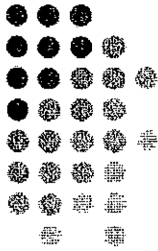
INLAND EMPIRE PALLIATIVE CARE COALITION

Physician Order for Life Sustaining Treatment: Frequently Asked Questions



Special points of interest:

- What is the value of the POLST Program?
- What are the goals of POLST?
- For what patients is POLST relevant?

What is Physician Orders for Life-Sustaining Treatment (POLST)?

The Physician Orders for Life-Sustaining Treatment (POLST) is a program designed to improve the quality of care people receive at the end of life by translating patient/resident goals and preferences into medical orders. POLST is based on communication between the patient/resident, Health Care Agent or other designated decision-maker and health care professionals that ensures informed medical decision-making.

What is the "POLST" Form?

The POLST form is a bright pink medical order form signed by a California State Licensed physician that indicates what types of life-sustaining treatment the patient does or does not want if they become seriously ill. Additionally, a health care professional must sign this form in order for it to be followed by other health care professionals. Other health professionals who work with the patients health care professional may complete the form.

The form includes medical orders and patient preferences regarding:

- CPR (cardiopulmonary resuscitation)
- Intubation and mechanical ventilation
- Artificial hydration and nutrition
- Future hospitalization and transfer
- Antibiotics

For which persons should POLST forms be used?

Use of the POLST form is most appropriate for seriously ill persons with life-limiting, also called terminal, illnesses. To determine whether a POLST form should be encouraged, clinicians should ask themselves, "Would I be surprised if this person died in the next year?" If the answer is "No, I would not be surprised", then a POLST form is appropriate. Remember that a POLST form is designed to express the individual's preferences for levels of treatment and can indicate either full treatment including resuscitation attempts or can be used to limit those interventions that are not desired by the individual. Unless it is the patient's preference, use of the POLST form to limit treatment is not appropriate for persons with stable medical or functionally disabling problems who have many years of life expectancy. In the absence of a POLST form or other state-specific do-not-resuscitate orders, patients will receive advanced cardiac life support, including CPR, endotracheal intubation, and defibrillation, by emergency medical personnel based on standard protocols.

For which persons should POLST forms be used?

POLST aims to improve the communication of personal wishes about life-sustaining treatments resulting in higher quality medical care. The POLST Program was designed to:

- Document a person's treatment preferences regarding:
    - Cardiopulmonary resuscitation (CPR)
    - Intubation and mechanical ventilation
    - Other life-sustaining treatments
- Coordinate physician orders with the individual's wishes.
- Communicate an individual's wishes regarding care across health care settings.
- Improve Emergency Medical Services (EMS) personnel's ability to treat according to the individual's wishes.
- Reduce repetitive documentation while complying with the federal Patient Self-Determination Act.

Does law require POLST?

The POLST form is voluntary.

Does the "POLST" form replace traditional Advance Directives?

No. Although the POLST form summarizes Advance Directives, it is not intended to replace traditional Advance Directives like the Health Care Proxy and Living Will.

What is the difference between a Health Care Proxy or Living Will and the POLST form?

A Health Care Proxy and a Living Will are traditional Advance Directives for all adults 18 years of age and older. These documents are completed ahead of time and only apply when decision making capacity is lost. To complement the use of traditional Advance Directives and facilitate the communication of medical orders impacting end-of-life care for patients with advanced chronic or serious illness, the Physician Orders for Life-Sustaining Treatment (POLST) program was created. In contrast to a Health Care Proxy, the POLST applies right now and is *not* conditional on losing decision making capacity. The POLST program is based on the belief that individuals have the right to make their own health care decisions, including decisions about life-sustaining treatments, to describe these wishes to health care providers and to receive comfort care while wishes are being honored.

Can the POLST be used for any persons with mental retardation or developmental disabilities or persons with mental illness?

In the inpatient setting, the POLST form may be completed by persons with mental retardation or developmental disabilities or persons with mental illness *with capacity* (capable of making their own decisions). The POLST may be completed for persons with mental retardation or developmental disabilities or persons with mental illness *who lack capacity* in accordance with Surrogate's Court Procedure Act §1750-B; however, legal counsel should be consulted.

> The POLST form is a bright pink medical order form that indicates what types of life-sustaining treatment the patient does or does not want if they become seriously ill.

In the community, the POLST form may be completed by persons with mental retardation or developmental disabilities or persons with mental illness *with capacity* (capable of making their own decisions). The Chapter Amendment provides for a carve-out, such that authorization does not extend the use of the POLST form to persons with mental retardation or developmental disabilities or persons with mental illness who *lack capacity*.

Does the existence of a POLST form mean that the patient has made a decision to forego cardiopulmonary resuscitation (CPR) and has a Do Not Resuscitate (DNR) order?

No. The POLST form is based on ensuring goal-based discussions that integrate patient preferences and informed medical decision-making. It is not based on limiting medical interventions. The existence of a POLST form signifies the occurrence of a thoughtful prior conversation and not the presence of a DNR order.

Does the POLST form indicate treatment preferences other than DNR?

The DNR order applies in situations when the patient has a complete cardiopulmonary arrest and has no pulse and/or respirations. In addition to the DNR order, the POLST contains orders for other life-sustaining treatment when the patient still has pulse and/or is breathing. These include orders for intubation and mechanical ventilation, artificial hydration and nutrition, antibiotics, and hospital transfer.

The form may be used in health care settings, including hospitals and nursing homes, to convert the patient's end-of-life treatment preferences beyond DNR into medical orders contained on a single form. The POLST can be used to transfer these orders from one site of care to another.

How much of the form should be completed?

Completion of the entire form is strongly recommended. Any section not completed implies full treatment for that section. Review of the entire form serves to educate the patient regarding additional choices for life sustaining treatment.

Does a DNR order imply that a patient does not want treatment?

No. Do Not Resuscitate (DNR) does not mean Do Not Treat (DNT). A well-informed patient may recognize the futility of CPR in the presence of advanced or serious illness and may request a DNR order. However, based on their goals for care, the patient may wish to receive further treatment. Furthermore, DNR applies to patient who experience acute cardiopulmonary arrest, where as DNI applies only to intubation for patients who experience impending pulmonary failure.

Patients may not want CPR and have a DNR order, but may benefit from ventilator support and therefore may not wish to have a DNI order.

Is there any reason to complete the POLST form if the patient chooses full cardiopulmonary resuscitation?

Reviewing the entire POLST form with a patient serves to educate the patient regarding additional choices for life-sustaining treatment. Inconsistencies in goals and preferences may emerge through the discussion that needs to be reconciled. For example, a patient may indicate a desire to never undergo intubation and mechanical ventilation under any circumstance. The patient may not realize that intubation and mechanical ventilation will be required if CPR is successful.

Who can complete a POLST form with the patient or Health Care Agent?

POLST must be completed by a health care professional, based on patient preferences and medical indications. Health care professionals should be trained, competent and comfortable with having the conversation in accordance with the POLST 7-Step Protocol. POLST must be signed by a California licensed physician to be valid.

Conversations between the health care professional and patient should be shared with the Health Care Agent and family to ensure the Health Care Agent and family are aware of the patient's wishes and to avoid future conflict. Conflict often arises when the wrong person is chosen as the Health Care Agent or if there is no antecedent conversation.

Conversations between the health care professional and patient should be shared with the Health Care Agent and family to ensure the Health Care Agent and family are aware of the patient's wishes and to avoid future conflict.

Can midlevel providers (NP, PA) complete the POLST form and issue DNR and other orders for life sustaining treatments?

While California Law allows only a doctor to complete a DNR order, practicality demands that there is a mechanism for conveying this order when the doctor is not on site. The midlevel provider NP/PA may complete POLST after a discussion with the attending or covering physician and the physician issues a verbal order. The midlevel notes this in the medical record and the POLST form and the physician signs the order later. Verbal orders are acceptable, in accordance with facility or community policy. The orders should be cosigned by an attending physician within a specified brief period of time; for example, within 24 hours in a hospital, and within 1-7 days in a nursing home.

Does the supplemental form for adults always need to be completed?

No. The POLST supplemental form for adults must be completed *only* when the adult patient *lacks capacity* to consent for him or herself.

What do you do with a completed POLST form?

POLST forms are designed to travel with the individual between care settings.

The form should be kept in the front of the individual's medical chart when the individual is in a facility. *When the individual is transferred between care settings*, a copy of the form should be made and kept in the medical chart at the transferring location. The original form should accompany the individual and be placed in the individual's medical chart at the new care setting. When the individual is at home, the POLST form should be kept on the refrigerator, by the phone in the kitchen or by the individual's bedside. In case of emergency, EMS personnel are trained to look for the POLST form in these locations. POLST, supplemental forms, traditional Advance Directives and documentation of any *'clear and convincing evidence'* should be kept together and transferred with patient at discharge. Otherwise the form may need to be redone.

If a completed POLST form is present upon admission or transfer to a health care facility and the patient does not remember the conversation, how should the health care professional proceed?

Assess patient capacity at the time of form completion. Was patient deemed to have decision capacity at the time of POLST completion, as evidenced by the fact that the patient completed the form and no supplemental documentation is completed and attached?

Review admission or transfer papers for evidence of documentation of the conversation.

If no documentation is present, verify information through a conversation with the physician who completed the POLST form. The physician license # and phone/pager # is on the POLST form. Reassess patient capacity at the time of transfer as the patient *may have had capacity* when the POLST form was completed but *lost capacity* in the interim.

If capacity is intact, the patient's goals for care may have changed. Initiate a goal-based discussion, per the 7-Step Protocol and complete a new POLST consistent the patient's current preferences.

How does POLST work with electronic health records?

Scan POLST into the computer at time of admission and discharge. Review POLST at the time of discharge or transition of care and retain an electronic copy. For example, if a patient is discharged to home, the original POLST form should go with the patient. A copy should be retained in the electronic medical record, a copy should go to the primary care physician's office and a copy should go to the health care agency if the patient has home care.

Where can I get POLST forms?

POLST forms are available at participating health care facilities in the Inland Empire or the Inland Empire Palliative Care Coalition.