

Washington POLST Clinician Toolkit

Advance Care Planning: Advance Directives & POLST

This document will show advance care planning, advance directives, and POLST all work together to guide an individual's health care decisions at different stages in their life.

This document is one resource of the *Washington POLST Clinician Toolkit* and is intended to be used in conjunction with the other documents. To find the full *Washington POLST Clinician Toolkit*, please visit: www.wsma.org/polst.

The Process of Advance Care Planning

Advance care planning is for every individual 18 years and older. Physicians and health care professionals can normalize and support this by making it a routine part of primary and specialty care. It is an ongoing process between individuals, those important to them, and the health care team. Advance care planning and resulting documentation, if any, can become more focused, over time, on specific expected outcomes related to the individual's disease or condition. ⁱⁱⁱ

Advance Directives

An individual's expressed goals, values, and preferences can be documented in an advance directive. An advance directive includes the following:

- Durable Power of Attorney for Health Care (Legal Document)
 - Names the health care agent(s). The Honoring Choices PNW DPOA-HC also helps you prepare the health care agent by sharing goals, values, and preferences.
- Health Care Directive/Living Will (Legal Document)
 - Guides decisions on whether to withhold or withdraw life-sustaining treatment at the end of life.
- Personal Statement
 - Summarizes an individuals' values and goals relating to future medical care.

POLST

Portable Orders for Life-Sustaining Treatment (POLST) is a set of medical orders that is designed to communicate an individual's treatment wishes about emergency care to emergency medical services (EMS) professionals and health care teams when the individual is unable to speak for themselves.



While written documents are preferred, please remember they are *voluntary*; no person should be required or coerced to complete an advance directive or POLST.



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Comparison of Advance Directives and POLST

	Advance Care Planning Documentation		
	Advance Directives		POLST
	Durable Power of Attorney for Health-Care (DPOA-HC)	Health Care Directive (i.e., Living Will)	
What is it?	Legal document	Legal document	Medical orders
What does it do?	Names health care agent. The Honoring Choices PNW DPOA-HC also prepares the health care agent by including an individual's goals, values, and preferences.	Guides decisions on whether to withhold or withdraw life-sustaining treatment at the end of life.	Actionable, portable orders for emergency medical services.
Who is it for?	Any adult with capacity.	Any adult with capacity.	Individuals with a serious life-limiting medical condition, regardless of capacity.
Who can complete it?	Only the individual.	Only the individual.	Individuals or their legal medical decision maker.
How is it used?	Used primarily in a hospital setting when individual does not have capacity.	Used primarily in a hospital setting when individual does not have capacity.	Emergency medical services use in out-of-hospital emergencies.

Table 1: This comparison reviews elements of advance care planning documentation.

Advance Care Planning in Practice

Both advance directives and POLST are advance care planning documents that can work together to communicate a spectrum of patient-centered, value-informed decisions when an individual is unable to make medical decisions for themselves. Health care teams play an active role in promoting and facilitating the advance care planning process with all adults.

For individuals with progressive disease or serious illness or conditions, physicians and advance care practitioners (MD, DO, ARNP, PA-C) play an essential role in discussing their medical prognosis and the implications of pursuing different medical treatment options. These types of conversations are referred to as goals of care conversations, thus differentiating them from advance care planning for healthy individuals.

Advance Care Planning: Advance Directives & POLST

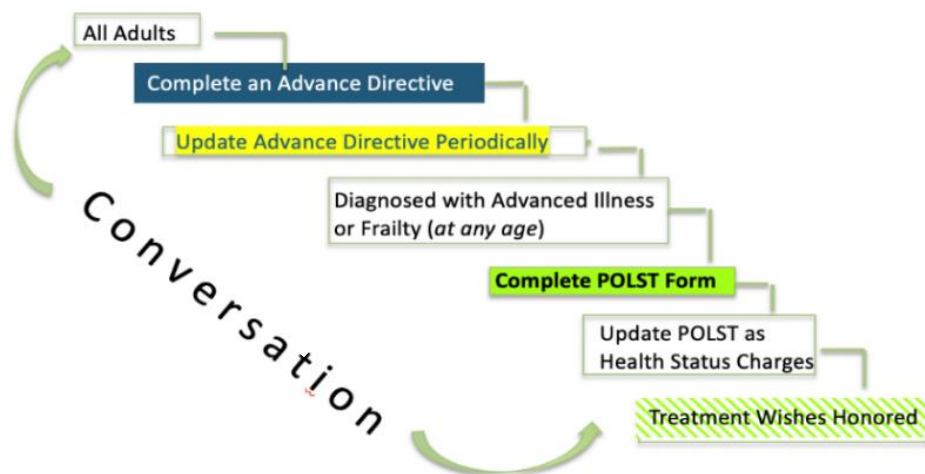


Image 1: Advance care planning over the lifespan. Adapted with permission from California POLST Education Program. © January 2010 Coalition for Compassionate Care California.^{iiiiv}

This ladder diagram shows how healthy adults should create advance directives, and how over time, or with progressive medical problems, the conversations are more disease-focused and can lead to the completion of POLST. The arrows on either end of the conversation indicate that at each step, more conversation continues to occur, to ensure that the documents are in alignment with and reflect the individual's goals, as they may change in the face of illness.

Example case: Two years ago, Alex Person, who will be referenced as an example throughout this toolkit, attended an advance care planning workshop

Patient demographics, at the time of the workshop: Alex Person, 64 y.o. female, mild asthma, osteoarthritis.

Identified goals and preferences: Her husband and three adult children are important to her. Sharing her stories and letters with her friends and family is her primary source of joy. She gets a lot of enjoyment from activities, such as hiking and boating. Maintaining the ability to communicate is important for her.

Decisions:

She wants all emergency measures done.

Use all reasonable measures to prolong life, but to stop if end of life is inevitable or would involve artificial means of support for nutrition or other vital signs, or if quality of life would require prolonged care outside the home. She does not want to be on machines to stay alive

Names her husband Nate as health care agent.

Documentation: Completed her health care directive and durable power of attorney for health care. POLST was not offered due to her health status and her expressed decision to have all emergency measures done.

ⁱ Butler M, Ratner E, McCreedy E, Shippee N, Kane RL. Decision Aids for Advance Care Planning: An Overview of the State of the Science. *Ann Intern Med*. 2014 Jul 29

ⁱⁱ Dr. Robert Bree Collaborative. End-of-Life Care Report and Recommendations. 2014 Nov 21

ⁱⁱⁱ Coalition for Compassion Care of California. California POLST Education Program. Coalitionccc.org. 2010 Jan

^{iv} National POLST Paradigm. Polst.org.n.d.

Washington POLST Clinician Toolkit

POLST Best Practices

This document explores best practices for the Washington POLST. These best practices have been selected to guide care, avoid common errors on the POLST, and support the development of systems for goal concordant care.

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BASICS OF POLST USE FOR CLINICAL TEAMS

1. [Completing a POLST is always voluntary.](#)
2. [POLST is a medical order: complete with medical oversight.](#)
3. [POLST is intended for people with a limited prognosis or high risk of harm.](#)

ENSURE A PERSON-CENTERED APPROACH TO POLST

4. [Initiate a goals of care conversation.](#)
5. [Discuss the diagnosis-specific implications of each decision.](#)
6. [Confirm concordance of decisions on POLST.](#)

FINALIZE COMPLETION OF POLST

7. [Ensure the POLST is signed and dated properly.](#)
8. [If appropriate, review preferences for medically assisted nutrition.](#)
9. [Ensure each POLST is recorded, stored, and accessible across settings.](#)

CONFIRM A SYSTEM FOR USE OF POLST

10. [Confirm policies to honor POLST.](#)
11. [Recognize POLST is intended primarily for Out-of-Hospital emergency care.](#)



BASICS OF POLST USE FOR CLINICAL TEAMS

1. Completing a POLST is always voluntary.



Individuals should not be required, coerced, or otherwise compelled to have POLST and/or other advance care planning documents or conversations. It must remain their *choice* to engage in advance care planning and complete documents.

Best practices for promoting advance care planning include:

- Have policies and procedures to ask about and offer advance care planning to all individuals.
- Disease/Prognoses-specific goals of care conversations should be offered (NOT coerced or required) as standard of care for people with a serious illness.
- Offer goals of care conversations as standard of care for individuals with a serious illness.
- When appropriate, inform individuals about the role of POLST in making their wishes known and honored.
- Complete POLST as desired by the individual or their legal medical decision maker.
- Encourage conversations between the individual and those who matter to them, including their legal medical decision maker(s).
 - Assist in preparing the decision maker(s) to be advocates for the individual and increase their comfort with making future decisions.

2. POLST is a medical order: complete with medical oversight.



Ensure the POLST is completed under medical guidance. Encourage the individual to make an appointment to discuss the POLST, and invite those who matter to them, including legal medical decision maker(s), to attend the appointment.

The POLST is a medical order; as such, it should not be finalized without the guidance of a health care professional. Individuals may want to take the POLST home to discuss their decisions with those who matter to them, including those who will act as a legal medical decision maker(s). A follow-up appointment should be set up between the individual and the physician or advanced care practitioner (MD, DO, ARNP, PA-C) for final review of their decisions and to complete the form with the proper signatures and date.



3. POLST is intended for people with a limited prognosis or high risk of harm.

POLST is intended for individuals with serious life-limiting medical conditions or advanced frailty. Examples of medical conditions in which a POLST should be considered (not a complete list):

- Severe Heart Disease
- Metastatic Cancer or Malignant Brain Tumor
- Advanced Lung Disease
- Advanced Renal Disease
- Advanced Liver Disease
- Advanced Frailty
- Advanced Neurodegenerative Disease (e.g., Dementia, Parkinson's Disease, ALS)ⁱ



POLST should be offered if you would not be surprised if the individual died in the next 1-2 years or if the individual would be potentially harmed by, or their overall condition worsened by, aggressive invasive measures, including cardiopulmonary resuscitation (CPR).

Healthy adults, including many individuals over the age of 65, are not the intended audience for the POLST; these individuals should have advance directives.

ENSURE A PERSON-CENTERED APPROACH TO POLST

4. Initiate a goals of care conversation.

The best way to know if POLST is 'right' for an individual is to have a high-quality goals of care conversation with them.



The skill of having a high-quality goals of care conversation, including an empathic delivery of prognostic information is invaluable in supporting individuals with serious illness. These conversations will help the individual and their legal medical decision maker understand how their medical condition may impact the outcome of medical interventions.

For more information about a goals of care conversation, see *Washington POLST Clinician Toolkit - Goals of Care*.



5. Discuss the diagnosis-specific implications of each decision.

The POLST Toolkit Completion Guide addresses the process of reviewing the CPR decision and the level of medical interventions that may be offered in an emergency. It is important to review and discuss the implications of each decision, given their medical condition, with the individual or the person making decisions on their behalf.



The decision on the level of medical intervention (Section B) is used when the patient is alive but in distress. Discuss this decision, and the implications of each level of care, before completing Section A.



It is important the individual understands that CPR is only initiated when there is no heartbeat and no breathing (i.e., they have died due to vital functions ceasing).

6. Confirm concordance of decisions on POLST.

It is important that an individual's decisions on the POLST reflect their values and preferences with consideration to their overall health status. In addition, the decisions in Sections A and B must be in alignment. Together these sections should reflect a plan of care that will be actionable by emergency responders and others providing care.

If an individual's heart and breathing stop and they have indicated "Attempt Resuscitation/CPR" on their POLST form, it is important that they understand that this includes all the following interventions to attempt resuscitation: defibrillation, chest compressions, and artificial ventilation.



By indicating "Attempt Resuscitation/CPR," Emergency Medical Services will perform the standard of care, which includes all the advanced resuscitation methods above and any other interventions that may be useful in an attempt to restore life.



Choosing "Yes-Attempt Resuscitation/CPR" but placing limits on this, including the choices of "Selective Treatment" in Section B is not recommended.

- First responders are trained to do everything possible that may be helpful, even if the odds of survival are very low. If an individual wants to limit which measures are started or how long they are attempted, this can be noted in bold print in the box above Section A.



7. Ensure POLST is signed and dated properly.

A valid Washington POLST requires two signatures:

- The signature of the clinician who is verifying it as a medical order. Qualified signing clinician include MDs, DOs, ARNPs, and PA-Cs.

AND

- The signature of the individual with decision-making capacity or their legal medical decision maker as determined by guardianship, durable power of attorney for health care (DPOA-HC), or a person authorized to give health care informed consent per [chapter 7.70.065 RCW](#).



Like all medical orders, each signature must be accompanied by the printed name and date. The POLST is not valid unless all appropriate dates and signatures are completed in Section C.

Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility.

See *Washington POLST Clinician Toolkit - POLST Completion Guide* for how to properly change the effective date upon a review of a completed POLST.

8. If appropriate, review preferences for medically assisted nutrition.

Medically assisted nutrition is not considered part of EMS' standard of care for medical interventions. However, goals of care conversations may include discussions about preferences for medically assisted nutrition and other life sustaining interventions. If the individual has capacity to indicate their preference regarding medically assisted nutrition, these may be captured in this section of the POLST and should also be reflected in their advance directives.

If the individual no longer has decision making capacity, a legal medical decision maker can indicate a preference here, either based on the individual's known preferences or based on what is in their best interest, under the guidance of the health care professional.

It is best practice to address the differences in function and expected outcomes of medically assisted nutrition as a time-trial, short term, or prolonged intervention.

(instructions for this section continued on next page)



POLST Best Practices



Preferences on medically assisted nutrition do not serve as actionable orders like those found in Sections A and B. This section is intended to guide care in a hospital or other inpatient setting.



The actionable orders on the POLST will remain valid if this section is not addressed/discussed.

9. Ensure each POLST is recorded, stored, and accessible across settings.

Everyone in your clinical setting should be trained to ensure that POLST is properly stored and accessible in the EHR, in personal health records, and if possible, in shared directories or repositories. By taking responsibility for proper storage of the POLST, health care professionals can help ensure goal concordant care.

Ensure that the original POLST and additional copies are given to the individual and/or their legal medical decision maker(s), as well as any additional supportive people who may be called or are likely to be present in an emergency. POLST is intended to travel with the individual to ensure it is available to emergency medical services, if needed.

Typical places POLST can be kept:

- On a refrigerator, or a prominent bulletin board in the main living area, or near the phone with other emergency documents and numbers. (Some like to keep in Freezer. Advise that a note be on the outside of the freezer door: *POLST in freezer*)
- Pictures and other virtual copies can be taken and kept on phone, or other device.
- Bracelets can be ordered to indicate POLST is available. Lifeline.org



It is also the responsibility of all health care team members to ensure the most recent POLST is accessible and shared across the care continuum. This includes, but is not limited to, specialists, primary care, hospitals, SNF, and EMS (if possible).



Original and copies of the POLST on paper remain the gold standard for ensuring that EMS can follow POLST orders. Digital images, such as pictures on a cell phone, are also encouraged.



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CONFIRM A SYSTEM FOR USE OF POLST

10. Confirm policies to honor POLST.

Best practices for POLST policies include:

- Addressing how the POLST will be stored and retrieved during an emergency.
- Reinforcing the rights of the individual to have advance care planning, including completion of a POLST, while acknowledging that the process is voluntary and free from coercion or threat of losing care or benefits.

11. Recognize POLST is intended primarily for Out-of-Hospital emergency care.

POLST is primarily intended to guide out-of-hospital emergency care provided by EMS professional or other members of the health care team.



POLST should be used to inform and establish a goal-concordant plan of care for an individual admitted to a hospital. The hospital admission process should include a reassessment of the individual's goals in the context of their current medical condition. While an individual may indicate DNR on their POLST that does not preclude from having a "Full Code" code status for a time-limited event, such as a surgery. Additionally, in-hospital orders may vary from the POLST as hospital-based care can offer more immediate intervention and support, making some resuscitation efforts more reasonable to pursue.



POLST should not be used to write code status orders while a person is hospitalized. Inpatient code status orders must be entered into the EMR. Orders might change day to day or might be dependent on various treatments or conditions.



On discharge, the goals should be reassessed and a POLST which expresses the person's wishes for out-of-hospital emergency care in the setting of their current condition (which may have changed during hospitalization) should be completed.

ⁱ National POLST. Intended Population & Guidance for Health Care Professionals. <https://polst.org/wp-content/uploads/2020/03/2019.01.14-POLST-Intended-Population.pdf#:~:text=Intended%20Population%20%26%20Guidance%20for%20Health%20Care%20Professionals,life-limiting%20medical%20condition%2C%20which%20may%20include%20advanced%20frailty.> 2019 Jan 14.

Washington POLST Clinician Toolkit

Goals of Care Conversations for Individuals with Serious Illness

Goals of care conversations for individuals with serious illness are an integral component to person-centered care.

This document is one resource of the *Washington POLST Clinician Toolkit* and is intended to be used in conjunction with the other documents. To find the full *Washington POLST Clinician Toolkit*, please visit: www.wsma.org/polst

Overview

To differentiate from other advance care planning, we are using the term "goals of care conversation" to refer to conversation intended for individuals with serious or chronic, progressive illness, or advanced frailty. These conversations lead to individuals receiving care that is aligned with their goals and values. High-quality goals of care conversations use a framework of intentional questioning, respectful sharing of information, and importantly, skillful listening for what is important and meaningful to the individual. Additionally, these conversations build trust between the individual and the health care professional by empowering the individual to have an active role in their own care planning.

Characteristics of a high-quality goals of care conversation include:

- Ask permission.
- Express intention to provide individual with care options that align with their stated values and goals.
- Assess the individual's understanding of their condition.
- Explore key topics.
- Respond to emotion when sharing information and mapping values.
- Summarize and determine next steps.

Health Care Team Approach

Many members of the clinical team can support goals of care conversations. Typically, prognostication is reserved for physicians and advanced care practitioners (MD, DO, ARNP, PA-C). Clinical chaplains, case managers, nurses, social workers, and therapy professionals (PT, OT, ST), are important members of the multidisciplinary team that can support and initiate many elements of the goals of care conversation within their scope of practice.

Documentation

All members of the health care team have a responsibility to document any, or all, parts of the goals of care conversation. This will promote continuity of care centered around the individual's

Goals of Care Conversations for Individuals with Serious Illness

preferences for their care and foster a team approach to care planning. Electronic health records now offer the opportunity to document goals of care discussions. Ideally, this will be a unique template or separate document. The note's contents should efficiently describe and reflect the individual's stated values, goals, and preferences, as well as the general content of the goals of care discussion.¹

POLST

It is important that the physician and other health care professionals on the team have a process for knowing when an individual might benefit from having a POLST.

POLST should be offered if the individual:

- Has a serious life-limiting medical condition or advanced frailty.
- Has a condition which would put them at risk of harm from aggressive invasive measures.
- The goals of care conversation reveals an individual's desire to limit care in an emergency.



Remember, you may offer POLST, but like all advance care planning, it is voluntary for the individual.

Example case; Alex Person, now 66 y.o. diagnosed with Stage 4 Breast Cancer

Situation: A year after completing her health care directive and durable power of attorney for health care, Alex was diagnosed with Stage 4 breast cancer. She has had three rounds of chemotherapy, but the degree of metastasis is not responding to these efforts; recent findings of metastasis to brain are worrisome. Her primary oncologist initiates a goals of care conversation.

Goals of Care Discussion: Alex expresses the following goals:

- She understands her disease is not curable and might shorten her life to a few years.
- She reiterates the importance of being with family; that they bring her joy and give her strength.
- She treasures the ability to communicate with her family and to "know my own mind". She fears not being able to control her thinking or speech, she does not want to end up on machines without the ability to know her family or speak to them.
- She is willing to have short-term measures, like intubation, to prolong life but just long enough to see if she will recover close to her current level of function or long enough to give her family a chance to gather. She also states she does not want "heroic" measures.
- She wants to attend her son's wedding next summer.
- She would like her family to know her wishes and be able to support her at home, if possible, at the end of life.

Plan: She is referred to an ACP facilitator to amend her health care directive. Her oncologist invites her to return for a second appointment to discuss POLST, inviting her to bring her husband and other family. They include a note in her chart outlining the key topic areas above and make a plan to address POLST at her next appointment.

Training

Honoring Choices PNW, in collaboration with Ariadne Labs, provides skills-based trainings to use the Serious Illness Conversation Guide. To register for this free training, visit [Serious Illness Conversation Guide - Washington State Hospital Association](#) and search for "Serious Illness Conversation Guide Training." This activity has been approved for *AMA PRA Category 1 Credit™*.

¹ Wilson, E, Bernacki R, Alexander C, Jackson V, Jacobsen J. Rapid Adoption of a Serious Illness Conversation Electronic Medical Record Template: Lessons Learned and Future Directions. *J Palliat Med.* 2020; 23(2):159.

Washington POLST Clinician Toolkit

POLST Completion Guide for Clinicians

This POLST Completion Guide is a resource designed to help physicians (MD, DO) and advance care practitioners (ARNP, PA-C) engage with individuals, or their legal medical decision makers, to meaningfully and effectively complete a POLST. We suggest you review this guide with a printed POLST form. This document is one resource of the *Washington POLST Clinician Toolkit* and is intended to be used in conjunction with the other documents. To find the full *Washington POLST Clinician Toolkit*, please visit: www.wsma.org/polst

POLST Overview

Portable Orders for Life-Sustaining Treatment (POLST) is a set of medical orders that is designed to communicate an individual's treatment wishes about emergency care to health care teams when the individual is unable to speak for themselves. POLST is voluntary, portable, and actionable.

Intended Population

POLST is intended for individuals with a serious or chronic, progressive illness, or advanced frailty. Examples of medical conditions in which a POLST should be considered (not an complete list):

- Severe Heart Disease
- Metastatic Cancer or Malignant Brain Tumor
- Advanced Lung Disease
- Advanced Renal Disease
- Advanced Liver Disease
- Advanced Frailty
- Advanced Neurodegenerative Disease (e.g., Dementia, Parkinson's Disease, ALS)ⁱ

Find out more about the intended population for the POLST in *Washington POLST Clinician Toolkit – POLST Best Practices*.

Does POLST Support the Individual's Goals?

After engaging the individual, or their legal decision maker, in a discussion of their goals and values, you can then assist the person in understanding their risk of having a medical emergency. With support, many people will express their preference for what kind of medical care they want in an emergency. This will help you as the clinician determine if the individual's goals will be supported by having a POLST.

Find out more about goals of care conversations in *Washington POLST Clinician Toolkit – Goals of Care Conversations*

POLST Completion Guide for Clinicians

Completing a POLST: Section by Section

This guide will review key elements of each section of the POLST:

- Individual Information
- Medical Conditions/ Individual Goals
- Level of Medical Interventions
- Cardiopulmonary Resuscitation (CPR)
- Confirm Understanding
- Complete Signatures
- Additional Contact Information
- Medically Assisted Nutrition (*Optional*)
- Review of POLST form

Throughout this toolkit we will use the example patient, Alex Person, to demonstrate how to synchronize the individual's goals with the decisions found on POLST.

PAGE 1

STEP 1

Individual's Information

It is important to complete this section to ensure correct identification of the individual. Gender and pronouns are optional fields.

Last Name – First Name – Middle Name/Initial

Alex Person

Date of Birth

01/01/1955

Gender (optional)

Female

Pronouns (optional)

she / her

Why do we ask about pronouns?

Pronouns are used in everyday speech and writing, including medical communications. When speaking of someone in the third person, using their correct pronouns is a way to accurately acknowledge their gender identity.

STEP 2

Medical Conditions / Individual Goals

Start with a high-quality goals of care conversation to assess the individual's understanding, share prognosis, and explore key topics.

Use this section of the POLST to capture the individual's stated goals to provide context for their treatment decisions.

Note: Some people may not want their diagnosis listed on the form. In that case, write "See medical record". Ask permission to name a diagnosis and their goals. Use their own words, when possible.

Medical Conditions/Individual Goals

Stage 4 Breast Cancer

Wants family to be with her when dying if possible. Agree to prolong life with machines for family to arrive. No heroics if heart stops.

STEP 3

Discussion of POLST Should Start with Section B

Starting with Section B builds rapport for exploring difficult decisions by first exploring scenarios in which the individual is alive. Section B translates the individual's identified goals of care into a level of care preference. Completing Section B first will help inform guidance on the CPR decision in Section A.

Guide the individual in understanding the implications of their decision in Section B within the context of their medical condition and prognosis.

Section B: Level of Medical Interventions

Level of Medical Interventions: When the individual has a pulse and/or is breathing.

Any of these treatment levels may be paired with DNAR / Allow Natural Death above

☐

FULL TREATMENT – Primary goal is prolonging life by all medically effective means. Includes care described below. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital if indicated. Includes intensive care.*

☐

SELECTIVE TREATMENT – Primary goals is treating medical conditions while avoiding invasive measures whenever possible. Includes care described below. Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. **Do not intubate.** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). *Transfer to hospital if indicated. Avoid intensive care if possible.*

☐

COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort. Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort. *Individual prefers no transfer to hospital.* EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

B

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(instructions for this section continued on next page)

Treatment Preferences and Location of Care

Goals	Longevity	Maintain Current Function / Level of Independence	Quality of Life / Relief of Symptoms
Location of Care	Hospital + ICU	Hospital, Basic Care	Stay at home, Hospice
Treatment Level (Section B)	Full Treatment	Selective Treatment	Comfort-focused Treatment
Preferences	Use all means to maintain life. OK with invasive, aggressive measures. Discuss time-trials.	Treat treatable conditions. Discuss all reasonable measures, including surgery.	Arrange care at home. Planning for end of life. Transfer only if comfort not possible.

Table 1: Treatment preferences by the location in which each level-of-care is given.



Explore a scenario in which the individual has a medical emergency. Provide level-of-care options by describing the location of care delivery.

Example

- **Pose the Scenario:** Alex Person (above) develops respiratory distress suddenly (e.g., pulmonary embolism or pneumonia); she suddenly has difficulty breathing and cannot speak for herself. Alex will need to know that she will be in distress and she is at high risk of dying.
- **Discussion:**
 - Explain what "Full Treatment" entails, including being in the ICU, potentially having a breathing tube and being on ventilator. Point out that being in the ICU and on a ventilator might meet her goal of keeping her alive until her family arrives. Also explain what "Selective" and "Comfort-Focused" care would entail. Confirm that she is willing to accept ICU-level care and be on a ventilator.
 - Time-limits are an important concept given Alex Person's stated goal, "Agree to prolong life with machines for family to arrive". Discussion around time-limits allows the exploration of "Full Treatment" as well as preferences for time-trials.
- **Decision:** Suggest "Full Treatment in Section B. Alex Person may also indicate preferences in "Additional Orders" found in the line at the end of Section B. In this situation, "Additional Orders" are "Full Treatment such as intubation ok up to 2 weeks, long only if improvement is clear, o/w transition to comfort".

Match resuscitation choices in Section A to range of treatment options in Section B.

The selection made in “Section B: Level of Medical Interventions” can inform the physician or advance care practitioner’s guidance to the individual in deciding their preference on whether or not to attempt CPR.

Guide the individual in understanding the implications of having CPR in the context of their medical condition. Address how the decisions made for “Section B: Level of Medical Interventions” affects resuscitation choices. Use their goal and the decision in Section B as a basis for making a recommendation about whether or not to attempt CPR.

Section A: Cardiopulmonary Resuscitation (CPR)

A

Check
One

Use of Cardiopulmonary Resuscitation (CPR): When the individual has no pulse and is not breathing.

☐

YES – Attempt Resuscitation / CPR (choose FULL TREATMENT in Section B)

☐

NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death

- If an individual chooses “Full Treatment” in Section B:
 - Use shared decision-making to discuss the expected outcomes of CPR, given their medical condition. Realize that “Full Treatment” can be matched with “Yes” or “No” to CPR.
 - NOTE: “Yes-Attempt Resuscitation/CPR” should be matched with “Full Treatment”.
- If an individual chooses “Selective Treatment” or “Comfort-Focused Treatment” in Section B:
 - Discuss how their Section B decision is inconsistent with having CPR.
 - Make medical recommendation: “No to CPR – DNAR / Allow Natural Death” is indicated for these treatment preferences.

(instructions for this section continued on next page)



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POLST Completion Guide for Clinicians

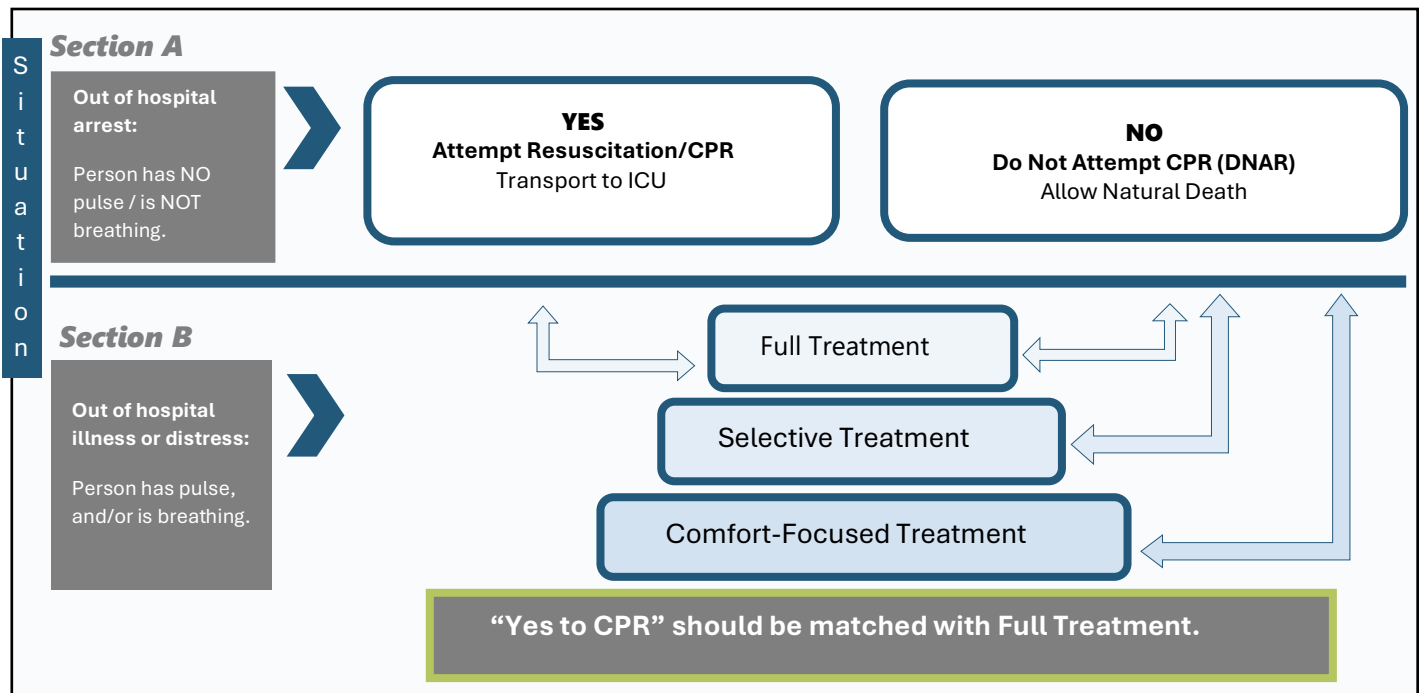


Diagram 1: Match resuscitation choices in Section A to range of treatment options in Section B.



Explore a scenario in which the individual's heart stops in an out-of-hospital setting. Refer to prior decision about level of care while discussing resuscitation options.

Example

- **Scenario:** Alex Person's heart stops in an out-of-hospital setting.
- **Discussion:** Alex Person stated, "No heroics if heart stops".
- **Decision:** Recommend that she choose "NO- Do Not Attempt Resuscitation (DNAR)/ Allow Natural Death" in Section A.



Other considerations: If Alex Person's heart stops while hospitalized, the in-hospital orders may vary from POLST as hospital-based care can offer more immediate intervention and support. The POLST should be honored during admission to a hospital, but the admitting process should include a reassessment of the individual's goals in the context of their current medical condition, including any new risks they face resulting from their current change in condition or emergency.



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STEP 5

Confirm Understanding

At this point it is important to summarize the discussion and ensure agreement with the individual.

- Can you tell me your understanding of the decisions we just discussed?
- Do these decisions make sense given your preferences?

The following are ways to ensure the choices on the POLST align with the individual's desired outcomes:

- Allow time, suggest a follow-up visit if needed.
- Revisit sections or discussions until the individual reports full understanding and consistently confirms the choices selected on the POLST.
- Ask open ended questions, e.g., "What questions do you have about 'x'?"

STEP 6

Complete Signatures

Signatures are required to make the POLST orders valid.

POLST must be signed by an MD/DO/ARNP/PA-C **and** the individual with decision-making capacity or their legal medical decision maker as determined by guardianship, durable power of attorney for health care (DPOA-HC), or a person authorized to give health care informed consent as outlined in chapter 7.70.065 RCW.ⁱⁱ

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Signatures: A legal medical decision maker (see page 2) may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed by not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of Minor ☐ Guardian with Health Care Authority ☐ Legal Health Care Agent(s) by DPOA-HC ☐ Other Medical Decision Maker by 7.70.065 RCW		MD/DO/ARNP/PA-C Signature (mandatory) _____ PRINT - MD/DO/ARNP/PA-C Name (mandatory)	Date (mandatory) _____ Phone Number _____
X Signature(s) of Individual or Legal Medical Decision Maker(s) (mandatory) _____		Date (mandatory) _____ Phone Number _____	
PRINT – Individual or Legal Medical Decision Maker(s) (mandatory)		Relationship to Individual _____	Phone Number _____
Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)		Encourage all advance care planning documents to accompany POLST.	

POLST Completion Guide for Clinicians



POLST does not establish the legal power of attorney for health care. This can only be established by a Durable Power of Attorney for Health Care (DPOA-HC).

If an individual does not have decision-making capacity and does not have a legal guardian or a named health care agent in a DPOA-HC, follow Washington state law to determine who is authorized to give health care informed consent as outlined in [chapter 7.70.065 RCW](#).

Multiple decision maker signatures are allowed, but not required. Virtual, remote, and verbal orders and consents are acceptable in accordance with the health care facility's policies. Dates are very important for tracking that the most current POLST is in the electronic health record (EHR).

PAGE 2

STEP 7

Additional Contact Information

Additional Contact Information (if any)		
LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC OR 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Complete the contact information for the legal medical decision maker(s) in this section. Advise individual to include supporting documentation (e.g. DPOA-HC, Guardianship Form) with their POLST.

The other contact person listed should be someone who can be easily reached in an emergency.

If a health care professional other than the signing MD/DO/ARNP/PA-C assists in completing this form, complete the contact information in this section.



**Washington State
Medical Association**
Physician Driven, Patient Focused

Preference: Medically Assisted Nutrition

This section deals with a preference for medically assisted nutrition (MAN), otherwise known as artificial feeding or "tube feeding". Options for MAN are most often discussed in the context of other medical care, not during the delivery of emergency care. Therefore, these preferences are not medical orders, and are not actionable by EMS.

If the individual has decision making capacity this information should also be in their advance directive. If the individual does not have decision making capacity this section can be discussed with the legal medical decision maker. If discussed, enter preferences for medically assisted nutrition and who took part in the discussion.

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition) ☐ Check here if not discussed

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.

Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

- ☐ Preference is to avoid medically assisted nutrition.
- ☐ Preference is to discuss medically assisted nutrition options, as indicated. *

Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

*Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: _____ Individual _____ Health Care Professional _____ Legal Medical Decision Maker



STEP 9

Review POLST form

Review of this POLST form: Use this section to update and confirm order and preferences.

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME ☐ No Change ☐ Form Voided ☐ New Form Completed
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SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

This section indicates when a completed POLST has been reviewed to reaffirm the individual's decisions. When the review takes place and there is no change to the previous decisions, this section creates a new "effective date." A recently completed POLST form should be considered valid unless a meaningful discussion reveals a change in goals.

Upon each review, if no changes are made, the new "effective date" of the POLST should be readily available. Please ensure that the policy in your institution ensures that the most current POLST can be found. Completing this section will meet the requirement of establishing "code status" on admission to a skilled nursing facility or long-term care.

If an individual's goals, preferences, or decisions change, a new POLST is recommended, if having a POLST is still in alignment with the individual's wishes.

Directions to Health Care Professionals

The instructions on the back of the POLST form provide additional guidance and tips for completing the POLST.

- Please read and review when questions arise.
- Remember: All advance care planning, including POLST, is voluntary for the individual.

MORE INFORMATION AND SUPPORT

Please see ***Washington POLST Clinician Toolkit - Contacts and References.***

ⁱ National POLST. Intended Population & Guidance for Health Care Professionals. <https://polst.org/wp-content/uploads/2020/03/2019.01.14-POLST-Intended-Population.pdf#:~:text=Intended%20Population%20%26%20Guidance%20for%20Health%20Care%20Professionals,life-limiting%20medical%20condition%2C%20which%20may%20include%20advanced%20frailty>. 2019 Jan 14.

ⁱⁱ Washington State Legislature. Informed consent- Persons authorized to provide for patients who are not competent-Priority. [Apps.leg.wa.gov/RCW/default.aspx?cite=7.70.065](https://apps.leg.wa.gov/RCW/default.aspx?cite=7.70.065). 2019