Durable Power of Attorney and Living Will for Healthcare-English*
2. Medical Durable Power of Attorney and Living Will for Healthcare-Spanish*
3. Do Not Resuscitate Directive - English
4. MOST Form - English
5. MOST Form - Spanish
6. DOC Policy Implementation / Adjustments

SOUTH DAKOTA DEPARTMENT OF CORRECTIONS – CLINICAL SERVICES MEDICAL DURABLE POWER OF ATTORNEY AND LIVING WILL FOR HEALTHCARE

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____, hereby appoint:
(Principal/Inmate/Patient Name)
(Healthcare Proxy Name) _____
(Address) _____
Home Telephone: _____ Work Telephone: _____
as my Agent to make health and personal care decisions for me as authorized in this document.

2. EFFECTIVE DATE AND DURABILITY.

By this document, I intend to create a durable power of attorney effective upon, and only during any period of incapacity in which, in the opinion of my Agent and attending physician, I am unable to make or communicate a choice regarding a particular health care decision.

3. AGENT'S POWERS.

I grant my Agent full authority to make decisions for me regarding my health care. In exercising this authority, my Agent shall follow my desires as stated in this document or otherwise known to my Agent. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based on what my Agent believes to be in my best interests. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, unless specifically limited by Section 4, below, my Agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnosis procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutrition support and hydration, and cardiopulmonary resuscitation.
B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others.
C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living, or similar facility or service.
D. To contract on my behalf for any healthcare-related service or facility on my behalf, without my Agent incurring personal financial liability for such contracts.
E. To hire and fire medical, social service, and other support personnel responsible for my care.
F. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death.
G. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law.
H. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my Agent, or to seek actual or punitive damages for the failure to comply.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.

A. The powers granted above do NOT include the following powers or are subject to the following rules or limitations:

_____
_____

B. With respect to any life-sustaining treatment, I direct the following: (**Initial One) If Other is chosen, instructions must be provided.**

_____ Even if my death is imminent or I am permanently unconscious, I choose to prolong my life.

_____ If my death is imminent or I am permanently unconscious, I choose NOT to prolong my life. If life-sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

_____ Other. I choose neither of the above options and here are my instructions should I become terminally ill, and my death is imminent, or I am permanently unconscious:

_____

_____

C. With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that **(Initial One)**

_____ Even if my death is imminent or I am permanently unconscious; I want artificial nutrition and hydration.

_____ If my death is imminent or I am permanently unconscious, I do not want artificial nutrition and hydration. If it has been started, stop it.

D. With respect to chest compressions **(Initial One)**

_____ I would like to have chest compressions.

_____ I do NOT want to have chest compressions.

E. With respect to a breathing tube and a breathing machine (ventilator) **(Initial Only One)**

_____ I want a breathing tube and breathing machine (ventilator)

_____ I do NOT want a breathing tube or breathing machine (ventilator)

5. SUCCESSORS.

If any Agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable, or (if any Agent is my spouse) be legally separated or divorced from me, I name the following (each to act alone and successively, in the order named) as successors to my Agent.

A. First Alternate Agent: _____

Address: _____

Telephone: _____

B. Second Alternate Agent: _____

Address: _____

Telephone: _____

6. PROTECTION OF THIRD PARTIES WHO RELY ON MY AGENT.

No person who relies in good faith upon my representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs, or assigns, for recognizing the Agent's authority.

7. NOMINATION OF GUARDIAN.

If a guardian of my person should for any reason be appointed, I nominate my Agent (or his or her successor), named above.

8. ADMINISTRATIVE PROVISIONS.

A. I revoke any prior power of attorney for health care.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

C. My Agent shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.

D. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

9. SIGNATURE AND ACKNOWLEDGEMENT.

BY SIGNING HERE, I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. **I UNDERSTAND THAT THIS DOCUMENT ALONE DOES NOT SERVE AS A DO-NOT-RESUSCITATE ORDER.**

I sign my name to this Durable Power of Attorney and Living Will for Healthcare on this ___ day of _____, 20___.
My current home address is: _____

Principal/Inmate/Patient Printed Name: _____
Principal/Inmate/Patient Signature: _____
Staff Witness: _____

STATE OF SOUTH DAKOTA, COUNTY OF _____

On this ___ day of _____, 20___ before me, the undersigned Notary Public, _____personally appeared _____, proved to me through satisfactory evidence of identification, which was validated to be the person whose name is signed on the preceding or attached document in my presence.

Witness my hand and Notarial seal.
Signature _____
Printed _____
My commission expires _____
(SEAL)

DEPARTAMENTO CORRECCIONAL DE DAKOTA DEL SUR – SERVICIOS CLÍNICOS PODER NOTARIAL MÉDICO DURADERO Y TESTAMENTO VITAL PARA ATENCIÓN MÉDICA

1. DESIGNACIÓN DEL AGENTE DE ATENCIÓN MÉDICA.

Yo, _____, por la presente nombro:
(Director/Recluso/Nombre del Paciente)
(Nombre del agente) _____
(DIRECCIÓN) _____
Teléfono de casa: _____ Teléfono de trabajo: _____
como mi Agente para tomar decisiones de salud y cuidado personal por mí según lo autorizado en este documento.

2. FECHA DE VIGENCIA Y DURABILIDAD.

Mediante este documento, tengo la intención de crear un poder duradero efectivo a partir de, y sólo durante, cualquier período de incapacidad en el cual, en opinión de mi Agente y médico tratante, no pueda tomar o comunicar una elección con respecto a una atención médica en particular. decisión.

3. PODERES DEL AGENTE.

Le otorgo a mi Agente plena autoridad para tomar decisiones por mí con respecto a mi atención médica. Al ejercer esta autoridad, mi Agente deberá seguir mis deseos tal como se establecen en este documento o de otro modo conocidos por mi Agente. Al tomar cualquier decisión, mi Agente intentará discutir la decisión propuesta conmigo para determinar mis deseos si puedo comunicarme de alguna manera. Si mi Agente no puede determinar la elección que yo quisiera que se hiciera, entonces mi Agente tomará una decisión por mí basándose en lo que mi Agente crea que es lo mejor para mis intereses. La autoridad de mi Agente para interpretar mis deseos pretende ser lo más amplia posible, excepto por las limitaciones que pueda indicar a continuación. En consecuencia, a menos que esté específicamente limitado por la Sección 4 a continuación, mi Agente está autorizado a lo siguiente:

A. Dar consentimiento, rechazar o retirar el consentimiento a cualquiera y todo tipo de atención médica, tratamiento, procedimientos quirúrgicos, procedimientos de diagnóstico, medicamentos y el uso de procedimientos mecánicos u otros que afecten cualquier función corporal, incluidos (pero no limitados a) respiración artificial, soporte nutricional e hidratación y reanimación cardiopulmonar.
B. Tener acceso a registros médicos e información en la misma medida a la que tengo derecho, incluido el derecho a revelar el contenido a otros.
C. Autorizar mi admisión o alta (incluso en contra del consejo médico) de cualquier hospital, hogar de ancianos, atención residencial, vida asistida o instalación o servicio similar.
D. Contratar en mi nombre cualquier servicio o instalación relacionada con la atención médica en mi nombre, sin que mi Agente incurra en responsabilidad financiera personal por dichos contratos.
E. Contratar y despedir al personal médico, de servicios sociales y de otro tipo de apoyo responsable de mi atención.
F. Autorizar o negarse a autorizar cualquier medicamento o procedimiento destinado a aliviar el dolor, aunque dicho uso pueda provocar daño físico, adicción o acelerar el momento de mi muerte (pero no causarla intencionalmente).
G. Hacer obsequios anatómicos de parte o la totalidad de mi cuerpo con fines médicos, autorizar una autopsia y dirigir la disposición de mis restos, en la medida que lo permita la ley.
H. Tomar cualquier otra acción necesaria para hacer lo que autorizo aquí, incluido (pero no limitado a) otorgar cualquier exención o exención de responsabilidad requerida por cualquier hospital, médico u otro proveedor de atención médica; firmar cualquier documento relacionado con el rechazo de tratamiento o el abandono de un centro en contra del consejo médico, y emprender cualquier acción legal en mi nombre y a expensas de mi patrimonio para forzar el cumplimiento de mis deseos según lo determine mi Agente, o para buscar acciones reales. o daños punitivos por el incumplimiento.

4. DECLARACIÓN DE DESEOS, DISPOSICIONES ESPECIALES Y LIMITACIONES.

A. Los poderes otorgados anteriormente NO incluyen los siguientes poderes ni están sujetos a las siguientes reglas o limitaciones:

_____

_____

B. Con respecto a cualquier tratamiento de soporte vital, ordeno lo siguiente: (Inicial uno) Si se elige Otro, se deben proporcionar instrucciones.

_____ Incluso si mi muerte es inminente o estoy permanentemente inconsciente, elijo prolongar mi vida.

_____ Si mi muerte es inminente o estoy permanentemente inconsciente, elijo NO prolongar mi vida. Si se ha iniciado un tratamiento de soporte vital, suspenderlo, pero mantenerme cómodo y controlar mi dolor.

_____ Otro. No elijo ninguna de las opciones anteriores y aquí están mis instrucciones en caso de que tenga una enfermedad terminal y mi muerte sea inminente o quede permanentemente inconsciente:

C. Con respecto a la Nutrición e Hidratación proporcionada mediante sonda nasogástrica o sonda hasta el estómago, intestinos o venas, deseo dejar claro que (Inicial)

_____ Incluso si mi muerte es inminente o estoy permanentemente inconsciente; Quiero nutrición e hidratación artificiales.

_____ Si mi muerte es inminente o estoy permanentemente inconsciente, no quiero nutrición e hidratación artificiales. Si se ha iniciado, deténgalo.

D. Con respecto a las compresiones torácicas (inicial)

_____ Me gustaría que me hicieran compresiones torácicas

_____ NO quiero que me hagan compresiones torácicas

E. Con respecto a un tubo de respiración y un respirador (ventilador) (inicialmente solo uno)

_____ Quiero un tubo de respiración y un respirador (ventilador)

_____ NO quiero un tubo de respiración ni un respirador (ventilador)

5. SUCESORES.

Si algún Agente nombrado por mí muere, queda legalmente discapacitado, renuncia, se niega a actuar, no está disponible o (si algún Agente es mi cónyuge) está legalmente separado o divorciado de mí, nombro a los siguientes (cada uno para actuar solo y sucesivamente , en el orden indicado) como sucesores de mi Agente.

A. Primer Agente Alterno: _____
DIRECCIÓN: _____
Teléfono: _____

B. Segundo Agente Alterno: _____
DIRECCIÓN: _____
Teléfono: _____

6. PROTECCIÓN DE TERCEROS QUE CONFÍAN EN MI AGENTE.

Ninguna persona que confíe de buena fe en mis representaciones por parte de mi Agente o Agente Sucesor será responsable ante mí, mi patrimonio, mis herederos o cesionarios por reconocer la autoridad del Agente.

7. NOMBRAMIENTO DE TUTOR.

Si por algún motivo se nombrara un tutor de mi persona, nombro a mi Agente (o su sucesor), nombrado anteriormente.

8. DISPOSICIONES ADMINISTRATIVAS.

A. Revoco cualquier poder notarial anterior para atención médica.

B. Se pretende que este poder sea válido en cualquier jurisdicción en la que se presente.

C. Mi Agente no tendrá derecho a compensación por los servicios prestados bajo este poder, pero tendrá derecho a un reembolso por todos los gastos razonables incurridos como resultado de la ejecución de cualquier disposición de este poder.
D. Los poderes delegados bajo este poder son separables, de modo que la nulidad de uno o más poderes no afectará a los demás.

9. FIRMA Y RECONOCIMIENTO.
AL FIRMAR AQUÍ, INDICO QUE ENTIENDO EL CONTENIDO DE ESTE DOCUMENTO Y EL EFECTO DE ESTA CONCESIÓN DE PODERES A MI AGENTE. ENTIENDO QUE ESTE DOCUMENTO POR SÍ ÚNICO NO SIRVE COMO UNA ORDEN DE NO RESUCITACIÓN.

Firmo con mi nombre este poder notarial duradero y testamento vital para atención médica en este ___ día de _____ de 20___.
Mi domicilio actual es: _____

Nombre impreso del director/recluso/paciente: _____
Firma del director/recluso/paciente: _____
Testigo del personal: _____

(Firma notarial y sello a continuación)
STATE OF SOUTH DAKOTA, COUNTY OF _____

On this ___ day of _____, 20___ before me, the undersigned Notary Public,
_____personally appeared _____, proved to me through satisfactory evidence of identification, which was validated to be the person whose name is signed on the preceding or attached document in my presence.

Witness my hand and Notarial seal
Signature _____
Printed _____
My commission expires _____
(SEAL)

EMS CARDIOPULMONARY RESUSCITATION DIRECTIVE

South Dakota EMS

PATIENT INFORMATION (Type or Print)

Patient Name: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

D.O.B: _____ Gender: M-☐ F-☐ Eye Color: _____ Hair Color: _____

Race/Ethnic Background: _____

Hospice Program Name (if applicable): _____

Attending Physician, Physician Assistant, or Nurse Practitioner Name, Address & Phone Number: **MUST BE COMPLETED.** _____

_____

_____

CERTIFICATION OF COMFORT ONE STATUS/EMS-CPR ADVANCE DIRECTIVE

This form constitutes reliable documentation that the above identified patient is certified as a **COMFORT ONE** patient and as such directs EMS personnel, health care providers and health care facilities to not resuscitate the patient in accordance with the South Dakota EMS Cardiopulmonary Resuscitation Directive Statute.

DO NOT RESUSCITATE

Patient Signature: _____ Date: _____

My signature below constitutes and confirms standing orders to emergency medical services personnel, health care providers and health care facilities to follow the **COMFORT ONE** / South Dakota EMS Cardiopulmonary Resuscitation Directive protocols. I affirm that this order is written in accordance with accepted medical and ethical guidelines.

Physician, Physician Assistant, or Nurse Practitioner Signature: _____ Date: _____

INFORMATION TO PATIENT

This form certifies you as a **COMFORT ONE** patient under South Dakota law. If this form or a **COMFORT ONE** bracelet is presented to pre-hospital emergency response personnel, they are required to provide the care described on the reverse side. Emergency medical care will be directed at preventing avoidable suffering and providing supportive comfort measures. It is understood that as a **COMFORT ONE** patient you will be allowed to die in the natural course of your illness or disease.

REVOCATION

The **COMFORT ONE** status of the patient may be revoked, at any time by the patient or the person authorized to make medical decisions for the patient. Written notice of the revocation shall be provided in writing as soon as practical to the Department, the attending physician and to those who have actual notice of the CPR directive.

If this form or a bracelet is not immediately available the patient will be resuscitated!

Patient Copy -- White Physician Copy – Yellow EMS Copy – Pink – **MUST BE ABLE TO READ**

INFORMATION FOR EMERGENCY MEDICAL SERVICES PERSONNEL

If you are presented with the **Comfort One** form or encounter a patient wearing a **Comfort One** bracelet, South Dakota law requires that you follow the **Comfort One**/South Dakota EMS Cardiopulmonary Resuscitation Directive protocols.

For a **Comfort One** patient, emergency medical services personnel:

WILL:

- Assist in maintenance of an open airway, **excluding** advanced airway procedures such as the insertion of PtL, combitubes or endotracheal intubation;
- Provide suction;
- Provide oxygen;
- Provide pain medications as directed by patient's physician, physician assistant, or nurse practitioner;
- Control bleeding;
- Provide comfort care; and
- Be supportive to patient and family.

If someone else has already begun resuscitating a **Comfort One** patient prior to your arrival you:

WILL WITHHOLD OR WITHDRAW:

- Chest Compressions;
- Defibrillation;
- Advanced airway procedures;
- Assisted breathing; or
- Administration of resuscitation medications.

Please mail 3rd copy of Completed form to:

ORH/EMS
600 East Capitol Avenue
Pierre, SD 57501

Phone: 773-4031
Website: ems.sd.gov

HIPAA PERMITS DISCLOSURE OF SOUTH DAKOTA MOST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

MEDICAL ORDERS FOR SCOPE OF TREATMENT

SOUTH DAKOTA MOST

LAST NAME _____
FIRST NAME _____
MIDDLE INITIAL _____
DATE OF BIRTH _____ (mm/dd/yyyy)

FIRST follow these orders, **THEN** contact medical provider. This is a Medical Order Sheet based on the patient's current medical condition and wishes. Any section that does not include an indication of the patient's or authorized representative's preference, is a directive to health care providers to use all necessary and appropriate medical interventions. The South Dakota MOST complements an advance health care directive and is not intended to replace that document.

Does patient have an advance health care directive? Yes ☐ No ☐

PATIENT'S DIAGNOSIS OF TERMINAL CONDITION:

_____
_____
_____

GOALS OF CARE:

_____
_____
_____

Check One

A. CARDIOPULMONARY RESUCITATION (CPR): PATIENT HAS NO PULSE AND IS NOT BREATHING

☐ CPR/Attempt Resuscitation (requires full intervention in section B)
☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)
When not in cardiopulmonary arrest, follow orders in B and C

Check One

B. MEDICAL INTERVENTIONS: PATIENT HAS PULSE AND IS BREATHING, OR HAS PULSE AND IS NOT BREATHING.

☐ Full Intervention: Treatment Goal: Full intervention including life support measures in the intensive care unit. In addition to treatment described in Comfort Measures and Selective Treatment below, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

☐ Selective Treatment: Treatment Goal: Stabilization of medical condition. In addition to treatment described in Comfort Measures below, use medical treatment, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Comfort Measures Only (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

ADDITIONAL ORDERS: (e.g. dialysis, etc.)

_____
_____
_____
_____

Check One in Each Column

C. ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION:

ALWAYS OFFER FOOD AND FLUIDS BY MOUTH AS TOLERATED.

Based on the Provider's medical judgment:

	YES	NO
1. Will artificially administered nutrition and hydration be unable to prolong life?	☐	☐
2. Will artificially administered nutrition and hydration be more burdensome than beneficial?	☐	☐
3. Will artificially administered nutrition and hydration cause significant physical discomfort?	☐	☐
4. Has patient previously expressed a desire to forgo artificially administered nutrition and hydration by tube?	☐	☐

In order for artificially administered nutrition and hydration to be withheld, there must be a "YES" answer to one or more of questions 1-4 above.

Check One

D. INFORMED CONSENT DISCUSSION:

_____ had an informed consent discussion with patient or authorized representative.
Name of Medical Provider (MD, DO, NP or PA)

DISCUSSED WITH: ☐ Patient ☐ Authorized Representative _____
(Name of Representative)

Check All That Apply

The basis for these orders is:

☐ Patient's declaration (can be verbal or nonverbal).
☐ Patient's Authorized Representative (patient without capacity).
☐ Patient's Advance Directive (if indicated, patient has completed an additional document that provides guidance for treatment measures if he /she loses medical decision-making capacity).
☐ Resuscitation would be medically non-beneficial.

This form is voluntary and the signatures below indicate that the medical orders are consistent with the patient's medical condition and treatment plan and are the known desires or in the best interests of the patient who is the subject of the document.

PRINT MEDICAL PROVIDER NAME	MEDICAL PROVIDER SIGNATURE (MANDATORY)	MEDICAL PROVIDER PHONE	DATE (MANDATORY)

PRINT PATIENT OR REPRESENTATIVE NAME	PATIENT OR REPRESENTATIVE SIGNATURE (MANDATORY)	DATE (MANDATORY)

REPRESENTATIVE RELATIONSHIP	REPRESENTATIVE ADDRESS	REPRESENTATIVE PHONE NUMBER

ENSURE PATIENT HAS THE CURRENT FORM.
PHOTOCOPIES AND FAXES OF SIGNED AND DATED SD MOST FORMS ARE LEGAL AND VALID.

INFORMATION FOR HEALTH CARE PROVIDERS

Last Name: _____ First Name: _____ DOB: ___/___/_____

COMPLETING SOUTH DAKOTA MOST

a. Must be completed by a physician, nurse practitioner or physician assistant based on patient's preferences and/or best interests, and medical indications.
b. **South Dakota MOST** must be signed and dated by a MD, DO, NP or PA to be valid.
c. **South Dakota MOST** must be signed by the patient or the patient's authorized representative.
d. Use of original form is strongly encouraged. Photocopies and faxes of signed and dated **South Dakota MOST** are legal and valid.

USING SOUTH DAKOTA MOST (Additional information available at: www.sdaho.org/MOST)

1. Any section that does not include an indication of the patient's or authorized representative's preference, is a directive to health care providers to use all necessary and appropriate medical interventions.

2. Artificial nutrition and hydration is optional when it cannot reasonably be expected to prolong life, would be more burdensome than beneficial, would cause significant physical discomfort, or patient had previously expressed a personal desire to forgo artificial nutrition by tube.

3. The determination of burden refers to the provision of artificial nutrition or hydration itself and not the quality of continued life of the patient.

4. A patient with capacity may revoke the **South Dakota MOST** at any time and request alternate treatment. Additionally, an authorized representative may revoke the MOST only if the MOST was executed by the authorized representative.

5. If there is a conflict between the patient's MOST document and the patient's written directives in any previously executed and unrevoked durable power of attorney or living will, the health care provider will treat the patient in accordance with the instructions in the MOST.

The duty of medicine is to care for patients even when they cannot be cured. Physicians, nurse practitioners and physician assistants, and their patients must evaluate the use of technology at their disposal based on available information. Judgments about the use of technology to maintain life must reflect the inherent dignity of the patient and the purpose of medical care. Everyone is to be treated with dignity and respect.

REVIEWING SOUTH DAKOTA MOST

It is recommended that this **South Dakota MOST** be reviewed periodically, such as when the patient is transferred from one care setting or care level to another, or there is a substantial change in the patient's health status. A patient may revoke a MOST at any time by:

a. Destroying or defacing the MOST with the intent to revoke;
b. A written revocation of the MOST, signed and dated by the patient; or
c. An oral expression of the intent to revoke the MOST, in the presence of a witness 18 years of age or older who signs and dates in writing, confirming that such expression of intent was made.

NOTE: An authorized representative may not revoke a MOST unless the MOST was executed by the authorized representative. Any such revocation by the authorized representative must be in writing.

A revocation is effective upon communication to the health care provider. A health care provider who is informed of a revocation shall record the date and time of the notification of revocation in the patient's medical record.

A new **South Dakota MOST** form should be completed if the patient wishes to make any substantive change to treatment goal(s) (e.g. reversal of prior directive). When completing a new form, the old form must be properly voided and retained in the medical record. To void the **South Dakota MOST** form, draw line through sections A through D and write "VOID" in large letters. This must be signed and dated.

REVIEW OF THIS SOUTH DAKOTA MOST FORM

REVIEW DATE AND TIME	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed
			☐ No Change ☐ Form Voided and New Form Completed

ENSURE PATIENT HAS THE CURRENT FORM.
PHOTOCOPIES AND FAXES OF SIGNED AND DATED SD MOST FORMS ARE LEGAL AND VALID.

PEDIDOS MÉDICOS PARA EL ALCANCE DEL TRATAMIENTO - SOUTH DAKOTA MOST

HIPAA PERMITE LA DIVULGACIÓN DE SOUTH DAKOTA MOST A OTROS PROVEEDORES DE ATENCIÓN MÉDICA SEGÚN SEA NECESARIO

PEDIDOS MÉDICOS PARA EL ALCANCE DEL TRATAMIENTO - SOUTH DAKOTA MOST

SOUTH DAKOTA MOST

PRIMERO seguir estas órdenes, **LUEGO** comunicarse con el proveedor médico. Esta es una Hoja de pedido médico basada en la condición médica actual y los deseos del paciente. Toda sección que no incluya una indicación de la preferencia del paciente o del representante autorizado, es una directiva para que los proveedores de atención médica utilicen todas las intervenciones médicas necesarias y apropiadas. South Dakota MOST actúa como complemento de una directiva anticipada de atención médica y no tiene la intención de reemplazar tal documento.

¿Tiene el paciente una directiva anticipada de atención médica? Sí ❒ No ❒

DIAGNÓSTICO DEL PACIENTE DE CONDICIÓN TERMINAL: _____

OBJETIVOS DEL CUIDADO: _____

Marcar una	**A. RESUCITACIÓN CARDIOPULMONAR (RCP):** EL PACIENTE NO TIENE PULSO Y NO RESPIRA. ❒ RCP/intento de reanimación (requiere intervención completa en la sección B) ❒ DNR/no aplicar técnicas de reanimación (permitir la muerte natural) Cuando no esté en paro cardiopulmonar, seguir las órdenes en B y C
Marcar una	**B. INTERVENCIONES MÉDICAS:** EL PACIENTE TIENE PULSO Y RESPIRA, O TIENE PULSO Y NO RESPIRA. ❒ Intervención completa: Objetivo del tratamiento: Intervención completa que incluye medidas de soporte vital en la unidad de cuidados intensivos. Además del tratamiento descrito en las Medidas de bienestar y el Tratamiento selectivo a continuación, usar intubación, intervenciones avanzadas en las vías respiratorias y ventilación mecánica como se indica. Trasladar al hospital o a la unidad de cuidados intensivos, si está indicado, para satisfacer las necesidades médicas. ❒ Tratamiento selectivo: Objetivo del tratamiento: Estabilización de la afección médica. Además del tratamiento descrito en las Medidas de bienestar a continuación, usar tratamiento médico, líquidos por vía intravenosa (hidratación) y monitoreo cardíaco como se indica para estabilizar la condición médica. Se pueden usar técnicas básicas de tratamiento de las vías respiratorias y presión positiva no invasiva de las vías respiratorias. No intubar. Trasladar al hospital si está indicado para gestionar las necesidades médicas o el alivio de molestias. Evitar los cuidados intensivos si es posible. ❒ Solo medidas de bienestar (permitir la muerte natural): Objetivo del tratamiento: Maximizar el bienestar mediante el manejo de los síntomas. Aliviar el dolor y el sufrimiento mediante el uso de cualquier medicamento por cualquier vía, posicionamiento, cuidado de heridas y otras medidas. Usar oxígeno, succión y tratamiento manual de la obstrucción de las vías respiratorias, según sea necesario, para lograr el bienestar. El paciente prefiere no ser trasladado al hospital para recibir tratamientos de soporte vital. Transferir al hospital solo si no se pueden satisfacer las necesidades de bienestar en la institución actual. **PEDIDOS ADICIONALES:** (p. ej., diálisis, etc.) _____
Marcar uno de cada columna	**C. NUTRICIÓN E HIDRATACIÓN ADMINISTRADAS ARTIFICIALMENTE:** SIEMPRE OFRECER ALIMENTOS Y LÍQUIDOS POR BOCA, SI ES TOLERADO. Según el criterio médico del proveedor: **SÍ** **NO** 1. ¿La nutrición y la hidratación administradas artificialmente no podrán prolongar la vida? ❒ ❒ 2. ¿La nutrición y la hidratación administradas artificialmente resultarán ser una complicación más que un beneficio? ❒ ❒ 3. ¿La nutrición y la hidratación administradas artificialmente causarán molestias físicas considerables? ❒ ❒ 4. ¿El paciente expresó previamente el deseo de renunciar a la nutrición e hidratación administradas artificialmente por sonda? ❒ ❒ Para que se retenga la nutrición e hidratación administradas artificialmente, debe haber una respuesta afirmativa a una o más de las preguntas 1 a 4 anteriores.
Marcar una	**D. EXPLICACIÓN DEL CONSENTIMIENTO INFORMADO:** _____ analizó el consentimiento informado con el paciente o un representante autorizado. Nombre del proveedor médico (MD, DO, NP o PA) **ANALIZADO CON:** ❒ Paciente ❒ Representante autorizado _____ (Nombre del representante)
Marcar todas las que correspondan	**El fundamento de estos pedidos es:** ❒ Declaración del paciente (puede ser verbal o no verbal). ❒ Representante autorizado del paciente (paciente sin capacidad). ❒ Directiva anticipada del paciente (si está indicado, el paciente ha completado un documento adicional que proporciona orientación para las medidas de tratamiento si pierde la capacidad de tomar decisiones médicas). ❒ La reanimación no sería médicamente beneficiosa. Este formulario es voluntario y las firmas a continuación indican que las órdenes médicas son coherentes con la afección médica y el plan de tratamiento del paciente y son los deseos conocidos del paciente o son en su propio beneficio, que es el sujeto del documento.

_____ a. m./p. m. _____ | _____ | _____ | _____

Hora | **Fecha (OBLIGATORIO)** | **NOMBRE DEL PROVEEDOR MÉDICO EN LETRA DE MOLDE** | **FIRMA DEL PROVEEDOR MÉDICO (OBLIGATORIO)** | **FECHA (OBLIGATORIO)**

_____ a. m./p. m. _____ | _____ | _____

Hora | **Fecha (OBLIGATORIO)** | **NOMBRE DEL PACIENTE O REPRESENTANTE EN LETRA DE MOLDE** | **FIRMA DEL PACIENTE O REPRESENTANTE (OBLIGATORIO)**

_____ | _____ | _____

RELACIÓN CON EL REPRESENTANTE | **DIRECCIÓN DEL REPRESENTANTE** | **NÚMERO DE TELÉFONO DEL REPRESENTANTE**

ASEGURARSE DE QUE EL PACIENTE TENGA EN SU PODER EL PRESENTE FORMULARIO.
LAS FOTOCOPIAS Y LOS FAXES DE LOS FORMULARIOS SD MOST FIRMADOS Y FECHADOS SON LEGALES Y VÁLIDOS.

Diciembre 2019

Formulario 0007-19 PS (4/20)

Página 1 de 2

PEDIDOS MÉDICOS PARA EL ALCANCE DEL TRATAMIENTO - SOUTH DAKOTA MOST

Apellido: _____ **Nombre:** _____ **FDN:** _____/_____/_____

CÓMO COMPLETAR SOUTH DAKOTA MOST

a. Debe ser completado por un médico, enfermero practicante o asistente médico basado en las preferencias del paciente o en su propio beneficio, y en las indicaciones médicas.
b. **South Dakota MOST** debe ser firmado y fechado por un MD, DO, NP o PA para que sea válido.
c. **South Dakota MOST** debe estar firmado por el paciente o representante autorizado del paciente.
d. Se recomienda firmemente el uso del formulario original. Las fotocopias y los faxes del formulario **South Dakota MOST** firmados y fechados son legales y válidos.

CÓMO USAR SOUTH DAKOTA MOST (información adicional disponible en: www.sdaho.org/MOST)

1. Toda sección que no incluya una indicación de la preferencia del paciente o del representante autorizado, es una directiva para que los proveedores de atención médica utilicen todas las intervenciones médicas necesarias y apropiadas.
2. La nutrición e hidratación artificial son opcionales cuando no se pueda esperar razonablemente que prolongue la vida, sea más una complicación que un beneficio, cause molestias físicas considerables o el paciente haya expresado previamente un deseo personal de abstenerse a la nutrición artificial por sonda.
3. La determinación de la complicación se refiere a la provisión de nutrición o hidratación artificial en sí misma y no a la calidad de la prolongación de la vida del paciente.
4. Un paciente con capacidad puede revocar el formulario **South Dakota MOST** en cualquier momento y solicitar un tratamiento alternativo. Además, un representante autorizado puede revocar el MOST solo si el representante autorizado ejecutó el MOST.
5. Si existe un conflicto entre el documento MOST del paciente y las directivas escritas del paciente en cualquier poder notarial o testamento vital duradero previamente ejecutado y no revocado, el proveedor de atención médica tratará al paciente de acuerdo con las instrucciones del MOST.

El deber de la medicina es cuidar a los pacientes incluso cuando no tengan cura. Los médicos, enfermeros practicantes y asistentes médicos, y sus pacientes deben evaluar el uso de la tecnología a su disposición en función de la información disponible. Los juicios sobre el uso de la tecnología para prolongar la vida deben reflejar la dignidad inherente del paciente y el propósito de la atención médica. Todos deben ser tratados con dignidad y respeto.

CÓMO REVISAR SOUTH DAKOTA MOST

Se recomienda que el presente formulario de **South Dakota MOST** se revise periódicamente, como cuando el paciente sea transferido de un entorno de atención o nivel de atención a otro, o si hubiera un cambio sustancial en el estado de salud del paciente. Un paciente puede revocar un formulario MOST en cualquier momento:

a. destruir o deshacerse del formulario MOST con la intención de revocarlo;
b. una revocación por escrito del formulario MOST, firmado y fechada por el paciente; o
c. una expresión oral de la intención de revocar el formulario MOST, en presencia de un testigo de 18 años de edad o mayor que firme y feche por escrito, confirmando que dicha declaración de voluntad se llevó a cabo.

NOTA: Un representante autorizado puede revocar el MOST solo si el representante autorizado ejecutó el MOST. Cualquier revocación por parte del representante autorizado debe hacerse por escrito.

Una revocación es efectiva tras la comunicación con el proveedor de atención médica. Un proveedor de atención médica que sea informado de una revocación deberá registrar la fecha y hora de la notificación de revocación en el registro médico del paciente.

Se debe completar un nuevo formulario **South Dakota MOST** si el paciente desea realizar algún cambio sustancial en el objetivo del tratamiento (p. ej., revocación de la directiva anterior). Al completar un nuevo formulario, el formulario anterior debe anularse y conservarse como corresponde en el expediente médico. Para anular el formulario **South Dakota MOST,** se debe trazar una línea en las secciones A a D y escribir "ANULAR" en letra grande. Esto debe estar firmado y fechado.

REVISIÓN DEL FORMULARIO SOUTH DAKOTA MOST

FECHA Y HORA DE REVISIÓN	REVISOR	LUGAR DE LA REVISIÓN	RESULTADO DE LA REVISIÓN
			❒ Sin cambio ❒ Formulario anulado y formulario nuevo completado
			❒ Sin cambio ❒ Formulario anulado y formulario nuevo completado
			❒ Sin cambio ❒ Formulario anulado y formulario nuevo completado

ASEGURARSE DE QUE EL PACIENTE TENGA EN SU PODER EL PRESENTE FORMULARIO.
LAS FOTOCOPIAS Y LOS FAXES DE LOS FORMULARIOS SD MOST FIRMADOS Y FECHADOS SON LEGALES Y VÁLIDOS.

Diciembre 2019