POLST
physician orders for life-sustaining treatment paradigm

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

- **What is the POLST Program?**
  POLST is "Pennsylvania Orders for Life-Sustaining Treatment." The POLST Program is designed to improve the quality of care people receive at the end of life by turning patient goals and preferences for care into medical orders.

  The physician orders are based on a patient's medical condition and his/her treatment choices as established in communication between the patient or the legal medical decision-maker and a health care professional. Use of the POLST form is completely voluntary.

  The POLST Program:
  1. Assists health care professionals to discuss and develop treatment plans that reflect patient wishes;
  2. Results in the completion of the POLST form;
  3. Helps physicians, nurses, health care facilities and emergency personnel honor patient wishes regarding life-sustaining treatments in emergency situations.

- **For whom is a POLST form appropriate?**
  Use of the POLST form is recommended for persons who have advanced chronic progressive illness and/or frailty, those who might die in the next year or anyone of advanced age with a strong desire to further define their preferences of care in their present state of health. To determine whether a POLST form should be encouraged, clinicians should ask themselves, "Would I be surprised if this person died in the next year". If the answer is "No, I would not be surprised", then a POLST form is appropriate. Unless it is the patient's preference, use of the POLST form is not appropriate for persons with stable medical or functionality problems who have many years of life expectancy.

- **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 with advanced illness and/or advanced frailty 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 special 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.

- **What are the requirements for a POLST form?**
  The POLST form at a minimum must include the patient name, resuscitation orders (Section A) and 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. Sections B, C and D are optional.

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- **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?**
  Ideally the values expressed on the advance directive do not conflict with the medical orders on the POLST. One document does not necessarily supersede the other. If there is conflict between the two instruments, then it is best to amend the one that is not representative of the patient's values and choices for medically indicated treatments.

- **What is recommended if the advance directive and the POLST conflict?**
  The usual process is to carefully elicit patient values from the patient or legal decision-maker, and making sure the POLST is consistent with these values. If in crisis and goals of care are not clear, then provide a higher level of care until more information is known.

- **Who is responsible to assure the POLST and advance directive are not in conflict?**
  Ultimately it is the attending physician. It would also be the responsibility of the physician's agent who is helping to complete the document (Nurse or social worker at nursing home, for example).

- **Is CPAP or BIPAP a treatment that can be offered to patients who desire "comfort measures only" or "limited additional interventions"?**
  For patients for whom the treatment is appropriate, the use of positive pressure ventilation may be viewed as a treatment that is consistent with the wishes of some patients who desire "comfort measures only" or "limited additional interventions". The treatment is non-invasive and improvement in comfort may occur as the work required for breathing decreases.

- **Does a DNR order imply that a patient does not want 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 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 for 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.

  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.