Pennsylvania POLST
Pennsylvania Orders for Life-Sustaining Treatment
A Participating Program of National POLST

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

- **What is POLST?**
  - 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 portable 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?**
  The POLST form is intended for patients:
  - whose healthcare professional would not be surprised if they died within 1–2 years; or
  - who are at an increased risk of experiencing a medical emergency based on their current medical condition and who wish to make clear their treatment preferences, including about CPR, mechanical ventilation, ICU; or
  - who have had multiple unplanned hospital admissions in the last 12 months, typically coupled with increasing frailty, decreasing function, and/or progressive weight loss.

- **May a healthcare 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. Facilities may choose to *offer* the POLST form to all individuals who meet the eligibility criteria outlined above.

- **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 portable 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

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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 valid 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 10 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 express the desire to 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 resident 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 on the patient’s preferences for care, including the POLST and advance directive.

More information is available through the POLST coordinator at **info@papolst.org** or online at: **www.papolst.org**

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- **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 healthcare 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 ensure 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.

- **If a POLST-eligible patient lives in Pennsylvania but receives care from providers in neighboring states, which state's POLST form should be completed?**
  POLST forms may differ from state to state. Some states offer reciprocity regarding POLST, but not all do. For patients who receive care in states outside of their primary place of residence, it is recommended that POLST forms be completed for both state of residence and where care is delivered. The existing POLST and any current advance directives forms can be used as guidance in completing an additional POLST.

- **Can a POLST be completed with a patient during a telehealth visit?**
  Yes, a POLST form may be completed during a telehealth visit. Arrangements for signatures for patient/surrogate and provider should be made per organization policy. Fully document the conversation in the medical record. Include:
  - Who was engaged in the conversation, patient or surrogate?
  - Were family members or others included?
  - If the patient, was it clear that he/she was capable of understanding the discussion and able to make health care treatment decisions?
  - When and how is the form being transmitted to location where patient is receiving care?

  Refer to the PA POLST *Guidance for Healthcare Professionals* for additional recommendations on POLST completion via telemedicine.

- **Is it appropriate for a provider to pre-fill responses on a POLST form based on a recent goals of care conversation with the patient and share it with the patient for review/signature?**
  A form that has been completed by the provider based on a thorough conversation around goals of care may be shared with the patient/surrogate, but each section must be reviewed thoroughly to ensure it is accurate and consistent with the patient's current care preferences.

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