TO THE PRESENTER:

This slideset is shortened from a longer version that is also available on the POLST Illinois website. In this basic presentation, important content from the longer version has been transposed into the notes sections of these slides.

In the effort to keep this basic presentation shorter, the notes contents may be long for some slides. We’ve done this in order to provide as much information as possible to the presenter so that even if you are not as familiar with the POLST paradigm you will have access to adequate explanations for important aspects of POLST.

Look for *** to identify issues that, in our experience, are particularly challenging for clinicians to master; we recommend including the notes that are marked in this way in your spoken comments throughout your presentation.
TO THE PRESENTER:
The POLST Illinois slide sets that are available on the website are locked so that we can maintain consistency of POLSTIL-approved presentations. However, if you would like to create your own presentation you are welcome to reproduce contents of the slides; in that case, please do NOT use screenshots nor the official POLST Illinois logo. These slides were created and are maintained by a generous group of volunteers across the state. Thank-you for your consideration.
Disclaimer

• Note that these slides are developed as clinical guidance for the POLST paradigm and should NOT be construed as medical nor legal advice.
• For answers to legal questions, check with your own organizational legal counsel.
TO THE PRESENTER:

In our experience, many clinicians, including first responders, hospice staff and nursing home staff, have many misunderstandings about the use of the POLST form. We have discovered many intelligent and competent clinicians who misunderstand some of the basic POLST information, and who “don’t know what they don’t know”. We believe that this presentation will help clinicians recognize and fill the gaps in their POLST knowledge base. You will also find useful information on the POLST Illinois website in the form of the Guidance Document and FAQ Document.

Lastly, you may wish to air this 8 minute national POLST overview video (www.youtube.com/watch?v=zlqQgCBChn0#t=118) as a part of or in preparation for your presentation.

As an example of the misunderstandings about POLST being a serious safety risk:


The aim of this study was to determine whether POLST documents are confusing in the emergency department setting and how confusion impacts the provision or withholding of lifesaving interventions.

Members of the Pennsylvania chapter of the American College of Emergency Physicians were surveyed between September and October 2013. Respondents were to determine code status and treatment decisions in scenarios of critically ill patients with POLST documents who emergently arrest. Combinations of resuscitations (do not resuscitate [DNR], cardiopulmonary resuscitation) and levels of treatment (full, limited, comfort measures) were represented. Our response rate was 26% (223/855). For scenarios specifying DNR and either full or limited treatment, most chose DNR (59%–84%) and 25% to 75% chose resuscitation. When the POLST specified DNR with comfort measures, 90% selected DNR and withheld resuscitation. When cardiopulmonary resuscitation/full treatment was presented, 95% selected “full code” and resuscitation. In most scenarios depicted, responses reflected confusion over its interpretation. Additional training and/or safeguards are needed to allow patient choice as well as protect their safety.
Nationally, the paradigm is called “Physician Orders for Life-Sustaining Treatment” (POLST)

The words cannot be used interchangeably. POLST is not just a form, but a conversation that includes shared decision making by health care professionals and their patients.

While POLST is the most common term used across the United States, POLST orders in other states may also be known by similar names: MOLST (Medical Orders for Life Sustaining Treatment), MOST (Medical Orders on Scope of Treatment), POST (Physician Orders on Scope of Treatment), or by a state name such as LaPOST (Louisiana Physician Orders for Scope of Treatment).

In Illinois, POLST now stands for “Practitioner Orders for Life-Sustaining Treatment”

**TO THE PRESENTER:**
This slide stresses the big picture that this is a process, a dialogue that involves not only a form but also multiple discussions over time.
Oregon released the first POLST form in 1995
Gradually expanded throughout the U.S.
Currently

TO THE PRESENTER:

Illinois has not yet applied for
TO THE PRESENTER:
For the most updated detailed evidence base, go to the national website at polst.org

Some examples of published evidence includes (from most to least recent): (The reason much of this research comes from Oregon is because Oregon is unique in having a mandatory statewide electronic POLST registry, which can be queried; Oregon also has the oldest POLST program, in place since 1995.)

1. Fromme, E.R., et al., “Oregon Physician Orders for Life-Sustaining Treatment (POLST): Completion in Proximity to Death”, Journal of Pain and Symptom Management, Volume 49, Issue 2, February 2015, Page 318. 18,285 Oregon POLST electronic registry participants were matched to death certificate data for 2010 and 2011. Diagnoses influence when POLSTs are completed. Among registrants who had multiple POLSTs, the later form usually, but not always, had fewer life-sustaining treatment orders. Data show that most final POLST forms are completed during the last year of life and support that POLST is being used in the intended patient population.

2. Fromme, E.R., et al., “Association between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon”, JAGS, Vol. 62, No. 7, July 2014, pp 1246–1251. Relationship between what POLST orders are selected and where people ultimately die. Analysis of Oregon death records, of 35,000 people who died during the period, almost 18,000 had a POLST form in the registry. 6.4% of patients who had a POLST Form specifying Comfort Measures Only treatment wishes died in a hospital (note that some patients require hospitalization for adequate comfort-focused care). Also, 22.4% for patients who wished for Limited Additional Interventions died in a hospital, 44.2% of patients whose POLST specified wishes for Full Treatment died in a hospital, but 34.2% of patients without a POLST Form died in a hospital.

3. Hickman, Susan E., et al., “Use of the Physician Orders for Life-Sustaining Treatment Program for Patients Being Discharged from the Hospital to the Nursing Facility”, Journal of Palliative Medicine, January 2014, 17(1): 43–49. 151 participants were hospitalized patients discharged to a nursing facility and/or their surrogates in La Crosse County, Wisconsin, POLST forms were abstracted from hospital records for 151 patients. Hospital and nursing facility chart data were abstracted and interviews were conducted with an additional 50 patients/surrogates. Overall, 176 patients had valid POLST forms at the time of discharge from the hospital, and many (38.6%, 68/176) only documented code status. When the whole POLST was completed, orders were more often marked as based on a discussion with the patient and/or surrogate than when the form was used just for code status. Most (71.9%, 13/18) appeared consistent with patient or surrogate recall of prior treatment decisions.

4. Fromme, E.R., et al., “POLST Registry Do-Not-Resuscitate Orders and Other Patient Treatment Preferences”, JAMA, 2012;307(1):34-35. In Oregon, POLST forms are entered into a registry, allowing emergency personnel and hospitals 24-hour access to POLST information when the physical form cannot be located during an emergency. Clinicians in Oregon are required by law to submit forms to the registry unless the patient opts out.

In this 2012 study examining this registry (25k registrants at the time of study), important findings include:

- Although 9% of registrants used the form to indicate a wish not have CPR in case of cardiac arrest, 9% of the registrants actually used to form to state their desire TO HAVE CPR IN CASE OF CARDIAC ARREST (Section A), demonstrating that this is not a form that is used solely to restrict emergency life-sustaining treatment.
- Even for the registrians who expressed the wish not to have CPR in case of cardiac arrest, 9% of that group DID WANT SOME FORM OF MEDICAL TREATMENT FOR OTHER MEDICAL EMERGENCIES (section B) 43% of the DNR group selected either full or selective treatment. In other words, “DNR” does not mean do nothing! This confirms that just having a “DNR order form” (such as the original Illinois “Orange DNR form” introduced in 2000) does not adequately allow patients to express their emergency medical wishes.

5. Hammes, Bernard J., et al., Journal of Palliative Medicine, January 2012, 15(1): 77-85. “The POLST Program: A Retrospective Review of the Demographics of Use and Outcomes in One Community Where Advance Directives Are Prevalent.” A retrospective review of medical record and death certificate data of 400 adults who died between September 1, 2007, and March 31, 2008, in comparison with decedents with POLST form, decedents with a POLST form were significantly older, more likely to die in a nursing home than in a hospital, and more likely to die from a terminal or chronic illness (97%). Decedents with POLST orders for higher levels of medical treatment received more treatment, and in only two cases was there evidence that treatment was discrepant with POLST orders.

6. Hickman, Susan, et al., “A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program”, Journal of the American Geriatrics Society, July 2010, Volume 58, Issue 7, pp. 1245–1248. A retrospective observational cohort study, conducted between June 2006 and April 2007, a stratified, random sample of 90 Medicaid-eligible nursing facilities in Oregon, Wisconsin, and West Virginia, one thousand seven hundred eleven living and deceased nursing facility residents aged 65 and older with a minimum 60-day stay. Residents with POLST forms were more likely to have orders about life-sustaining treatment preferences beyond cardiopulmonary resuscitation than residents without (98.6% vs 16.1%, P<.001). There were no differences between residents with and without POLST forms in symptom assessment or management. Residents with POLST forms indicating orders for comfort measures only were less likely to receive medical interventions (e.g., hospitalization) than residents with POLST full treatment orders, residents with traditional do-not-resuscitate orders, or residents with traditional full code orders.

POLST is designed to honor the freedom of persons with advanced illness to have or to limit treatment across settings of care. Comfort measures are always provided no matter what other choices patients make.
Proper function of the POLST form as documentation of patient wishes depends on the factors listed here.
In order to assess whether a POLST conversation is appropriate for a patient, clinician should ask “Would I be surprised if this patient died within the next year?” If the answer is “No, I would not be surprised” then a POLST conversation, and possibly a resulting POLST form, is appropriate.

These patients include those with advanced illness and the frail elderly (including most patients in nursing homes who are there for custodial, not rehabilitative, care).

POLST would only be appropriate for people with chronic disabilities if the persons health deteriorates that death within a year would not be unexpected.
Illinois Healthcare Power of Attorney or Five Wishes = both of the documents identify a healthcare agent and allow someone to make general statements about his/her healthcare wishes in the future.
The segmented bar in the middle represents the 3 “phases” of the Advance Care Planning “Life Cycle.”

The First Phase begins at adulthood. Once someone becomes an adult, they should be encouraged to start advance care planning as a healthy life habit. For a Healthy and independent adult, there are only a few advance care planning “tasks”. The first is to consider “Who in my life would I trust to represent my medical wishes if I couldn’t speak for myself?”. The second is to put that choice in writing in the form of a power of attorney for healthcare document. The third is to consider “If I suddenly became irreversibly neurologically devastated, i.e., vegetative, would I want ongoing treatment or would I want to be allowed to die?” (be aware that this is a controversial subject for observant Catholics). The fourth is to notify the selected agent, and give that person a copy of the document. These are the “First Steps”.

The Next Phase begins when a patient has a chronic illness that has begun to advance such that there is a functional decline. For this patient, the life habit continues, and is built upon the considerations in the First Phase. Now it is time to think about one’s specific conditions and the specific kinds of deterioration that can be can be expected with those conditions. For example, a person who has COPD is now requiring oxygen use at home, and/or is experiencing hospital admissions for acute exacerbations. That patient should understand the risk of being intubated and the nature of that procedure including its benefits and burdens. The patient should also consider whether, if unweanable, tracheostomy and longer-term care in a facility that treats patients on ventilators would be acceptable, and if so, would there come a point when it would no longer be acceptable? If there are no limitations of treatment desired at this point, there is not a new document to complete here, but specific discussion about specific treatment wishes is appropriate, with both the primary care provider as well as the identified agent. These are the “Next Steps”.

The Last Phase is when a patient is likely to be in the last year or so of life, as mentioned. This is the patient with multiple comorbidities and/or increasing frailty. In this phase, it is possible that the person making decisions is not even the patient, but instead the substitute decision-maker (who is ideally also the assigned agent with Power of Attorney for Health Care). In this phase, there are specific decisions to be made, including wishes about CPR in case of cardiac arrest, and in other critical conditions, level-of-treatment wishes based on patient goals, which can range from strictly comfort care all the way to aggressive treatment with all medically indicated means. These are the “Last Steps”, and are documented on the POLST form so that ALL providers who may encounter this patient in an emergency situation will have guidance regarding the desired treatment(s).
TO THE PRESENTER:

Other recent support of POLST includes:

1. *Institute of Medicine* report “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life” (Sept 2014) prominently features POLST outcomes and training programs (Sept 2014)

   The report focuses on a number of end of life issues, including access to high-quality end-of-life care and the need for more readily available advance care planning. Notably, the report highlights POLST and includes it in one of the committee’s recommendations. Specifically, the committee suggests that “Actions should … encourage states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements.”

Illinois is unique in that our POLST form has evolved from previous versions of out-of-hospital DNR order forms. Over the past several years, Illinois legislation has resulted in the IDPH POLST form becoming closer to the national POLST standards used in other states.

This is the sixth version and offers patients and providers both more options and more concrete guidance.

The most recent change, in 2016, is that the form is now officially called the “Illinois Uniform POLST Form”, no longer carrying “DNR” in the title. This is a crucial update, because when the form was called a “DNR” form, it reinforced a DANGEROUS MISUNDERSTANDING that the form is only used for patients who do NOT want CPR in case of cardiac arrest. In fact, this form may also be used by patients who wish to state that they WOULD ACCEPT CPR in case of cardiac arrest.
This is the revised document as of April, 2016.

As you can imagine, if staff were to look at a completed form and automatically assume it indicated that the patient was DNR, a patient who is full code might be inappropriately allowed to die from cardiac arrest without intervention, which would be a grave medical error.
This slide shows the general outline of decision categories in the POLST form, as compared to the “old” IDPH DNR Advance Directive to which we are accustomed. We will go in detail through each of the sections. One of the most important things to notice immediately, is that the mere existence of a POLST form does not imply that the patient is DNR in case of a cardiac arrest. This is an important safety issue. Section B still addresses pre-arrest emergencies, but the levels of treatment instructions are more understandable compared to pre-2015 form, and reordered from most invasive to least invasive, as are the options in Section C.
The IDPH Uniform POLST Form
Practitioner Orders for Life-Sustaining Treatment

Cardio-Pulmonary Resuscitation (CPR)
- Medical Interventions
- Medically Administered Nutrition
- Documentation of Discussion
- Signature of Attending Practitioner
- Reverse Side – Contains More Information and Instructions

POLST ILLINOIS
Again, notice that the POLST form may also be used when a patient wants to document that s/he in fact WOULD accept CPR in case of cardiac arrest. Of course, “Yes to CPR in case of cardiac arrest” is our default instruction in any case.

Section A is geared specifically to treatment in case of CARDIAC ARREST, i.e., the patient is unconscious, has no pulse and is not breathing.

***Some patients may state that they are willing to have CPR with the exception of intubation/mechanical ventilation. This treatment plan request in case of cardiac arrest would represent medically faulty reasoning: We know that CPR is often NOT successful. However, with rare exception, all patients who suffer cardiac arrest and survive a resuscitation attempt will end up intubated, mechanically ventilated and in an ICU, at least for a brief period of time. It would not make sense to initiate CPR and successfully revive someone in cardiac arrest, only to have to let the person “die again” because intubation is being withheld.

In our experience, people who ask for the above treatment plan generally need additional education about the nature of CPR and the intubation that accompanies it; without this education they often think about CPR as a “one-time event” (might as well do it, if it works, great, if not, nothing lost, I’m still dead), whereas they may tend to equate intubation/mechanical ventilation with a chronic existence (i.e., living depending on machines). These patients can be educated to recognize that the two come as a package, and that it is possible to also state what OUTCOMES WOULD BE UNACCEPTABLE and withdraw ongoing treatment based on their goals. Most of these educated patients will no longer request CPR without intubation.

In making this decision, it is critical for patients to understand a) odds of resuscitation success as it applies to their own medical condition, b) that if CPR does successfully resuscitate patient, nearly all patients will end up intubated, at least for a short time, and in the intensive care unit.

There are additional medical emergencies aside from cardiac arrest, which are dealt with SEPARATELY in Section B.

**TO THE PRESENTER:**
The above notes describe a very common misunderstanding regarding Section A. Many competent clinicians do not realize that they do not understand this nuance. Please consider dwelling on this content until you feel confident your audience fully grasps it. Understanding this is key to supporting patient-centered care.
Again, notice that the POLST form may also be used when a patient wants to document that s/he in fact WOULD accept CPR in case of cardiac arrest. Of course, “Yes to CPR in case of cardiac arrest” is our default instruction in any case.

Reference IDPH citation at LTC facility in Belleville Illinois 3/16: violation of patient right to refuse treatment. Failure to comply with resident’s advance directives. Initiated CPR but then LPN apparently misinterpreted existence of POLST form to mean DNR so they stopped and patient died. Facility failed to have system in place that ensured that all staff was trained in procedures related to each resident’s code status.
The IDPH Uniform POLST Form
Practitioner Orders for Life-Sustaining Treatment

Cardio-Pulmonary Resuscitation (CPR)
Medical Interventions
Medically Administered Nutrition
Documentation of Discussion
Signature of Attending Practitioner
Reverse Side – Contains More Information and Instructions
Section B now is formatted according to intensity of treatment wishes in pre-arrest situations. Which level is selected will be based on the patient’s specific medical conditions, plus what is medically feasible, plus the patient’s own goals of care.

*** Section B options are for medical emergencies ASIDE FROM CARDIAC ARREST. These are situations when there is a heart beat and breathing, but one or the other or both are deteriorating. These situations could lead to cardiac arrest if left untreated.

There are three levels of treatment, which can be thought of as Full (all indicated medical treatment aimed at prolonging life); Selective (limited medical treatment that does NOT include intubation and mechanical ventilation; aimed at achieving patient-specific goals such as reversing potentially reversible conditions to get back to existing baseline without necessarily accepting the most “invasive” or “burdensome” treatments); Comfort-focused treatment (often compatible with hospice care, usually outside of hospital unless comfort needs can’t be met anywhere else).

• Three categories defining the intensity of treatment when the patient has requested DNR for full arrest, but is still breathing or has a pulse.
  • Full – all indicated treatments are acceptable
  • Selective – no aggressive treatments such as mechanical ventilation
  • Comfort-Focused – patient prefers symptom management and no transfer if possible
Note here that a treatment is said to be “futile” if it does not meet the goals for patient. (The challenge here is that it is not always clear whose goals are being considered: is it the patient’s goals or the providers’ goals being considered?). A full discussion of the meaning of “futility” is beyond the scope of this presentation, but the key concept is that although a patient may be willing to receive a treatment, that willingness does not force a provider to go against medical standards of care to provide it.

- Use “Additional Orders” for other treatments that might come into question (such as dialysis, surgery, chemotherapy, blood products, etc.).
- An indication that a patient is willing to accept full treatment should not be interpreted as forcing health care providers to offer or provide treatment that will not provide a reasonable clinical benefit to the patient (would be “futile”).
If the patient who has opted to limit emergency treatment in case of a non cardiac-arrest emergency in Section B, and further deteriorates, the patient may actually go into cardiac arrest (i.e., unconscious, no heartbeat, no breathing). If that same patient incorrectly has also selected “Yes to CPR” in Section A, then the same team who “stood by” withholding treatment during the initial deterioration would now be required to spring into action and attempt to save the person’s life once she/he goes into full arrest.

This approach would require first responders to stand by while adverse medical outcomes transpire only to step in and try to reverse those outcomes later. This would be faulty medical practice.

**TO THE PRESENTER:**
This is a key concept that many competent clinicians do not realize that they do not understand. Lack of understanding of the relationship between the choices in Sections A and B have led to INCORRECT COMPLETION OF THE FORM, and confusion on the part of first responders encountering such a form. Please consider dwelling on this and the next slide until you are confident that participants truly understand these principles. Understanding this is key to supporting patient-centered care.
***Remember: Section B options are for medical emergencies ASIDE FROM CARDIAC ARREST. These are situations when there is a heart beat and breathing, but one or the other or both are deteriorating. These situations could lead to cardiac arrest if left untreated.

For example, a person with COPD may be willing to be intubated in case of respiratory distress. This patient’s goal with intubation might be to support disordered breathing during an acute exacerbation, until the underlying cause of the exacerbation (eg., pneumonia) can be treated and reversed. The hoped-for outcome for this patient might be is return to baseline nonintubated, outpatient status. On the other hand, this same patient, were s/he to experience a CARDIAC ARREST, might NOT want to have a CPR attempt, knowing that the odds of successful resuscitation from cardiac arrest are slim and the burdens to great. In this case, the patient would mark “No CPR” in Section A and “Full Treatment” in Section B.

To the presenter: This is a key concept that many competent clinicians do not realize that they do not understand. Lack of understanding of the relationship between the choices in Sections A and B have led to INCORRECT COMPLETION OF THE FORM, and confusion on the part of first responders encountering such a form. Please consider dwelling on this and the next slide until you are confident that participants truly understand these principles. Understanding this is key to supporting patient-centered care.
Section “B”: Comfort ALWAYS!

- Regardless of the option selected in section B, comfort care is always provided

- To clarify: if a patient is choking, suction, manual treatment of airway, Heimlich maneuver would be implemented:

  **Choking is NOT COMFORTABLE!!**

Combine 26 and 27
Section “A” choices influence medical interventions in Section “B”

Section A
- Yes! Do CPR
- DNR: No CPR

Section B
- Full Treatment
- Full Treatment or Selective Treatment
- Full Treatment or Comfort-Focused Treatment

*Requires documentation of a “qualifying condition” ONLY when requested by a Surrogate.
DNR refers to the orders in Section A, whereas Comfort or DNI or Full refers to the orders in Section B.
# The IDPH Uniform POLST Form

**Practitioner Orders for Life-Sustaining Treatment**

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Cardio-Pulmonary Resuscitation (CPR)</td>
</tr>
<tr>
<td>B</td>
<td>Medical Interventions</td>
</tr>
<tr>
<td>C</td>
<td><strong>Medically Administered Nutrition</strong></td>
</tr>
<tr>
<td>D</td>
<td>Documentation of Discussion</td>
</tr>
<tr>
<td>E</td>
<td>Signature of Attending Practitioner</td>
</tr>
<tr>
<td>R</td>
<td>Reverse Side – Contains More Information and Instructions</td>
</tr>
</tbody>
</table>
Section “C”: Medically Administered Nutrition

- Medically Administered Nutrition can include temporary NG tubes, TPN, or permanent placement feeding tubes such as PEG or J-tubes.

- A trial period may be appropriate before permanent placement, especially when the benefits of tube feeding are unknown, or when the patient is undergoing other types of treatment where nutritional support may be helpful.
The IDPH Uniform POLST Form
Practitioner Orders for Life-Sustaining Treatment

A. Cardio-Pulmonary Resuscitation (CPR)
B. Medical Interventions
C. Medically Administered Nutrition
D. Documentation of Discussion
E. Signature of Attending Practitioner
R. Reverse Side – Contains More Information and Instructions
The legal representative may only sign this document if the physician has determined that the patient is unable to give his/her own informed consent on these matters.
This hierarchy is in keeping with the principles of informed consent and Illinois laws regarding the Durable Power of Attorney for Healthcare and the Healthcare Surrogate Act.
Remember that the patient has the right to accept or decline medical treatment as long as s/he has the capacity to do so.

Patients may have decisional capacity for one task but not another, depending on the complexity and gravity of the decision-making task in question.

For a substitute decision-maker to be authorized to act on behalf of a nondecisional patient, the physician must determine based on medical judgment that the patient lacks decision making capacity. Details of and regulations around such a determination are beyond the scope of this talk.

Of course, it is ideal to have a discussion about care preferences near the end-of-life with the patient him- or herself whenever possible, especially given that the literature consistently shows that substitute decision-makers do not make the same decisions that patients would have, and their choices tend toward more aggressive care than the patients would have wanted.
Common sense and practicality must be used here: the purpose of a witness signature is to provide a “third party” protection of the patient, to assure that the patient is in fact engaging in a fully informed decision-making process and is not being coerced by the physician. If a resident physician or another nurse signs as a witness, does this comfortably demonstrate to all that the patient is not being coerced by the attending physician? There is a risk that the answer could be no. On the other hand, there are circumstances, for example, in home hospice, where there are very few persons available to sign as a witness. Again, the content of these slides should not be taken as medical nor legal advice; follow your own institutional guidance/policies.
A power of attorney can answer the wide range of questions that are not covered by this form, and can provide consents within the parameters already established by the patient.

If the patient has chosen DNR, s/he has planned for the eventuality of a full arrest situation, has discussed this with their physician, and has legally documented their refused of the procedure. The PoA can make new decisions, and must make those decisions in a manner in which the patient would make them for himself or herself. Thus, with evidence of the patient’s refusal, it would take a rather extraordinary set of circumstances where providers could override an informed refusal of a procedure by the patient.

With Limited or Comfort interventions, the patient has refused some elements of treatment and again, that refusal should be honored by both providers and a PoA. However, a medical evaluation may provide new evidence, and the PoA can make decisions about those elements of care that the patient has not previously refused.
The IDPH Uniform POLST Form
Practitioner Orders for Life-Sustaining Treatment

A
Cardio-Pulmonary Resuscitation (CPR)

B
Medical Interventions

C
Medically Administered Nutrition

D
Documentation of Discussion

E
Signature of Attending Practitioner

R
Reverse Side – Contains More Information and Instructions
As of January 2015, the list of authorized practitioners who may sign this medical order set has been expanded to include these clinicians. Note that your own organization may place additional conditions/restrictions on who may sign these orders.

On the other hand, if a patient presents with a POLST form signed by ANY ONE OF THESE PRACTITIONERS, you are required to follow its instructions, no matter what your internal organizational policy is for signing the orders. This includes forms containing signatures by practitioners from outside your organization, even if you do not recognize the name. Care providers are obligated to follow orders on a patient POLST form in good faith and are protected legally from liability in doing so, provided the form is properly completed.
Requirements for a Valid Form

- Patient name
- Resuscitation orders (Section “A”)
- 3 Signatures
  - Consent by patient or legally recognized representative
  - Witness
  - Practitioner
- Date
- All other information is optional
- Pink paper is recommended to enhance visibility, but color does not affect validity of form
- Photocopies and faxes ARE acceptable.
The IDPH Uniform Form
Practitioner Orders for Life-Sustaining Treatment

A
Cardio-Pulmonary Resuscitation (CPR)

B
Medical Interventions

C
Medically Administered Nutrition

D
Documentation of Discussion

E
Signature of Attending Practitioner

R
Reverse Side – More Information and Instructions
Note on back of POLST form “Verbal/phone orders are acceptable with follow-up signature by attending physician [should read “practitioner”] in accordance with facility/community policy.”
## Potential System Concerns

1. Signing practitioner *doesn’t have privileges* here
   - Orders still must be translated into specific institutional orders
   - Suggest using “Pt is DNR per POLST form” and have that order signed by assigned staff attending

2. Our clinicians have *never seen this patient* before
   - Law indicates POLST orders must be honored in all care settings
   - Protected from liability for following an POLST form in good faith

3. Developing best practices for *storing, locating*, and transmitting document between care settings
   - Institutions should standardize where the document is located so that it is easily available during an emergency, but also protects the patient’s privacy
What Should I do with an Older IDPH Form?

- Continue to follow older IDPH DNR Forms (may be called “IDPH DNR”; “IDPH Uniform DNR form”; “IDPH Uniform DNR Advance Directive”; “IDPH Uniform POLST form”)
- Update the older form to the new form when it is feasible.
- Review the form with the patient or legal representative when a change in the patient’s medical condition, goals, or wishes occurs.
This presentation is a description of the “What”, “When”, “Where”, and “Why” of the POLST paradigm. It does NOT describe HOW this Advance Care Planning discussion should best be conducted, which is beyond the scope of this presentation. There are many online and training resources available to teach clinicians how to have effective Advance Care Planning conversations with patients and their loved ones. Competent conversations maximize the odds of a POLST document truly reflecting actual patient goals and wishes.

TO THE PRESENTER: This slide is an important reinforcement of earlier discussion in presentation about the importance of the conversation and the process, as opposed to focusing solely on the form.
This presentation for the POLST Illinois Taskforce has been made possible by in-kind and other resources provided by:

POLST ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

JourneyCare
Retirement Research Foundation
SIU School of Medicine
UIC University of Illinois at Chicago
Advocate Health Care
Chicago Organization of Long-Term Care Ombudsmen
POLST
THANK YOU!

Polstil.org (Illinois)
Polst.org (National)

info@PolstIL.org

Original presentation developed by K. Armstrong for the Illinois POLST Taskforce