POLST: Provider Orders for Life Sustaining Treatment POLST

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

FIRST follow these orders, THEN contact the patient's provider. This is a provider order sheet based on the patient's medical condition and wishes. POLST translates an advance directive into provider orders. Any section not completed implies the most aggressive treatment for that section. Patients should always be treated with dignity and respect.

Last Name

First/Middle Initial

Date of Birth

Primary Care Provider/Phone

A — CARDIOPULMONARY RESUSCITATION (CPR):

Check One

Patient has no pulse and is not breathing.

☐ **CPR/ATTEMPT RESUSCITATION**

☐ **DNR/DO NOT ATTEMPT RESUSCITATION** (Allow Natural Death)

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

An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."

B — GOALS OF TREATMENT:

Check One Goal

Patient has pulse and/or is breathing. See Section A regarding CPR if pulse is lost.

Additional Orders (e.g. dialysis, etc.)

☐ **COMFORT CARE —** Do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort.

Check all that apply:

- ❑ In an emergency, call _____ (e.g. hospice)
- ❑ If possible, do not transport to ER (when patient can be made comfortable at residence)
- ❑ If possible, do not admit to the hospital from the ER (e.g. when patient can be made comfortable at residence)

☐ **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS —** Provide interventions aimed at treatment of new or reversible illness / injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited. (Transport to ER presumed)

Check one:

- ❑ Do not intubate
- ❑ Trial of intubation (e.g._____days) or other instructions: _____

☐ **PROVIDE LIFE SUSTAINING TREATMENT**

Intubate, cardiovert, and provide medically necessary care to sustain life. (Transport to ER presumed)

C — INTERVENTIONS AND TREATMENT

Check All That Apply

ANTIBIOTICS *(check one)*:

- ❑ No Antibiotics (Use other methods to relieve symptoms whenever possible.)
- ❑ Oral Antibiotics Only (No IV/IM)
- ❑ Use IV/IM Antibiotic Treatment

NUTRITION/HYDRATION *(check all that apply)*:

- ☑ Offer food and liquids by mouth (Oral fluids and nutrition must always be offered if medically feasible)
- ❑ Tube feeding through mouth or nose
- ❑ Tube feeding directly into GI tract
- ❑ IV fluid administration
- ❑ Other: _____

Additional Orders:

Provider Name (MD/DO/APRN/PA when delegated, are acceptable) | Provider Signature | Date

FAXED COPIES AND PHOTOCOPIES OF THIS FORM ARE VALID.
TO VOID THIS FORM, DRAW A LINE ACROSS SECTIONS A - D AND WRITE "VOID" IN LARGE LETTERS.

POLST

D

Check All That Apply

SUMMARY OF GOALS

POLST

DISCUSSED WITH:

- ☐ **PATIENT**
- ☐ **PARENT(S) OF MINOR**
- ☐ **HEALTH CARE AGENT:** _____
- ☐ **COURT-APPOINTED GUARDIAN**
- ☐ **NONE** ☐ **OTHER:** _____

THE BASIS FOR THESE ORDERS IS PATIENT'S (check *all* that apply):

- ☐ **REQUEST**
- ☐ **KNOWN PREFERENCE**
- ☐ **HEALTH CARE DIRECTIVE/ LIVING WILL**
- ☐ **BEST INTEREST**
- ☐ **OTHER:** _____

Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

E

SIGNATURE OF PATIENT OR HEALTH CARE AGENT / GUARDIAN / SURROGATE

THESE ORDERS REFLECT THE PATIENT'S TREATMENT WISHES

Name	Date
Relationship to Patient	Phone Number
Signature*	

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING POLST

- Must be completed by a health care professional based on patient preferences and medical indications.
  - If the goal is to support quality of life in last phases of life, then DNR must be selected in Section A.
  - If the goal is to maintain function and quality of life, then either CPR or DNR may be selected in Section A.
  - If the goal is to live as long as possible, then CPR must be designated in Section A.
- POLST must be signed by a physician, advance practice registered nurse, Doctor of Osteopathy, or Physician Assistant (when delegated).* The signature of the patient or health care agent/ guardian/surrogate is strongly encouraged.

USING POLST

- Any section of POLST not completed implies most aggressive treatment for that section.
- An automatic external defibrillator (AED) should not be used for a patient who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort.
- An IV medication to enhance comfort may be appropriate for a patient who has chosen "Comfort Measures Only".
- Artificially-administered hydration is a measure which may prolong life or create complications. Careful consideration should be made when considering this treatment option.
- A patient with capacity or the surrogate (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.
- **Comfort care only:** At this level, provide only palliative measures to enhance comfort, minimize pain, relieve distress, avoid invasive and perhaps futile medical procedures, all while preserving the patients' dignity and wishes during their last moments of life. This patient must be designated DNAR status in section A for this choice to be applicable in section B.
- **Limit Interventions and Treat Reversible Conditions:** The goal at this level is to provide limited additional interventions aimed at the treatment of new and reversible illness or injury or management of non life-threatening chronic conditions. Treatments may be tried and discontinued if not effective.
- **Provide Life-Sustaining Care:** The goal at this level is to preserve life by providing all available medical care and advanced life support measures when reasonable and indicated. For patient's designated DNR status in section A above, medical care should be discontinued at the point of cardio and respiratory arrest.

REVIEWING POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

1. The patient is transferred from one care setting or level to another, **or**
2. There is a substantial change in the patient's health status.
3. A new POLST should be completed when the patient's treatment preferences change.

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