A Provider's Guide to POLST

(Provider Orders for Life-Sustaining Treatment)

Maintained for Hawai'i by Kōkua Mau

Kōkua Mau
Continuous Care
A Movement to Improve Care

What is POLST?

POLST (Provider Orders for Life-Sustaining Treatment) is a medical order that gives patients more control over their end-of-life care. It specifies the types of treatments that a patient wishes to receive towards the end of life. Completing a POLST form encourages communication between healthcare providers and patients, enabling patients to make more informed decisions. The POLST form documents those decisions in a clear manner and can be quickly understood by all providers, including first responders and emergency medical services (EMS) personnel. As a result, the patient's wishes can be honored across all settings of care.

Is the POLST simply a DNR order?

No, POLST is a document that empowers a patient or their legally authorized representative (see below) to make decisions along the whole continuum of care, from very aggressive, life sustaining care, to comfort care only, including choices about full resuscitation or do not attempt resuscitation.

Is POLST the same as an Advance Health Care Directive?

No, POLST does not replace an Advance Health Care Directive (AHCD). The AHCD can provide significantly more detail about an individual's wishes and preferences for treatment. In addition, the AHCD is the most common mechanism for designating a legally authorized representative decision maker for the patient.

Will the CCO-DNR Bracelet still be honored by EMS?

Yes, the CCO-DNR Bracelet is still a valid method to communicate a person's intent about attempts to resuscitate. There are still thousands of these bracelets in use, and EMS personnel will continue to honor this directive.

Why is the POLST form lime green?

The POLST form is usually completed on a distinctive bright lime-green form, but is also freely available from the internet (at www.kokuamau.org/polst) and is acceptable in black and white. The bright color is to make the form quickly visible to families and emergency medical services personnel. The lime-green color is also easily copied. A copy on white paper is a valid document.

Does the POLST form travel with the patient between settings of care?

Yes, the POLST form is designed to be a standard form that may be accepted by all providers across the state. As a legal medical order, it will be honored by EMS. Hospitals, long-term care facilities, home care and hospice providers may also voluntarily honor the form and include it into their medical records. However, providers with electronic medical records may choose to adapt the essence of the orders into their specific system. Hospital discharge planners are encouraged to support the completion of the POLST form (when clinically appropriate) as a part of their daily practice.

Is implementing the orders from the POLST form protected under Hawai'i Law?

Yes. The law states that no provider will be subject to criminal prosecution and civil liability for carrying out the treatment orders in good faith or for performing cardiopulmonary resuscitation if the person performing CPR was unaware of the POLST order to not attempt resuscitation or they believed that the treatment orders (including the DNR order) had been revoked or canceled.

How do providers get more copies of the POLST form?

The form is available on the Kōkua Mau web site (www.kokuamau.org/polst) in PDF format for easy replication. It is the standard that the form be on an 8½" X 11" sheet of lime colored paper. The form must have both sides copied on the front and back of the paper.

Where is the family encouraged to keep the form?

For the patient at home, the POLST form should be kept in a place readily accessible by family members. Examples include on the refrigerator, in the medicine cabinet, on the back of a bedroom door or on a bedside table. It should be kept with the AHCD.

Which patients should complete a POLST form?

It is recommended that a patient with a chronic debilitating disease, a seriously ill patient, or a terminally ill patient have both an Advance Health Care Directive and a signed POLST form. Both forms should be kept together.

Who can explain the POLST form and fill it out?

The patient's physician, APRN or another health care provider must explain to the patient or Legally Authorized Representative the nature and content of the form, including any medical interventions or procedures. Additionally, the provider must also explain the difference between the POLST form and an Advance Directive. The physician, APRN or other healthcare provider may prepare (or fill in) the form, but it MUST be signed by the patient's physician or APRN and the patient or their Legally Authorized Representative in order to be valid.

Which Physician or Advanced Practice Registered Nurse (APRN) should be signing the POLST form?

The law stipulates that the physician or APRN who is co-signing the POLST form with the patient or their Legally Authorized Representative must be a physician or APRN licensed in the state of Hawai'i and must have examined the patient. The intent of this definition is to assure that there has been a professional relationship between the patient and physician or APRN.

What is a Legally Authorized Representative (LAR)?

This is someone who is able to make decisions for the patient when they are not able to make decisions on their own. A Legally Authorized Representative can be 1) an agent designated by the patient through a Power of Attorney for Healthcare, 2) a guardian, 3) a surrogate designated by the patient when the patient is still able to make that decision, or 4) a surrogate designated by consensus of interested persons. If a patient is not able to make decisions on their own, the patient's primary physician determines that is the case. After that, efforts are made to find all the people who have exhibited special care and concern for the patient and are familiar with the patient's wishes. Some of these people may include a spouse who is not separated or estranged, parents, and children, but interested persons do not necessarily need to be related by blood or marriage. This group of people select a surrogate decision maker by consensus. This is in accordance with HRS 327E-5.

What decisions can be made by a Legally Authorized Representative?

A Legally Authorized Representative can make all decisions that the patient would make on their own behalf with one exception. This exception is that the surrogate appointed by consensus in accordance with HRS 327E-5 has limitations placed upon him or her about decisions about withholding or withdrawing artificial nutrition and hydration. The surrogate by consensus can only make the decision to withhold or withdraw artificial nutrition and hydration if two physicians independently certify in the patient's medical records that the artificial nutrition and hydration only prolongs the act of dying and the patient is highly unlikely to have any neurological response in the future.

When should the POLST form be reviewed?

The physician or APRN should review the POLST form with the patient or their Legally Authorized Representative whenever there are substantial changes in the health status, when there is a transfer from one setting to another or when the goals for treatment change.

How is the form modified or voided?

A patient or their Legally Authorized Representative may revoke or void the POLST form in any manner that communicates that intent. The form may also be voided by drawing a line through the front of the page (sections A – E) writing "VOID" in large letters on the original and copies, and signing and dating that action.

For more information, contact Kōkua Mau at 808-585-9977 or info@kokuamau.org. www.kokuamau.org/professionals/polst

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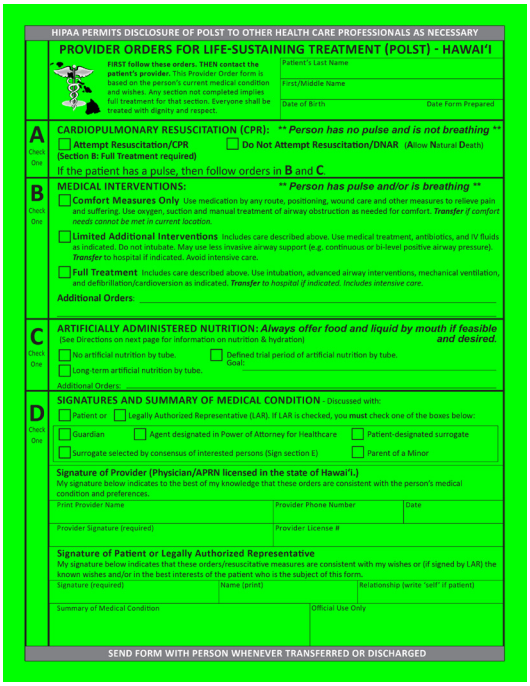

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) - HAWAI'I

FIRST follow these orders; THEN contact the patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name | First/Middle Name | Date of Birth | Date Form Prepared

A Check One — CARDIOPULMONARY RESUSCITATION (CPR): ** Person has no pulse and is not breathing **
☐ Attempt Resuscitation/CPR (Section B: Full Treatment required) ☐ Do Not Attempt Resuscitation/DNAR (Allow Natural Death)
If the patient has a pulse, then follow orders in B and C.

B Check One — MEDICAL INTERVENTIONS: ** Person has pulse and/or is breathing **
☐ Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Transfer if comfort needs cannot be met in current location.*
☐ Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). *Transfer* to hospital if indicated. Avoid intensive care.
☐ Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*
Additional Orders:

C Check One — ARTIFICIALLY ADMINISTERED NUTRITION: *Always offer food and liquid by mouth if feasible and desired.*
(See Directions on next page for information on nutrition & hydration)
☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube. Goal:
☐ Long-term artificial nutrition by tube.
Additional Orders:

D Check One — SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:
☐ Patient or ☐ Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:
☐ Guardian ☐ Agent designated in Power of Attorney for Healthcare ☐ Patient-designated surrogate
☐ Surrogate selected by consensus of interested persons (Sign section E) ☐ Parent of a Minor

Signature of Provider (Physician/APRN licensed in the state of Hawai'i.)
My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.
Print Provider Name | Provider Phone Number | Date
Provider Signature (required) | Provider License #

Signature of Patient or Legally Authorized Representative
My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the known wishes and/or in the best interests of the patient who is the subject of this form.
Signature (required) | Name (print) | Relationship (write 'self' if patient)
Summary of Medical Condition | Official Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED