Plan for Life-Sustaining Treatment (PLST)

BAYCREST KEEPS THE ORIGINAL PLST FORM. THE CLIENT TAKES A COPY OF THE PLST FORM DURING TRAVEL TO DIFFERENT CARE SETTINGS.

FULL NAME OF BAYCREST CLIENT		
ADDRESS		PHONE # OF CLIENT
CITY/PROVINCE	POSTAL CODE	GENDER
DATE OF BIRTH (DD/MM/YYYY)		MEDICAL RECORD #

This Plan for Life-Sustaining Treatment (PLST) is a plan of treatment under the *Health Care Consent Act.* A plan of treatment is defined as a plan that:

(a) is developed by one or more health practitioners,
(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition.

The PLST is signed by a physician only when a capable client (or if incapable, the client's substitute decision-maker (SDM), the highest-ranked person under section 20 of the *Health Care Consent Act*) consents to a plan of treatment under the *Health Care Consent Act* regarding proposed life-sustaining treatment. Such treatment orders will adhere to standard medical practice. A physician signs the PLST form and all health care professionals should follow this medical order as the client moves from one location to another, unless the client and/or SDM withdraws consent to the plan of treatment documented in the PLST. The physician will work with the client and/or SDM to document the consent to the plan of treatment in the PLST. Some treatment options included in this document may be inconsistent with the teachings of your particular faith/religious tradition (e.g. Jewish law or Halakhah). If this is a concern, please feel free to contact your religious authority or spiritual advisor for guidance or speak to one of our chaplains.

☐ **For all clients of Baycrest:** The client or SDM understands that the client will not be refused admission nor will the client be discharged from Baycrest because consent with respect to the PLST has not been given or if this consent form is withdrawn or revoked in the future.

SECTION A Documentation

Does client have any kind of advance directive? (e.g., Power of Attorney for Personal Care, Living Will – this guides the decision-making in cases where the client is incapable and the SDM must make a decision about the proposed plan of treatment based on the Client's prior capable wishes).

☐ Yes ☐ No

Please describe:

SECTION B Client's or SDM's understanding of current health condition(s)

Does client or SDM understand the diagnosis and progressive trajectory of illness?
Check one:

☐ Yes ☐ No – must be addressed before completing PLST

Client's Advance Care Plans (e.g. maintain/improve function/quality of life, optimize comfort)
Please describe:

SECTION C1 In the event that the client's heart stops or the client stops breathing

Check one:

☐ **Attempt cardio-pulmonary resuscitation (full code)**
CPR involves forceful pressure on the chest to try to restart the heart. It usually involves electric shock (defibrillation) and artificial breathing achieved by placing a plastic tube down the throat into the windpipe (intubation) to assist breathing (ventilation). The client will be transferred to an acute care hospital and may be placed on a breathing machine.
If it is deemed that there has been an unwitnessed death and CPR would be futile, death will be pronounced.

☐ **Do not attempt resuscitation (allow natural death)**
This means do not begin CPR, as defined above, to make the heart or breathing start again if either stops. Comfort care will be administered.

SIGNATURE

☐Check if verbal consent
(Leave signature line blank)

DATE/TIME

Who made the decisions?
☐ Client ☐ SDM

SECTION C2	In the event of an acute medical illness (when the client has a pulse and is breathing)

Check one:

☐ **Transfer to hospital**
Client will be transferred to an acute care hospital in the event that medical intervention requires treatment beyond that which can be offered at Baycrest.

☐ **Provide care at Baycrest only (no transfer to acute care)**
Medical interventions offered at Baycrest include administration of medication by mouth, by subcutaneous infusion, or by intravenous; vital sign and other monitoring including blood work. Treatment offered will be based on consent provided for the plan of treatment and as documented in the PLST. If life-sustaining treatment is started, but turns out not to be helpful, consent to the treatment can be withdrawn and the treatment stopped, consistent with the consent of the client (or if incapable, the SDM). In this case comfort measures will be provided.

Instructions for intubation and mechanical ventilation:
Check ALL that apply:

☐ **Intubation and mechanical ventilation:** Place a tube down the client's throat and connect to a breathing machine.

☐ **Do not intubate (DNI):** Do not place a tube down the client's throat or connect to a breathing machine that pumps air into and out of lungs. Treatments are available for symptoms of shortness of breath, such as non-invasive ventilation, oxygen and opioids. (This box should not be checked if full CPR is checked in Section B above).

☐ **Noninvasive ventilation (e.g. BIPAP)**

Fluids and nutrition

When a client can no longer eat or drink, and the condition is not expected to improve, liquid food and fluids can be given by a tube inserted in the stomach. If a client chooses not to have a feeding tube, food and fluids are offered as tolerated (comfort feeding).

Nutrition
Check one:

☐ Feeding tube ☐ No feeding tube (comfort feeding)

Transfusions:
Check one:

☐ Administer blood transfusion.
☐ Do not administer blood transfusion. Provide comfort care to relieve symptoms.

Antibiotics:
Check one:

☐ Trial of antibiotics when infection occurs.
☐ Do not use antibiotics. Provide comfort measures to relieve symptoms.

SIGNATURE

☐ Check if verbal consent
(Leave signature line blank)

DATE/TIME

PRINT NAME OF DECISION-MAKER

Who made the decisions?
☐ Client ☐ SDM

Other Instructions about starting or stopping treatments discussed with the doctor or about other treatments not listed above (dialysis, transfusions, antibiotics etc.), based on the client's current health condition and other health conditions that the client is likely to develop given his/her current health condition:

PHYSICIAN SIGNATURE

PRINT PHYSICIAN NAME

DATE / TIME

PHYSICIAN LICENSE NUMBER

PHYSICIAN PHONE / PAGER NUMBER