

Pennsylvania Orders for Life-Sustaining Treatment (POLST) Frequently Asked Questions

- **What is the POLST Paradigm?**

- An approach to end of life planning that emphasizes eliciting, documenting and honoring patients' preferences about medical treatments they want to receive during a medical crisis or as they decline in health;
- Translates a patient's goals of care at the end of life into medical orders that follow the patient across care settings;
- In an emergency, the form serves as an immediately available and recognizable order set in a standardized format.

While the program is known by different names elsewhere, in our state POLST stands for "Pennsylvania Orders for Life-Sustaining Treatment".

- **For whom is a POLST form intended?**

POLST forms should only be used with the intended population. The POLST Paradigm is intended to be used by patients who are seriously ill or frail and whose health care professionals wouldn't be surprised if they died within a year—regardless of patient age or what facility a patient is in. For example, most 65-year-olds are too healthy to have POLST orders and not all residents in a nursing home may be appropriate for a POLST form. Patients who do not meet these criteria are not appropriate to have a POLST Form.

- **May a health care provider (hospital, nursing home, hospice, other) require completion of a POLST form for all patients?**

No. Use of the POLST form is completely voluntary and completed only after a discussion of choices between a patient or his/her legal decision-maker and physician. However, facilities may choose to offer the POLST form to document Do-not-Resuscitate vs. full code status for all patients, including those less seriously ill.

- **Is POLST an advance directive?**

No, the POLST form is NOT an advance directive (i.e., living will or health care power of attorney). A POLST form represents and summarizes a patient's wishes in the form of medical orders for end-of-life care. The POLST form is designed to be most effective in emergency medical situations.

- **Is an advance directive required in order to have a POLST?**

No, an advance directive is not required for the completion of POLST. The POLST is an instrument that complements an advance directive. An advance directive, in which a healthcare agent is appointed, allows for the designated agent to be engaged in care planning and healthcare decision-making even when a patient is no longer able to be involved in his/her treatment choices. It is recommended that people who are seriously ill or frail have both an Advance Directive and a POLST form.

- **Can a POLST form be completed following discussion with someone other than the patient?**

Yes, a POLST form can be completed based on a patient's treatment choices as expressed by a health care agent, guardian, health care representative or parent of a minor (legal decision-maker).

- **Are there any limitations on a POLST form completed by someone other than the patient?**

Yes. Neither a health care representative nor a guardian of the person may decline care necessary to preserve life unless the patient is in an end-stage medical condition or is permanently unconscious. Only a competent patient or a health care agent authorized by a health care power of attorney may decline such care. In addition, if the health care decision-maker is a court appointed guardian of the person, the court order should be examined to determine whether the order of appointment specifically deals with health care decision-making. If it does not specify powers regarding health care, particular care should be exercised to discuss the completion of the POLST with any other available family members, and if there is disagreement, a court order may be advisable.

More information is available through the POLST coordinator at papolst@verizon.net or online at: www.aging.pitt.edu/professionals/resources-polst.htm or www.polst.org.

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- **What are the requirements for a POLST form?**

The POLST form at a minimum must include the patient name and resuscitation orders (Section A). The signature of the patient or his/her legal decision-maker is also required as well as the signature of a physician, physician assistant or certified registered nurse practitioner (Section E). A physician countersignature is required for physician assistant signed forms within ten days or less as established by facility policy and procedure. Completion of Section B is strongly recommended.

- **Why is completion of Section B strongly recommended?**

This section provides necessary direction about treatment preferences to emergency personnel and other professionals in situations other than full cardiac and respiratory arrest. If a patient is responsive, has a pulse, or is breathing, the question in this circumstance is no longer whether the patient wants to be resuscitated, but rather what level of treatment and what other medical interventions the patient wants—or does not want—in that medical crisis. Neither a DNR order nor a POLST form with only Section A completed provides that time-sensitive, critical information. It is also recommended that the “Artificially Administered Hydration/Nutrition be completed.

- **Does a DNR order imply that a patient does not want treatment?**

No, a DNR order is only a decision about CPR and does not relate to any other treatment. An informed patient may recognize the futility of CPR in the presence of advanced or serious illness and may request a DNR order. However, based on their goals for care, the patient may wish to receive further treatment.

- **How and when does one review and update a POLST Form?**

The POLST form should be reviewed if (1) the patient is transferred from one care setting or care level to another, (2) there is a substantial change in patient health status, or (3) the patient's treatment preferences change. The patient (or person completing the form on behalf of the patient) can also identify when to review the POLST form: closeness to death, extraordinary suffering, improved condition, advanced progressive illness, and/or permanent unconsciousness. An emergency room visit or inpatient hospitalization calls for a review. A person with capacity or the legal decision-maker of a person without capacity can always ask for review or alternate treatment.

- **Can a patient revoke a POLST?**

Yes. Should a patient revoke a POLST, "VOID" should be written on the front side of the form. A new form can then be completed, but a new POLST is not required.

- **Can a copy of the POLST form, rather than the original, accompany a transferring patient?**

Yes, a copy of the POLST form should be accepted when it is sent with the patient. It is recommended that the copy be made on pulsar pink paper.

- **If a nursing home patient with a POLST and an advance directive is being transferred, is the advance directive also sent along with the POLST?**

Yes, it is important that the treating facility have all available information including the POLST and advance directive.

- **Does one document, the advance directive or POLST, supersede the other and what is recommended if they conflict?**

If a POLST order conflicts with a provision of an advance health care directive, the provision of the instrument latest in date of execution prevails to the extent of the conflict. In such a situation It is recommended that patient values be elicited and then make sure the POLST is consistent with those values. If in crisis and goals of care are not clear, provide a higher level of care is provided until more information is known.

- **How does the POLST program ensure incapacitated individuals are not harmed by the POLST?**

The POLST is specifically designed to assure that an individual's treatment choices for end-of-life care are respected whether the choices are full or limited treatment or comfort measures only. The orders on the form are based on a patient's medical condition and his/her treatment choices. Use of the POLST form is completely voluntary. A POLST form is completed only after a discussion of end-of-life choices between a patient or his/her legal decision-maker and physician.