Summary of Act 186 Relating to Physician Orders for Life Sustaining Treatment (POLST)

Purpose

This law is intended to:

- Provide a means to convey end-of-life wishes
- Ensure that a person's wishes regarding end-of-life care are followed
- Allow the use of a standardized form called the Physician Orders for Life Sustaining Treatment form (POLST)
- Simply put, the form states an individual's wishes regarding end-of-life treatment in all pre-hospital and health care settings.

Who Completes the Form

The bill identifies who may execute the form and under what conditions: essentially the patient and physician

- The form shall be prepared by the patient's physician or a health care provider
- It shall be based on the patient's preferences and matching medical indications
- It must be executed by the patient, the patient's physician, and the patient’s surrogate but only if the patient lacks capacity or has designated that the surrogate is authorized to execute the form.

How is it Completed

- The patient's physician or another health care provider has to explain to the patient the nature and content of the form
- The physician or provider shall also explain the difference between an advance health-care directive and the form
- Include any medical interventions or procedures
- In order to be valid a form shall be signed by the patient's physician and the patient, or the patient's physician and the patient's surrogate.

Revocation or Change of a Valid Form

- The form may be revoked at any time and in any manner that communicates intent to revoke
- A patient or the patient's surrogate may request alternative treatment at any time that differs from the treatment indicated on the form. This change can be considered a form of revocation.
- New orders can be written following a medical evaluation of the patient by the patient's physician. The new orders should be consistent with the most current information available about the individual's health status and goals of care
- The patient's physician shall consult with the patient or the patient's surrogate before issuing any new orders on a form
- The patient or the patient's surrogate may choose to execute or not execute any new form
- If a patient is incapacitated, the patient's surrogate shall consult with the patient's physician before requesting the patient's physician to modify treatment orders on the form.

Compliance

- Any health care provider, including the patient's physician, emergency medical services personnel, and emergency physicians shall comply with a properly executed and signed form
- Treat the patient according to the orders on the form
- Caveat: except if the orders request medically ineffective health care or health care that is contrary to generally accepted health care standards

Immunity

There are provisions for immunity from criminal prosecution or civil liability:

- When carrying out care in good faith
- Or when the provider is unaware of a valid executed form
- Or when the provider believes that the form had been revoked

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient 's Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A — Check One

CARDIOPULMONARY RESUSCITATION (CPR): ***Person has no pulse and is not breathing.***

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (**A**llow **N**atural **D**eath)
(Section B: Full Treatment required)

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

B — Check One

MEDICAL INTERVENTIONS: ***Person has pulse and/or is breathing.***

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). ***Transfer*** to hospital if indicated. Avoid intensive care.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — Check One

ARTIFICIALLY ADMINISTERED NUTRITION: ***Always offer food and liquid by mouth if feasible and desired.***

(See Directions on next page for information on nutrition & hydration)

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.
Goal:_____

☐ Long-term artificial nutrition by tube.

Additional Orders:_____

D

SIGNATURES AND SUMMARY OF MEDICAL CONDITION:

Discussed with:

☐ Patient ☐ Patient's Surrogate (Health Care Decision-maker) ☐ Parent of Minor ☐ Guardian

Signature of Physician

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

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Surrogate, Parent of Minor or Guardian

By signing this form, the legally recognized decision maker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and in the best interests of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)

Summary of Medical Condition	Office Use Only

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGE

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)	Date of Birth	Gender: M F
Patient Current Address		

Contact Information

Patient's Surrogate (Health Care Decisionmaker)	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/surrogate to be valid. Verbal orders are not acceptable.
- A surrogate may be designated by a patient or if the patient lacks capacity to consent to or refuse treatment, a non-designated surrogate may be appointed by consensus of the interested persons as per HRS §327E-5
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Section C:

- A surrogate who is not designated by the patient may make all health-care decisions for the patient except that artificial nutrition and hydration may be withheld or withdrawn only when the primary physician and a second independent physician certify in the medical records that the provision/continuation of nutrition/hydration prolongs the act of dying and the patient is highly unlikely to have any neurological response in the future. HRS §327E-5

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A person with capacity or, if lacking capacity, the surrogate can request a different treatment plan and may revoke the POLST at any time and in any manner that communicates an intention as to this change.
- To void or modify a POLST form, draw a line through Sections A through D and write "VOID" in large letters on the original and all copies. Sign and date this line. Complete a new POLST form indicating the modifications.
- The patient's physician may medically evaluate the patient and recommend new orders based on the patient's current health status and goals of care.

Kokua Mau

Kokua Mau is the lead agency for implementation of POLST in Hawaii. This form has been adopted by the Department of Health. For more information or to download a copy, visit www.kokuamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED