



## FREQUENTLY ASKED QUESTIONS FOR PROVIDERS

### WHAT DOES “POLST” STAND FOR?

POLST stands for Practitioner Orders for Life-Sustaining Treatment

### WHAT IS THE POLST FORM?

POLST is a set of medical orders that help give seriously ill or frail elderly individuals more control over their end-of-life care. Produced on a distinctive green form and signed by both the doctor or advance practice nurse (APN) and individual/surrogate, POLST specifies the types of medical treatment that an individual wishes to receive toward the end of life. As a result, POLST can prevent unwanted or medically ineffective treatment, reduce patient and family suffering, and help ensure that individual’s wishes are honored.

### WHAT INFORMATION IS INCLUDED ON THE POLST FORM?

Documentation on the POLST form includes:

- Goals of care for the individual
- Preferences regarding cardiopulmonary resuscitation attempts
- Preferences regarding use of intubation and mechanical ventilation for respiratory failure
- Preferences for artificially administered nutrition and hydration
- Other specific preferences regarding medical interventions that are desired or declined

### WHY WAS POLST DEVELOPED?

POLST was developed in response to seriously ill patients receiving medical treatments that were not consistent with their wishes. The goal of POLST is to provide a framework for healthcare professionals so they can provide the treatments patients DO want and avoid those treatments that patients DO NOT want.

### IS POLST MANDATED BY LAW?

Filling out a POLST form is entirely voluntary. However, NJ law requires that medical orders contained in a POLST be followed by health care practitioners, and provides immunity from civil or criminal liability to those who comply in good faith with a individual’s POLST.

### WHO SHOULD HAVE A POLST FORM?

POLST is designed for seriously ill individuals with a life expectancy of a year or less, or those who are medically frail with limited life expectancy, regardless of their age.

### WHAT ARE THE DIFFERENCES BETWEEN ADVANCE DIRECTIVES AND POLST?

- Advance directives are *statements of patient intention*, not *medical orders*. The provisions in advance directives must be translated by health care practitioners into medical orders to become operational. POLST is a consolidated set of *medical orders* that are **immediately operational**.
- Advance directives are appropriate for all persons age 18 and over. POLST is appropriate for persons with life-limiting illnesses and a life expectancy of one year or less.
- The provisions of advance directives are activated only after a patient has been determined to have lost decision-making capacity. POLST is operational as soon as it is completed and signed by the patient or surrogate and a physician or APN, regardless of the patient’s decisional capacity when treatment decisions become necessary.

## **DOES THE POLST FORM REPLACE A TRADITIONAL ADVANCE DIRECTIVE?**

The POLST form complements an Advance Directive and is not intended to replace that document. An Advance Directive may still be necessary to appoint a legal health care decision maker, and is recommended for all adults, regardless of their health status.

## **IF SOMEONE HAS A POLST FORM AND AN ADVANCE DIRECTIVE THAT CONFLICTS, WHICH TAKES PRECEDENCE?**

Ideally, the values expressed on both documents should be the same. If there is conflict between the two documents, a conversation with the individual or his/her surrogate should take place as soon as possible in order to determine the most current preferences. The POLST and the Advance Directive can then be updated based on these more current treatment choices. If this cannot be done and a crisis ensues, care should be provided in accordance with the most recent document, whether it be the Advance Directive or the POLST.

## **WHO SHOULD DISCUSS AND COMPLETE THE POLST FORM WITH PATIENTS?**

Having a conversation with an individual about end-of-life issues is an important and necessary part of good medical care. The law allows a physician or an advance practice nurse to complete a POLST form. In many cases, these practitioners will initiate conversations with their patients to understand their wishes and goals of care. Depending on the situation and setting, other trained staff members – such as nurses, palliative care team members, social workers or chaplains – may also play a role in starting the POLST conversation. However, physicians/APNs are responsible for the final clarification of those preferences and documentation of the appropriate orders on the POLST form.

## **CAN A POLST FORM BE COMPLETED FOR PATIENTS WHO CAN NO LONGER COMMUNICATE THEIR TREATMENT WISHES?**

Yes. A physician or advance practice nurse can complete the POLST form based upon a legally recognized surrogate decision maker's understanding of the patient's preferences. The surrogate can then sign the POLST form on behalf of the patient.

## **WHAT SHOULD BE DONE WITH THE FORM AFTER IT IS COMPLETED AND SIGNED?**

The original POLST form, on green paper, stays with the individual at all times. If the individual is transferred to another setting, the original POLST form goes with him/her.

- In the acute care or long term care settings, the original form should be kept in the patient's medical record or file in the doctors' order section and copies should be made or scanned into the medical record to maintain. The original must be returned to the individual before discharge.
- At home, individuals should be instructed to place the original form in a visible location so it can be found easily by emergency medical personnel – usually on a table near the patient's bed or on the refrigerator. Copies may be kept for record keeping.

## **CAN AN INDIVIDUAL'S POLST FORM BE CHANGED?**

Yes, the POLST form can be modified or rescinded by an individual with decision-making capacity, verbally or in writing, at any time. Changes may also be made by the individual's legally recognized surrogate, if the individual previously authorized the surrogate, via the POLST form, to make such modifications. Any changes to the POLST form should be made in collaboration with the individual's physician or advance practice nurse.

## WHEN SHOULD AN INDIVIDUAL'S POLST FORM BE REVIEWED?

It is good clinical practice to review an individual's POLST form when any of the following occur:

- The individual is transferred from one medical or residential setting to another;
- There is a significant change in the person's health status, or there is a new diagnosis;
- The individual's treatment preferences change

## ARE FAXED COPIES AND/OR PHOTOCOPIES VALID? MUST GREEN PAPER BE USED?

Faxed copies and photocopies are valid. Green paper is preferred and should be used to distinguish the form from other forms in the patient's medical record; however, the form will be honored on any color paper as long as it contains the appropriate signatures and license number of practitioner.

## WHERE IS POLST BEING USED NOW?

POLST was originally developed in Oregon. There are a number of states which have established POLST programs or are currently developing programs. For more information on the national POLST paradigm, including published research and a complete listing of states using POLST, visit: [www.POLST.org](http://www.POLST.org)

## DOES A POLST FORM TAKE THE PLACE OF OTHER DNR ORDER FORMS?

The individual's preferences for cardiopulmonary resuscitation attempts and airway management are contained in a POLST form and should be honored upon receipt. However, hospitals and/or nursing facilities may still use other forms of Do Not Resuscitate order forms in addition to the POLST in keeping with institutional policies. The NJ Out of Hospital DNR Form that has been utilized by EMS since 1997 will remain valid and should be honored upon receipt. However, eventually, the POLST form will evolve to replace most other order forms for resuscitation in all settings; but until that time, it is appropriate to honor all forms that are current and have not been rescinded or replaced by a more current form.

## DOES THE POLST FORM EXPIRE?

No. However, it is recommended that a POLST form be reviewed frequently and especially when there is a change in medical condition, transfer to a different level of care setting or a change in preferences of the individual.

## WHAT HAPPENS IF A POLST FORM IS WILLFULLY IGNORED?

Health care professionals who intentionally ignore a POLST form will be subject to discipline for professional misconduct pursuant to N.J.S.A. 45:1-21. Hospitals/facilities that intentionally ignore a POLST are subject to fines. Other individuals such as family who willfully conceal, ignore, hide, forge, falsify, or fail to disclose a valid POLST form are guilty of a crime in the fourth degree. If willful action leads to the involuntary earlier death of the patient, it shall constitute a crime of the first degree.

## WHY IS THE FIRST SECTION ABOUT "GOALS OF CARE"?

The goals of care for an individual's health care plan are an important part of the comprehensive understanding of the individual's medical condition, expected prognosis and the individual's specific goals that are important to him/her, such as wanting to spend time at home with family, wanting to get treatments that allow the individual to live until a son's wedding or wanting to be comfortable and pain free regardless of length of life. These specific goals should be part of every conversation with individuals about their treatment plans and the translation of those goals into physician/APN orders to accomplish those goals.

## HOW IS POLST HANDLED IN INSTITUTIONS THAT HAVE PHYSICIAN ORDER ENTRY SYSTEMS, AND POLST IS A PART OF THAT SYSTEM?

At this time in New Jersey there isn't uniformity in how orders are handled in hospitals' computerized order entry systems (CPOE). Also, all of the systems do not "talk" to each other. For the time being, if a patient executes a POLST document while an inpatient in a healthcare facility, upon discharge, that POLST should be transcribed onto the green NJ form and given to the individual. Do not print out a copy of the computerized form and give to the individual, unless

it looks exactly like the approved NJ POLST form. It will be unnecessarily confusing to the healthcare community to have different versions of the NJ form in circulation and this may result in the individual receiving care that he/she did not want.

**WHAT IF A PATIENT WITH A VALID POLST FORM NEEDS TO GO TO THE OPERATING ROOM? CAN THE POLST FORM AND ITS ORDERS BE HELD FOR THE PERIOD OF THE SURGERY?**

First, consideration must be given as to the reason for the surgery and if it is consistent with the patient's wishes and goals of care, as documented on the POLST form. A conversation should occur between the surgeon or anesthesiologist and the patient and/or family or surrogate as to the purpose of the surgery and what needs to happen regarding intubation. Consideration could also be given to using a mode of anesthesia that does not require intubation, or where an LMA could be used. This conversation should be carefully documented in the medical record. The patient, if competent, could void the POLST prior to surgery and then once recovered from anesthesia, the physician/APN could execute a new POLST. If there is a designated surrogate, and the patient is not competent, then the surrogate could void the POLST and then execute another one after surgery. As always, if there are any concerns about any aspect of what to do about a POLST document, the facility's ethics committee should be consulted.

**WHAT ABOUT THE JOINT COMMISSION'S STANDARD ON NOT FOLLOWING MEDICAL ORDERS IF THE PHYSICIAN IS NOT CREDENTIALLED BY THE FACILITY?**

In a communication between The Joint Commission and the NJHA Institute for Quality and Patient Safety staff on Oct. 3, 2013, the following decision was reached: "The opinion (of their Standards Interpretation Group) is that if the POLST is properly completed and the organization follows state law and regulation, there are no Joint Commission requirements that would prevent a hospital from carrying out the POLST directives."

