



CALIFORNIA  
COALITION FOR  
COMPASSIONATE  
CARE

## Model Policy for **HOSPICES**

### Physician Orders for Life Sustaining Treatment (POLST)

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#### **PURPOSE**

The purpose of this policy is to define a process for hospice providers to follow when a patient who is enrolled in hospice has a Physician Orders for Life Sustaining Treatment (POLST) form. This policy also outlines procedures regarding the completion of a POLST form and the steps necessary when reviewing or revising a POLST form.

#### **PREAMBLE**

The Physician Orders for Life-Sustaining Treatment (POLST) is a physician order form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders. It is designed to be a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be a portable, authoritative and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings.

The POLST form:

- Is a standardized form that is brightly colored and clearly identifiable<sup>1</sup>;
- Can be revised or revoked by an individual with decisionmaking capacity at any time;
- Is legally sufficient and recognized as a physician order;
- Is recognized and honored across treatment settings;
- Provides statutory immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction or any other sanction to a healthcare provider who relies in good faith on the request and honors a POLST;
- Can be an alternative to the "Pre-Hospital Do Not Resuscitate (DNR)," "Preferred Intensity of Care" and "Preferred Intensity of Treatment" forms<sup>2</sup>, although POLST is more comprehensive than a Pre-Hospital DNR in that it addresses other life-sustaining treatment in addition to resuscitative measures; and,
- Should be made available for patients who wish to execute a POLST form while enrolled in hospice.

**The original form in its most current version must remain physically with the patient across all care settings.**

A health care provider is not required to initiate a POLST form, but is required to treat an individual in accordance with a POLST form. This does not apply if the POLST requires medically ineffective health care or health care contrary to generally accepted health care standards.<sup>3</sup>

A legally recognized health care decisionmaker<sup>4</sup> may execute, revise or revoke the POLST form for a patient only if the patient lacks decisionmaking capacity and if the action is consistent with the known desires of, and with the best interest of, the patient. This policy does not address the criteria or process for determining or appointing a legally recognized health care decisionmaker, nor does it address the criteria or process for determining decisionmaking capacity.<sup>5</sup>

While a health care provider<sup>6</sup> such as a hospice nurse or hospice social worker can explain the POLST form to the patient and or the patient's legally recognized health care decisionmaker, the patient's physician or the hospice physician is responsible for discussing any concerns or questions on the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks decisionmaking capacity, with the patient's legally recognized health care decisionmaker.

Once the POLST form is completed, it must be signed by the patient, or if the patient lacks decisionmaking capacity the patient's legally recognized health care decisionmaker, AND the patient's physician or hospice physician.

The POLST is particularly useful for persons who are frail and elderly or who have a compromised medical condition, a prognosis of one year of life or less, and/or a terminal illness, which account for most hospice patients. The POLST form should be executed as part of the health care planning process and ideally is a complement to a patient's advance directive. A POLST form may also be used by patients who do not have an advance directive. Completion of a POLST form should reflect a process of careful decisionmaking by the patient, or if the patient lacks decisionmaking capacity, the patient's legally recognized health care decisionmaker, in consultation with the patient's hospice team, about the patient's medical condition and known treatment preferences.

## **HOSPICE PROCEDURES<sup>7</sup>**

### **I. Patient Admitted with a Completed POLST Form**

1. The admitting nurse will note the existence of the POLST form on the admission assessment and review the form for completeness (e.g. signed by patient or legally recognized healthcare decisionmaker, and by a physician) and confirm with the patient, if possible, or the patient's legally recognized health care decisionmaker, that the POLST form in hand has not been revoked or superseded by a subsequent POLST form. A completed, fully executed POLST is a legal physician order, and is immediately actionable.

2. Once reviewed, the POLST should be scanned or copied, with a copy provided to the hospice. The current original form placed in the front of the patient's chart, along with the patient's advance directive if he/she has one. As the patient moves from one health care setting to another, the original pink POLST and copies of the patient's advance directive should always accompany the patient.
3. If a patient resides at home, the original POLST should be prominently displayed in an easily accessible and visible location.
4. POLST may replace the "Pre-Hospital DNR" form. Out-of-date Pre-Hospital DNR forms should be clearly marked "VOID" and placed in the appropriate section of the hospice medical record. (See also Section IV, POLST and the Medical Record.)
5. If the POLST conflicts with the patient's previously-expressed health care instructions or advance directive, then, to the extent of the conflict, the most recent expression of the patient's wishes governs. (*See "Conflict Resolution" for additional guidance.*)
6. A qualified health care provider<sup>8</sup>, preferably a physician, registered nurse or social worker, will conduct an initial review of the POLST with the patient, or if the patient lacks decisionmaking capacity, with the legally recognized health care decisionmaker, within the first required assessment period as part of the comprehensive assessment and care planning process.
7. If the patient, or when the patient lacks decisionmaking capacity, the legally recognized health care decisionmaker, expresses concern about the POLST form, or if there has been a significant change in the patient's condition or wishes, then the patient's physician or hospice physician will be notified as soon as possible to discuss the potential changes with the patient, or if the patient lacks decisionmaking capacity the legally recognized decisionmaker.
8. The initial review and any discussion about continuing, revising or revoking the POLST should be documented in the medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.

## **II. Reviewing/Revising the POLST**

1. The POLST will be reviewed by the hospice interdisciplinary team during the initial Interdisciplinary Team Meeting after admission to hospice and at anytime that the patient, or if the patient lacks decisionmaking capacity, the legally designated health care decisionmaker, requests it.
2. At any time, a patient with decisionmaking capacity can revoke the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or, after consultation with the patient's physician or hospice physician, a new POLST. The new POLST form must be signed by the physician and the patient and the revoked POLST must be voided.

3. If a patient decides to revoke the POLST form, the patient's physician or hospice physician should be notified and appropriate changes to the physician orders should be obtained as soon as possible to ensure that the patient's wishes are accurately reflected in the plan of care.<sup>9</sup>
4. If the patient lacks decisionmaking capacity and the legally recognized health care decisionmaker wants to consider revising or revoking the POLST form, he/she must consult the patient's physician or hospice physician before any change is made to the patient's POLST form.<sup>10</sup> The legally recognized health care decisionmaker, together with the physician, may revise the POLST as long as it is consistent with the known desires of and in the best interest of the patient.
5. All discussions about revising or revoking the POLST should be documented in the patient's medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.
6. To void POLST, draw a line through the entire Section A through D and write "VOID" in large letters. The original POLST marked "VOID" should be signed and dated.

### **III. Initiating a POLST**

1. If a patient, or if the patient lacks decisionmaking capacity, the legally recognized health care decisionmaker, wishes to complete a POLST form while on service with hospice, obtain a POLST form for the physician and the patient or the patient's legally designated health care decisionmaker to discuss, fill out and sign. Notify the patient's physician or the hospice physician that the patient, or the legally designated health care decisionmaker if the patient lacks decisionmaking capacity, wishes to discuss the treatment options on the POLST form.
2. Generally, the physician should discuss the benefits, burdens, efficacy and appropriateness of treatment and medical interventions with the patient, or if the patient lacks decisionmaking capacity, the patient's legally recognized health care decisionmaker. A qualified health care provider such as a hospice nurse or hospice social worker may also explain the POLST form to the patient and/or the patient's legally recognized health care decisionmaker. The physician should discuss any areas of concern with the patient and/or the patient's legally recognized health care decisionmaker.

The completed POLST form must be signed by the physician and the patient, or if the patient lacks decisionmaking capacity, the patient's legally recognized health care decisionmaker.

3. Scan or make a copy of the completed POLST form, or request that the patient provide a copy of the POLST form. Mark the copy as "COPY" with the date the copy was made. File the copy in the advance directive or legal section of the medical record.
4. The current original POLST form is considered the property of the patient, and is to remain with the patient across all treatment settings, along with a copy of the patient's advance directive (if one exists), which should be placed at the front of the medical record.

#### **IV. POLST and the Medical Record<sup>11</sup>**

1. The most current POLST in its original format will always be kept with the patient.
2. A copy of the POLST will be placed in the hospice chart (if one exists) at the residence and in the medical record at hospice.
3. If the patient has an advance directive, copies of it should be attached to the current original POLST in the front of the chart.
4. If the patient is transferred, admitted to a facility, or discharged from hospice, the current original POLST must remain with the patient.
5. A fully executed, dated copy of the POLST, marked “COPY,” should be retained in the medical record in the advance directive or legal section of the hospice medical record.
6. All voided versions of the POLST, clearly marked “VOID,” should be retained in the medical record if available.
7. Whenever the POLST is reviewed, revised, and/or revoked, this will be documented in the medical record by the physician and/or the health care provider(s) involved.
8. For hospices with electronic health records, the POLST should be scanned in and placed in the appropriate section of the health care record per facility/agency policy.

#### **V. Conflict Resolution**

If the POLST conflicts with the patient’s health care instructions or advance directive, then, to the extent of the conflict, the most recent expression of the patient’s wishes governs.

If there are any conflicts or ethical concerns about the POLST orders, appropriate hospice resources – e.g., Ethics Committees, care conferences, legal, risk management or other administrative and medical staff resources – may be utilized to resolve the conflict.

During conflict resolution, consideration should always be given to: a) the assessment by the patient’s physician or hospice physician of the patient’s current health status and the medical indications for care or treatment; b) the determination by the physician as to whether the care or treatment specified by POLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and c) the patient’s most recently expressed preferences for treatment and the patient’s treatment goals.

## ENDNOTES

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<sup>1</sup> *Note: The official POLST form for California is approved by the Emergency Medical Services Authority. You can download a copy of the form for printing by going to the California Coalition of Compassionate Care website at: [www.finalchoices.org](http://www.finalchoices.org).*

*Wausau Pulsar Pink paper (65 lb. paper stock recommended) is the color used for the POLST form. It is important to use this specific color of pink paper so that the form can be photocopied and faxed. Although Pulsar Pink is the recognized and recommended color, the form remains valid if another color paper is used. A photocopy of the form is also valid.*

<sup>2</sup> *Note: In order to promote consistency and efficiency of communication of a patient's wishes across treatment settings, we recommend that, for patients who have a POLST, that the POLST form replace the PIC, PIT, and Pre-Hospital DNR for that patient.*

<sup>3</sup> California Probate Code §4781.2. (a) A health care provider shall treat an individual in accordance with a POLST form. (b) This does not apply if the POLST form requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution. (c) A physician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care decisionmaker, issue a new order consistent with the most current information available about the individual's health status and goals of care.

<sup>4</sup> Legally recognized health care decisionmaker includes the person's agent as designated by a power of attorney for health care, surrogate, conservator or closest available relative as described in California Probate Code §§ 4671, 4711, 1880, and *Cobbs v Grant*, 8 Cal3d 229, 244 (1972) respectively.

<sup>5</sup> *Note: Hospices should refer to their specific policies, the Health Care Decisions Law (Probate Code §§4600-4805), and relevant case law regarding determination of capacity, and of a legally recognized health care decisionmaker.*

<sup>6</sup> California Probate Code §4621. "Health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law of this state to provide health care in the ordinary course of business or practice of a profession.

<sup>7</sup> *Note: Individual hospices may adapt the model procedures in accordance with their existing structures and related policies.*

<sup>8</sup> "Qualified" means that they have had training in the purpose and use of the POLST form, and on the hospice's policy regarding implementing or reviewing the POLST, including how to respond to questions from the patient and/or the patient's legally recognized health care decisionmaker regarding the specific interventions described on the POLST. And see 6 above regarding "health care provider."

<sup>9</sup> See 3 above.

<sup>10</sup> California Probate Code §4781.2(d). The legally recognized health care decisionmaker of an individual without capacity shall consult the physician who is, at that time, the individual's treating physician prior to making a request to modify that individual's POLST form.

<sup>11</sup> *Note: Facilities should decide the most appropriate filing system for POLST depending on their specific medical records system and modify this model policy accordingly. The main considerations are: 1) that the most current POLST be available in a location of prominence in order to increase awareness of its existence and promote compliance, and 2) that the current original POLST must travel with the patient, so obtaining and filing of a copy is critical.*