POLST ILLINOIS

Practitioner Orders for Life-Sustaining Treatment

THE 2022 ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH) UNIFORM PRACTIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

Training for Emergency Medical Services & First Responders

Version 4/23

DISCLAIMER

- Note that this presentation provides clinical guidance for the POLST Model and should NOT be construed as medical or legal advice.

- For answers to legal questions, check with your organization's legal counsel.

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Practitioner Orders for Life-Sustaining Treatment

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Practitioner Orders for Life-Sustaining Treatment

Objectives

By the end of this session, participants will:

- Understand the **POLST Model** and how a person's wishes are determined and documented in a standard form;
- Understand why IDPH revised the Illinois POLST form in 2022
- Understand how the sections of the 2022 form have changed from the 2017 version
- Advocate for patients by accurately interpreting IDPH POLST form instructions and taking appropriate action

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Practitioner Orders for Life-Sustaining Treatment

POLST Model Overview

What is POLST?

- In Illinois - POLST stands for **Practitioner** Orders for Life Sustaining Treatment
- Must be executed by a *qualified health care practitioner* (QHCP):
  - Physician
  - Advanced Practice Registered Nurse
  - Physician Assistant
  - Resident in 2nd year or higher of residency program

  All must be licensed in Illinois OR if needed, the state where the Illinois resident is being treated.
- NOT just a form, but a process
  - Approach to end-of-life planning based on thoughtful conversations with the patient/patient legal representative and healthcare professionals
  - Incorporates values, beliefs and priorities as these relate to prognosis & treatment choices

FULL TEXT of the Illinois Health Care Surrogate Act:
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2111

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Practitioner Orders for Life-Sustaining Treatment

Why does the POLST Form exist?

First responders need clear guidance for how to respond to a medical emergency in the field.

- Recognized IDPH standardized form for the entire State of Illinois
- **Medical orders -** EMS providers and first responders must follow, so that treatment is in keeping with the patient's wishes.
  - If patient wishes are uncertain, contact medical control.
  - If orders are beyond scope of practice, contact medical control and/or consider transport.
- Original IDPH DNR form did not address pre-cardiac arrest emergencies (prior versions of forms are valid)

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Intended Use of POLST Form

The POLST decision-making process and resulting medical orders are intended for people of any age who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.

- **COMPLETING FORM IS VOLUNTARY**: The form cannot be required of any patient as a precondition of admission to a healthcare facility or the provision of care. A patient can void their form at will.

- **The POLST form speaks for patients ONLY when they can't speak for themselves.**

- **Pediatric patients with a valid POLST form should be treated the same as an adult.**

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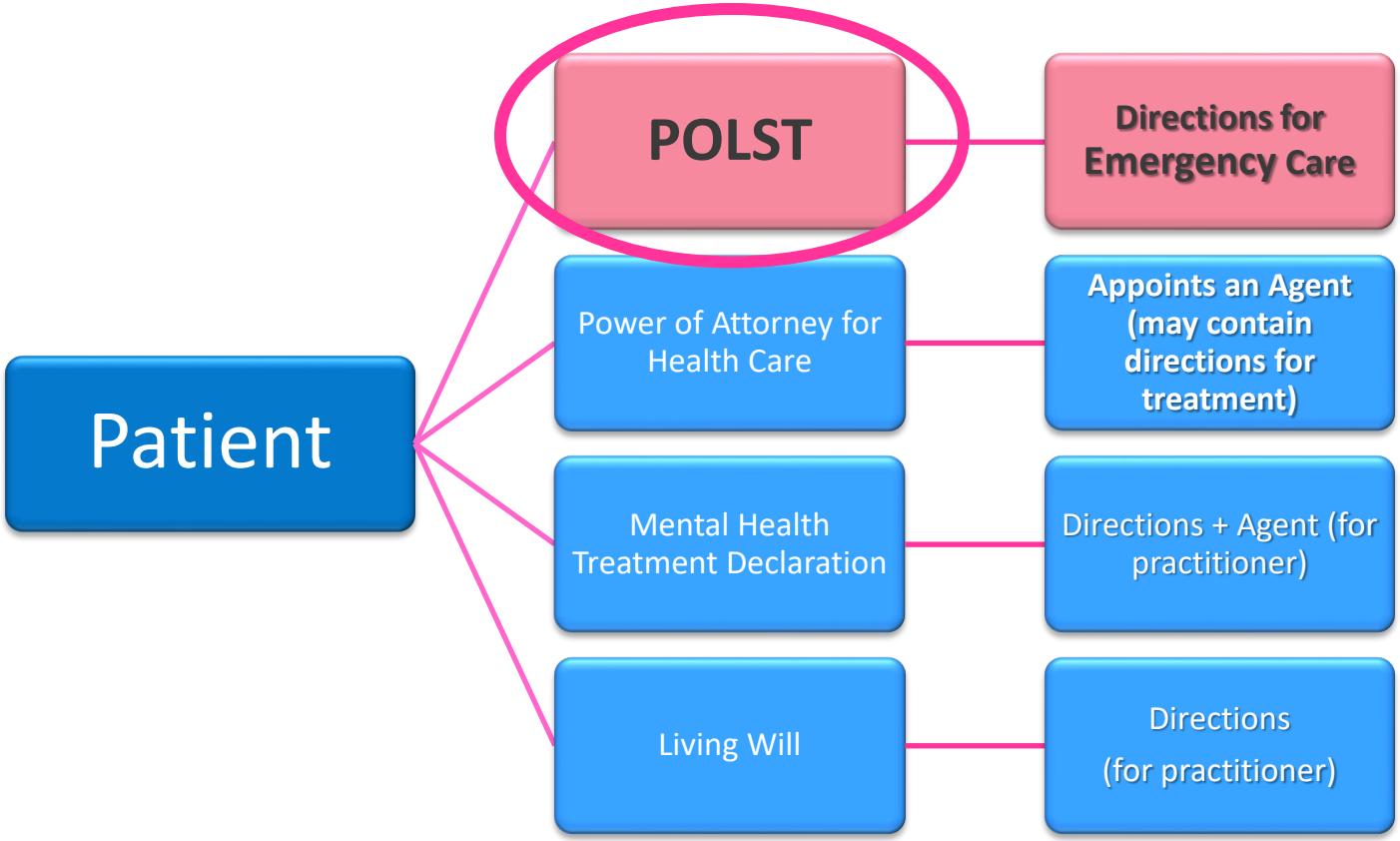
Practitioner Orders for Life-Sustaining Treatment

Rely on POLST ONLY if Patient CANNOT Make Decisions



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Practitioner Orders for Life-Sustaining Treatment

2022 Form Changes: Background

Why were revisions made to the IDPH Uniform POLST form?

- Illinois Health Care Surrogate Act amended to remove witness signature requirement
- Make the form easier to understand, explain and implement

Has the purpose of the form changed in making the revisions?

- No substantive changes
- Revisions enhance existing features and address information gaps
- More medically accurate

Can the form be completed electronically?

- Form completed on a computer, tablet or other device are valid
- Both electronic and written signatures valid

FULL TEXT of the Illinois Health Care Surrogate Act:
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2111

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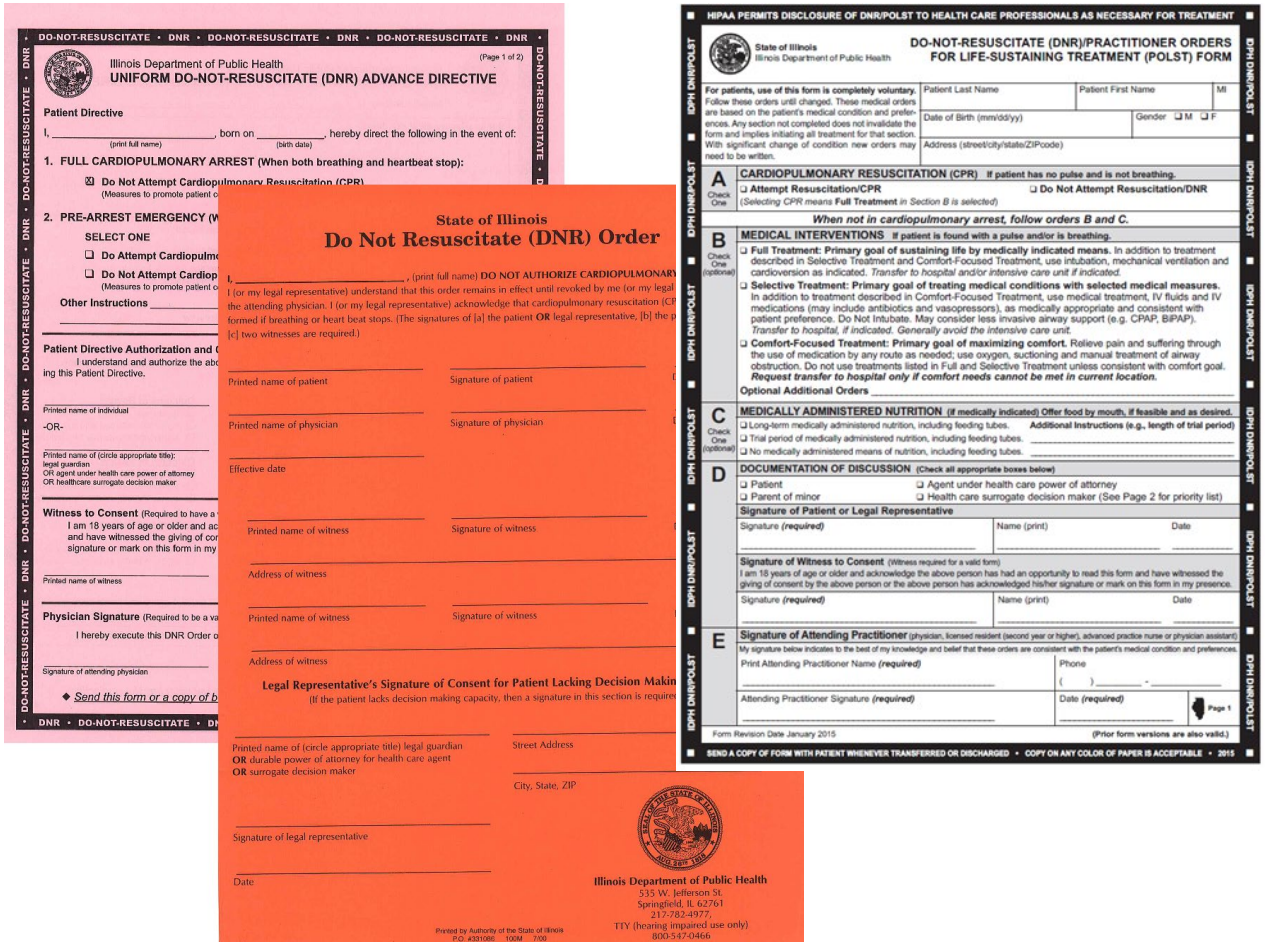
Practitioner Orders for Life-Sustaining Treatment

Prior Versions of IDPH Form Are All Valid



DO-NOT-RESUSCITATE • DNR • DO-NOT-RESUSCITATE • DNR • DO-NOT-RESUSCITATE • DNR

(Page 1 of 2)

Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

Patient Directive

I, _____ (print full name), born on _____ (birth date), hereby direct the following in the event of:

1. FULL CARDIOPULMONARY ARREST (When both breathing and heartbeat stop):

☒ Do Not Attempt Cardiopulmonary Resuscitation (CPR)

(Measures to promote patient c

2. PRE-ARREST EMERGENCY (W

SELECT ONE

❑ Do Not Attempt Cardiopulm

❑ Do Not Attempt Cardiop

(Measures to promote patient c

Other Instructions _____

Patient Directive Authorization and

I understand and authorize the abc

ing this Patient Directive.

Printed name of individual

-OR-

Printed name of (circle appropriate title):
legal guardian
OR agent under health care power of attorney
OR healthcare surrogate decision maker

Witness to Consent (Required to have a

I am 18 years of age or older and ac

and have witnessed the giving of cor

signature or mark on this form in my

Printed name of witness

Physician Signature (Required to be a va

I hereby execute this DNR Order a

Signature of attending physician

◆ Send this form or a copy of b

DNR • DO-NOT-RESUSCITATE • DN

State of Illinois

Do Not Resuscitate (DNR) Order

I, _____, (print full name) DO NOT AUTHORIZE CARDIOPULMONAR

I (or my legal representative) understand that this order remains in effect until revoked by me (or my legal

the attending physician. I (or my legal representative) acknowledge that cardiopulmonary resuscitation [C

formed if breathing or heart beat stops. (The signatures of [a] the patient OR legal representative, [b] the p

[c] two witnesses are required.)

Printed name of patient

Signature of patient

Printed name of physician

Signature of physician

Effective date

Printed name of witness

Signature of witness

Address of witness

Printed name of witness

Signature of witness

Address of witness

Legal Representative's Signature of Consent for Patient Lacking Decision Makin

(If the patient lacks decision making capacity, then a signature in this section is require

Printed name of (circle appropriate title) legal guardian
OR durable power of attorney for health care agent
OR surrogate decision maker

Street Address

City, State, ZIP

Signature of legal representative

Date

Illinois Department of Public Health
535 W. Jefferson St.
Springfield, IL 62761
217-782-4977,
TTY (hearing impaired use only)
800-547-0466

Printed by Authority of the State of Illinois
P.O. #331066 100M 7/06

IDPH DNR/POLST

HIPAA PERMITS DISCLOSURE OF DNR/POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

State of Illinois
Illinois Department of Public Health

DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name | Patient First Name | MI

Date of Birth (mm/dd/yy) | Gender ❑ M ❑ F

Address (street/city/state/ZIPcode)

A Check One — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

❑ Attempt Resuscitation/CPR ❑ Do Not Attempt Resuscitation/DNR

(Selecting CPR means Full Treatment in Section B is selected)

When not in cardiopulmonary arrest, follow orders B and C.

B Check One (optional) — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

❑ Full Treatment: Primary goal of sustaining life by medically indicated means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ Comfort-Focused Treatment: Primary goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C Check One (optional) — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

❑ Long-term medically administered nutrition, including feeding tubes.

❑ Trial period of medically administered nutrition, including feeding tubes.

❑ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period) _____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Parent of minor ❑ Agent under health care power of attorney ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature (required) | Name (print) | Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature (required) | Name (print) | Date

E — Signature of Attending Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Attending Practitioner Name (required) | Phone ( ) -

Attending Practitioner Signature (required) | Date (required)

Page 1

Form Revision Date January 2015 (Prior form versions are also valid.)

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2015

Revisions to the Health Care Surrogate Act Expands Valid Form Types

Valid Form Types:

- 2022 IDPH POLST form
- Previously completed Illinois POLST forms on prior form versions
- POLST, MOST, POST, MOLST endorsed by other states
- Out-of-Hospital DNAR Forms endorsed by other states
- **National POLST form**

Follow most recently dated, valid form

FULL TEXT of the Illinois Health Care Surrogate Act:
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2111

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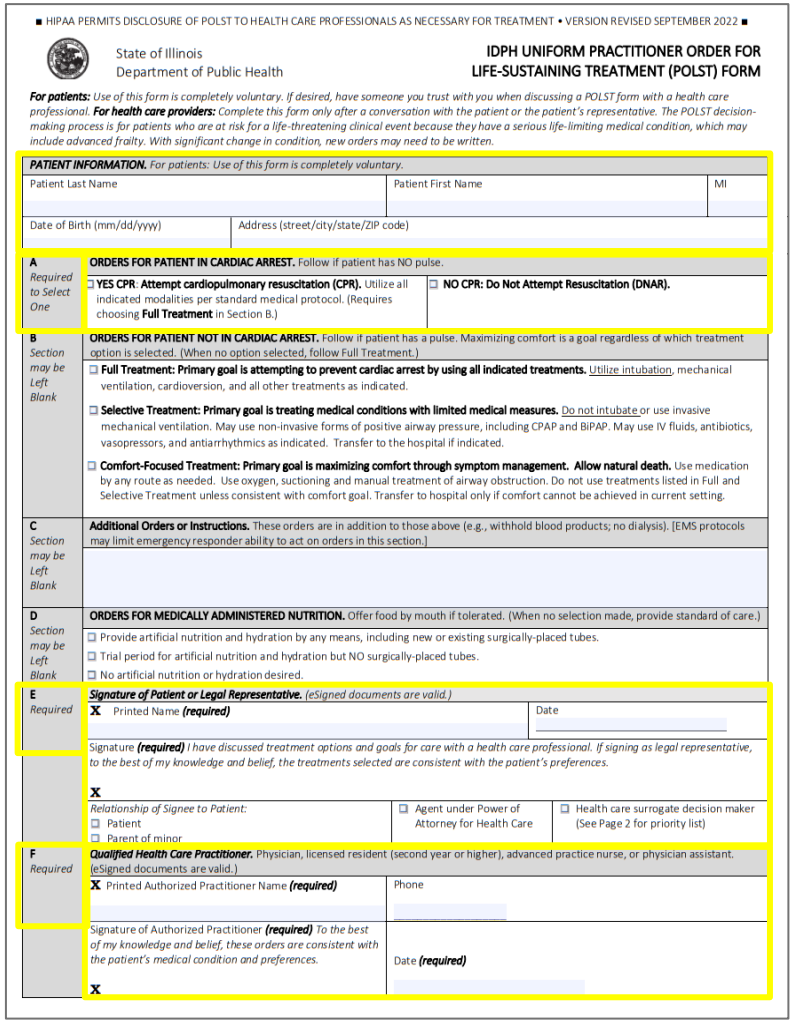
Practitioner Orders for Life-Sustaining Treatment

2022 IDPH Uniform POLST

2022 Form Overview (page 1)

Patient identifiers plus sections A, E, & F are required.

Sections B, C, & D may be left blank – all indicated treatment used when decision unspecified.



■ HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT • VERSION REVISED SEPTEMBER 2022 ■

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*

Patient Last Name | Patient First Name | MI

Date of Birth (mm/dd/yyyy) | Address (street/city/state/ZIP code)

A *Required to Select One*

ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.

☐ **YES CPR: Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)

☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

B *Section may be Left Blank*

ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.

☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.

☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C *Section may be Left Blank*

Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D *Section may be Left Blank*

ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.

☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.

☐ No artificial nutrition or hydration desired.

E *Required*

Signature of Patient or Legal Representative. *(eSigned documents are valid.)*

X Printed Name ***(required)*** | Date

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

X

Relationship of Signee to Patient: ☐ Patient ☐ Parent of minor | ☐ Agent under Power of Attorney for Health Care | ☐ Health care surrogate decision maker (See Page 2 for priority list)

F *Required*

Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

X Printed Authorized Practitioner Name ***(required)*** | Phone

Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.* | Date ***(required)***

X

PATIENT INFORMATION

A: ORDERS IF IN CARDIAC ARREST

B: ORDERS IF NOT IN CARDIAC ARREST

C: ADDITIOANL ORDERS/INSTRUCTIONS

D: ORDERS FOR MEDICALLY ADMINISTERED NUTRITION

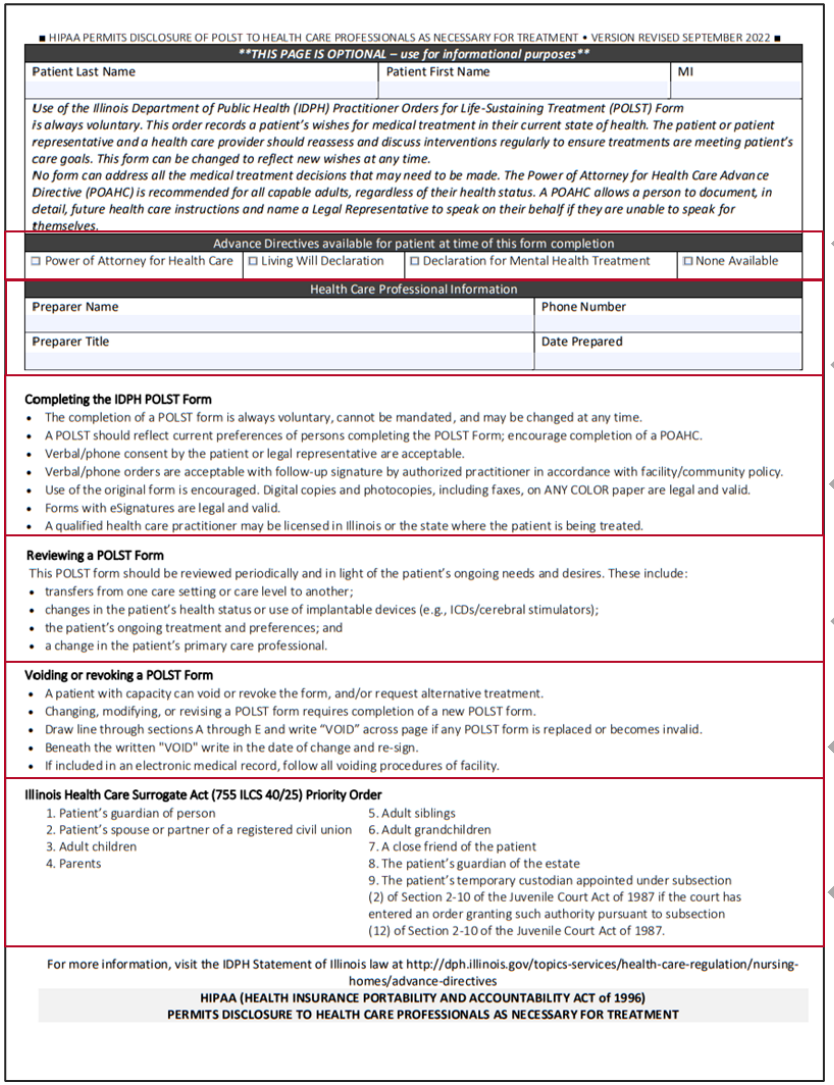
E: SIGNATURE OF PATIENT OR LEGAL REP

F: SIGNATURE OF QUALIFIED HEALTH CARE PRACTITIONER

2022 Form Overview (page 2)

Forms with incomplete information on page 2 are valid.

Forms missing page 2 altogether are valid.



■ HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT • VERSION REVISED SEPTEMBER 2022 ■

THIS PAGE IS OPTIONAL – use for informational purposes

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion

☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

OTHER ADVANCE DIRECTIVES: (check the EHR)

HEALTHCARE PROFESSIONAL WHO HELPED COMPLETE FORM

BASIC COMPLETION INSTRUCTIONS

WHEN TO REVIEW THE FORM

HOW TO REVOKE A COMPLETED FORM

HCSA PRIORITY INFORMATION

Primary Medical Order Sections

A. If NO pulse: CPR wishes
- Attempt resuscitation
- Do Not Attempt resuscitation (DNAR)

B. If pulse present: Care wishes
- Full Treatment
- Selective Treatment
- Comfort-Focused Treatment

C. Additional Orders & Instructions

D. Medically Administered Nutrition
- Acceptable
- Trial Period
- None

Do **NOT** assume that the presence of a POLST form means DNAR

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Practitioner Orders for Life-Sustaining Treatment

POLST '22 Section A Revisions

A *Required to Select One*	**ORDERS FOR PATIENT IN CARDIAC ARREST.** Follow if patient has NO pulse.	
	☐ **YES CPR: Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)	☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

- ✓ Section A is required for form to be valid; ONLY one box can be marked
  - If no box or both boxes are marked, form is invalid, and CPR should be initiated.
- ✓ The revision reinforces that this is a medical order that should be followed when the patient is in cardiac arrest.
- ✓ **"CPR" used both with YES and NO – signals a binary choice**
- ✓ **Term "attempt" included in both options – manages expectations because CPR is often ineffective in saving the patient's life**

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Practitioner Orders for Life-Sustaining Treatment

Attempt CPR is the Default so…
Why use the form to request CPR?

- Elderly and those with disabilities may fear they will not receive same emergency care as others
- May have created a POLST form marking Do Not Attempt Resuscitation (DNAR) box during a serious illness. May create a new form if health improves or they desire to reach a milestone moment; now selecting attempt CPR

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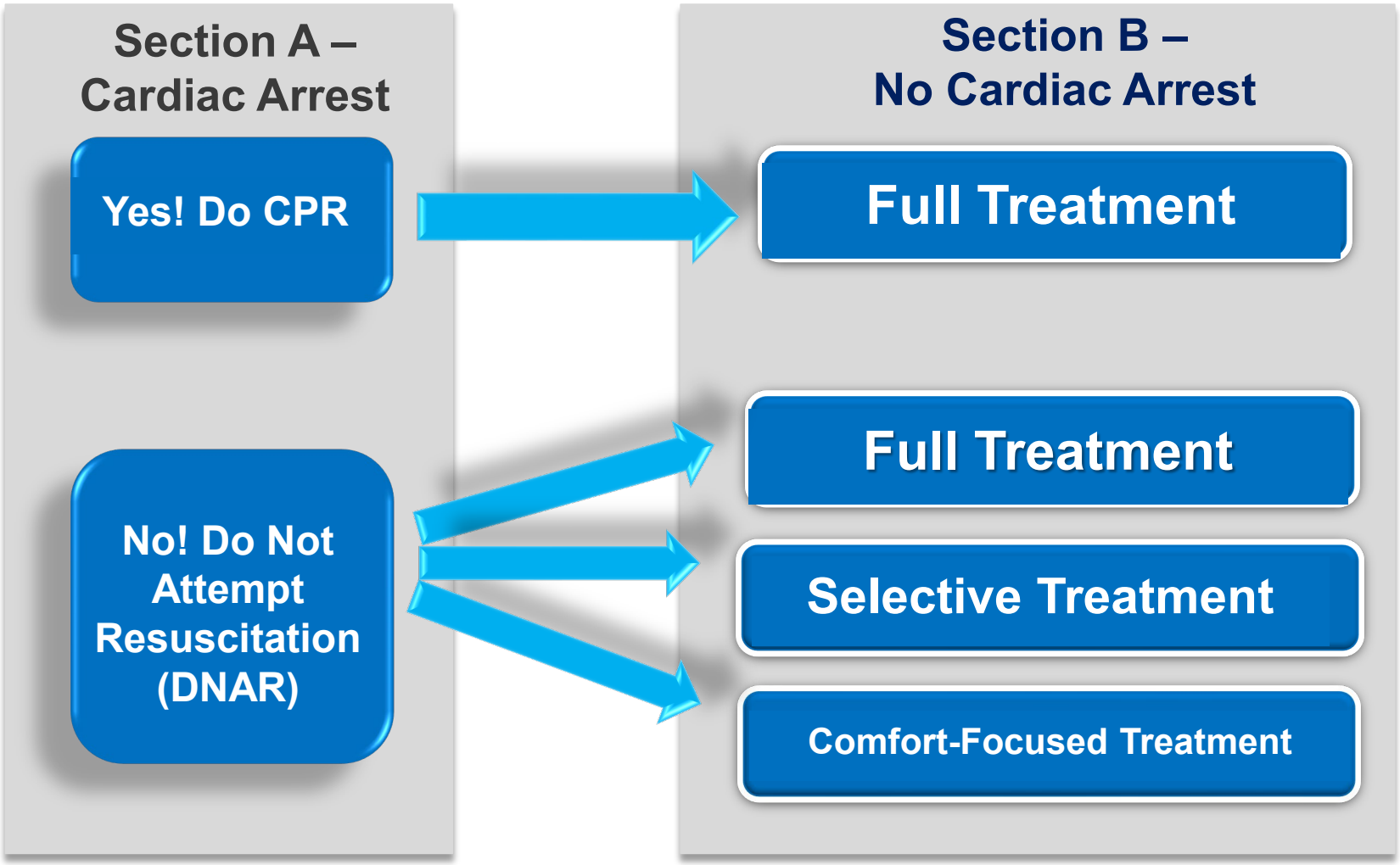
Acceptable Options for a Valid Form



POLST '22 Section B Revisions

B *Section may be Left Blank*	**ORDERS FOR PATIENT NOT IN CARDIAC ARREST.** Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)
	☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
	☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
	☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

- ✓ Section B may be left blank; if completed ONLY one box should be marked. If no box marked = Full Treatment as default

- ✓ Orders when patient in crisis/quickly declining but **has a pulse**
  - Instructs maximizing comfort is a goal regardless of which choice selected
  - Differentiates each option by stating primary goal first

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Practitioner Orders for Life-Sustaining Treatment

Section B Summary

Just because there is a POLST form present and valid, it DOES NOT MEAN "Don't Treat"

- ✓ All patients receive comfort-focused treatment regardless of selection in Section B.
- ✓ If any doubt about form validity or if questions, EMS can call medical control and ask for clarification from a physician.
- ✓ Transporting patients:
  - Consult hospice nurse if applicable and feasible.
  - First responders are sometimes unable to make patients comfortable at home, so transfer to hospital is needed.
  - Make sure a copy of the POLST form goes with the patient when transported whether from a facility, a hospital or home.

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Practitioner Orders for Life-Sustaining Treatment

POLST ’22 Section C Revisions

C *Section may be Left Blank*	**Additional Orders or Instructions.** These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

Section C has changed from prior forms.

- ✓ Section C may be left blank
- ✓ Orders inserted by patient’s Qualified Health Care Practitioner (QHCP) indicate orders/instructions **in addition** to Section B orders
  - Treatments needed in a medical emergency outside of the hospital setting or before a provider can consult with a substitute decision-maker
  - Examples:
    Use of pain medications and antiemetics but no cardiac medications
    No defibrillation, no oral airways or nasal airways
    IV fluid for hydration only
- ✓ EMS protocol may dictate EMS ability to follow Section C orders

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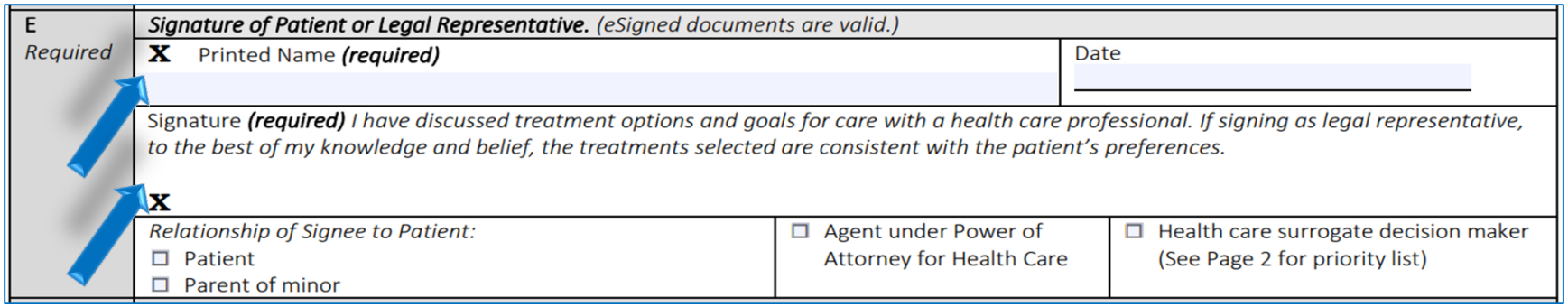
Practitioner Orders for Life-Sustaining Treatment

POLST ’22 Section E Revisions



E *Required*	***Signature of Patient or Legal Representative.*** *(eSigned documents are valid.)*		
	X Printed Name ***(required)***		Date
	Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient’s preferences.*		
	X		
	Relationship of Signee to Patient: ☐ Patient ☐ Parent of minor	☐ Agent under Power of Attorney for Health Care	☐ Health care surrogate decision maker (See Page 2 for priority list)

Section E is now for “Signature of Patient or Legal Representative”
(formerly Section D)

- ✓ Signer attests to statement, prints and signs their name – Required.
- ✓ Electronically signed document by patient or legal representative acceptable
- ✓ **“Signature of Witness to Consent” field removed per 2022 amendment to Illinois Health Care Surrogate Act.**

FULL TEXT of the Illinois Health Care Surrogate Act:
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2111

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Practitioner Orders for Life-Sustaining Treatment

POLST ’22 Section F - NEW

F *Required*	***Qualified Health Care Practitioner.*** Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)	
	X Printed Authorized Practitioner Name ***(required)***	Phone
	Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient’s medical condition and preferences.* **X**	Date ***(required)***

- ✓ “Qualified Health Care Practitioner” (QHCP)
- ✓ Printed Name of QHCP, Signature of QHCP, Date QHCP signed – Required.
- ✓ Electronically signed document by QHCP acceptable.

POLST ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

Applying POLST Forms in the Field

Requirements for a Valid POLST Form

THE SIGNATURE OF A "*WITNESS TO CONSENT*" IS NO LONGER PART OF THE IDPH POLST FORM.

FULL TEXT of the Illinois Health Care Surrogate Act:
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2111

Requirements for a Valid POLST Form

REQUIRED

- Patient Identifying Information
- Section A
- **2 Signatures**:
  1) Patient or legal substitute decision-maker
  2) Qualified Health Care Practitioner
- Date of Practitioner Signature

NOT REQUIRED

- All other information fields
- All indicated treatment used where a decision is unspecified
- **Pink** paper recommended to enhance visibility, but color does not affect validity of form

Valid POLST Forms

- ✓ Properly executed prior versions of the IDPH Uniform DNR or the DNR/POLST Advance Directive are still valid. **Most recently dated is followed.**
- ✓ Photocopies or FAX of forms are valid.
- ✓ Picture of POLST form on electronic device is valid.
- ✓ Verbal/Phone:
  - Patient or legal representative verbal/phone consent acceptable
  - Verbal/phone orders by QHCP acceptable with a follow-up signature in accordance with facility/institutional policy

Each health care facility may have different policies on whether copies of DNR or POLST orders completed on a form other than an IDPH Uniform POLST Form are accepted as valid. It is advisable to check with a health care facility regarding its DNR or POLST policy.

POLST ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

Who can revoke POLST orders?

- **Patient,** if able to make their own medical decisions, can revoke a POLST at any time
  - A POAHC/surrogate should generally not overturn decisions made, documented, and signed by a patient
- POAHC/Surrogate revocation may take time for EMS/first-responders to resolve
  - If any doubt or dispute, **call OLMC right away**
  - Start treatment while trying to sort this out or talking with Medical Control.
  - Don't withhold non-invasive treatment to determine the proper course of action. (BVM, oxygen, CPR, etc.)
- EMS responders are **legally protected** if they follow orders on a valid form in good faith

POLST ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

What if a POAHC or Surrogate disputes a valid POLST order to which they previously consented?

Determine if person disputing order is the original consenting POAHC or surrogate

- If yes: The POAHC/surrogate may change the order and/or care wishes
- If no: Follow orders on the POLST form; contact On-Line Medical Control for further direction

POLST ILLINOIS
Practitioner Orders for Life-Sustaining Treatment

Legal Risk for EMS Following POLST Form

"A health care professional who in good faith complies with a do-not-resuscitate order made in accordance with this Act is not, as a result of that compliance, subject to any criminal or civil liability, except for willful and wanton misconduct, and may not be found to have committed an act of unprofessional conduct."

Illinois Health Care Surrogate Act

FULL TEXT of the Illinois Health Care Surrogate Act:
https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2111

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Practitioner Orders for Life-Sustaining Treatment

Document, Document, Document

- Where POLST form was found
- A call Medical Control
  - Time of call
  - Who first-responder talked with
  - What orders were given
- People present at the scene (family, bystanders, etc.)
- Discussion with family/others

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Practitioner Orders for Life-Sustaining Treatment

QUESTION & ANSWER

Let’s Review

Check for understanding

An unconscious adult presents in bed at home. The patient is struggling to breathe and has a weak pulse. An IDPH POLST form is on the fridge. What part of the form is most relevant right now?

A. Section A: Has the patient marked DNAR?
B. Section B: How aggressively does the patient want to be treated?
C. Section D: Has the patient consented to artificial nutrition?

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Answer

Answer is B. Because the patient still has a pulse, section A does not apply now.

Section D discusses medically administered nutrition and is not immediately relevant here.

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Practitioner Orders for Life-Sustaining Treatment

Check for understanding

You are called to an emergency in a person's home and find a man lying in his own bed. He has no pulse.

The neighbor has already started CPR. The IDPH POLST form is on the fridge. What instructions are you looking for?

A. Section A: has the patient marked DNAR?
B. Section B: how aggressively does the patient want to be treated?
C. Section D: has the patient consented to artificial nutrition?

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Answer

Answer is A. Patient does not have a pulse so sections B and D would not apply now.

If the neighbor is not a healthcare provider, they would not be expected to know about or follow the POLST form. If the neighbor has not restored breathing or a pulse, the EMS provider would still follow the POLST instructions under section A.

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Check for understanding

A patient presents in cardiac arrest and his wife provides two forms, one earlier IDPH DNR Advance Directive/POLST form, dated 3/16/15 and one revised IDPH POLST form dated 3/27/2019. The options chosen on the two forms conflict. What should you do?

A. Provide the more aggressive treatment indicated, just in case.
B. Ask the patient's wife to resolve the difference between the forms.
C. Provide the treatment indicated in the most recently dated POLST form.

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Answer

Answer is C. Provide the treatment indicated in the most recently dated POLST form.

Newest valid form voids past forms. Follow instructions on form with most recent date and all required elements.

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Check for understanding

An unconscious female presents on the floor at home. The patient is having a seizure and has a pulse. The patient's husband shows you her IDPH Uniform POLST form where "Yes CPR" is selected in Section A, and Comfort-Focused Care is selected in Section B. What should you do?

A. Provide Full Treatment as indicated and within your scope of practice.
B. Provide Comfort-Focused Treatment only.
C. Contacting OLMC for assistance before doing anything.

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Answer

A person who choses "Yes CPR" in Section A of IDPH Uniform POLST form will receive all medically indicated treatments in a pre-arrest emergency, i.e. Full Treatment in Section B, even if they chose Comfort Focused Treatment or Selective Treatment on the form.

A patient wanting to have CPR when in cardiac arrest will have the highest chance of survival if cardiac arrest is prevented by any means in the first place. Therefore, it would not make sense to provide only comfort-focused treatment up until a person goes arrests and then provide CPR.

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Resources

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For POLST Illinois information:
polstIllinois@gmail.com
www.polstil.org

National POLST Program
www.polst.org