

Practitioner Orders for Life-Sustaining Treatment

**Emergency Medical Services & First Responder Audience** 

## Permission to Use

- This slide presentation may be used without permission.
   To promote consistency across the state, the slides may not be altered.
- You may freely take language (but not screenshots) from this presentation to use in your own presentations.
- Please send requests for institutionally specific modifications to polstIllinois@gmail.com.



#### DISCLAIMER

- Note that this presentation provides 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 legal counsel.



## **Objectives**

# By the end of this session, participants will be able to:

- Understand the <u>POLST Model</u> and how a person's wishes are determined and documented in a standard form;
- Describe how POLST form builds upon and improves existing advance directives
- Advocate for patients by accurately interpreting IDPH POLST form instructions and taking appropriate action



## **POLST Program Overview**

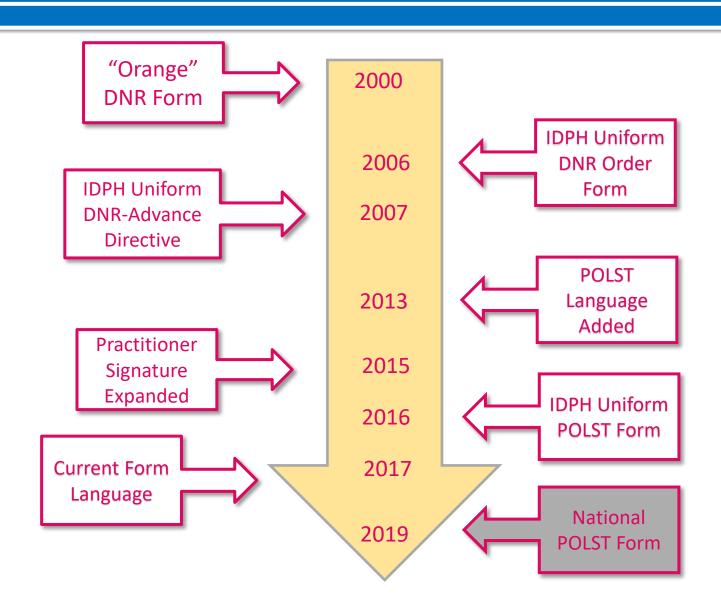
#### What is POLST?

- In Illinois POLST stands for <u>Practitioner</u>\* Orders for Life Sustaining Treatment
- It is NOT just a form, it is a process
  - Approach to end-of-life planning based on thoughtful conversations with the person, a friend or family if desired, and healthcare professionals
  - Incorporates values, beliefs and priorities as these relate to prognosis, likely disease course & treatment choices

<sup>\*</sup> Physician, Advanced Practice Registered Nurse, Physician Assistant, Resident in 2<sup>nd</sup> year or higher of residency program



#### **Evolution of the IDPH Uniform POLST Form**



## Various Forms Past & Present

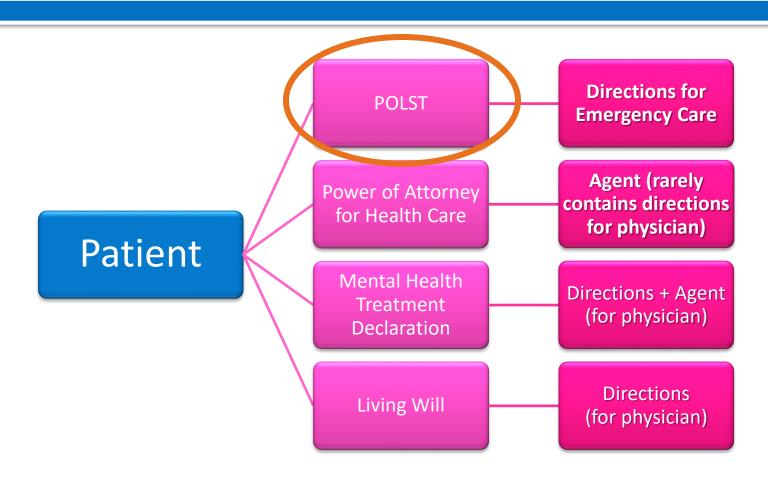
Illinois Department of P UNIFORM DO-NOT	Public Health RESUSCITATE (DNR) ADVANCE	(Page 1 of 2	O-NOT-RES	And the last	Follow I	Illinois Department lents, use of this form is hese orders until changed	completely voluntary.  These medical orders			Patient First Nan	THO
Patient Directive			ESU		ences.	ed on the patient's medic Any section not completed d implies initiating all tre	does not invalidate the		s'yy)	Ge	ender 🗆 M 🔾
<u>,</u> է	porn on , hereby direct the foll	lowing in the event of:	SCII		With si	gnificant change of cond be written.	Stion new orders may	Address (street/city/s	state/ZIPcode)		
(print full name)	(birth date)		SCITATE		Δ	CARDIOPULMON	IARY RESUSCITA	ATION (CPR) If par	tient has no pu	alse and is not bre	athing.
	REST (When both breathing and heartbe	eat stop):		ì	Check One	☐ Attempt Resusci (Selecting CPR mean		action B is selected	□ Do No	t Attempt Resus	scitation/DNR
Measures to promote patient c	Imonary Resuscitation (CPR)		В		0.0			oulmonary arrest,	follow orde	rs B and C.	
					В	MEDICAL INTER	VENTIONS If patie	ent is found with a pr	ulse and/or is	breathing.	
2. PRE-ARREST EMERGENCY (V		State of Illin			Check One	☐ Full Treatment: F	rimary goal of sust	taining life by medi Comfort-Focused Tre	ically indicate	d means. In addit	tion to treatme
SELECT ONE	Do Not Re	esuscitate	(DNR) Ore	der	(optional	cardioversion as it	ndicated. Transfer to	hospital and/or inter	nsive care unit	if indicated.	
☐ Do Attempt Cardiopulmo					3	In addition to trea	tment described in 0	of treating medical Comfort-Focused Tre	eatment, use	medical treatment	t, IV fluids and
☐ Do Not Attempt Cardiop	L. , (p	rint full name) DO NOT	AUTHORIZE CARDIOPU	LMONARY RESU		medications (may patient preference	include antibiotics a b. Do Not Intubate. I	and vasopressors), a May consider less in	as medically a vasive airway	ppropriate and co support (e.g. CP)	onsistent with AP, BIPAP).
(Measures to promote patient o	I (or my legal representative) understand that	this order remains in eff	ect until revoked by me (o	or my legal represe		Transfer to hospit	al, if indicated. Gene	erally avoid the inter	nsive care unit		
Other Instructions	the attending physician. I (or my legal representations) formed if breathing or heart beat stops. (The s	ntative) acknowledge th	at cardiopulmonary resus	citation (CPR) will		the use of medica	tion by any route as	needed; use oxygen	n, suctioning ar	nd manual treatme	ent of airway
	formed if breathing or heart beat stops. (The s Icl two witnesses are required.)	agnatures of [a] the pain	ent Ok legal representativ	e, [b] the physicia		Request transfer	ot use treatments list or to hospital only if	ed in Full and Select comfort needs car	tive Treatment nnot be met i	unless consistent in current location	with comfort
Patient Directive Authorization and (	[c] two witnesses are required.)			250 700		Optional Additiona	Orders				
I understand and authorize the abo				:	C	MEDICALLY ADMI					
ing this Patient Directive.	Printed name of patient	Signature of patie	ent	Date	Check One	☐ Long-term medically ☐ Trial period of medic				I Instructions (e.g.,	length of trial
The state of the s					(optional)			on, including feeding tu			
Printed name of individual				Date	D	DOCUMENTATION					
-OR-	Printed name of physician	Signature of phys	sician	Date	ľ	Patient Parent of minor		<ul> <li>Agent under healt</li> <li>Health care surro</li> </ul>			2 for priority
				1000000		Signature of Patier			gaio occioni	manor (oce r ago	a not priority
Printed name of (circle appropriate title): legal guardian	Effective date					Signature (required)		No	ame (print)		Date
OR agent under health care power of attorney OR healthcare surrogate decision maker	Encoure said										
						Signature of Witness I am 18 years of age or			ad an opportunity	to read this form and	d have witnesses
Witness to Consent (Required to have a				:		giving of consent by the	above person or the abo	ove person has acknowle	ledged his/her sig	gnature or mark on th	is form in my pre
I am 18 years of age or older and ac and have witnessed the giving of cor	Printed name of witness	Signature of witr	ness	Date		Signature (required)		N	ame (print)		Date
signature or mark on this form in my						Signature of Attend	ding Practitioner		harand constants back	and and assert construction	
	Address of witness				E	My signature below indicate					
Printed name of witness	Address of withess				3	Print Attending Practit	ioner Name (required	9	Pt	none	
		_							(	)	
Physician Signature (Required to be a va	Printed name of witness	Signature of with	ness	Date		Attending Practitioner	Signature (required)		Di	sto (required)	4
I hereby execute this DNR Order o											
	-	-				Revision Date January 201					ersions are also
	Address of witness			and the second	11000	COPY OF FORM WITH PAT	ENT WHENEVER TRANSP	FERRED OR DISCHARGED	O - COPY ON AN	IY COLOR OF PAPER I	IS ACCEPTABLE
Signature of attending physician		re of Consent for Pa	atient Lacking Decision	on Making Capac	ity	#2 - U					
	Legal Representative's Signatur		a cionature in this section	i is required.)							
Signature of attending physician  Send this form or a copy of b	Legal Representative's Signatur (If the patient lacks decision	on making capacity, then	a signature in this section								
◆ Send this form or a copy of b	Legal Representative's Signatu (If the patient lacks decision	on making capacity, then	a signature in ans section			9					
◆ Send this form or a copy of b	(If the patient lacks decisio	n making capacity, then				4					
◆ Send this form or a copy of b	(If the patient lacks decision)  Printed name of (circle appropriate title) legal	n making capacity, then	reet Address								
◆ Send this form or a copy of b	(If the patient lacks decisio	n making capacity, then				-					
◆ Send this form or a copy of b	(If the patient lacks decision  Printed name of (circle appropriate title) lega  OR durable power of attorney for health care	on making capacity, then		STATE							
◆ Send this form or a copy of b	(If the patient lacks decision  Printed name of (circle appropriate title) lega  OR durable power of attorney for health care	on making capacity, then	reet Address	The state of the s		-					
Signature of attending physician  • Send this form or a copy of both  ONR • DO-NOT-RESUSCITATE • DI	(If the patient lacks decision  Printed name of (circle appropriate title) lega  OR durable power of attorney for health care	on making capacity, then	reet Address			-					
◆ Send this form or a copy of b	(If the patient lacks decision  Printed name of (circle appropriate title) lega  OR durable power of attorney for health care	on making capacity, then	reet Address			-					
◆ Send this form or a copy of b	(If the patient lacks decision Printed name of (circle appropriate title) lega OR durable power of attorney for health care OR surrogate decision maker	on making capacity, then	reet Address			-					
♦ Send this form or a copy of b	(If the patient lacks decision Printed name of (circle appropriate title) lega OR durable power of attorney for health care OR surrogate decision maker  Signature of legal representative	on making capacity, then	reet Address ity, State, ZIP			-					
◆ Send this form or a copy of b	(If the patient lacks decision Printed name of (circle appropriate title) lega OR durable power of attorney for health care OR surrogate decision maker	on making capacity, then	reet Address ity, State, ZIP	Department of Pul		- -					

#### All Previous Version are Still Valid

- Older versions of the Illinois form are still valid and should direct treatment.
- A valid form does not expire and should be honored.
- Form should always travel with patient and be readily accessible to healthcare professionals.



# Rely on Advance Directives (POLST) ONLY if Patient CANNOT Make Decisions





## Why does the POLST Form exist?

## First responders need clear guidance for how to respond to a medical emergency in the field

- Recognized IDPH standardized form for the entire state of Illinois
- Concrete <u>medical orders</u> that must be followed by healthcare providers and first responders, so that treatment is in keeping with the person's wishes
- Evolved from the original IDPH DNR form (prior versions of forms are valid)

Practitioner Orders for Life-Sustaining Treatment

#### Intended Use of POLST Form

The POLST decision-making process and resulting medical orders are intended for people of any age who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.

- <u>COMPLETING FORM IS VOLUNTARY</u>: Language added stressing that the form cannot be required of any patient and is completely voluntary
- Pediatric patients with a valid POLST form should be treated the same as an adult.



#### What are the benefits of POLST?

#### **Promotes Person-Centered Care**

- Allows the person, loved ones and providers to discuss and document the person's values and preferences for treatment in a medical emergency
- Protects individuals who live in the community from treatment that is inconsistent with their preferences
- Reduces medical errors by improving guidance during lifethreatening emergencies



# IDPH Uniform POLST: Form Explanation

## **The IDPH Uniform POLST Form**

HIPAA PERMITS DISCLOSURE OF POL	LST TO HEALTH CARE F	PROFESSIO	NALS AS NECES	SARY FOR TRE	ATMENT
State of Illinois Illinois Department of Public Health			ORM PRACTIT		
patients, use of this form is completely vol low these orders until changed. These medical or		ne	Patient F	irst Name	MI
ed on the patient's medical condition and prefer section not completed does not invalidate the fr ities initiating all treatment for that section. With sign	form and ignificant		'	Gender	M DF
nge of condition new orders may need to be wri	fiten. Address (street/o	city/state/ZIF	code)		
ARDIOPULMONARY RESU	ISCITATION (CPR)	f patient has	no pulse and is	not breathing.	
Attempt Resuscitation/CPR (Selecting CPR means Full Treatme	ent in Section R is selected		Do Not Attempt	Resuscitation	VDNR
-	ardiopulmonary arr		orders B and	C.	
MEDICAL INTERVENTIONS					
In addition to treatment describ medications (may include antib preference. Do Not Intubate. M pital if indicated Generally a w	biotics and vasopressor flay consider less invasi	Treatment s), as medi ve airway s	, use medical tre cally appropriate	and consistent	with patier
medications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally a vi Comfort-Focused Treatment: use of medication by any route. Do not use treatments listed in in transfer to hospital only if co	bed in Comfort-Focused biotics and vasopresson flay conside riess invasi- oid the intensive care un : Primary goal of maxi- as needed; use oxygen Full and Selective Treat	Treatment s), as medi ve airway s nit imizing coi , suctioning ment unless	, use medical tre cally appropriate upport (e.g. CPA mfort. Relieve pa and manual trea s consistent with (	and consistent P, BiPAP). <i>Trai</i> an and suffering tment of airway	with patier asfer to hos through the obstruction
medications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av Comfort-Focused Treatment: use of medication by any route: Do not use treatments listed in in transfer to hospital only if co	bed in Comfort-Focused poliotics and vasopresson flay consider less invasi old the intensive care ur : Primary goal of maxi as needed; use oxygen Full and Selective Treat comfort needs cannot be primary selective Treat primary selective primary selective primary primar	Treatment s), as medi ve airway s nit im izing co , suctioning ment unles be met in c	, use medical tre cally appropriate upport (e.g. CPA mfort. Relieve ps and manual trea s consistent with uurrent location.	and consistent P, BiPAP). Tran in and suffering tment of airway comfort goal. R	with patiensfer to hos gith rough the obstruction equest
me dications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focus ed Treatment use of medication by any route. Do not use treatments listed in transfer to hospital only if co	bed in Comfort-Focused biotics and vasopressor lay consider less invasi loid the intensive care us Primary goal of maxi as needed, use oxygen Full and Selective Treat or mfort needs cannot be NUTRITION (if medical utrition, including feeding to	Treatment s), as medi ve airway s nit im izing co , suctioning ment unless be met in c  ly indicated) ubes. Ac	, use medical tre cally appropriate upport (e.g. CPA mfort. Relieve ps and manual trea s consistent with uurrent location.	and consistent P, BiPAP). Tran in and suffering tment of airway comfort goal. R	with patiensfer to hos gthrough to obstruction equest
medications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focused Treatment use of medication by any route Do not use treatments listed in I transfer to hospital only if co	bed in Comfort-Focuseo blotics and vasopressor lay consider less invasi- old the intensive care ui: Frimary goal of maxi- saneeded; use oxygen Full and Selective Treat omfort needs cannot b NUTRITION (if medical lutrition, including feeding to ad nutrition, including feeding to	if Treatment s), as medi ve airway s nit im izing co , suctioning ment unless be met in c  ly indicated) ubes. Ac ag tubes.	, use medical tre cally appropriate upport (e.g. CPA mfort. Relieve pa and manual treas s consistent with a urrent location.  Offer food by mou	and consistent P, BiPAP). Tran in and suffering tment of airway comfort goal. R	with patiensfer to hos gthrough to obstruction equest
medications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av Do Comfort-Focus ed Treatment use of medication by any route Do not use treatments listed in I transfer to hospital only if co Optional Additional Orders	bed in Comfort-Focused blotts and vasopressor lay consider less invasi- old the intensive care ui: Erhimary goal of maxi- as needed; use oxygen Full and Selective Treat full and Selective Treat omfort needs cannot be NUTRITION (if medical utrition, including feeding to the dutrition, including feeding of nutrition, including feeding full files.	if Treatment s), as medi ve airway s nit im izing co , suctioning ment unles be met in c  ly indicated) ubes. Ac g tubes. g tubes.	, use medical tre cally appropriate upport (e.g. CPA mfort. Relieve ps and manual trea s consistent with urrent location. Offer food by mou tititional instruction	and consistent P, BiPAP). Tran in and suffering tment of airway comfort goal. R	with patier nsfer to hos g through the obstruction equest
me dications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focus ed Treatments use of medication by any route. Do not use treatments listed in it ransfer to hospital only if cooptional Additional Orders  MEDICALLY ADMINISTERED D. Long-term medically administered in Trial period of medically administered. No medically administered means of DOCUMENTATION OF DISCUSS.	bed in Comfort-Focused biotics and vasopressor lay consider less invasi- loid the Intensive care us: Primary goal of maxi- as needed, use oxygen Full and Selective Treat- pornfort needs cannot be NUTRITION (If medical utrition, including feeding to admittal to the control of ruttion, including feeding of nutrition, including feeding SION (Check all appropria	d Treatment s), as medi s), as medi ve airway s n/t im izing coi , suctioning ment unless the met In c  ty indicated) ubes. A  g tubes. g tubes. ste boxes beleatth care	, use medical tre cally appropriate upport (e.g. CPA mmfort. Relieve pa and manual trea s consistent with urrent location. Offer food by mou ktitional Instruction	and consistent P, BiPAP). Trai in and suffering thent of airway comfort goal. R	with patier to how of the how of the patier to how
me dications (may include antilipreference. Do Not Intubate. Mindicated. Generally av. Comfort-Focus ed Treatment use of medication by any route Do not use treatments listed in transfer to hospital only if cooptional Additional Orders  IEDICALLY ADMINISTERED IN Long-term medically administered in the Documental State of Mindicational Occumentation of medically administered means of Documentation of Discussional Patient Dearent of minor	bed in Comfort-Focuseo blootics and vasopressor fay consider less invasi- old the intensive care ui: Primary goal of maxi- sor and the intensive care ui: Primary goal of maxi- som for the company of the company NUTRITION (if medical uutrison, including feeding to ad nutrison, including feedin of nutrition, including feedin Of nutrition, including feedin Agent under h Health care si	d Treatment s), as medi s), as medi ve airway s n/t im izing coi , suctioning ment unless the met In c  ty indicated) ubes. A  g tubes. g tubes. ste boxes beleatth care	, use medical trecally appropriate acally appropriate upport (e.g. CPA mfort. Relieve ps and manual treas and manual treas urrent location.  Offer food by mountain differ food differ food by mountain differ food by mountain differ food differ foo	and consistent P, BiPAP). Trai in and suffering thent of airway comfort goal. R	with patien sfer to hos g through the obstruction equest d as desired of trial period
me dications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focus ed Treatments use of medication by any route. Do not use treatments listed in it ransfer to hospital only if cooptional Additional Orders  MEDICALLY ADMINISTERED D. Long-term medically administered in Trial period of medically administered. No medically administered means of DOCUMENTATION OF DISCUSS.	bed in Comfort-Focuseo blootics and vasopressor fay consider less invasi- old the intensive care ui: Primary goal of maxi- sor and the intensive care ui: Primary goal of maxi- som for the company of the company NUTRITION (if medical uutrison, including feeding to ad nutrison, including feedin of nutrition, including feedin Of nutrition, including feedin Agent under h Health care si	d Treatment s), as medi s), as medi ve airway s n/t im izing coi , suctioning ment unless the met In c  ty indicated) ubes. A  g tubes. g tubes. ste boxes beleatth care	, use medical trecally appropriate upport (e.g. CPA mfort. Relieve ps and manual treas a consistent with ourrent location.  Offer food by mountail treas to the food by mountail treas to consistent with ourrent location.	and consistent P, BiPAP). Tran in and suffering in and suffering thent of airway comfort goal. R  th, if feasible am ns (e.g., length of e Page 2 for pr	with patien sfer to hos g through the obstruction equest d as desired of trial period
medications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focus ed Treatment use of medication by any route Do not use treatments listed in transfer to hospital only if co Optional Additional Orders	bed in Comfort-Focuseo blootics and vasopressor fay consider less invasi- old the intensive care ui: Primary goal of maxi- sor and the intensive care ui: Primary goal of maxi- som for the company of the company NUTRITION (if medical uutrison, including feeding to ad nutrison, including feedin of nutrition, including feedin Of nutrition, including feedin Agent under h Health care si	I Treatment I Treatment I Treatment I Treatment I Treatment I I I I I I I I I I I I I I I I I I I	, use medical trecally appropriate upport (e.g. CPA mfort. Relieve ps and manual treas a consistent with ourrent location.  Offer food by mountail treas to the food by mountail treas to consistent with ourrent location.	and consistent P, BiPAP). Tran in and suffering in and suffering thent of airway comfort goal. R  th, if feasible am ns (e.g., length of e Page 2 for pr	with patier to hos g through the obstruction equest d as desired of trial perior iority list)
medications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focus ed Treatment use of medication by any route Do not use treatments listed in transfer to hospital only if co Optional Additional Orders	bed in Comfort-Focused blottos and vasopressor lay consider less invasi- loid the intensive care us. Primary goal of maxi- s an eeded; use oxygen Full and Selective Treat buffort needs cannot butter. In the selection of the selection of nutrition, including feeding in Agent under health care stepresentative	I Treatment I Treatment I Treatment ve airway s nit mizing co , suctioning ment unless ve met in c  ly indicated) bbs. An g tubes.  ate boxes beleeath care urrogate de  Name (pfir  m) ss had an opp ss had an opp ss had an opp	, use medical trecally appropriate upport (e.g. CPA mfort. Relieve ps and manual treas a consistent with our ment location.  Offer food by mountail treas to make the second of the food by mountail treas to make the second of the food by mountail treas to the food by mountail	and consistent P, BiPAP). Tran in and suffering in and suffering thent of airway comfort goal. R  th, if feasible and ns (e.g., longth of e Page 2 for pri  Dr  Tom and have with	with patiet safer to ho  g through the obstruction equest  d as desirect of that period  ionity list)  ate
me dications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focus ed Treatment use of medication by any route Do not use treatments listed in it transfer to hospital only if co Optional Additional Orders	bed in Comfort-Focused blottos and vasopressor lay consider less invasi- loid the intensive care us. Primary goal of maxi- s an eeded; use oxygen Full and Selective Treat buffort needs cannot butter. In the selection of the selection of nutrition, including feeding in Agent under health care stepresentative	I Treatment I Treatment I Treatment ve airway s nit mizing co , suctioning ment unless ve met in c  ly indicated) bbs. An g tubes.  ate boxes beleeath care urrogate de  Name (pfir  m) ss had an opp ss had an opp ss had an opp	, use medical trecally appropriate upport (e.g. CPA mfort. Relieve ps and manual treas so consistent with urrent location.  Offer food by mountilitional Instruction with the maker (Second of the mak	and consistent P, BiPAP). Trait in and suffering thrent of airway comfort goal. R  th, if feasible are ns (e.g., length of  e Page 2 for pr  Do  command have with sk on this form in	with patier sifer to hos g through the obstruction equest  d as desired of trial period ionity list) sate
me dications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focus ed Tre atmentuse of medication by any route. Do not use treatments listed in it ransfer to hospital only if co Optional Additional Orders    MEDICALLY ADMINISTERED     Long-term medically administered in Trial period of medically administered. In medically administered means of DOCUMENTATION OF DISCUS:   Patient   Parent of minor     Signature of Patient or Legal R: Signature (required)    Signature of Witness to Consent   Iam 18 years of age or older and actino giving of consent by the above person of Signature (required)    Signature of Authorized Practitic preference of Signature of Authorized Practitic preference in the preference of Signature of Authorized Practitic preference in the preference of Signature of Authorized Practitic preference in the preference of Signature of Authorized Practitic preference in the preference of Signature of Authorized Practitic preference in the preference of Signature of Authorized Practitic preference in the preference of Signature of Authorized Practitic preference in the preference of Signature of Authorized Practitic preference in the preference i	oed in Comfort-Focused bloots and vasopressor lay consider less invasion to the intensive care uit. Primary goal of maxima as needed; use oxygen Full and Selective Treat purfort needs cannot but the control of the co	I Treatment I Treatment I Treatment I Treatment I I I I I I I I I I I I I I I I I I I	, use medical tre cally appropriate upport (e.g., CPA mfort. Relieve ps and manual trea s consistent with urrent location.  Offer food by mou utilitional Instruction  ow) power of attorney cision maker (Se  it)  cortunity to read this utility to read this utility to read this unity to read this un	and consistent P, BiPAP). Trait in and suffering thent of airway comfort goal. R  th, if feasible are is (e.g., length of  Page 2 for pr  Or  Torm and have with ask on this form in in  Di  depractice nurse or pi	with patien series to how a series to how a series to how a series obstruction equest as desired as desired fittal period to rity list) attempts as the massed the may presence at the mysician assists.
me dications (may include antib preference. Do Not Intubate. M pital, if indicated. Generally av. Comfort-Focused Treatment: use of medication by any route. Do not use treatments listed in it transfer to hospital only if co Optional Additional Orders    MEDICALLY ADMINISTERED   Optional Additional Orders	bed in Comfort-Focused blotos and vasopressor lay consider less invasion to the intensive care ut: Primary goal of maximum as needed; use oxygen Full and Selective Treat puriforn, including feeding to the control of nutrition, including feeding function, including feeding to the sale of th	I Treatment I Treatment I Treatment I Treatment I I I I I I I I I I I I I I I I I I I	, use medical tre cally appropriate upport (e.g., CPA mfort. Relieve ps and manual trea s consistent with urrent location.  Offer food by mou utilitional Instruction  ow) power of attorney cision maker (Se  it)  cortunity to read this utility to read this utility to read this unity to read this un	and consistent P, BiPAP). Trait in and suffering thent of airway comfort goal. R  th, if feasible are is (e.g., length of  Page 2 for pr  Or  Torm and have with ask on this form in in  Di  depractice nurse or pi	with patients of hot government of hot governmen

HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

-	THIS SIDE FOR INFOR	MATIONAL PURI	POSES ONLY**	
Patient Last Name		Patient First Name		MI
is always voluntary. This order re- medical treatment is begun and change. Your medical care and thi address all the medical treatment Directive (POAHC) is recommend	cords your wishes for the risks and bene is form can be change decisions that may ne ed for all capable ad	medical treatments of further the distribution of further the distribution of the made. The made is the made of th	is for Life-Sustaining Treatment (POLS ent in your current state of health. On herapy are dear, your treatment wish new wishes at any time. However, no he Power of Attorney for Health Care of their health status. A POAHC allow gal Representative to speak for you if	ce initia les ma form car Advano s you t
	Advance D	irective informati	on	
I a	lso have the following	advance directiv	ves (OPTIONAL)	
☐ Health Care Power of Attorney	☐ Living Will Dec	faration 🗅	Mental Health Treatment Preference De	daration
Contact Person Name			Contact Phone Number	
	Health Care P	rofessional inforr	natio n	
Preparer Name			Phone Number	
Preparer Title			Date Prepared	
<ul> <li>A POLST should reflect current prefe</li> </ul>	is always voluntary, or rences of persons comp with follow-up signature	leting the POLST I by authorized prac	ed and may be changed at any time. Form; encourage completion of a POAHC.	ity polic

#### Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- · transfers from one care setting or care level to another:
- changes in the patient's health status or use of implantable devices (e.g. ICDs/cerebral stimulators);
- . the patient's ongoing treatment and preferences; and
- · a change in the patient's primary care professional.

#### Voiding or revoking a POLST Form

- . A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- . If included in an electronic medical record, follow all voiding procedures of facility.

#### Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

- 1. Patient's guardian of person
- 2. Patient's spouse or partner of a registered civil union
- 3. Adult child
- 4 Parent

- 6. Adult grandchild
- 7. A close friend of the patient
- 8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT



■ SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2017 ■

## 3 Primary Medical Order Sections

#### A. If NO pulse and NO breathing: CPR wishes

- Attempt resuscitation
- Do Not Attempt resuscitation (DNR)

# B. If pulse and/or breathing are present: Care wishes

- Full Treatment
- Selective Treatment
- Comfort-Focused Treatment

#### C. Medically Administered Nutrition

- Acceptable
- Trial Period
- None



CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

☐ Attempt Resuscitation/CPR

□ Do Not Attempt Resuscitation/DNR

(Selecting CPR means Full Treatment in Section B is selected)

When not in cardiopulmonary arrest, follow orders B and C.

Section A documents what a person wishes to occur if they are found with no pulse and not breathing.

The presence of a POLST form <u>DOES NOT</u> mean DNR. Patients can use a POLST Form to indicate "Attempt Resuscitation" as well as "Do Not Attempt Resuscitation".



If "Attempt Resuscitation/CPR" box checked: Start CPR and full cardiac arrest care per local protocol.



If "DNR" box checked: Do NOT begin CPR.

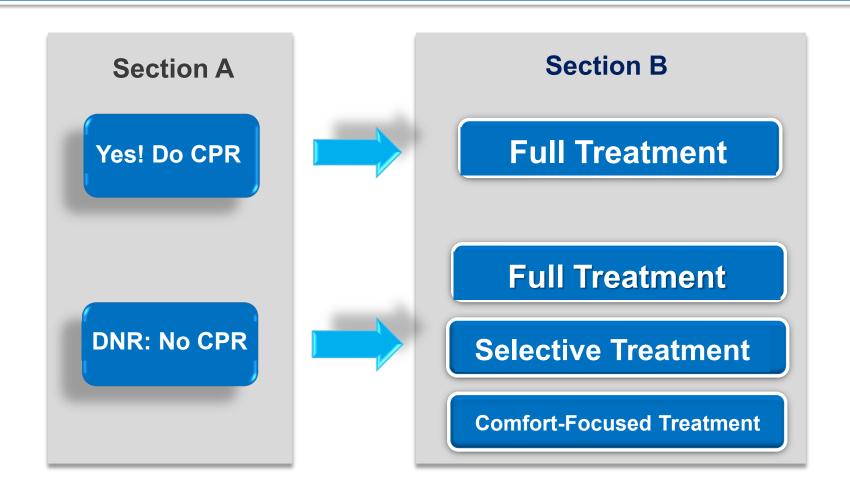


# Attempt CPR is the Default Why use the form to request CPR?

- Elderly and those with disabilities may fear they will not receive same emergency care as others
- May have created a POLST form marking DNR box during a serious illness. May create a new form if health improves or they desire to reach a milestone moment; now selecting attempt CPR



## **Acceptable Options for a Valid Form**



Check One (optional)

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

□ Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. Transfer to hospital and/or intensive care unit if indicated.

DPH POLST

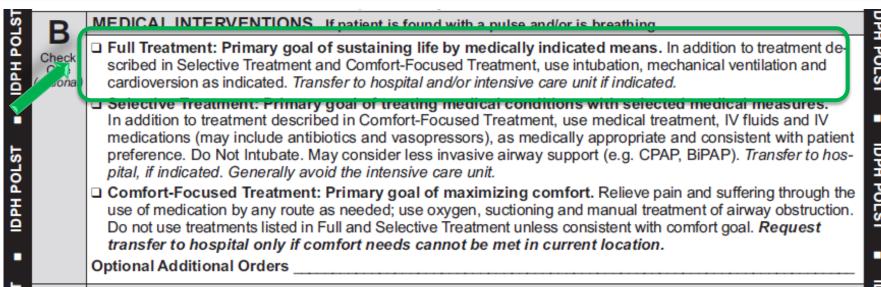
**IDPH POLST** 

- □ Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital, if indicated. Generally avoid the intensive care unit.
- Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of 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.

**Optional Additional Orders** 

Section B documents what a person wishes to occur if they are found with a pulse and/or breathing present but unable to communicate; cardiac arrest may occur shortly.

The checked box explains patient's goal for treatment and specifies which treatments the patient wants to have and avoid.



✓ Full Treatment: Transfer me to the hospital and provide all appropriate treatment. I want to live as long as possible.

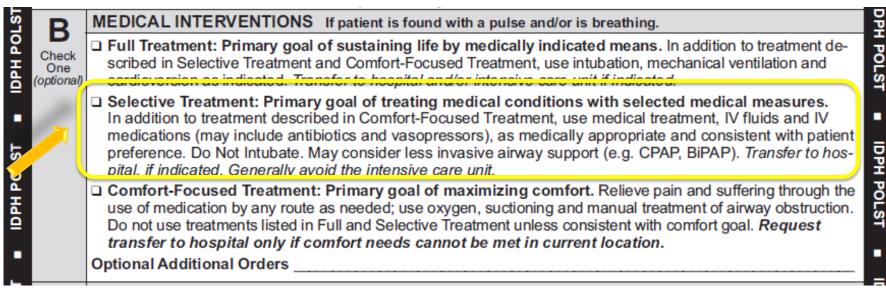
Must be selected when selecting CPR in section A

Either box may be marked in Section A



DPH POLST

IDPH POLST



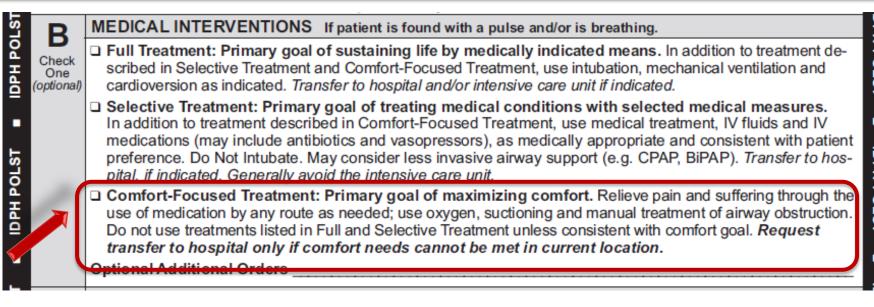
✓ Selective Treatment: Transfer me to the hospital for medical treatment, but I do not want to be on the ventilator.

Person could receive treatments such as:

- IV fluids; IV meds as appropriate
- May use CPAP, BiPAP, BVM
- Other treatments as needed to return to "baseline"



DPH POLST



✓ **Comfort-Focused Treatment**: I want to be as comfortable as possible where I am but transfer me to the hospital if my pain or symptoms cannot be alleviated.



DPH POLST

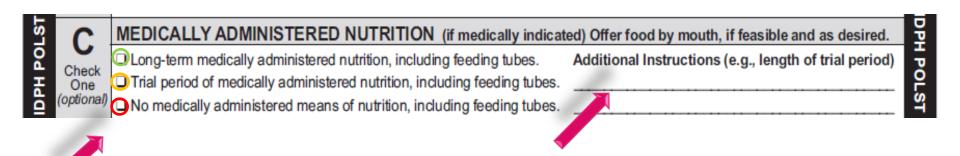
IDPH POLST

=

Optional Additional Orders - used to customize form for individual medical conditions when necessary



#### Section "C": Medically Administered Nutrition



#### Documents how nutrition should be administered

- Always offer food by mouth if safe and desirable
- This section does not typically apply to an emergency
- Provides clear direction to avoid contested care
- For patients with TPN/tube feedings needing transport, contact Medical Control



#### Section D: Documentation of Discussion

	D	DOCUMENTATION OF DISC	USSION (Check all appropria	ite boxes below)		
ST	U	☐ Patient☐ Parent of minor		ealth care power of attor	rney (See Page 2 for priority list)	БЬ
POLST		Signature of Patient or Lega	al Representative			Ī
IDPH		Signature (required)		Name (print)	Date	OLST
ST .		Signature of Witness to Consol am 18 years of age or older and a giving of consent by the above personal signature.	cknowledge the above person ha	s had an opportunity to read	this form and have witnessed the or mark on this form in my presence.	■ IDP
ры Росят		Signature (required)		Name (print)	Date	H POLS

#### **Need 2 signatures here**

- Patient, agent (POAHC), or healthcare surrogate
- Witness to consent

If consented by patient's legal representative, supporting documents verifying agent powers are NOT needed by EMS



## Section E: Signature of Practitioner

<b>-</b>	E	Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)					
	_	My signature below indicates to the best of my knowledge and belief that these orders are		_			
_		Print Authorized Practitioner Name (required)	Phone				
STO			( )	뫄			
IDPH POLST		Authorized Practitioner Signature (required)	Date (required)	POLST			
	Form	Revision Date - April 2016	(Prior form versions are also valid.)				
	SEND A	A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED . CO	OPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2016				

Must have practitioner's name, signature, and effective date to be valid. Verbal orders are allowable.

Practitioner's signature may be written by a nurse who adds her/his own initials - acceptable and form is valid



#### Back Page – EMS does not take action

HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

"THIS SIDE FOR INFORMATIONAL PURPOSES ONLY"

Patient Last Name	Patient Fire	t Name		MI
Use of the Illinois Department of P is always voluntary. This order re medical treatment is begun and change. Your medical care and thi address all the medical treatment Directive (POAHC) is recommend document, in detail, your future he unable to speak for yourself.	cords your wishes for medical to the risks and benefits of fur s form can be changed to reflect decisions that may need to be maded for all capable adults, regar	ther the tyour reade. To dless of	ent in your current state of health, herapy are dear, your treatment hew wishes at any time. However, he Power of Attorney for Health C of their health status. A POAHC a	Once initial wishes may no form can are Advance illows you to
	Advance Directive Inf	orm atk	on	
Ti	iso have the following advance	directiv	es (OPTIONAL)	
☐ Health Care Power of Attorney	☐ Living Will Declaration		Mental Health Treatment Preference	Declaration
Contact Person Name			Contact Phone Number	
	Health Care Professiona	Inform	natio n	
Preparer Name			Phone Number	
Preparer Title			Date Prepared	
	1978, 30, 30, 30, 31, 31, 31, 31, 31, 31, 31, 31, 31, 31			

#### Completing the IDPH POLST Form

- . The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- · Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

#### Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- · transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g. ICDs/cerebral stimulators);
- . the patient's ongoing treatment and preferences; and
- · a change in the patient's primary care professional.

#### Voiding or revoking a POLST Form

- · A patient with capacity can void or revoke the form, and/or request alternative treatment.
- . Changing, modifying or revising a POLST form requires completion of a new POLST form.
- . Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- · If included in an electronic medical record, follow all voiding procedures of facility.

#### Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person

- 2. Patient's spouse or partner of a registered civil union
- 6. Adult grandchild

7. A close friend of the patient

3. Adult child 4 Parent

8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

mich 100 17-564

- Completing the back page of the POLST form is optional
- Form is valid if only first page.
- Information is helpful in identifying next of kin/emergency contact information.

# Applying POLST Forms in the Field

## Requirements for a Valid POLST Form

#### REQUIRED

Patient Identifying Information

#### Section A

#### 3 Signatures:

- 1) Patient or legal substitute decision-maker
- 2) Witness
- 3) Practitioner

Date of Practitioner Signature

#### **OPTIONAL**

All other information optional

All indicated treatment used where a decision is unspecified

Pink paper recommended to enhance visibility, but color does not affect validity of form

#### Valid POLST Forms

- ✓ Properly executed prior versions of the IDPH Uniform DNR or the DNR/POLST Advance Directive are still valid. Most recently dated is followed.
- ✓ Photocopies of forms are valid.
- ✓ Picture of POLST form on electronic device is valid.



#### What if 2 or more POLST forms are present?

- Newest valid form voids past forms
- Follow instructions on form with most recent date and all required elements
- EMS is not responsible for investigating presence of other forms - consider form presented to be most current and valid.



#### Who can revoke POLST orders?

- Patient, if competent to make decisions, can revoke a POLST at any time
- Other situations more complicated and may take time to resolve
- If any doubt or dispute, call OLMC
  - A POA/Surrogate should generally not overturn decisions made, documented, and signed by a <u>patient</u>
- EMS responders are legally protected if they follow orders on a valid form in good faith



# What if a POAHC or Surrogate disputes a valid POLST order to which they previously consented?

# Determine if person disputing order is the original consenting POAHC or surrogate

- If yes: The POAHC/surrogate may change the order and/or care wishes
- If no: Follow orders on the POLST form; contact
   OLMC for further direction



#### Legal Risk for EMS Following POLST Form

"A health care professional who in good faith complies with a do-not-resuscitate order made in accordance with this Act is not, as a result of that compliance, subject to any criminal or civil liability, except for willful and wanton misconduct, and may not be found to have committed an act of unprofessional conduct."

Illinois Health Care Surrogate Act



## **QUESTION & ANSWER**

## Let's Review

An unconscious adult presents in bed at home. The patient is not breathing but does have a weak pulse. An IDPH POLST form is on the fridge. What part of the form is most relevant right now?

- A. Section A: Has the patient marked DNR?
- B. Section B: How aggressively does the patient want to be treated?
- C. Section C: Has the patient consented to artificial nutrition?



Answer is B. Because the patient still has a pulse, section A does not apply now.

Section C discusses the placement of a feeding tube and is not immediately relevant here.



You are called to an emergency in a person's home and find a gentleman lying in his own bed. He is not breathing and has no pulse.

The neighbor has already started CPR. The IDPH POLST form is on the fridge. What instructions are you looking for?

- A. Section A: has the patient marked DNR?
- B. Section B: how aggressively does the patient want to be treated?
- C. Section C: has the patient consented to artificial nutrition?



Answer is A. Patient is not breathing and does not have a pulse so sections B and C would not apply now.

If the neighbor is not a healthcare provider, they would not be expected to know about or follow the POLST form. If the neighbor has not restored breathing or a pulse, the EMS provider would still follow the POLST instructions under section A.



A patient presents in cardiac arrest and his wife provides two forms, one earlier IDPH DNR Advance Directive/POLST form, dated 3/16/15 and one revised IDPH POLST form dated 3/27/ 2019. The options chosen on the two forms conflict. What should you do?

- A. Provide the more aggressive treatment indicated, just in case.
- B. Ask the patient's wife to resolve the difference between the forms.
- C. Provide the treatment indicated in the most recently dated POLST form.



Answer is C. Provide the treatment indicated in the most recently dated POLST form.

Newest valid form voids past forms. Follow instructions on form with most recent date and all required elements.



An unconscious female presents on the floor at home. The patient is is having a seizure, is breathing and has a pulse. The patient's husband shows you her IDPH Uniform POLST form where CPR is selected in Section A, and Comfort-Focused Care is selected in Section B. What should you do?

- A. Provide Full Treatment as indicated and within your scope of practice.
- B. Provide Comfort-Focused Treatment only.
- Contacting OLMC for assistance before doing anything.



A person who has chosen CPR in Section A of IDPH Uniform POLST form will receive all medically indicated treatments in a pre-arrest emergency, i.e. Full Treatment in Section B, even if Comfort Care or Limited Additional Interventions are selected on the form.

It would not make sense to provide only comfort-focused treatment up until a person dies and then provide CPR.



#### **POLST Resources**

For POLST Illinois information:
polstlllinois@gmail.com
1-855-765-7845
www.polstil.org

National POLST Program www.polst.org

This presentation created by the POLST Illinois Education Committee has been made possible by in-kind and other resources provided by:



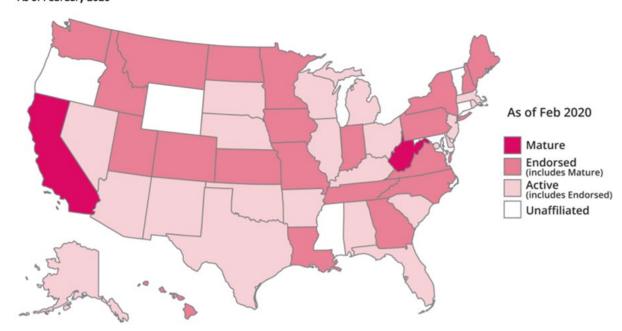
Practitioner Orders for Life-Sustaining Treatment



## Where did POLST come from?



National POLST Program Designations As of February 2020





#### Why would a person need a POLST form?

- Helps ensure appropriate care and treatment if a person experiences an acute deterioration of their health
- Helps share goals-of-care preferences and instructions amongst family caregivers or when transferring sites of care (e.g., nursing home, paramedics, hospital, home)
- Allows loved-ones to contact 911 in a critical medical emergency without fear of patient receiving unwanted treatment if death is imminent



# How is a POLST Form different from a Power of Attorney for Health Care?

	POWER of ATTORNEY for HEALTH CARE	POLST Form
Who needs	All Decisional Adults	Serious Life-limiting Medical Condition
Who completes	Individual	Health Care Practitioner
Appoints a substitute decision maker	Yes	No
Real-time instructions for first responders	No	Yes



## **Acceptable Options for a Valid Form**

