



Summary of Changes to the 2021 POLST

New form is available at: www.wsma.org/POLST

General Revisions

	LD LS sible Orders for Life-Sustaining Treatment toppaging Program of National POLST	DATE OF BIRTH		GENDE	R (optional)	PHONOUNS (optional)
	This is a medical order. It must		rith a medical professio		oleting a POLST	is always voluntary.
EDI	CAL CONDITIONS/INDIVIDUAL GOAL				AGENCY INFO	/ PHONE (if applicable)
38	Use of Cardiopulmonary TES – Attempt Resuscita					is not breathing.
	☐ NO – Do Not Attempt Re	suscitation (C	ONAR) / Allow Natura	l Death		arrest, go to Section B.
	□ SELECTIVE TREATMENT - Primary goal is treating medical conditions while avoiding invasive measures whenever possible. Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. Do not intubate. May use les invasive airway support (e.g., CPAP, BIPAP, high-flow oxygen). Includes care described below. □ COMPORT-POCUSED 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): 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 but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.					
	Discussed with: ☐ Individual ☐ Parent(s) of min ☐ Guardian with health care author	ority OA-HC	PRINT - NAME OF MOJO			DATE (mandator)
	 Legal health care agent(s) by Di 			ry) RE	ATIONSHIP	DATE (mandator)
			ECISION MAKER(S) (mandate			
	 Legal health care agent(s) by Di Other medical decision maker b 	LEGAL MEDICAL DI				PHONE

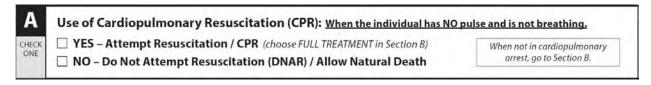
- Changed subject of form: formerly "patient" or "person," now "individual."
- Changed title and language for inclusion of all signers.
- Changed from "Physician Orders" to "Portable Orders"; reference it as medical order
- Legal Medical Decision Maker used as inclusive term:
 - Includes those with authority via guardianship, powers of attorney (via DPOA-HC documents) or by other relationship per 7.70.065 RCW
- Specific inclusion of use for children.
- Specific allowance of multiple signers (parents or other).
- Also added basic reference to virtual, remote, verbal consents and signing

Header, Page 1

Washington POIST	LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL			
Portable Orders for Life-Sustaining Treatment A Participating Program of National POLST	DATE OF BIRTH / /	GENDER (optional		
This is a medical order. It must	be completed with a medical p IMPORTANT: See page 2 for c		POLST is always voluntary.	
MEDICAL CONDITIONS/INDIVIDUAL GOAL	S:	AGEN	CY INFO / PHONE (if applicable)	

- Changed name to "Portable Orders for Life Sustaining Treatment."
- New logo from National POLST
- Changed identity box
- Simplified instructions. Reference the full instructions on the back.
- Emphasis: 1) POLST as a "medical order," 2) complete with "medical professional," 3) voluntary nature of the process.

Section A



- Added Yes/No as response to the question.
- More explicit situational guidance: "When the individual has NO pulse..."
- Added the instruction "choose FULL TREATMENT in Section B" next to the option "Yes Attempt Resuscitation/CPR."
- Moved directions pertaining to Section B from Section A into that section below.

Section B

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. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below. Transfer to hospital if indicated. Includes intensive care.
SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible. Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. <i>Do not intubate</i> . May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below. <i>Transfer to hospital if indicated. Avoid intensive care if possible</i> .
□ 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.

- Moved "Any of these treatment levels may be paired with DNAR/AND above" from Section A to this section.
- For "Selective Treatment," replaced "- goal of treating medical conditions while avoiding burdensome measures" with "Primary goal is treating medical conditions while avoiding invasive measures whenever possible."
- Added "and medications" to indicate inclusion of IV antibiotics and other IV meds
- Bolded "Do not intubate" for clarity.
- Added "(e.g., blood products, dialysis)" to the "Additional orders" line

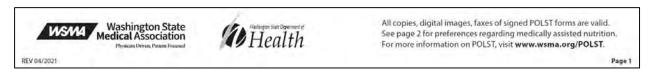
Section C

Discussed with: ☐ Individual ☐ Parent(s) of minor	SIGNATURE – MD/DO/ARNP/PA-C (mandatory) PRINT – NAME OF MD/DO/ARNP/PA-C (mandatory)		DATE (mandatory) PHONE
 Guardian with health care authority Legal health care agent(s) by DPOA-HC Other medical decision maker by 7.70.065 RCW 			
SIGNATURE(S) – INDIVIDUAL OR LEGAL MEDICAL DE	CISION MAKER(S) (mandatory)	RELATIONSHIP	DATE (mandatory
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECIS	ION MAKER(S) (mandatory)		PHONE

• Removed: "The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate."

- Replaced with: "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 but not required. Virtual, remote, and verbal consents and orders are
 addressed on page 2."
- "Legal health care agent" refers specifically to a person named by DPOA-HC. "Legal medical decision maker" refers to a legal health care agent or another surrogate medical decision maker as outlined in RCW 7.70.065.
- Added a box to clarify the relationship between the individual and their legal medical decision maker.

Footer, Page 1



- Removed icon of Washington state.
- Updated WSMA logo.
- Added page numbers.
- Removed "Photocopies and faxes of signed POLST forms are legal and valid. May make copies
 for records." and replaced it with "All copies, digital images, faxes of signed POLST forms are
 valid. See page 2 for preferences regarding medically assisted nutrition."

Header, Page 2

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY			
LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		DATE OF BIRTH / /	
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	

- Added DPOA-HC and RCW indication to the Legal Medical Decision Maker line.
- Added a row for contact information for the health care professional completing the form. This
 is a return to prior versions of POLST, based on many requests.

Non-Emergency Medical Treatment Preferences

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 Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance The POLST does not replace an advance directive. When an individual is no longer able to make their own decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on printindividual, preferences noted here or elsewhere, and current medical condition. Document specific decision	ce directives which are advised for all adults. lecisions, consult with the legal medical or known wishes, best interests of the
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	of tube).
* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associate or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.	ed with complications. People may have documents
Discussed with: Individual Health Care Professional Legal Medical Decision M	aker

- "Section D" designation was removed to emphasize the optional nature of this section.
- Removed the Antibiotics row. IV antibiotics are included as part of "IV medications" in Section B under "Selective Treatments." Oral antibiotics may be used in any of the three treatment paths.
- "Section D" designation was removed to emphasize the optional nature of this section.
- Removed the Antibiotics row. IV antibiotics are included as part of "IV medications" in Section B
 under "Selective Treatments." Oral antibiotics may be used in any of the three treatment paths.

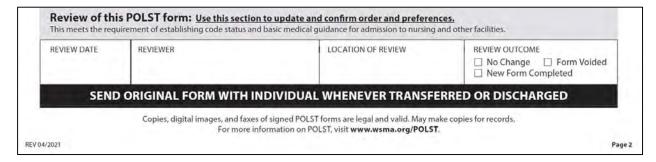
Directions

NOTE: An individual with capacity may always consent to or refuse medical care or Directions for Health Care Professionals interventions, regardless of information represented on any document, including this one. Any incomplete section of POLST implies full treatment for that section. NOTE: This form is not adequate to designate someone as a health care This POLST is valid in all care settings. It is primarily intended for out of agent. A separate DPOA-HC is required to designate a health care agent. hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces **Honoring POLST** all previous orders. Everyone shall be treated with dignity and respect. **Completing POLST** SECTIONS A AND B: · Completing POLST is voluntary for the individual; it should be offered · No defibrillator should be used on an individual who has chosen as appropriate but not required. "Do Not Attempt Resuscitation. · Treatment choices documented on this form should be the result of · When comfort cannot be achieved in the current setting, the individual shared decision making by an individual or their health care agent should be transferred to a setting able to provide comfort (e.g., treatment and health care professional based on the individual's preferences of a hip fracture). This may include medication by IV route for comfort. and medical condition. Treatment of dehydration is a measure which may prolong life. · POLST must be signed by an MD/DO/ARNP/PA-C and the individual An individual who desires IV fluids should indicate "Selective" or or their legal medical decision maker as determined by guardianship, "Full Treatment." DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. **Reviewing POLST** Multiple decision maker signatures are allowed, but not required. This POLST should be reviewed whenever: · Virtual, remote, and verbal orders and consents are acceptable in • The individual is transferred from one care setting or care level to another. accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST. There is a substantial change in the individual's health status. · The individual's treatment preferences change. · POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) To void this form, draw a line across the page and write "VOID" in large sign the form along with the health care professionals. See FAQ at letters. Notify all care facilities, clinical settings, and anyone who has a www.wsma.org/POLST. copy of the current POLST. Any changes require a new POLST.

- Clarified and rearranged directions.
- Updated the section to read: "This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy."
- Added NOTE in second column: a reminder that POLST does NOT authorize powers of attorney for health care.

- Added the instruction: "Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility."
- Removed the instruction "An IV medication to enhance comfort may be appropriate for a
 person who has chosen 'Comfort-Focused Treatment." The instructions for this are explicit in
 Section B.
- Clarified instructions on how to void a POLST.

Review and Footer, Page 2



- Expanded the gray box to read, "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."
- Removed one of the review lines; one is sufficient. Encourages updating of POLST.