POLST ILLINOIS

Practitioner Orders for Life-Sustaining Treatment

Emergency Medical Services & First Responder Audience

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POLST ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

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.

POLST ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

Objectives

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

- Understand the **POLST Model** 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 ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

POLST Program Overview

What is POLST?

- In Illinois - POLST stands for **Practitioner*** 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

* Physician, Advanced Practice Registered Nurse, Physician Assistant, Resident in 2nd year or higher of residency program

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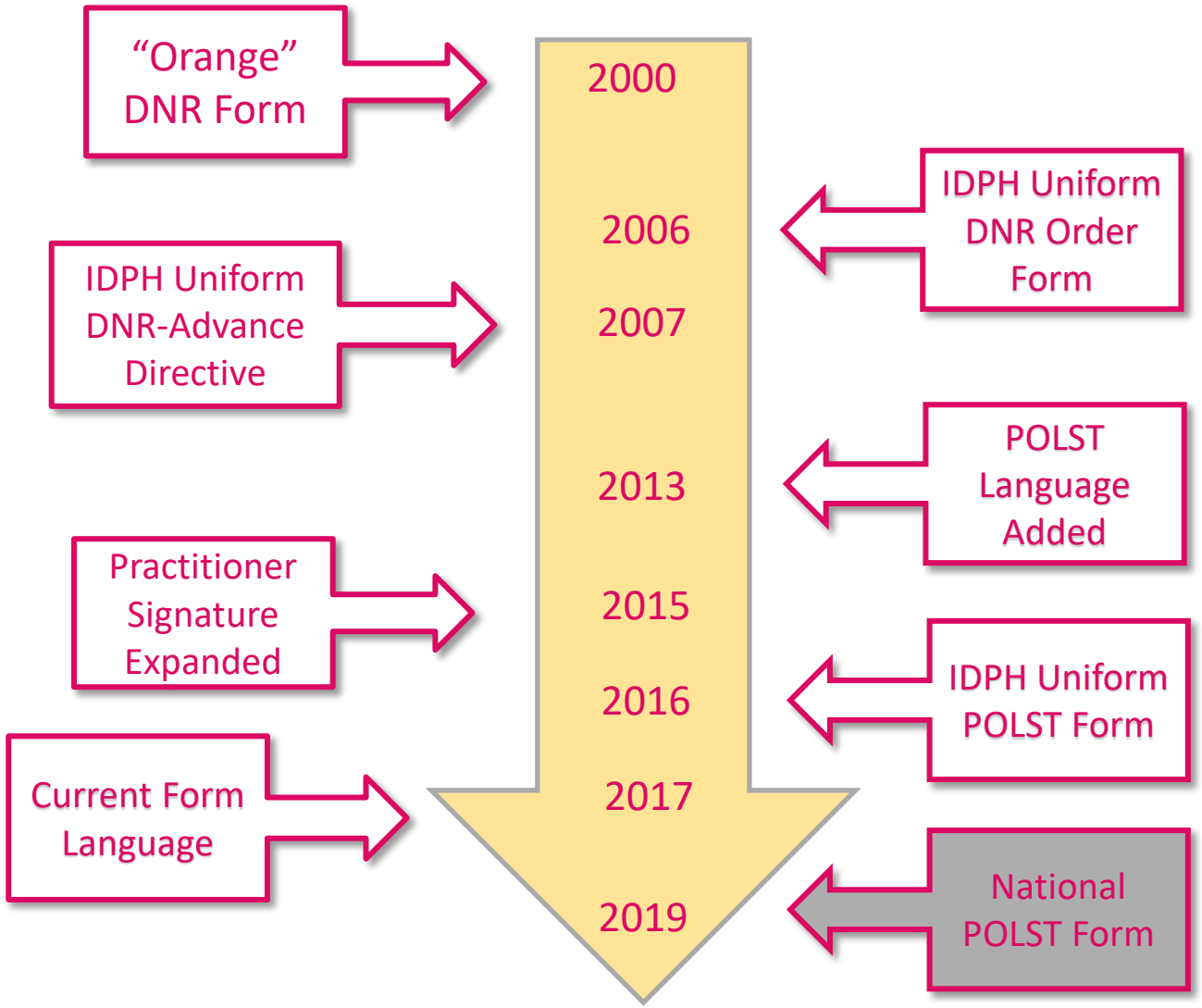
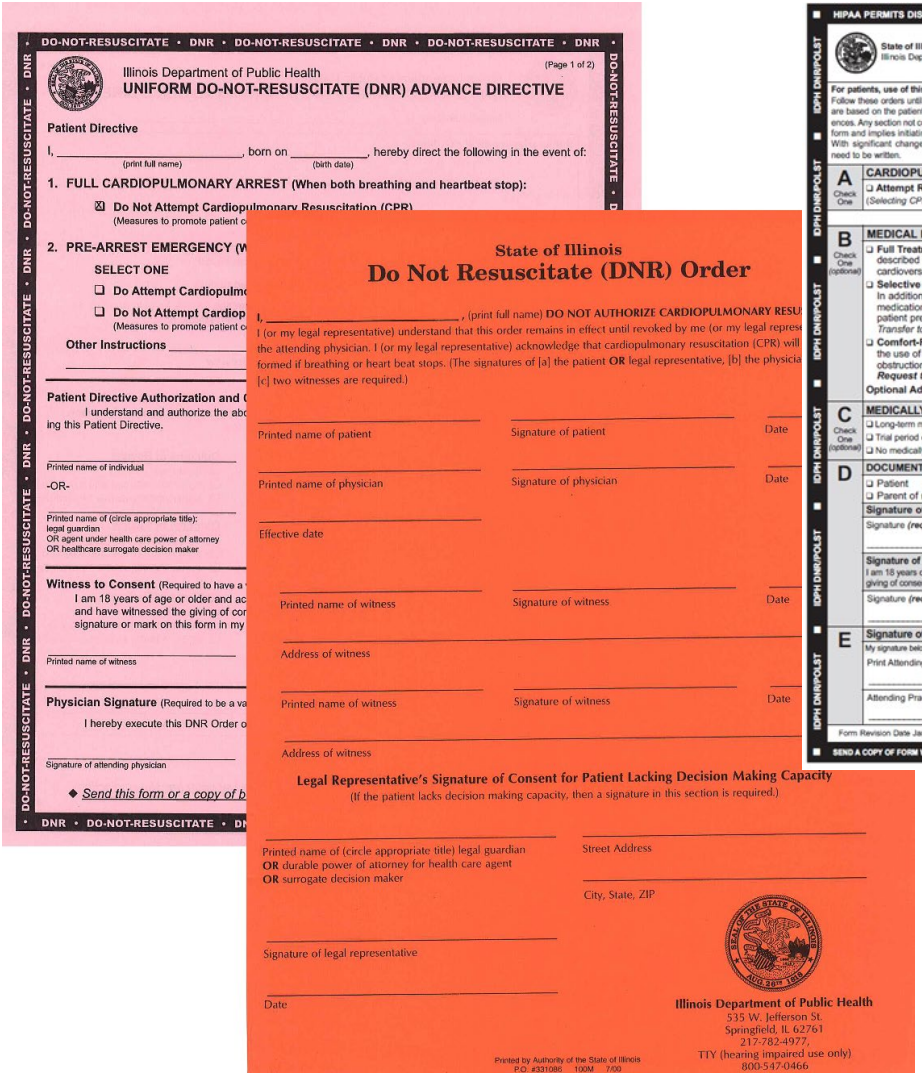
Evolution of the IDPH Uniform POLST Form



Various Forms Past & Present



DO-NOT-RESUSCITATE • DNR • DO-NOT-RESUSCITATE • DNR • DO-NOT-RESUSCITATE • DNR •

(Page 1 of 2)

Illinois Department of Public Health
UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

Patient Directive

I, _____ (print full name), born on _____ (birth date), hereby direct the following in the event of:

1. FULL CARDIOPULMONARY ARREST (When both breathing and heartbeat stop):

☒ **Do Not Attempt Cardiopulmonary Resuscitation (CPR)**
(Measures to promote patient c

2. PRE-ARREST EMERGENCY (W

SELECT ONE

❑ Do Attempt Cardiopulm

❑ Do Not Attempt Cardiop
(Measures to promote patient c

Other Instructions _____

Patient Directive Authorization and
I understand and authorize the ab
ing this Patient Directive.

Printed name of individual

-OR-

Printed name of (circle appropriate title):
legal guardian
OR agent under health care power of attorney
OR healthcare surrogate decision maker

Witness to Consent (Required to have a
I am 18 years of age or older and ac
and have witnessed the giving of cor
signature or mark on this form in my

Printed name of witness

Physician Signature (Required to be a va
I hereby execute this DNR Order o

Signature of attending physician

◆ *Send this form or a copy of b*

DNR • DO-NOT-RESUSCITATE • DN

State of Illinois
Do Not Resuscitate (DNR) Order

I, _____, (print full name) **DO NOT AUTHORIZE CARDIOPULMONARY RESU**
I (or my legal representative) understand that this order remains in effect until revoked by me (or my legal repres
the attending physician. I (or my legal representative) acknowledge that cardiopulmonary resuscitation (CPR) will
formed if breathing or heart beat stops. (The signatures of [a] the patient **OR** legal representative, [b] the physicia
[c] two witnesses are required.)

Printed name of patient | Signature of patient | Date

Printed name of physician | Signature of physician | Date

Effective date

Printed name of witness | Signature of witness | Date

Address of witness

Printed name of witness | Signature of witness | Date

Address of witness

Legal Representative's Signature of Consent for Patient Lacking Decision Making Capacity
(If the patient lacks decision making capacity, then a signature in this section is required.)

Printed name of (circle appropriate title) legal guardian
OR durable power of attorney for health care agent
OR surrogate decision maker

Street Address

City, State, ZIP

Signature of legal representative

Date

Illinois Department of Public Health
535 W. Jefferson St.
Springfield, IL 62761
217-782-4977,
TTY (hearing impaired use only)
800-547-0466

Printed by Authority of the State of Illinois
P.O. #331085 100M 7/00

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

IDPH DNR/POLST

State of Illinois
Illinois Department of Public Health

DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name | Patient First Name | MI

Date of Birth (mm/dd/yy) | Gender ❑ M ❑ F

Address (street/city/state/ZIPcode)

A Check One — **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.

B 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.*
❑ **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 _____

C Check One (optional) — **MEDICALLY ADMINISTERED NUTRITION** (if medically indicated) Offer food by mouth, if feasible and as desired.
❑ Long-term medically administered nutrition, including feeding tubes. **Additional Instructions (e.g., length of trial period)**
❑ Trial period of medically administered nutrition, including feeding tubes.
❑ No medically administered means of nutrition, including feeding tubes.

D **DOCUMENTATION OF DISCUSSION** (Check all appropriate boxes below)
❑ Patient ❑ Agent under health care power of attorney
❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative
Signature (*required*) | Name (print) | Date

Signature of Witness to Consent (Witness required for a valid form)
I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.
Signature (*required*) | Name (print) | Date

E **Signature of Attending 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 consistent with the patient's medical condition and preferences.
Print Attending Practitioner Name (*required*) | Phone
Attending Practitioner Signature (*required*) | Date (*required*)

Page 1

Form Revision Date January 2015 (Prior form versions are also valid.)

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2015

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.

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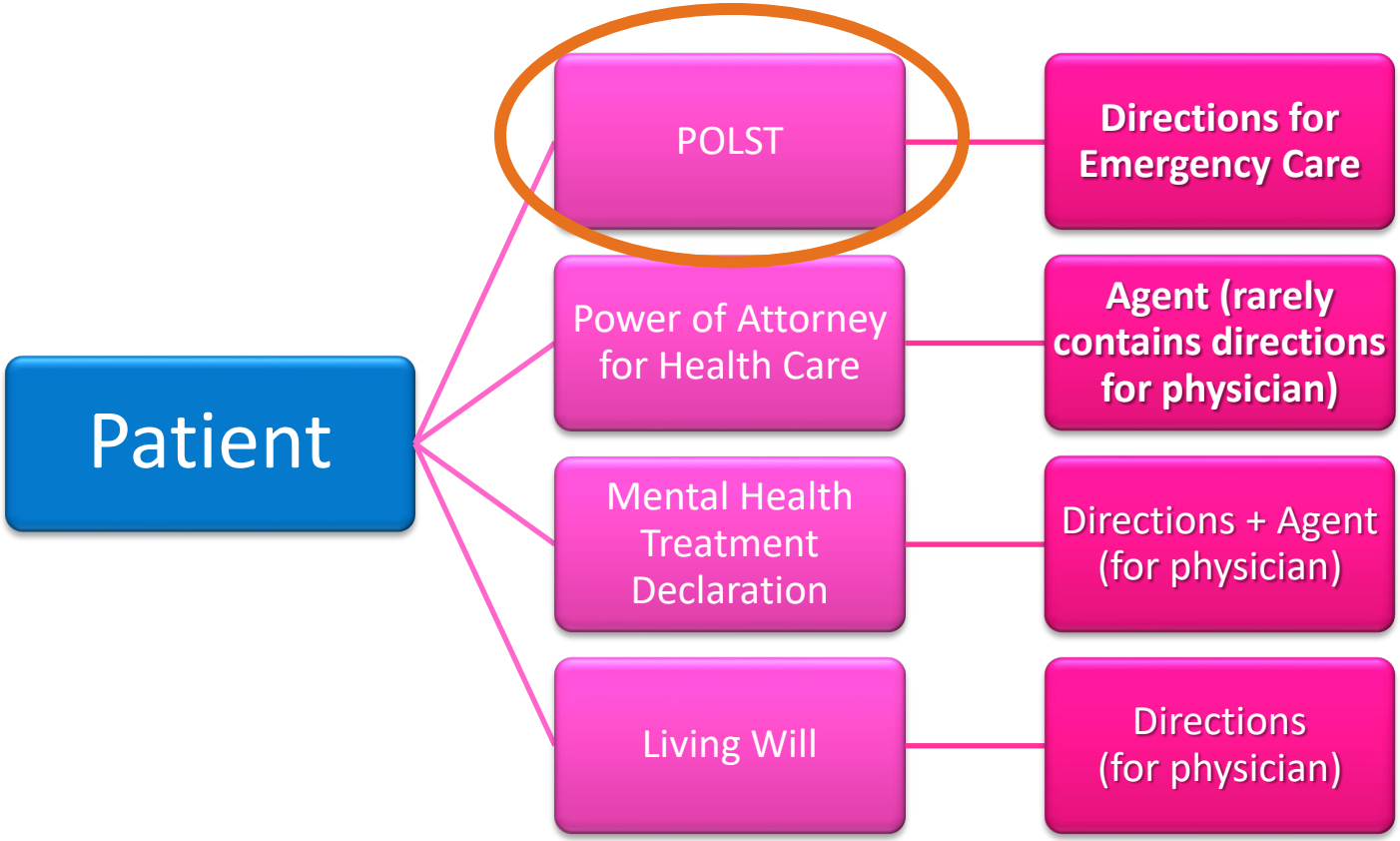
Rely on Advance Directives (POLST) ONLY if Patient CANNOT Make Decisions



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Practitioner Orders for Life-Sustaining Treatment

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 **medical orders** 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)

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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.

- **COMPLETING FORM IS VOLUNTARY**: 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.

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Practitioner Orders for Life-Sustaining Treatment

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 life-threatening emergencies

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IDPH Uniform POLST: Form Explanation

The IDPH Uniform POLST Form

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

State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIP code)		

A Check One

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.

B Check One

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.*

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Optional Additional Orders _____

C Check One

MEDICALLY ADMINISTERED NUTRITION (If medically indicated) Offer food by mouth, if feasible and as desired.

❑ Long-term medically administered nutrition, including feeding tubes. **Additional Instructions (e.g., length of trial period)**

❑ Trial period of medically administered nutrition, including feeding tubes. _____

❑ No medically administered means of nutrition, including feeding tubes. _____

D

DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

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 consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name *(required)*	Phone ( ) -
Authorized Practitioner Signature *(required)*	Date *(required)*

Page 1

Form Revision Date - May 2017 (Prior form versions are also valid.)

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

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

"THIS SIDE FOR INFORMATIONAL PURPOSES ONLY"

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

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
3. Adult child
4. Parent
5. Adult sibling
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

IOCI 17-564

Page 2

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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

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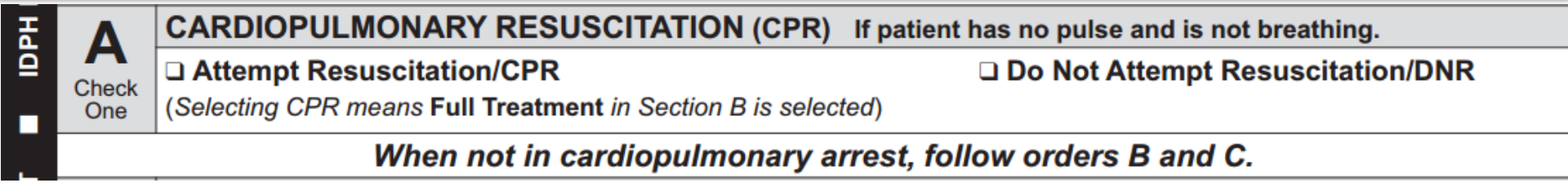
Practitioner Orders for Life-Sustaining Treatment

Section “A”: Cardio-Pulmonary Resuscitation



IDPH

A Check One

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 DOES NOT 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.

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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

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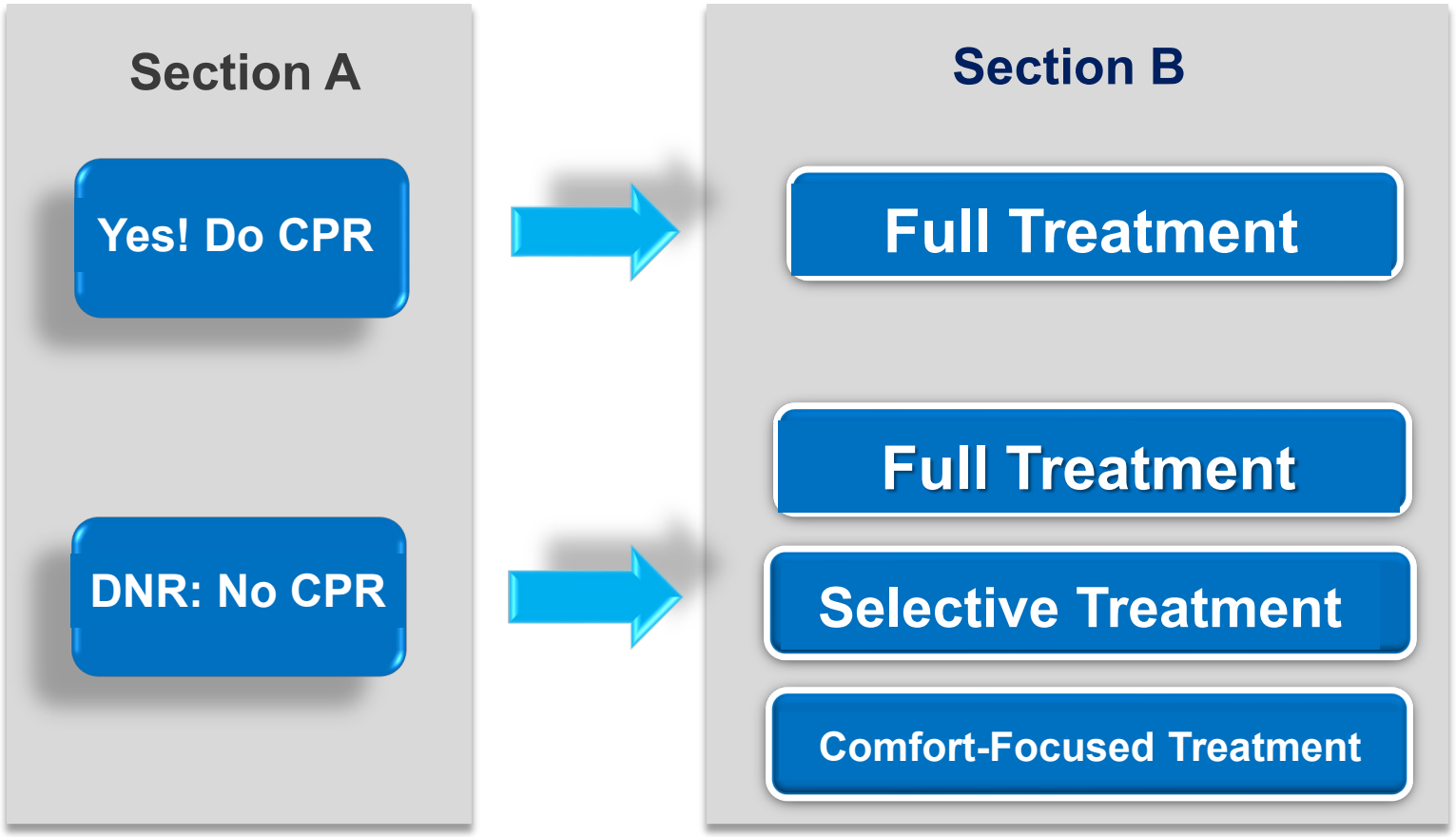
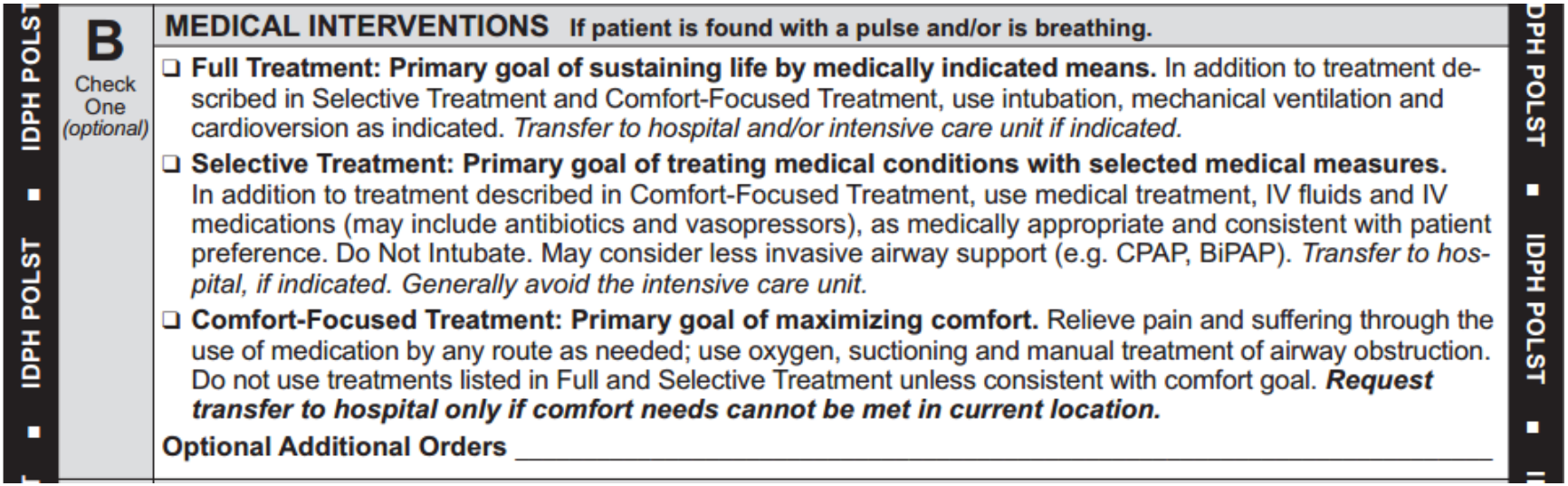
Acceptable Options for a Valid Form



Section “B”: Medical Interventions



IDPH POLST ■ IDPH POLST ■

B
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.*
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- ❑ **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.***

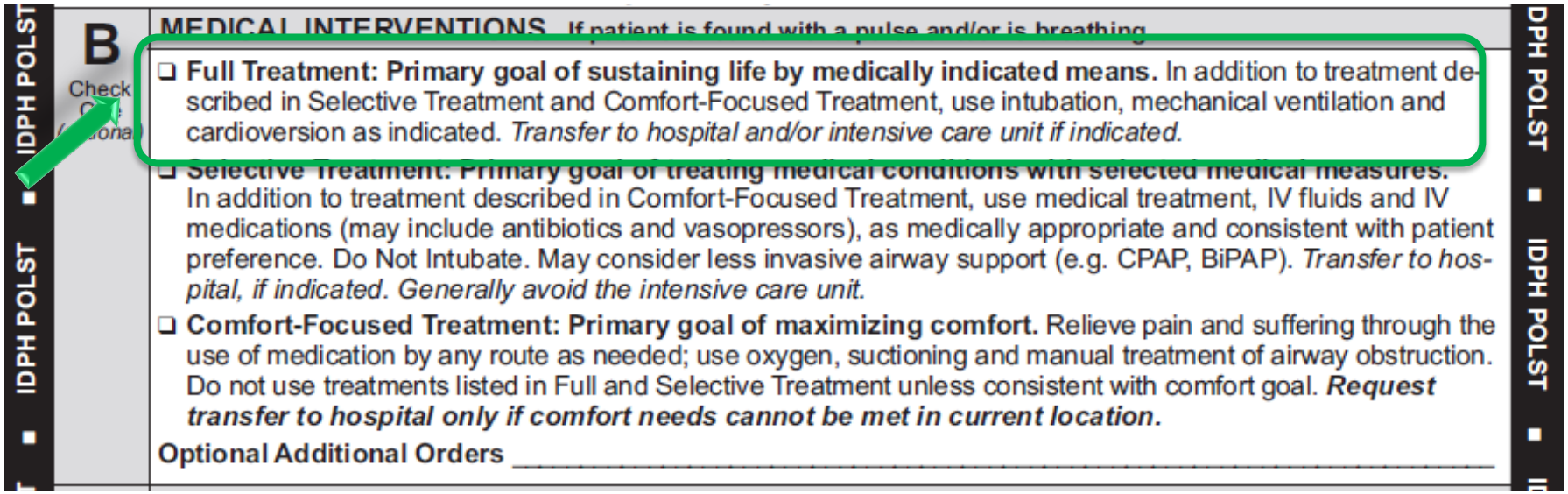
Optional Additional Orders _____

IDPH POLST ■ IDPH POLST ■

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.

Section "B": Medical Interventions



✓ **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

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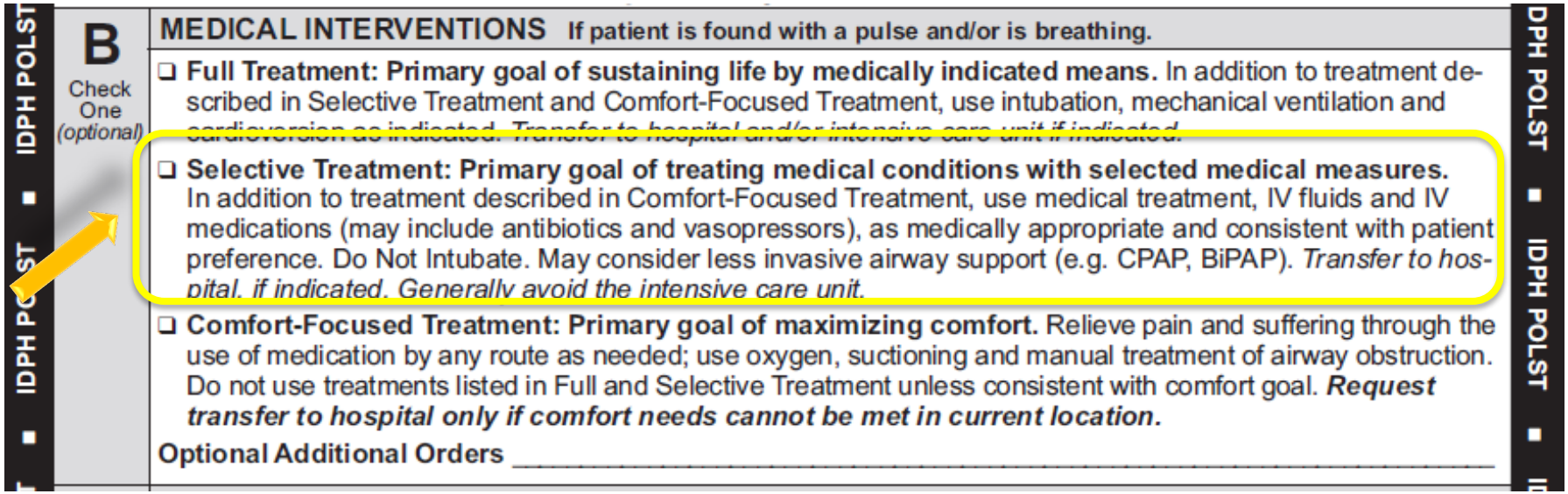
Section "B": Medical Interventions



IDPH POLST ■ IDPH POLST ■ IDPH POLST ■ IDPH POLST

B
Check One *(optional)*

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

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Optional Additional Orders _____

✓ **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"

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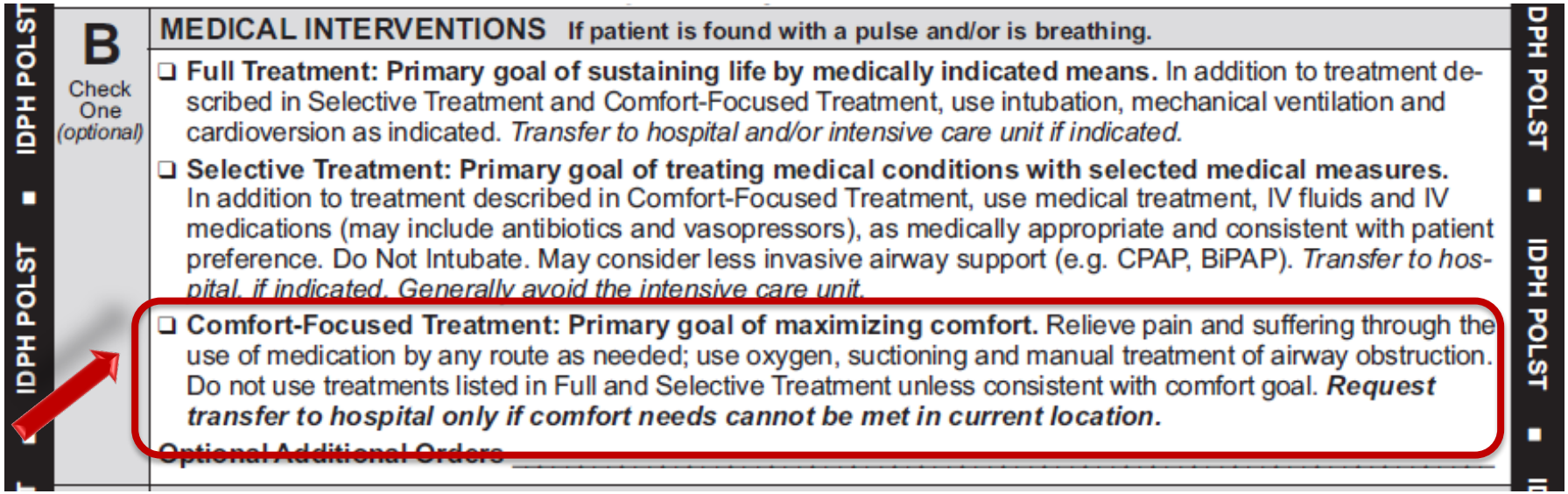
Section "B": Medical Interventions



IDPH POLST ■ IDPH POLST

B
Check One *(optional)*

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Optional Additional Orders _____

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- ✓ **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.*

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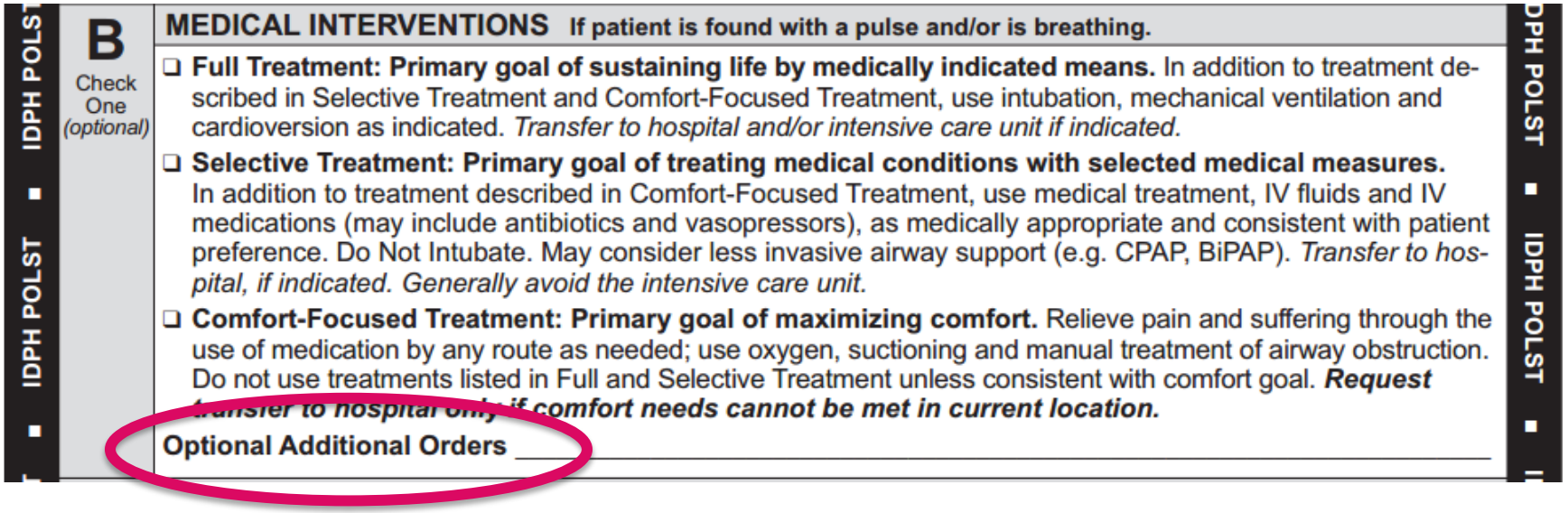
Section “B”: Medical Interventions



IDPH POLST ■ IDPH POLST ■

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

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Optional Additional Orders _____

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

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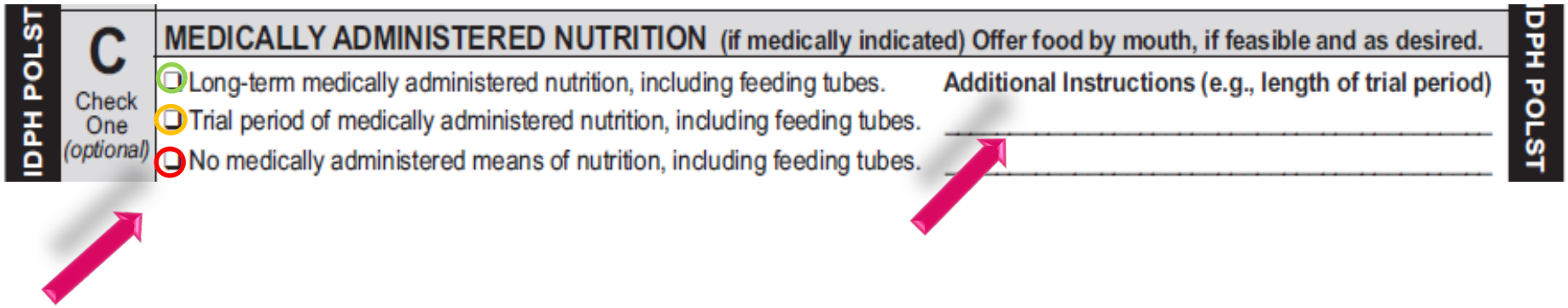
Practitioner Orders for Life-Sustaining Treatment

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

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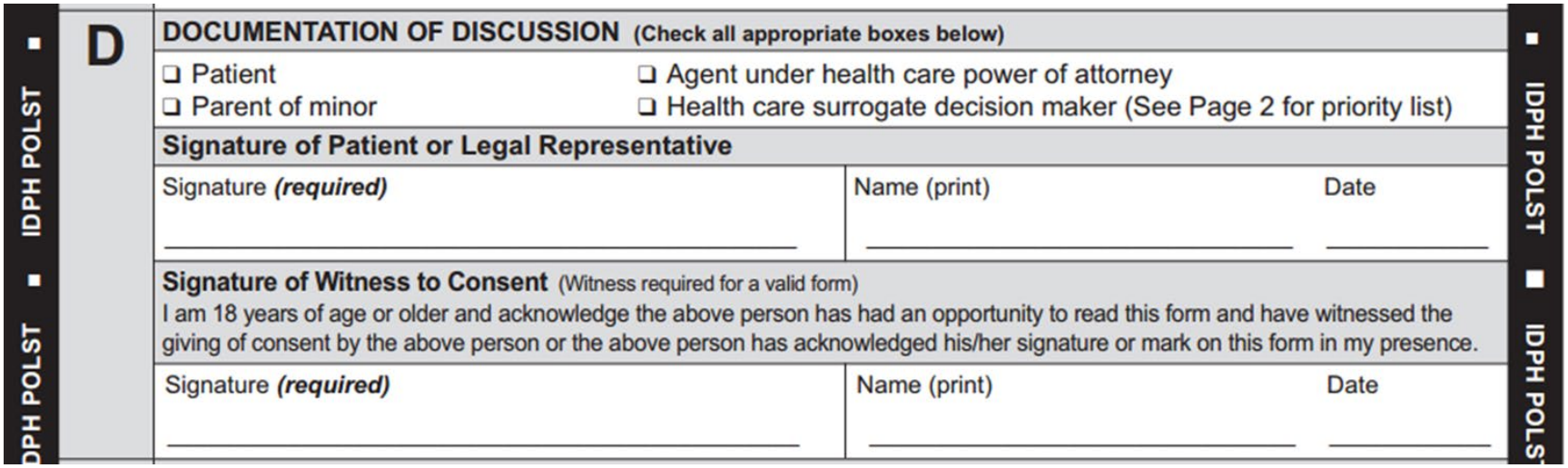
Practitioner Orders for Life-Sustaining Treatment

Section D: Documentation of Discussion



IDPH POLST ■ IDPH POLST ■ IDPH POLST

D

DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

- ❑ Patient
- ❑ Parent of minor
- ❑ Agent under health care power of attorney
- ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

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

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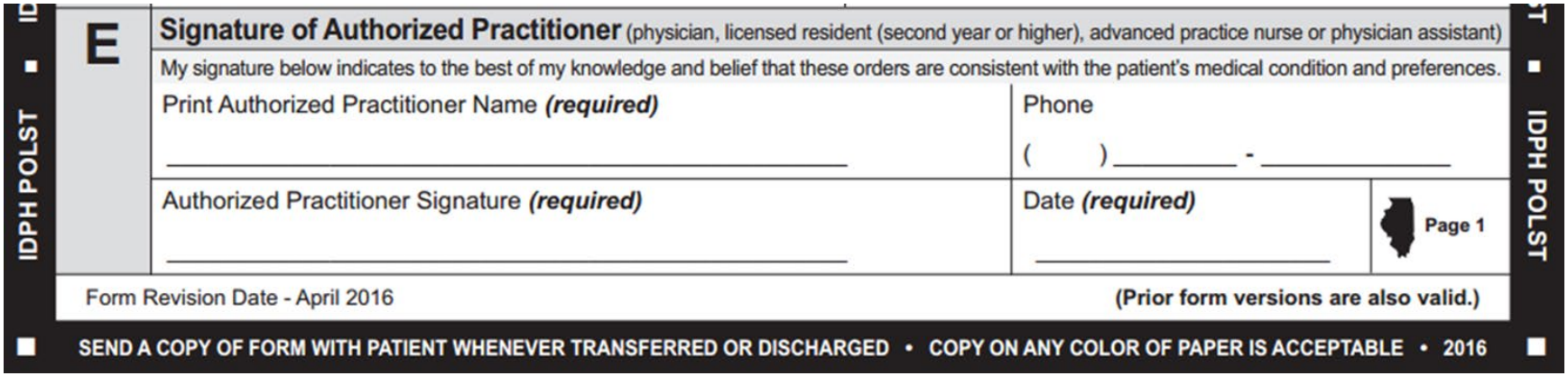
Section E: Signature of Practitioner



IDPH POLST

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 consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name ***(required)***

Phone

( ) _____ - _____

Authorized Practitioner Signature ***(required)***

Date ***(required)***

Page 1

Form Revision Date - April 2016

(Prior form versions are also valid.)

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2016

IDPH POLST

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

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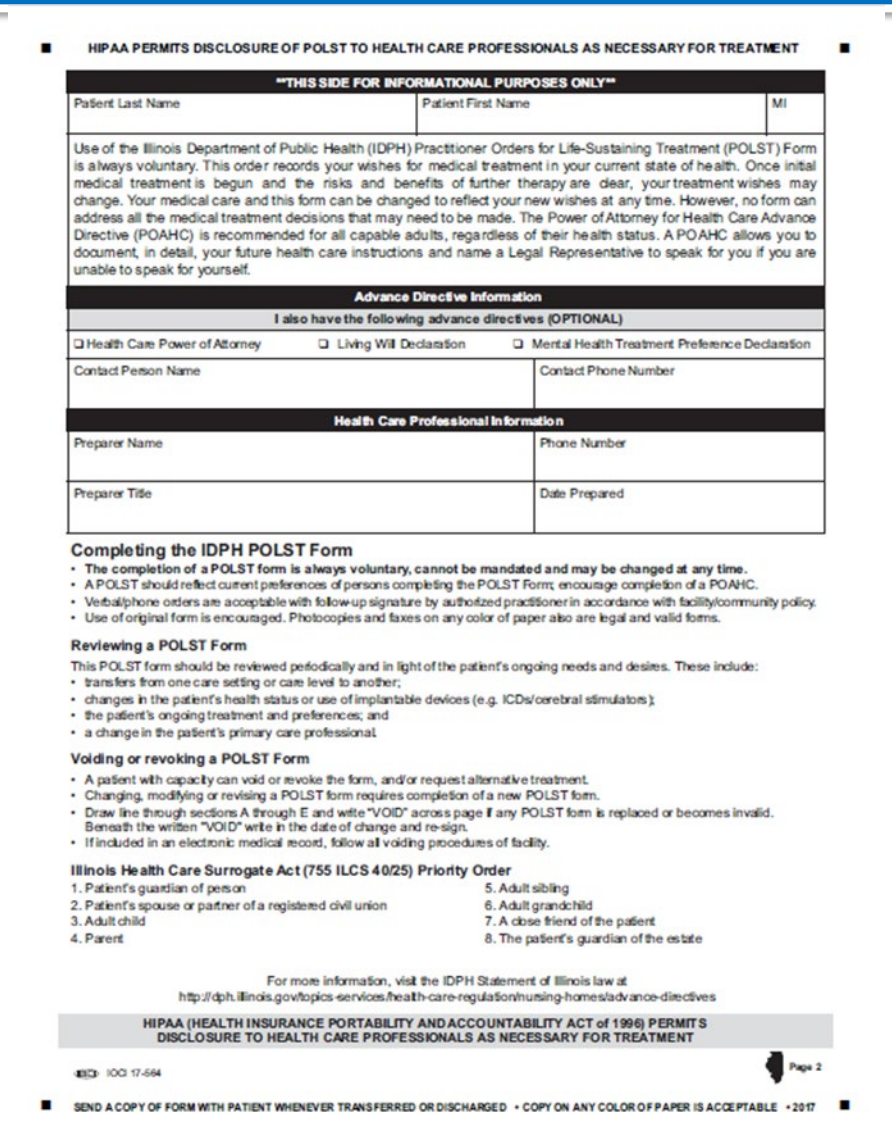
Back Page – EMS does not take action



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

"THIS SIDE FOR INFORMATIONAL PURPOSES ONLY"

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

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
3. Adult child
4. Parent
5. Adult sibling
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

IOCI 17-564 Page 2

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

- 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.

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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.**

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Practitioner Orders for Life-Sustaining Treatment

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 patient
- EMS responders are **legally protected** if they follow orders on a valid form in good faith

POLST ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

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

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Practitioner Orders for Life-Sustaining Treatment

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

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QUESTION & ANSWER

Let’s Review

Check for understanding

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?

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Answer

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.

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Check for understanding

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?

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Answer

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.

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Check for understanding

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.

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Answer

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.

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Check for understanding

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.
C. Contacting OLMC for assistance before doing anything.

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Answer

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.

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POLST Resources

For POLST Illinois information:

polstIllinois@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:

POLST ILLINOIS

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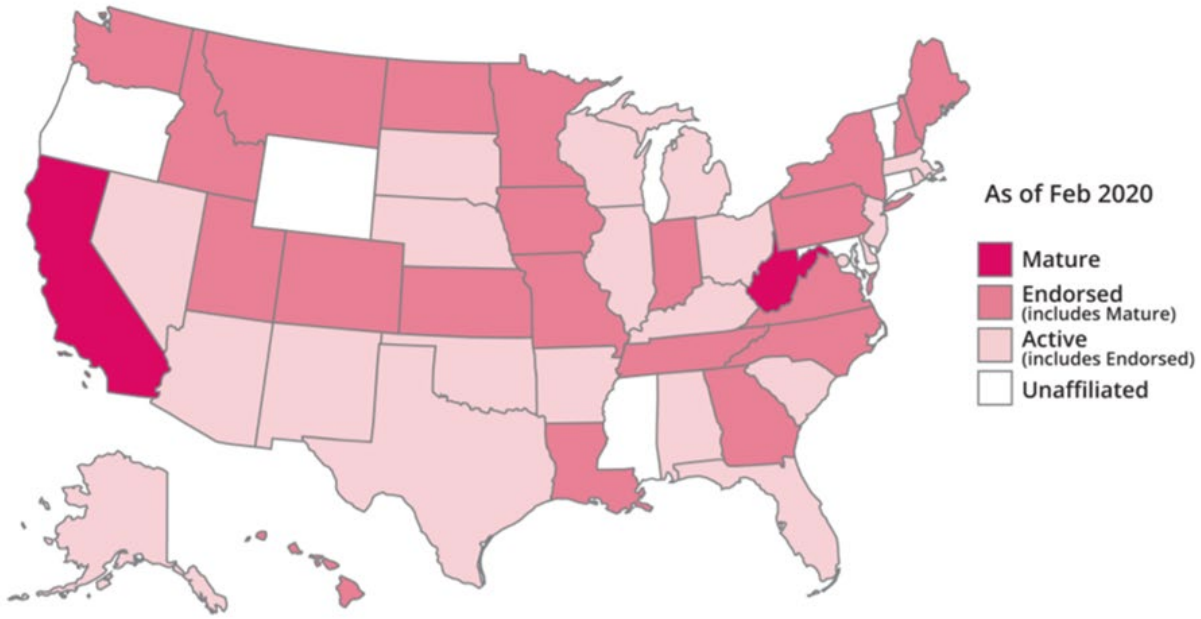
Illinois Hospice & Palliative Care Organization

il-hpco.org

Where did POLST come from?

National POLST
www.polst.org

National POLST Program Designations
As of February 2020



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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

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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**

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Acceptable Options for a Valid Form