HGFOUNDATION

Caring. Giving. Together.

Understanding The POLST Form

Physician Orders for Life-Sustaining Treatment

Today's Speaker

Maureen McEachen, LCSW,
Central Coast VNA + Hospice

Tips for using the zoom Q&A feature

- In your controls at the bottom of the window, click Q&A. If you are on a mobile device, tap Participants, then Q&A,
- The Q&A window will open on the right side or at the bottom of your screen.
- You can ask me questions and answer my questions in the Q&A window.
- Type your message into the Q&A window and press ‘enter’ to send me your message.

Define what you want in an emergency

- The POLST: Physician Orders for Life-Sustaining Treatment.
- The current standard of care is to do everything possible to attempt to save a life.
- POLST provides the option to state what level of treatment you want.

A POLST form is a portable medical order

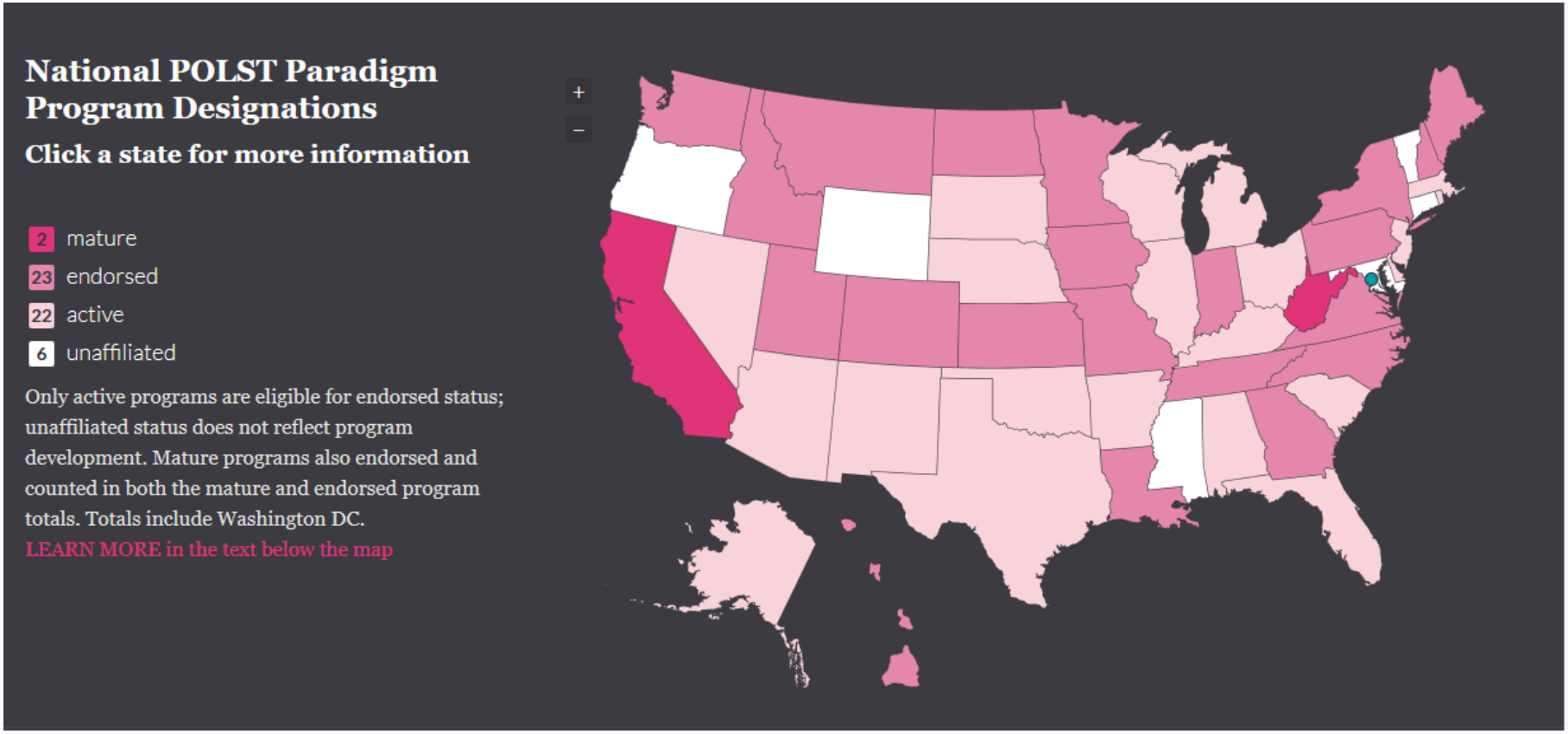
- A POLST form gives medical orders to emergency personnel.
- POLST forms are completed with your doctor after discussing your medical conditions.
- A doctor, physician assistant, or nurse practitioner must sign the POLST form for it to be valid.
- POLST forms vary by state.

The POLST form goes with you, the patient, wherever you are

- In the event of an emergency, first responders will look for your POLST when they arrive.
- That is why we encourage you to have it in an obvious, visible place.
- The POLST allows emergency medical personnel to make the care decisions you want.

POLST Website

https://polst.org/programs-in-your-state/



California POLST Website

https://capolst.org/

POLST
CALIFORNIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

POLST Form

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B (Effective 4/1/2017)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B Check One — **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

- ☐ **Full Treatment – primary goal of prolonging life by all medically effective means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - ☐ *Trial Period of Full Treatment.*
- ☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ☐ *Request transfer to hospital only if comfort needs cannot be met in current location.*
- ☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.** Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

Additional Orders: _____

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

- ☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
- ☐ Trial period of artificial nutrition, including feeding tubes. _____
- ☐ No artificial means of nutrition, including feeding tubes. _____

D — **INFORMATION AND SIGNATURES:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

- ☐ Advance Directive dated _____, available and reviewed →
- ☐ Advance Directive not available
- ☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Forms versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	Preparer Name (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended 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, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

What is CPR?

CPR (Cardio-Pulmonary Resuscitation) is an attempt to restart a person's heart when the heart has stopped beating or cannot pump blood.

POLST Section A

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing.***
If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

What is a ventilator?

A ventilator (also called a breathing machine) does the work for the lungs when someone is unable to breathe on their own.

What is palliative care and hospice?

- Both palliative care and hospice care provide comfort.
- But palliative care can begin at diagnosis, and at the same time as treatment.
- Hospice care begins after treatment of the disease is stopped and when it is clear the person is not going to survive the illness.

POLST Section B

B

Check One

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**

In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**

In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**

Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

_____

What is tube feeding or artificial nutrition?

Tube feeding (also called artificial nutrition) is a medical treatment that provides liquid food (nutrition) to the body.

POLST Section C

C — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

- ☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
- ☐ Trial period of artificial nutrition, including feeding tubes. _____
- ☐ No artificial means of nutrition, including feeding tubes. _____

POLST Section D

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

POLST HIPAA Section

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Who should get a copy of my POLST form?

- Doctors
- Hospitals
- Healthcare Decision Maker
- Family
- Friends

Make sure your POLST form is visible

- In the event of an emergency, first responders such as the firefighters, police, or EMTs, will look for your POLST when they arrive.
- That is why we encourage you to have it in an obvious, visible place like your refrigerator or on the back of your entry door.

Questions & Answers

hospicegiving.org/resources

Thank you for attending this webinar!

Final Reminders…

- Talk with your doctor about your health care wishes.
- Join a future workshop and visit our website for information and resources.
- Contact HG Foundation if you need assistance.

Hospice Giving Foundation is here to help

- Visit our website for guides, documents, and information:
  - hospicegiving.org/resources
- Contact Hospice Giving Foundation for direct assistance:
  - Philip Geiger, Director of Outreach
    pgeiger@hospicegiving.org
  - Call 831.333.9023