POLST-Pennsylvania Orders for Life-Sustaining Treatment

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The Law

- In 2006, Act 169 was signed into law. The purpose of the act was to provide a comprehensive statutory framework governing Advanced Directives and Healthcare decision making for incapable ("unable") patients

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What is an Advanced Healthcare Directives

1. Can be a living will,(sometimes called a declaration of life);
2. Can be a Healthcare Power-Of-Attorney (HCPOA);
3. Or, can be BOTH.

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What is a LIVING WILL?

1. A written statement of patient(s) desires regarding life-sustaining treatments.
2. ACT 169 defines life-sustaining treatments as *treatment that prolongs the process of dying or maintains the patient in a permanently unconscious state.*
3. The Living Will is not operative or in effect until the patient is "unable" and is in a status condition.

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What is a Healthcare Power-of-Attorney (HCPOA)?

- A written document in which the patient (while ABLE) appoints a person to serve as the patient's decision-maker.

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What is a Healthcare Representative?

- If a patient has no controlling living will, a healthcare POA or a court-appointed guardian, a healthcare representative will be initiated. The statutory list gives priority in the following order:
- Spouse
- Adult child
- Parent
- Adult sibling
- Adult grandchild
- Close friend

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What are the Requirements on Executing a Healthcare Directive?

1. The patient must be "able";
2. Must be done in writing;
3. Must be signed by the patient;
4. Must be witnessed by 2 individuals over the age of 18.

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What is CAPABLE vs. INCAPABLE("able" vs "unable")?

- Act #169 defines three critical elements in sound healthcare decision-making:
  1. Understanding the risks, benefits, and alternatives;
  2. Making a decision; and,
  3. Communicate the decision to another person.

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Capable vs. Incapable (cont'd)

- If the ability to perform any of these 3 elements is absent, the individual is "incapable". When all 3 are present, the person is "capable".
- PA Law requires only one physician to evaluate and determine capability for a patient. ***Please note,*** CRNP's ***CANNOT*** determine capability, only a physician (MD) can determine capability.

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What is a STATUS CONDITION?

1. End Stage Condition: an advanced, progressive, irreversible condition caused by injury, disease, or illness that has resulted in severe and permanent deterioration indicated by incapacity and complete physical dependency and that, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.
2. Persistent Vegetative State: caused by injury, disease, or illness resulting in a loss of consciousness; that this individual exhibits no behavioral evidence of self-awareness or awareness of surroundings in a learned manner other than reflex activity of muscles or nerves for low level conditioned response and that after the passage of medically appropriate period of time, it has been determined, to a reasonable degree of medical certainty, there can be no recovery.
3. Terminal Condition: Caused by injury, disease, or illness and, which despite the application of life-sustaining treatments, there can be no recovery.

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Important to Note

- A Healthcare Representative can only withhold or withdraw medical interventions when the patient is deemed to be "unable" and is in a "status condition".

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The POLST Program

- The POLST program is designed to improve the quality of care people receive at the end of life by turning patient goals and preferences into medical orders. The purpose of a the POLST is to limit care.
- The POLST is an order. The physician's orders reflected in the POLST are based on the patient's medical condition, his/her treatment choices as established in the communication between the patient or the legal medical decision-maker, and Healthcare professional.

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POLST and Advanced Directives

- POLST is not intended to replace an advanced health care directive document or the medical orders. *It is an instrument that complements an advanced directive*
- The POLST process and the healthcare decision-making works best when the person has appointed a health care agent to speak for them when they become unable to speak for themselves.
- A health care agent can only be appointed through an advanced health care directive called a healthcare power of attorney (HC POA)

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POLST Facts

- Use of the POLST is voluntary (but it is encouraged).
- The POLST is portable and enduring. The POLST should be sent with the patient whenever the patient is transferred from one level of care to another (e.g., nursing home to hospital).
- THE POLST form is designed to be most effective in emergency medical situations (as a snap-shot to care).
- EMS personnel may honor a POLST only upon receiving an order from a medical command physician.
- If a patient wishes to be a DNR in section A, it is recommended that Out of Hospital DNR form be initiated

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CAUTIONS

- The original POLST form should be copied onto pulsar pink paper.
- The original should remain in the resident's chart and POLST form should be copied and sent with resident upon transfer.

- Only an "able" patient or healthcare agent can complete a POLST that reflects limited care.
- Healthcare representatives can only limit care if the resident is determined to be "unable" and in a "status condition".

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The POLST Form

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POLST

- The POLST is double-sided. The front side of the document contains the PA orders for life-sustaining treatment (Sections A-E).
- The back-side provides space to indicate the patient's healthcare agent (referred to as the Surrogate on the POLST form) contact information and space for the healthcare professional who prepared the form for review (i.e., nurses, doctor, social worker, etc.).

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What are the Minimal Requirements for Completing the POLST Form?

1. Patient demographics: Name and date of birth.
2. Section A: resuscitation orders.
3. Signature of physician, PA*, or Nurse Practitioner.(verbal orders are acceptable with follow up signature)
4. Signature of patient or legal decision-maker (surrogate)
5. *All other information is optional*

*physicians assistant signature requires a physician co signature within 10 day

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When Should the POLST Form be Reviewed?

1. When the patient is transferred from one level of care (or setting) to another.
2. There is a substantial change in the patient health status.
3. The patient's treatment preferences change.
4. Reviewed at every care plan meeting.

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POLST, Who Fills It Out?

- Physician or physicians designee facilitator (RN, NP, PA, social worker, admissions)
- Facilitators need to be skilled, knowledgeable and credible to physicians/providers as well as patients and families
- Verbal orders are accepted with follow up signature by physician , NP in PA in accordance with facility/community policy

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Using the POLST Form

- If in section A, CPR/Attempt resuscitation is marked, then FULL TREATMENT must be marked in section B.
- When comfort cannot be achieved in the current setting, including persons with "comfort measures only", should be transferred to a setting able to provide comfort (i.e. sutures, hip fracture)
- An IV medication to enhance comfort may be appropriate for persons who have chosen "comfort measure only".
- Treatment for dehydration is a measure which may prolong life, a person who desires IV fluids should indicate either "limited medical interventions" or "Full treatment"
- POLST is "fluid", it is based on the patient's current medical condition, his/her treatment choices, and patient preferences. This is why it should be reviewed with each transfer and/or significant change.

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Revocation of POLST Form

- May be revoked by patient at any time, or legal decision maker at any time
- Revocation can be verbal statement

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Voiding the POLST

- Should a patient revoke a POLST,

"VOID"

- should be written across the front-side of the form. A new form can be completed, however, this is not required.

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Out-of-Hospital DNR

to ensure that an EMS provider can honor an individuals DNR order

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Out-of-Hospital DNR cont'd

- In PA, EMS will honor an Out-of-Hospital DNR as prescribed by PA Statute, but the required statutory form and procedure is different from the POLST. Not all EMS providers will recognize the POLST as a DNR order.
- It is recommended that residents who requests to be a DNR on the POLST form, also complete the Out-of-Hospital DNR.

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PA POLST Tools

- http://www.upmc.com/services/aginginstitute/pages/default.aspx
- www.caring.org
  Download state specific advanced directives
- www.polst.org
- www.parmedsoc.org
  PA Medical Society – a guide to Act 169 of 2006

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