# Empowering Advocates & Navigators to Facilitate POLST Discussions in their Community

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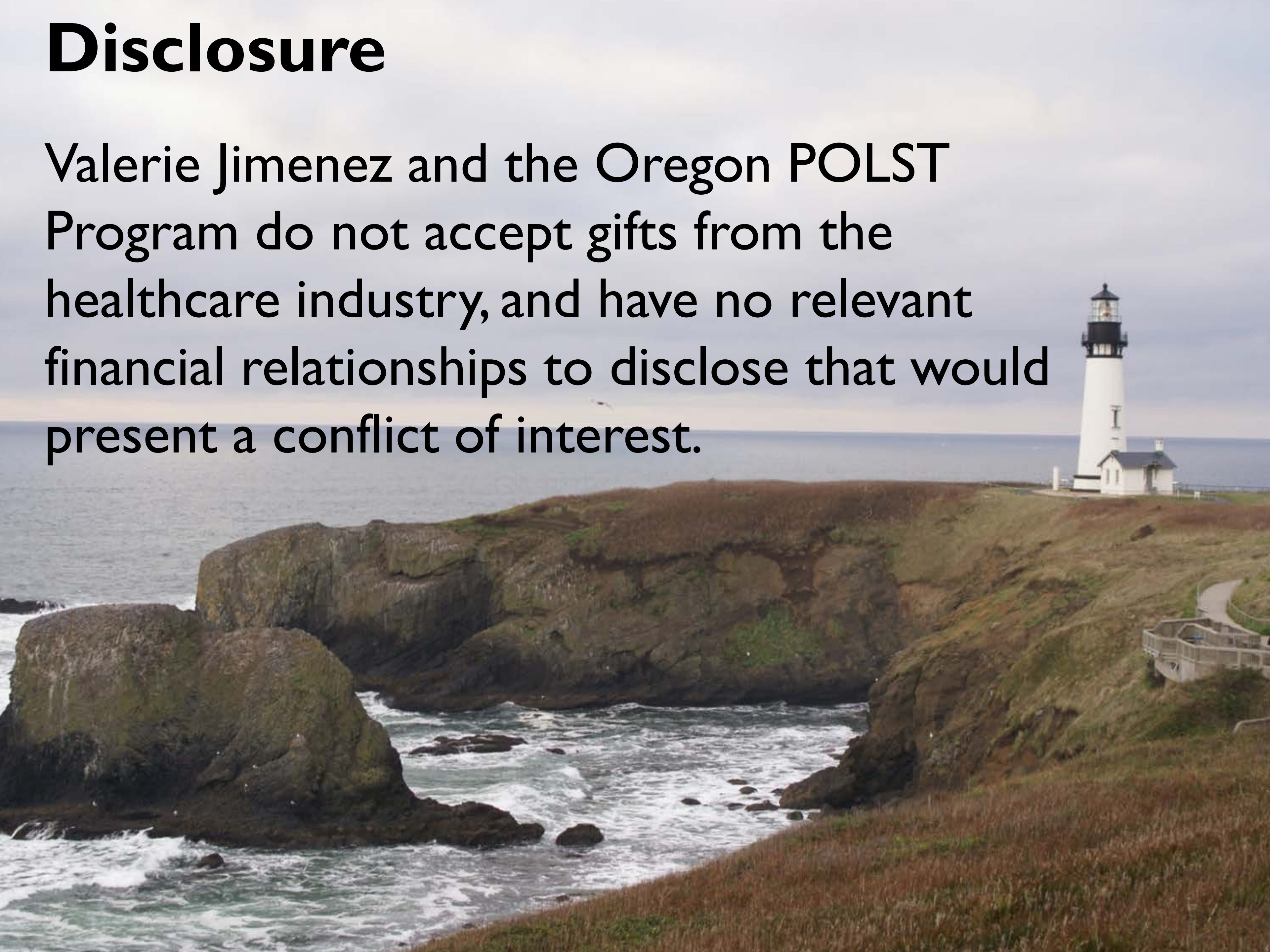
OREGON POLST®

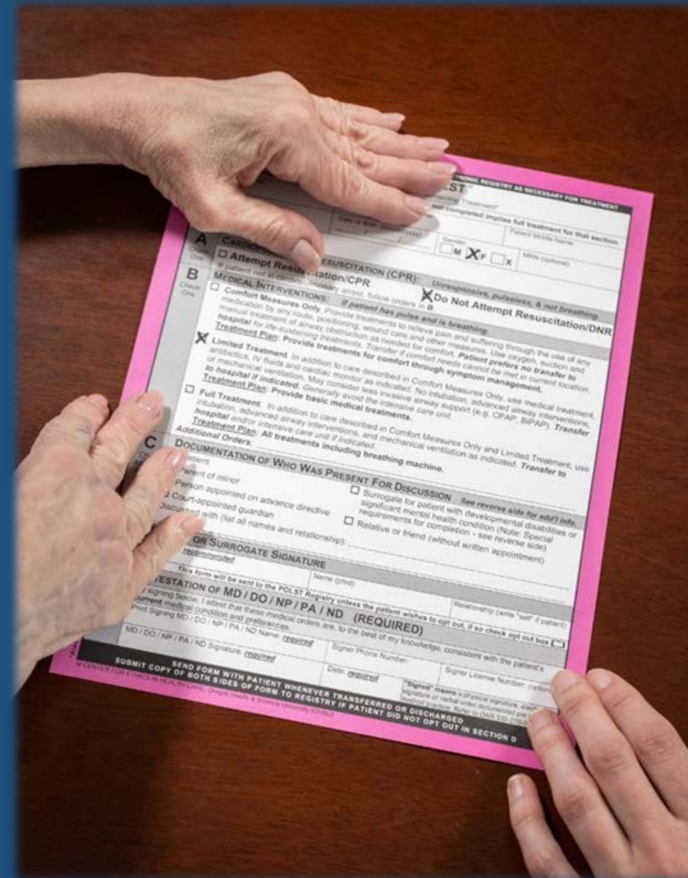

Disclosure
Valerie Jimenez and the Oregon POLST Program do not accept gifts from the healthcare industry, and have no relevant financial relationships to disclose that would present a conflict of interest.

# Objectives

1. Review 2019 POLST form
2. Understand which patients are POLST appropriate
3. Examine misunderstandings about POLST
4. Learn how to encourage goals of care conversations

# 2019 Oregon POLST Form

**P**ortable
**O**rders for
**L**ife-
**S**ustaining
**T**reatment



# 2019 POLST Form

- New name
- Pink border
- No tube feeding section

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY AS NECESSARY FOR TREATMENT

## Oregon POLST™

Portable Orders for Life-Sustaining Treatment*

**Follow these medical orders until orders change. Any section not completed implies full treatment for that section.**

| Patient Last Name: | Suffix: | Patient First Name: | Patient Middle Name: |
|---|---|---|---|
| Preferred Name: | Date of Birth: (mm/dd/yyyy) ______/______/______ | Gender: ☐M ☐F ☐X | MRN (optional) |

Address: (street / city / state zip):

**A** *Check One* — **CARDIOPULMONARY RESUSCITATION (CPR):** *Unresponsive, pulseless, & not breathing.*

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR**

If patient not in cardiopulmonary arrest, follow orders in **B**.

**B** *Check One* — **MEDICAL INTERVENTIONS:** ***If patient has pulse and is breathing.***

☐ **Comfort Measures Only**. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital** for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
**Treatment Plan: Provide treatments for comfort through symptom management.**

☐ **Limited Treatment**. In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital if indicated.** Generally avoid the intensive care unit.*
**Treatment Plan: Provide basic medical treatments.**

☐ **Full Treatment**. In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, and mechanical ventilation as indicated. ***Transfer to hospital** and/or intensive care unit if indicated.*
**Treatment Plan: All treatments including breathing machine.**

*Additional Orders:* ______________________________

**C** *Check All That Apply* — **DOCUMENTATION OF WHO WAS PRESENT FOR DISCUSSION** ***See reverse side for add'l info.***

☐ Patient
☐ Parent of minor
☐ Person appointed on advance directive
☐ Court-appointed guardian
☐ Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion - see reverse side)
☐ Relative or friend (without written appointment)

Discussed with (list all names and relationship): ______________________________

**D** — **PATIENT OR SURROGATE SIGNATURE**

| Signature: ***recommended*** | Name (print): | Relationship (write "self" if patient): |
|---|---|---|

**This form will be sent to the POLST Registry unless the patient wishes to opt out, if so check opt out box ☐**

**E** *Must Print Name, Sign & Date* — **ATTESTATION OF MD / DO / NP / PA / ND (REQUIRED)**

By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's **current** medical condition and preferences.

| Print Signing MD / DO / NP / PA / ND Name: ***required*** | Signer Phone Number: | Signer License Number: *(optional)* |
|---|---|---|
| MD / DO / NP / PA / ND Signature: ***required*** | Date: ***required*** | **"Signed"** means a physical signature, electronic signature or verbal order documented per standard medical practice. Refer to OAR 333-270-0030 |

**SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED**
**SUBMIT COPY OF BOTH SIDES OF FORM TO REGISTRY IF PATIENT DID NOT OPT OUT IN SECTION D**

*Also known as Physician Orders for Life-Sustaining Treatment

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# “Understanding POLST”

# The POLST form

In current state of health, turns wishes into actions

For people with serious illness or frailty, and who may want to limit treatments

# POLST is **not** appropriate for “healthy” people.

# Healthy people should be encouraged to complete an advance directive.

# POLST is a **voluntary** process

No one has to have a POLST.

POLST forms can be changed or voided at any time.

# Starting conversations about advance care planning

# Advance Directive

Legal document for all competent adults

Communicates a person's philosophy

# Advance Directive

Allows a surrogate/health care decision maker to be named

**Note:** Emergency medical services (EMS) cannot follow during an emergency

# POLST: When is the right time?

Advance Directives and POLST are both **voluntary** forms.

# Resources for patients and families

## POLST

oregonpolst.org
orpolstregistry.org

## Advance Care Planning

conversationproject.org
oregonhealthdecisions.org
prepareyourcare.org

# Questions?

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PORTABLE ORDERS FOR LIFE-SUSTAINING TREATMENT