

## Summary of Changes to the 2021 POLST


New form is available at: [www.wsma.org/POLST](http://www.wsma.org/POLST)

### General Revisions

| HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY   |   |   |   |
|---|---|---|---|
| <br><small>Portable Order for Life-Sustaining Treatment<br/>A Participating Program of National POLST</small>  | LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL  |   |   |
|   | DATE OF BIRTH   | GENDER (optional)   | PRONOUNS (optional)   |
| <b>This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.</b><br><small>IMPORTANT: See page 2 for complete instructions.</small>  |   |   |   |
| MEDICAL CONDITIONS/INDIVIDUAL GOALS:  |   | AGENCY INFO / PHONE (if applicable)   |   |
| <b>A</b><br><small>CHECK ONE</small>  | <b>Use of Cardiopulmonary Resuscitation (CPR): <u>When the individual has NO pulse and is not breathing.</u></b>  |   |   |
|   | <input type="checkbox"/> YES – Attempt Resuscitation / CPR (choose FULL TREATMENT in Section B)   |   | <small>When not in cardiopulmonary arrest, go to Section B.</small> |
| <input type="checkbox"/> NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death   |   |   |   |
| <b>B</b><br><small>CHECK ONE</small>  | <b>Level of Medical Interventions: <u>When the individual has a pulse and/or is breathing.</u></b><br><small>Any of these treatment levels may be paired with DNAR / Allow Natural Death above.</small>   |   |   |
|   | <input type="checkbox"/> 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.   |   |   |
| <input type="checkbox"/> 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 less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below. Transfer to hospital if indicated. Avoid intensive care if possible. |   |   |   |
| <input type="checkbox"/> 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>C</b>  | <b>Signatures:</b> 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:<br><input type="checkbox"/> Individual <input type="checkbox"/> Parent(s) of minor<br><input type="checkbox"/> Guardian with health care authority<br><input type="checkbox"/> Legal health care agent(s) by DPOA-HC<br><input type="checkbox"/> Other medical decision maker by 7.70.065 RCW   | <input checked="" type="checkbox"/> SIGNATURE – MD/DO/ARNP/PA-C (mandatory) | DATE (mandatory)  |
|   | PRINT – NAME OF MD/DO/ARNP/PA-C (mandatory)   | PHONE   |   |
| <input checked="" type="checkbox"/> SIGNATURE(S) – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)  | RELATIONSHIP  | DATE (mandatory)  |   |
| PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)   | PHONE   |   |   |
| Individual has: <input type="checkbox"/> Durable Power of Attorney for Health Care <input type="checkbox"/> Health Care Directive (Living Will)<br><small>Encourage all advance care planning documents to accompany POLST.</small>   |   |   |   |
| <b>SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED</b>  |   |   |   |

- 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

| HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY   |  |                                     |                     |
|---|--|-------------------------------------|---------------------|
|    | LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL |                                     |                     |
|   | DATE OF BIRTH<br>/ /                         | GENDER (optional)                   | PRONOUNS (optional) |
| <p><b>This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.</b><br/> <i>IMPORTANT: See page 2 for complete instructions.</i></p> |  |                                     |                     |
| MEDICAL CONDITIONS/INDIVIDUAL GOALS:  |  | AGENCY 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

|                       |   |   |
|-----------------------|---|---|
| <b>A</b><br>CHECK ONE | <b>Use of Cardiopulmonary Resuscitation (CPR): <u>When the individual has NO pulse and is not breathing.</u></b>  | <i>When not in cardiopulmonary arrest, go to Section B.</i> |
|                       | <input type="checkbox"/> <b>YES – Attempt Resuscitation / CPR</b> <i>(choose FULL TREATMENT in Section B)</i><br><input type="checkbox"/> <b>NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death</b> |   |




- 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

|                       |   |
|-----------------------|---|
| <b>B</b><br>CHECK ONE | <b>Level of Medical Interventions: <u>When the individual has a pulse and/or is breathing.</u></b><br>Any of these treatment levels may be paired with DNAR / Allow Natural Death above.  |
|                       | <input type="checkbox"/> <b>FULL TREATMENT – Primary goal is prolonging life by all medically effective means.</b> Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.<br><i>Transfer to hospital if indicated. Includes intensive care.</i>  |
|                       | <input type="checkbox"/> <b>SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.</b> Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. <b>Do not intubate.</b> May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.<br><i>Transfer to hospital if indicated. Avoid intensive care if possible.</i> |
|                       | <input type="checkbox"/> <b>COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.</b> 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.<br><i>Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.</i>                           |
|                       | <b>Additional orders (e.g., blood products, dialysis):</b> _____  |

- 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

|   |  |  |                         |
|---|--|--|-------------------------|
| <b>C</b>  | <b>Signatures:</b> A legal medical decision maker ( <i>see page 2</i> ) 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. |  |                         |
|   | <b>Discussed with:</b><br><input type="checkbox"/> Individual <input type="checkbox"/> Parent(s) of minor<br><input type="checkbox"/> Guardian with health care authority<br><input type="checkbox"/> Legal health care agent(s) by DPOA-HC<br><input type="checkbox"/> Other medical decision maker by 7.70.065 RCW   |  <b>SIGNATURE – MD/DO/ARNP/PA-C (mandatory)</b> | <b>DATE (mandatory)</b> |
|   |  <b>PRINT – NAME OF MD/DO/ARNP/PA-C (mandatory)</b>   | <b>PHONE</b>   |                         |
|   |  <b>SIGNATURE(S) – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)</b>  | <b>RELATIONSHIP</b>  | <b>DATE (mandatory)</b> |
|   | <b>PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) (mandatory)</b>   |  | <b>PHONE</b>            |
| Individual has: <input type="checkbox"/> Durable Power of Attorney for Health Care <input type="checkbox"/> Health Care Directive (Living Will)<br><i>Encourage all advance care planning documents to accompany POLST.</i> |  |  |                         |
| <b>SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED</b>  |  |  |                         |

- 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

|   |   |   |   |
|---|---|---|---|
|  | <b>Washington State Medical Association</b><br><small>Physician Driven, Patient Focused</small> |  | All copies, digital images, faxes of signed POLST forms are valid. See page 2 for preferences regarding medically assisted nutrition. For more information on POLST, visit <a href="http://www.wsma.org/POLST">www.wsma.org/POLST</a> . |
| REV 04/2021   |   | 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<br>/ / |       |
| <b>Additional Contact Information (if any)</b>                                |                      |       |
| 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

|  |  |
|--|--|
| <b>Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)</b>   | <input type="checkbox"/> Check here if not discussed |
| <p><i>This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.</i></p> <p>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 with 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.</p> <p><b>Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.</b></p> <p><input type="checkbox"/> Preference is to avoid medically assisted nutrition.</p> <p><input type="checkbox"/> Preference is to discuss medically assisted nutrition options, as indicated.*</p> <p><i>Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).</i></p> <p><small>* 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.</small></p> <p>Discussed with:   ___ Individual   ___ Health Care Professional   ___ Legal Medical Decision Maker</p> |  |

- “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

|  |   |
|--|---|
| <b>Directions for Health Care Professionals</b>  | <small>NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.</small>  |
| <p><i>Any incomplete section of POLST implies full treatment for that section. 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. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.</i></p> <p><b>Completing POLST</b></p> <ul style="list-style-type: none"> <li>• Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.</li> <li>• Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.</li> <li>• POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.</li> <li>• Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at <a href="http://www.wsma.org/POLST">www.wsma.org/POLST</a>.</li> <li>• POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at <a href="http://www.wsma.org/POLST">www.wsma.org/POLST</a>.</li> </ul> | <p><b>NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.</b></p> <p><b>Honoring POLST</b><br/>Everyone shall be treated with dignity and respect.</p> <p><b>SECTIONS A AND B:</b></p> <ul style="list-style-type: none"> <li>• No defibrillator should be used on an individual who has chosen “Do Not Attempt Resuscitation.”</li> <li>• When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.</li> <li>• Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate “Selective” or “Full Treatment.”</li> </ul> <p><b>Reviewing POLST</b><br/>This POLST should be reviewed whenever:</p> <ul style="list-style-type: none"> <li>• The individual is transferred from one care setting or care level to another.</li> <li>• There is a substantial change in the individual's health status.</li> <li>• The individual's treatment preferences change.</li> </ul> <p><i>To void this form, draw a line across the page and write “VOID” in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.</i></p> |

- 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

|  |          |                    |  |
|--|----------|--------------------|--|
| <p><b>Review of this POLST form: Use this section to update and confirm order and preferences.</b><br/>         This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.</p> |          |                    |  |
| REVIEW DATE  | REVIEWER | LOCATION OF REVIEW | REVIEW OUTCOME<br><input type="checkbox"/> No Change <input type="checkbox"/> Form Voided<br><input type="checkbox"/> New Form Completed |
| <b>SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED</b>   |          |                    |  |
| Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.<br>For more information on POLST, visit <a href="http://www.wsma.org/POLST">www.wsma.org/POLST</a> .                                       |          |                    |  |
| REV 04/2021  |          |                    | 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.