



Practitioner Orders for
Life-Sustaining Treatment

Long Term Care & Skilled Nursing Facility Setting

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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 **POLST Model** and when it is an appropriate part of advanced care planning
- Describe the relationship between Advance Directives and POLST forms, and when each is appropriate for completion
- Describe the elements of a quality POLST conversation
- Understand the sections of the POLST form
- Recognize the importance of care providers being properly educated regarding POLST Model policy and practice

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

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)

Various Forms Past & Present

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

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

(Page 1 of 2)

Patient Directive

I, _____, born on _____, hereby direct the following in the event of:

(print full name) (birth date)

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

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

2. **PRE-ARREST EMERGENCY (When patient is not breathing or has no pulse and is not breathing):**

SELECT ONE

☐ **Do Attempt Cardiopulmonary Resuscitation (CPR)**
(Measures to promote patient comfort)

☐ **Do Not Attempt Cardiopulmonary Resuscitation (CPR)**
(Measures to promote patient comfort)

Other Instructions _____

Patient Directive Authorization and Acknowledgment

I understand and authorize the above 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 witness if patient is 18 years of age or older and acknowledge the giving of consent or mark on this form in my presence)

I am 18 years of age or older and acknowledge the giving of consent or mark on this form in my presence.

Printed name of witness _____

Physician Signature (Required to be a valid physician)

I hereby execute this DNR Order on _____

Signature of attending physician _____

♦ *Send this form or a copy of this form to the patient's family and to the patient's healthcare provider.*

DNR • DO-NOT-RESUSCITATE • DNR

State of Illinois
Do Not Resuscitate (DNR) Order

I, _____, (print full name) **DO NOT AUTHORIZE CARDIOPULMONARY RESUSCITATION (CPR)** in the event of my death or in the event of my becoming unconscious. I (or my legal representative) understand that this order remains in effect until revoked by me (or my legal representative) and that this order does not constitute an admission of guilt or liability. I (or my legal representative) acknowledge that cardiopulmonary resuscitation (CPR) will be performed if breathing or heart beat stops. (The signatures of [a] the patient **OR** legal representative, [b] the physician, and [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 _____ Street Address _____
OR durable power of attorney for health care agent _____
OR surrogate decision maker _____

City, State, ZIP _____

Signature of legal representative _____

Date _____

Illinois Department of Public Health
535 W. Jefferson St.
Springfield, IL 62761
217-783-4977
TTY (hearing impaired use only)
800-547-0466

Printed by Authority of the State of Illinois
IC-4331086 100M 1/00

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

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/yyyy) _____ Gender ☐ M ☐ F

Address (street/city/state/ZIPcode) _____

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

☐ **Attempt Resuscitation/CPR** (Selecting CPR means Full Treatment in Section B is selected)

☐ **Do Not Attempt Resuscitation/DNR**

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

B 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 cardiopulmonary resuscitation 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 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) _____

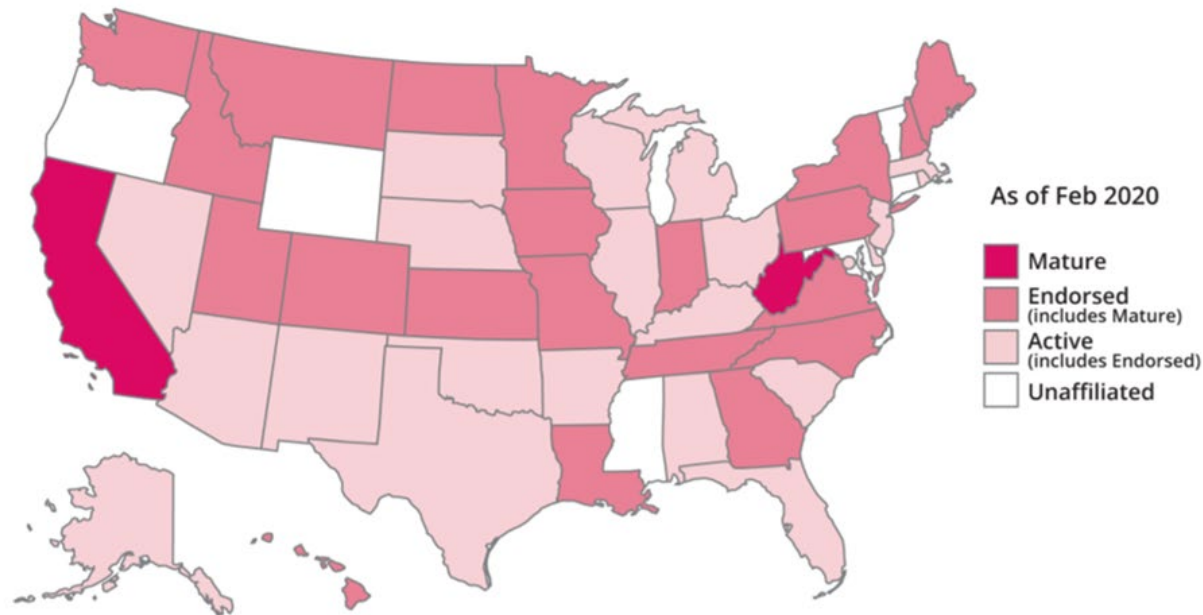
Form Revision Date January 2015 (Prior form versions are also valid.)

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

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

Who should have a 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.

This includes but is not limited to people with:

- Severe Heart Disease
- Metastatic Cancer or Malignant Brain Tumor
- Advanced Lung, Renal or Liver Disease
- Advanced Frailty
- Advanced Neurodegenerative Disease
(e.g., Dementia, Parkinson's Disease, ALS)

What else to know about a POLST?

- Most people over age 65 are too healthy to have POLST orders.
- POLST **is not intended** for people with chronic, stable disability, who must not be mistaken for being at the end of life.
- The POLST form speaks for patients **ONLY** when they can't speak for themselves.
- The patient can void or change their POLST form at anytime as their disease and health changes.
- A patient without POLST orders receives FULL TREATMENT as the default, and this **may** be a reason not to complete the form.
- **Accompanies patient from care setting to care setting**

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

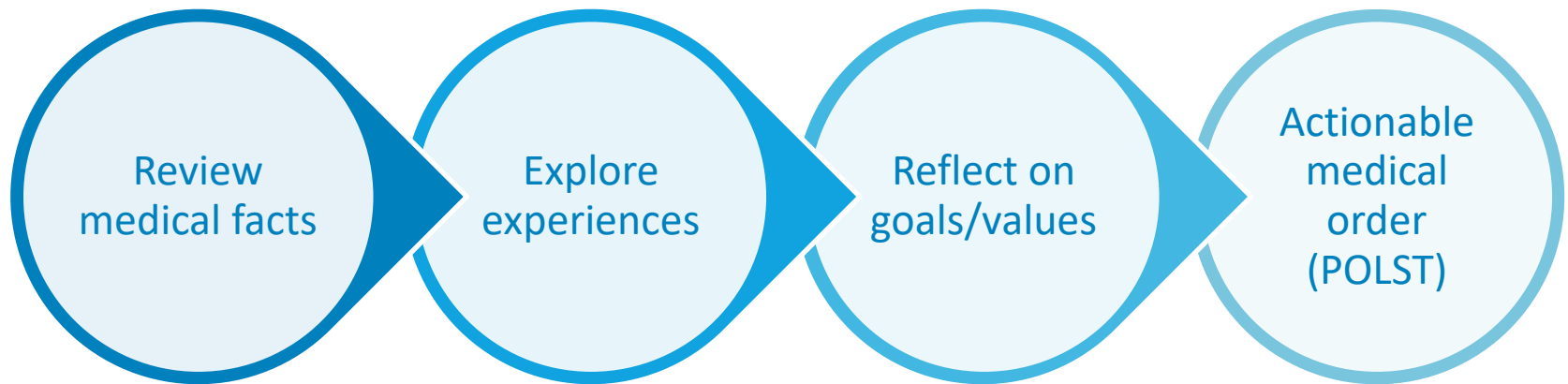
IDPH Uniform POLST:

I. The Conversation

Checklist for the POLST Conversation

- ✓ Use simple language
- ✓ Start with a **DISCUSSION**, then end with the POLST form itself
- ✓ Inform that POLST form is optional and can be changed at any time
- ✓ Explain under what circumstances the form might be useful
- ✓ Ensure that resident/decision maker has full information to make each decision

Flow of POLST Conversation



POLST Conversation – BEFORE the Form

- Review relevant medical facts; uncovering gaps in person's understanding of prognosis
- **Explore** experiences; identifying fears and concerns
 - Awareness of potential complications resulting from illness
 - Awareness of potential emergency treatments of these complications (e.g., CPR, intubation, hospitalization in ICU)
- Ask resident to reflect on goals/values and how they influence preferences
- And then, put the preferences in writing to translate them into actionable medical order

Knowledge GAP - Decision Point

Non-practitioner POLST conversation reveals one or more:

- ✓ Diagnosis/prognosis not understood
- ✓ Family member/s and resident/proxy not on the same page
- ✓ Risks & benefits of POLST treatment options not understood
- ✓ resident/proxy wishes are significantly different than anticipated
- ✓ Other substantial conflicts arise during the POLST conversation

IF YES -

Refer to medical practitioner for additional, appropriate clinical information

IF NO –

Continue to discuss POLST Form

Case Studies

1. A 60 y/o with metastatic cancer who was recently hospitalized, and a POLST conversation is being conducted at his SNF before he is discharged to home. He recognizes his illness is terminal and does not wish to undergo CPR in case of cardiac arrest. He also does not want to be intubated should he suffer a primary respiratory arrest. However, as his quality of life is still good, he is willing to attempt low burden, less-invasive measures to prolong his life. **REFER FOR MORE INFO?**
2. A 78 y/o with late-stage COPD and frailty who, while hospitalized, was intubated and successfully extubated. A POLST conversation is conducted with the resident and, with his permission, his brother, who is also the resident's POAHC, before the resident returns to his skilled nursing facility. The resident believes that should he suffer a cardiac arrest, the odds of his surviving an attempt at resuscitation are slim, and he does not wish to have CPR attempted. He is unsure about being intubated again should he suffer a potentially reversible condition, such as a pneumonia, but seems to prefer to stay at the SNF rather than go to the hospital. His brother feels very strongly that the resident should be full code, he survived the ICU once and will again. **REFER FOR MORE INFORMATION?**

Demonstrating That You Care

- Always approach with compassion
- Ask for permission to proceed with difficult discussions
- Encourage understanding between residents and family members
 - Hearing the information for the first time is hard.
 - It's normal to need time to think things through.
 - Use multiple conversations as needed.

IDPH Uniform POLST:

II. The Form

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/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Address (street/city/state/ZIP code)		

A 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 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 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.)

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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)		
<input type="checkbox"/> Health Care Power of Attorney	<input type="checkbox"/> Living Will Declaration	<input type="checkbox"/> 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 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

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

Section “A”: Cardio-Pulmonary Resuscitation

IDPH	A	CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.	
		<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR means Full Treatment in Section B is selected)	<input type="checkbox"/> Do Not Attempt Resuscitation/DNR
Check One		When not in cardiopulmonary arrest, follow orders B and C.	

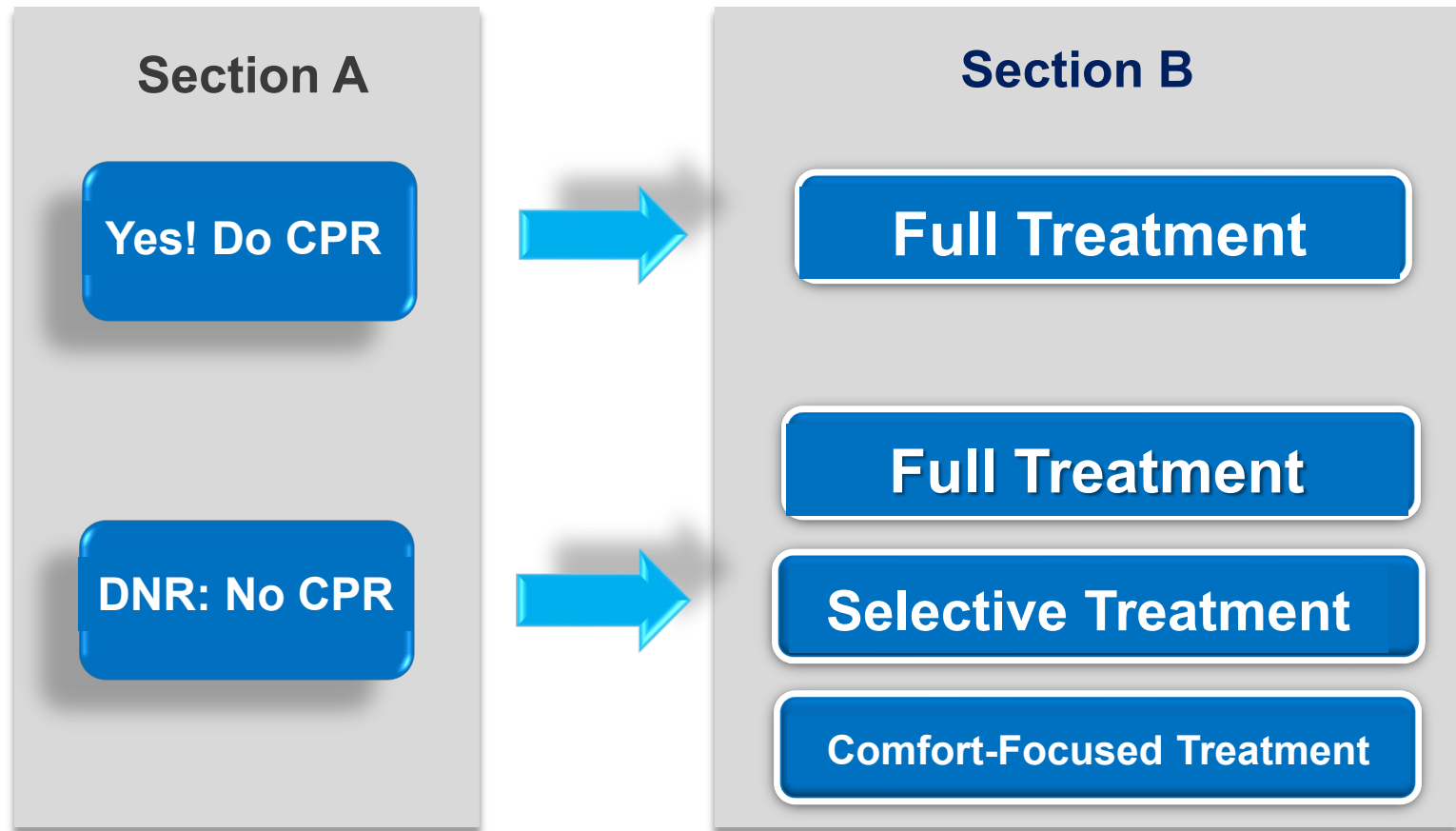
Section A documents what a person wishes to occur if they are found with no pulse and not breathing.

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.

Acceptable Options for a Valid Form



Section “B”: Medical Interventions

IDPH POLST IDPH POLST IDPH POLST	B Check One (optional)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="background-color: #d3d3d3; padding: 5px;"> MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing. </th> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> 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. <i>Transfer to hospital and/or intensive care unit if indicated.</i> </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> 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). <i>Transfer to hospital, if indicated. Generally avoid the intensive care unit.</i> </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> 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. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i> </td> </tr> <tr> <td style="padding: 5px;"> Optional Additional Orders _____ </td> </tr> </table>	MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.	<input type="checkbox"/> 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. <i>Transfer to hospital and/or intensive care unit if indicated.</i>	<input type="checkbox"/> 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). <i>Transfer to hospital, if indicated. Generally avoid the intensive care unit.</i>	<input type="checkbox"/> 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. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i>	Optional Additional Orders _____	IDPH POLST IDPH POLST IDPH POLST
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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.

B		MEDICAL INTERVENTIONS	
Check (Circulation)	<p>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. <i>Transfer to hospital and/or intensive care unit if indicated.</i></p> <p>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). <i>Transfer to hospital, if indicated. Generally avoid the intensive care unit.</i></p> <p>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. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i></p>	<p>If patient is found with a pulse and/or is breathing</p>	
		Optional Additional Orders _____	

- 
- POLST**
ILLINOIS
Practitioner Orders for
Life-Sustaining Treatment

Section “B”: Medical Interventions

IDPH POLST	B Check One (optional)	MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.	IDPH POLST
		<p><input type="checkbox"/> 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. <i>Transfer to hospital and/or intensive care unit if indicated.</i></p> <p><input type="checkbox"/> 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). <i>Transfer to hospital, if indicated. Generally avoid the intensive care unit.</i></p> <p><input type="checkbox"/> 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. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i></p> <p>Optional Additional Orders _____</p>	

✓ **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”

<div>DPH POLST</div> <div>DPH POLST</div> <div>DPH POLST</div> <div>DPH POLST</div>	<div> <div> <div>B</div> <div>Check One (optional)</div> </div> <div> <div>MEDICAL INTERVENTIONS</div> <div>If patient is found with a pulse and/or is breathing.</div> <div> <input type="checkbox"/> 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. <i>Transfer to hospital and/or intensive care unit if indicated.</i> </div> <div> <input type="checkbox"/> 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). <i>Transfer to hospital, if indicated. Generally avoid the intensive care unit.</i> </div> <div> <input checked="" type="checkbox"/> 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. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i> </div> <div>Optional Additional Orders</div> </div> </div>
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- POLST**
ILLINOIS
Practitioner Orders for
Life-Sustaining Treatment

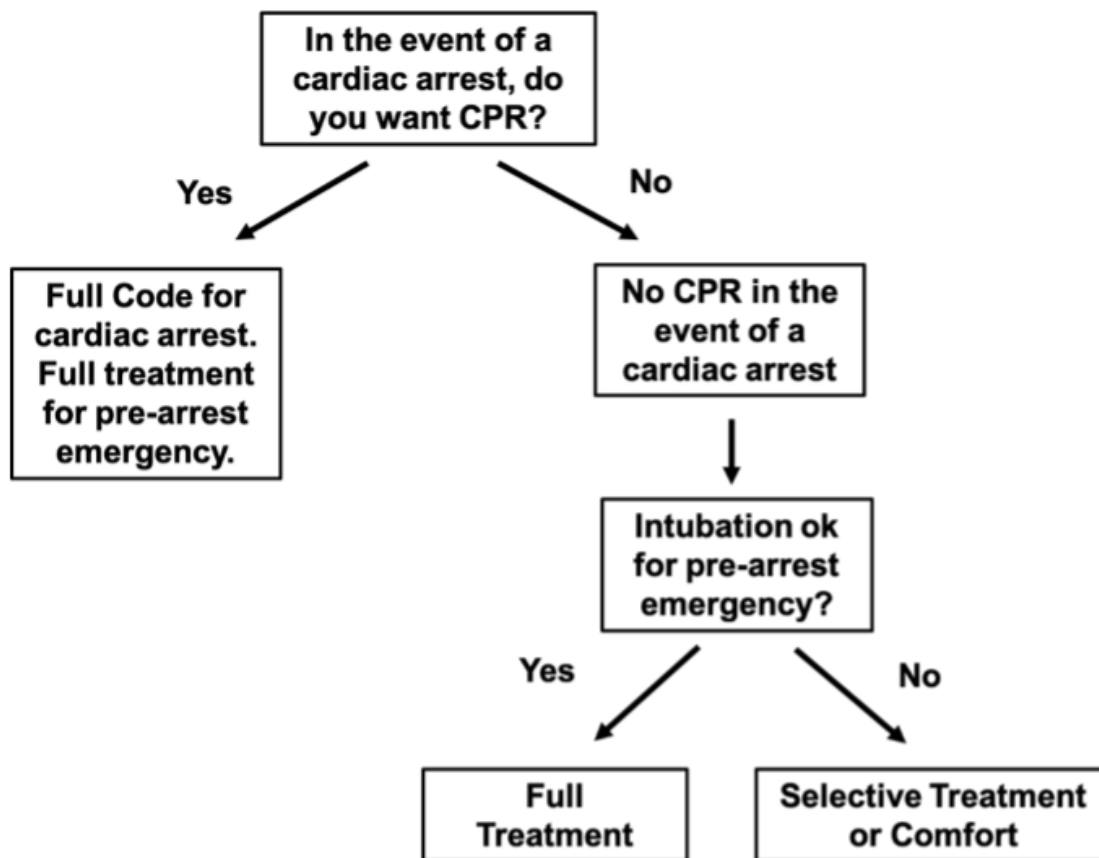
Section “B”: Comfort Focused Treatment

“Comfort-focused treatment” requires a clear explanation to the patient/substitute decision-maker:

- Regardless of the option selected in section B, treatment for comfort is always provided – **we never do nothing!**
- For example, if a person is choking, suction, manual treatment of airway, Heimlich maneuver would be implemented:

Choking is **NOT COMFORTABLE!!**

Another way to think about Sections A & B




B Check One (optional)	MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.
	<ul style="list-style-type: none"> <input type="checkbox"/> 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. <i>Transfer to hospital and/or intensive care unit if indicated.</i> <input type="checkbox"/> 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). <i>Transfer to hospital, if indicated. Generally avoid the intensive care unit.</i> <input type="checkbox"/> 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. <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i> <p>Optional Additional Orders _____</p>



POLST
ILLINOIS
Practitioner Orders for
Life-Sustaining Treatment

Section C: Medically Administered Nutrition

IDPH POLST		MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.		IDPH POLST
C Check One (optional)	<input type="checkbox"/>	Long-term medically administered nutrition, including feeding tubes.	Additional Instructions (e.g., length of trial period) _____ _____	
	<input type="checkbox"/>	Trial period of medically administered nutrition, including feeding tubes.		
	<input type="checkbox"/>	No medically administered means of nutrition, including feeding tubes.		



Although it isn't critical for emergency care, it is very helpful for healthcare providers to know your wishes about feeding tubes, called medically administered nutrition.

- ✓ *Yes, I do want long-term artificial nutrition if I am no longer able to take foods or liquids by mouth*
- ✓ *Trial period, I do want artificial nutrition for a trial period (see additional instructions)*
- ✓ *No, I do not want long-term artificial nutrition if I am no longer able to take foods or liquids by mouth*

Section D: Documentation of Discussion


IDPH POLST	D	DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)		
		<input type="checkbox"/> Patient <input type="checkbox"/> Agent under health care power of attorney		
		<input type="checkbox"/> Parent of minor <input type="checkbox"/> Health care surrogate decision maker (See Page 2 for priority list)		
		Signature of Patient or Legal Representative		
		Signature (<i>required</i>) _____ Name (print) _____ Date _____		
IDPH POLST		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 (<i>required</i>) _____ 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

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 ■				

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 First Name	MI
<p>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.</p>		
Advance Directive Information		
I also have the following advance directives (OPTIONAL)		
<input type="checkbox"/> Health Care Power of Attorney	<input type="checkbox"/> Living Will Declaration	<input type="checkbox"/> 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 | 5. Adult sibling |
| 2. Patient's spouse or partner of a registered civil union | 6. Adult grandchild |
| 3. Adult child | 7. A close friend of the patient |
| 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

- 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.

Case 1: John

A 60-year-old with metastatic prostate cancer who was previously able to live at home and manage his own ADLs. He has been in and out of the hospital frequently. Upon goals of care conversation with the resident, you learn that he recognizes his illness is terminal, and for that reason does not wish to undergo CPR in case of cardiac arrest. He also does not want to be intubated should he suffer a primary respiratory arrest. However, as his quality of life is still good, he is willing to attempt low burden, less-invasive measures to prolong his life.



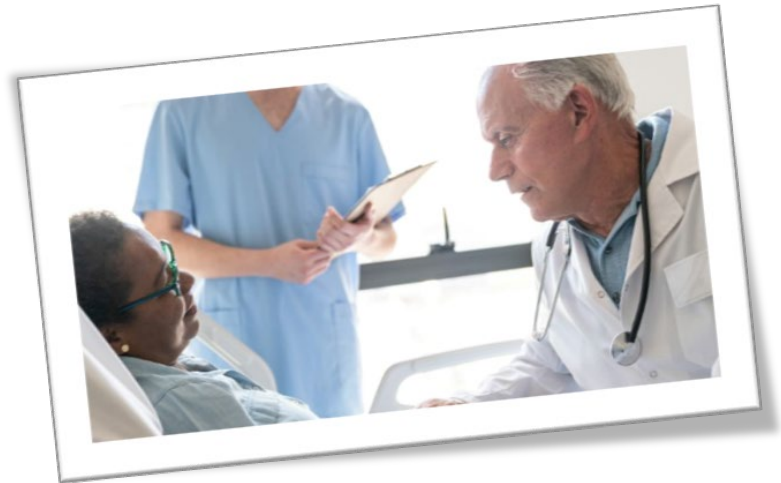
Case 2: Harold

A 75-year-old with late-stage COPD, who when recently hospitalized was intubated and successfully extubated and discharged to your facility. Upon conversation with the resident, you learn that the resident understands that should he suffer a cardiac arrest (no breathing, no pulse, unresponsive), the odds of his surviving an attempt at resuscitation are slim, and he does not want to have CPR attempted. However, he is willing to be intubated should he suffer a potentially reversible condition, such as pneumonia, that renders him temporarily unable to breath on his own.



Case 3: Ellen

An 85-year-old woman with advanced dementia who recently became a resident due to increased confusion and lethargy. Her husband gives admission staff documents that show he is the POAHC. You find the husband is anxious to document her strong wishes that under no circumstances does she want to have artificial nutrition through a tube, even temporarily, and she doesn't want to be resuscitated for any reason.



Applying the POLST Program

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

Special Considerations for Nursing Homes

- A POLST **discussion** can be a standard part of the admission process **BUT** form completion **cannot be required for admission or care.**
- Be aware if your institution uses different color forms for those with DNR vs Full Code in section A.
- Systematic quality improvement process to find and replace/update old DNR forms is encouraged.
- Facility policy must include that all appropriate staff are given some training/guidance about:
 - having and documenting effective POLST conversations,
 - completing a POLST form and
 - communicating with practitioner for verbal orders or signatures.

POLST in COVID-19 Pandemic

COVID-19 is particularly risky for frail and chronically ill nursing home residents:

- POLST is for a **limited population**: facilities and providers should offer this population the opportunity to have or review a POLST form right away
- Specifically discuss the potential risks and benefits of treatments considering COVID-19, and revise the POLST form if desired
- Document resident treatment preferences even if it may not be possible to honor all preferences depending on available resources
- POLST forms should not have expiration dates even considering COVID-19
- POLST forms can be changed if lower/higher risk of COVID-19 effects goals of care

Review and Revision of POLST

- POLST forms should be reviewed and updated periodically when the resident:
 - is transferred between ICU and general medical unit;
 - has a substantial change in clinical condition;
 - changes treatment preferences or goals of care
- The POLST conversation should be repeated before documenting new treatment decisions or confirming current treatment decisions

NOT Recommended for Organizational POLST Policies

1. Mandating completion of POLST forms
2. Providing incentives for POLST form completion
3. Completing a form without meaningful conversation first
4. Giving a person a POLST form to complete for themselves
5. Completing POLST form without resident/substitute decision-maker knowledge
6. Signing POLST form for resident/substitute decision-maker
7. Never reviewing completed POLST forms
8. Organizational failure to evaluate use of POLST

Voiding or Changing a POLST

resident who regains
decisional capacity:

POLST is no longer
consulted.

resident should revisit
POLST conversation and
potentially revise form.

Power of Attorney for
Health Care (always) &
Surrogate (if no existing
POLST):

Can void and/or complete a
new POLST for non-
decisional resident as
conditions change

Substituted judgement if
wishes are
known/documented in AD

Best interest of resident if
wishes are not
known/documented in AD

Health Care Surrogate if
existing POLST **consented
to by resident
themselves:**

Must consult with attending
practitioner

Encourage “substituted
judgment standard” document
in resident’s POLST

Document new information
known about resident’s
wishes in EHR

POLST
ILLINOIS

Practitioner Orders for
Life-Sustaining Treatment

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.

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

QUESTION & ANSWER

POLST Resources

For POLST Illinois information:

polstIllinois@gmail.com

www.polstil.org

National POLST Program

www.polst.org

Resources for “the conversation”

- <https://www.theconversationproject.org/>
- <https://respectingchoices.org/>
- <https://www.ariadnelabs.org/areas-of-work/serious-illness-care/resources/#Downloads&%20Tools>
- <https://pact.northwestern.edu/>
- <https://www.vitaltalk.org/>

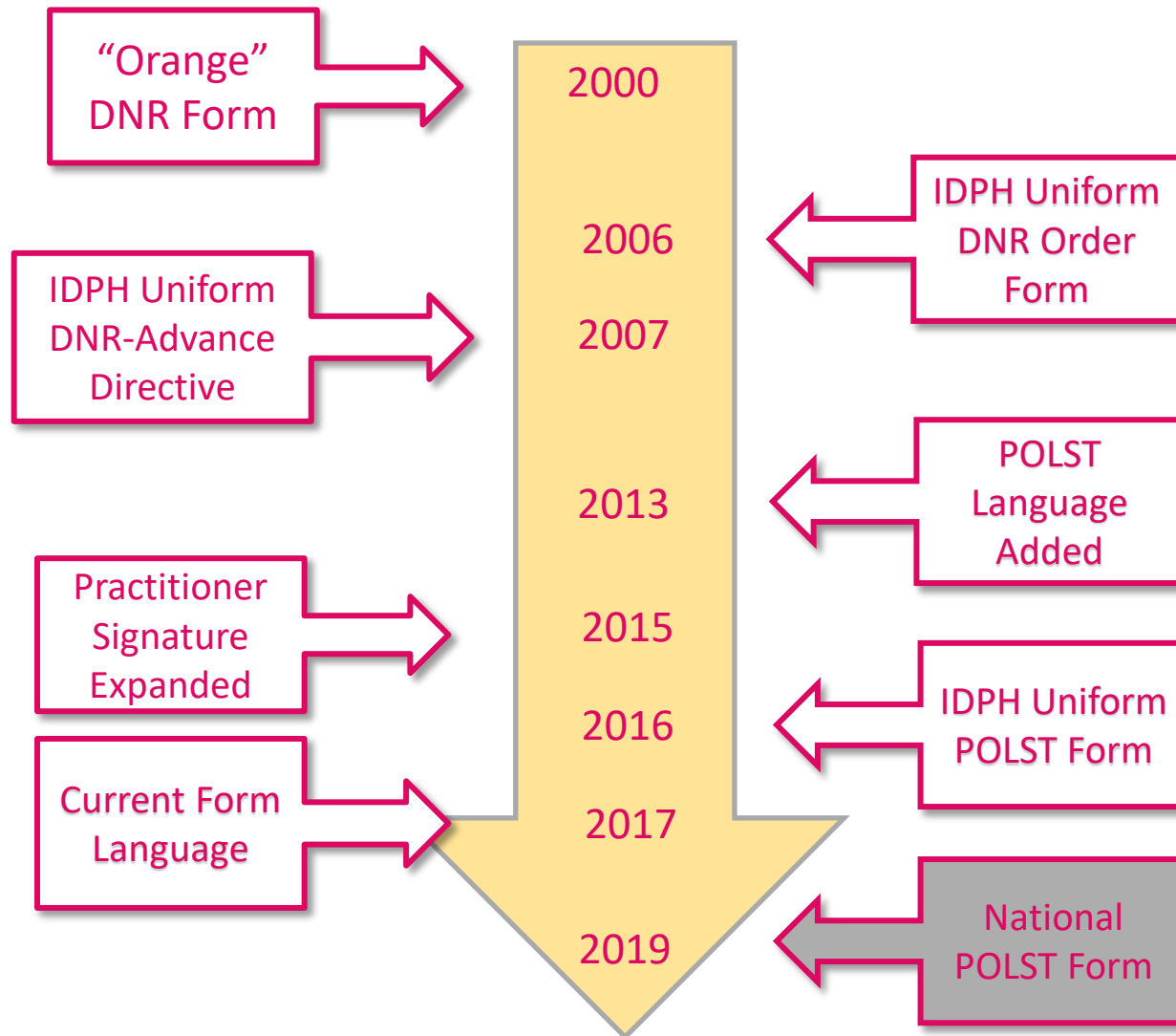
*This presentation created by the POLST Illinois Education Committee
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Practitioner Orders for
Life-Sustaining Treatment



Evolution of the IDPH Uniform POLST Form



Additional Criteria for Evaluating Appropriate Use of POLST

Patients with a serious life-limiting medical condition or advanced frailty:

- whose health care professional would not be surprised if they died within 1-2 years; or
- who are at an increased risk of experiencing a medical emergency based on their current medical condition and who wish to make clear their treatment preferences, including about CPR, mechanical ventilation, ICU; or
- who have had multiple unplanned hospital admissions in the last 12 months, typically coupled with increasing frailty, decreasing function, and/or progressive weight loss.

National Support for POLST:

Landmark Study JAGS 2014

- Study on the relationship between what POLST orders are selected and where people ultimately die. 18,000 death records (2010-2011) reviewed from Oregon's electronic POLST registry
- **Relationship between options selected on the POLST form and where people die:**
 - **6.4% of persons who had a POLST Form specifying *Comfort Measures Only* treatment wishes died in a hospital**
 - **22.4% for persons who wished for *Limited Additional Interventions* died in a hospital**
 - **44.2% of persons whose POLST specified wishes for *Full Treatment* died in a hospital**
 - **34.2% of persons without a POLST Form died in a hospital**

(Fromme, Erik, 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.)