

National POLST Paradigm Appropriate POLST Paradigm Form Use Policy

The National POLST Paradigm is an approach to end-of-life planning that emphasizes eliciting, documenting and honoring patients' preferences about the medical treatments they want to receive during a medical crisis or as they decline in health. Fundamentally, the POLST Paradigm is not a form: it is a *process*.

The POLST Form is a portable medical order designed to support patients transitioning between health care facilities or living in the community by communicating patient treatment preferences. In the event of a medical emergency, when time is of the essence for medical decision-making, the POLST Form serves as an immediately available and recognizable order set in a standardized format. This aids emergency personnel in implementing patient treatment preferences as communicated to—and documented by—the patient's health care professional. This information and the documentation occurs after a conversation involving shared decision-making.

Using POLST Forms appropriately supports the integrity of the POLST Paradigm in honoring the treatment preferences of those with serious illness and frailty and whom health care professionals wouldn't be surprised if they died within the year. Below are seven fundamental tenets all health care professionals should follow to ensure appropriate POLST Form use:

1. **POLST Form completion should always be voluntary.** Just as patients may choose to refuse treatment or not to have an advance directive, patients may refuse to have a POLST Form completed on their behalf. It is inappropriate to require a patient to have a POLST Form because it may be forcing them into either making decisions that they may not be ready to make or participating in advance care planning, which they may not want to do.

A facility may have a policy to *offer* a POLST Form to all appropriate patients but should never have a *requirement* of completion.

2. **Completion of a POLST Form without patient or surrogate/proxy knowledge is contrary to the purpose and intent of the POLST Paradigm and violates informed consent and principles of person and family-centered care.** Patients have a right to participate in medical decision-making regarding their treatment plan.

A patient's surrogate/proxy needs to make decisions for the patient in the context of the current diagnosis, health status and prognosis. If a patient is incapacitated and cannot weigh in on treatment options, the surrogate/proxy may complete the POLST Form on the patient's behalf. Regardless of whether the surrogate/proxy is completing an original form or a revision, their choices should reflect what the patient would want, according to the patient's known values and preferences - not the surrogate/proxy's preferences - or best interest and in consideration of the patient's current diagnosis, health status and prognosis.

3. **Conversation is the cornerstone of the POLST Paradigm: the POLST Form is only as good as the conversation(s) preceding it.** The POLST Form is a step in a process that includes—and in fact, depends upon—a conversation. The form is designed to document treatment decisions

made after shared decision-making conversations between a patient and his/her health care professional. The conversation should include the patient's current diagnosis, prognosis, treatment options (including risks and benefits of each) and goals of care. The result of the conversation may be the completion of a POLST Form—or it may be a first step in the care planning process.

The POLST Paradigm emphasizes the need for a patient-professional conversation in two ways:

- a. The National POLST Paradigm Task Force encourages all states to require patient or surrogate/proxy signature, attestation or acknowledged verbal approval for POLST Form orders to be valid.
 - b. Most state POLST Forms include attestation statements so that, by signing a POLST Form, the health care professional is acknowledging the orders contained on that POLST Form are consistent with patient treatment preferences. Patient preferences cannot be known unless at least one conversation has occurred.
4. **POLST Forms should be used within the intended population.** The POLST Paradigm is intended to be used by patients who are seriously ill or frail and whose health care professionals wouldn't be surprised if they died within a year—regardless of patient age or what facility a patient is in. For example, most 65-year-olds are too healthy to have POLST orders and not all residents in a nursing home may be appropriate for a POLST form. Generally, patients who do not meet these criteria are not appropriate to have a POLST Form.

The intended population are the individuals with whom health care professionals can initiate specific and detailed conversations about current diagnosis, prognosis, treatment options, the likely effect those treatments will have on that patient (e.g., what will most likely happen if CPR is attempted) and identify the patient's goals of care. For example, the POLST Form provides medical orders for what happens tonight if a medical crisis occurs given the patient's current medical condition. If conversations with this level of specificity cannot happen, or if the patient is not appropriate for a POLST Form based on their clinical status and prognosis, then a POLST Form should not be offered to, or completed for, that patient (and an advance directive should be offered instead).

5. **Health care professionals should complete the POLST Form.** Since POLST Forms are medical orders completed by health care professionals to communicate treatment decisions to other health care professionals, it is **never** appropriate to provide a POLST Form to a patient, surrogate, or family member to complete.

Additionally, since POLST Forms use medical terms not all patients understand, it is important that health care professionals share treatment options utilizing language and tools (e.g., videos or visuals) to help patients and families understand. It is the task of the health care professional to translate the individual's goals of care, priorities, and wishes into medical orders using the language of medical professionals.

6. **A POLST Form is not a "one-and-done" document.** The POLST Paradigm recognizes that things change over time, including a patient's prognosis, health status, goals of care, treatment options, and preferences for treatments. It is well known that some patients change their mind

about treatment options over the trajectory of their illness or want their surrogate or proxy to be able to consider their values when their condition or prognosis changes. The POLST Form is intended to be dynamic, reflecting the patient's current preferences about the medical treatments he/she wants to receive. This dynamic process is achieved through ongoing conversations when a POLST Form review is completed: upon changes in level of care, location or patient's goals of care.

7. **Completing only Section A (Cardiopulmonary Resuscitation options) can be a disservice to patients.**

The POLST Form is intended to provide emergency personnel more than just code status information:

- Section A (Cardiopulmonary Resuscitation options) allows a patient either to confirm they actually *do* want CPR attempted or that they want to refuse attempted resuscitation.
- Section B (Medical Interventions or Treatments) provides direction about treatment preferences to emergency personnel and other health care professionals in situations other than full cardiac and respiratory arrest.

Limited information about patient treatment preferences is provided if a patient has a DNR order or only Section A on a POLST form completed. A DNR (do-not-resuscitate) order (also known as a do-not-attempt resuscitation [DNAR] order, or an order to allow natural death) only indicates that a health care professional has issued an order based on the patient's wish to forgo resuscitation in the event of a cardiac or 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.

Understanding the importance of Section B on a POLST Form is very important- it is the heart of the POLST Paradigm. The literature indicates not all people who complete a DNR order want the same level of treatment; half of patients with only Section A of a POLST Form completed or only a DNR order may receive treatment they didn't want.¹ If a patient wants have a POLST Form, both Sections A and B completed should be completed in order to fully document and protect patients' treatment wishes.

¹ A majority of individuals with DNR orders requested some other form of life-extending treatment. Hickman, S. E., Tolle, S. W., Brummel-Smith, K. and Carley, M. M. (2004), Use of the Physician Orders for Life-Sustaining Treatment Program in Oregon Nursing Facilities: Beyond Resuscitation Status. *Journal of the American Geriatrics Society*, 52: 1424–1429. doi:10.1111/j.1532-5415.2004.52402.x