Using the Montana POLST Form
Guidance for Healthcare Professionals

These guidelines are created to assist Montana Healthcare Professionals in completing the POLST form. This form is referenced and amended from nationally endorsed state POLST programs. See the National POLST website for further information. The Montana POLST form is endorsed by the National POLST Coalition.

Additionally, the guidelines are based on the recommendations of the Montana POLST Coalition, which is made up of providers, DPHHS EMS representatives, DOJ's End-of-Life Registry and the BOME. It is our hope that the addition of guidelines for usage will streamline utilization of the 2014 updated POLST Form.

INTRODUCTION

The Montana "Provider Orders for Life Sustaining Treatment" (POLST) form is a document designed to help health care professionals know and honor the treatment wishes of their patients. The POLST form helps physicians, nurses, long-term care facilities, hospices, home health agencies, emergency medical services and hospitals:

- promote patient autonomy by documenting treatment preferences and converting them into physician's orders;
- clarify treatment intentions and minimize confusion regarding patients' treatment preferences;
- facilitate appropriate treatment by emergency medical services personnel; and
- enhance the HIPAA-compliant transfer of patients' records between health care professionals and health care settings.

The POLST form:

- is intended to enhance the quality of a person's care and to complement the advance care planning process.
- is a short summary of treatment preferences and a clear physician's order for care in an emergency situation.
- is not intended to replace a living will or medical power of attorney form.
- puts the advance directive into action by translating the patient's treatment wishes into a medical order, centralizing information, facilitating record-keeping and ensuring transfer of appropriate information among health care professionals and across settings.

Use of the POLST form is voluntary and conforms to the Montana Rights of the Terminally Ill Act, **Montana Code Annotated, 50-9-101**. It may not be legally recognized in bordering states. However, facilities in bordering states may be willing to record the physician's orders in the medical chart and work with MT facilities to make sure they honor a patient's wishes.

HOW TO IMPLEMENT THE POLST FORM

The POLST form should be completed after discussion with the patient, incapacitated patient's medical power of attorney representative or surrogate decision-maker regarding treatment preferences. The POLST conversation may be facilitated by health care professionals other than a provider, including nurses and social workers who have knowledge of end-of-life care issues and have been trained to conduct these discussions.

The Respecting Choices® POLST Paradigm Program ACP Facilitator Course is an example of a curriculum that would certify (or validate) the skill set of health care professionals in discussing these issues and choices with patients and families. This same professional staff may also assist the patient with completion of the POLST form; however, **the form must be signed by a medical provider** licensed in Montana who has examined the patient. The medical provider may be either a physician, physician assistant or advanced practice registered nurse.

- **Who Should Have a POLST Form?**
  The POLST form should be completed for individuals who have a serious illness that may be life limiting. The "surprise" question ("Would you be surprised if this patient died in the next year?") is helpful to identify patients who can benefit from this form. It may also be completed for those older individuals who are very clear about their end-of-life wishes and have discussed this with their provider.

  The POLST form is also highly recommended for hospitalized patients being discharged to a nursing home, or to home with home health or hospice care. Other nursing home residents can potentially be identified during quarterly care planning.

Identification of Existing POLST form

- **Previous versions of POLST forms remain valid until replaced by new version.**
- For those persons in institutional settings the form by law must accompany the person upon transfer from one setting to another.
- In the patient's home, it is recommended that the form be kept on the outside of the kitchen refrigerator with a magnet.
  - For those at home, the form by law must accompany the patient to a health care setting.
- A copy of the form on white paper may be sent rather than the original. For photocopying instructions please refer to the section below.

Photocopying the POLST Form (*HIPAA permits disclosure of POLST information to other health care professionals across treatment settings*)

A photocopy of the POLST form (on white paper) should be made to accompany the patient when he/she is transferred from one health care setting to another (e.g. being admitted from a nursing home to a hospital).

The reason to send a copy and retain the original is to prevent the original from being lost in a patient's transfer from one health care setting to another.

SECTION BY SECTION REVIEW OF THE POLST FORM

The POLST form is a double-sided **terra green** form. One side of the form contains the provider orders **(Sections A-D).** The other side of the form includes the Directions for Health Care Professionals.

I. Provider Orders (Sections A-D):

The four different sections include: A) Cardiopulmonary Resuscitation, B) Medical Interventions, C) Artificially Administered Nutrition, and D) Discussed with:

The bottom of the form is for signatures which include: Signature of patient or decision maker, Person preparing form, Provider signatures. All signatures should be completed.

A- Cardiopulmonary Resuscitation usage guideline

Section A Select only one box	**Treatment Options:** If patient does not have a pulse and is not breathing:
	☐ **Resuscitate (CPR)** ☐ **Do Not Resuscitate (DNR/No CPR)** (Allow Natural Death)
	If patient is not in cardiopulmonary arrest, follow orders found in sections **B** and **C**

These orders apply only to the circumstances in which the person has no pulse and is not breathing. If a patient is in respiratory distress but is still breathing or has low blood pressure with an irregular pulse, a first responder should refer to sections B, C and D for corresponding orders.

- **Resuscitate** is used if the person wants cardiopulmonary resuscitation (CPR). Full CPR measures should be carried out and 9-1-1 should be called in an emergency situation.

- **Do Not Resuscitate (DNR/no CPR)** is used if a person has indicated that s/he does not want CPR in the event of no pulse and no breathing. The person should understand that comfort measures will always be provided and that CPR will not be attempted.

B- Medical Interventions usage guideline

Section B Select only one box	**Treatment Options:** If patient has a pulse and/or is breathing: ☐ **Comfort Measures ONLY:** Relieve pain and suffering through the use of medication by any route, positioning, wound care or other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Transfer to hospital ONLY if comfort needs cannot be met in current location.* ☐ **Limited Additional Interventions:** In addition to the care described above, use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions or mechanical interventions. May consider use of less invasive airway support such as CPAP or BiPAP. *Transfer to hospital if indicated for treatment or comfort. Generally Avoid Intensive Care.* ☐ **Full Treatment:** In addition to the care described above, use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. *Transfer to hospital if indicated. Include Intensive Care.* **Other Instructions:** _____

These orders apply only to emergency medical circumstances for a person who has a pulse and/or is breathing. This section provides orders for situations that are not covered in Section A. These orders were developed in accordance with EMS protocol. Health care professionals should first administer the level of emergency medical services ordered and then contact the physician.

- **Comfort measures only:** Comfort measures indicates a desire for those measures that enhance comfort. Care to promote comfort should always be provided regardless of ordered level of treatment. Use medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction for comfort. **Transfer to hospital ONLY if comfort needs cannot be met in current location.**

- **Limited Additional Interventions**: In addition to the care described above, use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions or mechanical interventions. May consider use of less invasive airway support such as CPAP or BiPAP. *Transfer to hospital if indicated for treatment or comfort. Generally Avoid Intensive Care.*

- **Full Treatment:** In addition to the care described above, use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. *Transfer to hospital if indicated. Include Intensive Care.*

C- Artificially Administered Nutrition

Section C Select only one box	**Artificially Administered Nutrition: (Offer food and fluid by mouth if feasible and/or desired)** ☐ **No Artificial Nutrition by Tube.** ☐ **Defined trial period of Artificial Nutrition by Tube. Specifically:** _____ ☐ **Long Term Artificial Nutrition by Tube.**

- **No artificial nutrition by tube:** Indicates a preference for nothing except what might be needed to alleviate symptoms of pain or discomfort.
- **Defined trial period of Artificial Nutrition by Tube:** Means that patient or medical surrogate has decided on a trial of artificial nutrition by tube to allow time to determine the course of the illness or to allow the person an opportunity to clarify goals of care.
- **Long Term Artificial Nutrition by Tube:** Would be for those who desire consistent hydration and nutrition

D- Discussed With

Section D Select only one box	**Discussed With:** ☐ **Patient** ☐ **Health Care Agent or Decision-Maker** ☐ **Court Appointed Guardian** ☐ **Other** _____ *By signing below, the decision-maker acknowledges that these orders are consistent with the known desires of the patient.*

- Indicates who was part of the discussion. This may be discussed with both the patient and the health care decision maker. If the patient has decision making capacity, it is their wishes that are to be indicated in the form.

Signature Section

Signature of Patient or Decision-Maker (required)	**Printed Name**	**Relationship if not Patient**

Name of Person Preparing Form	**Phone Number of Preparer**	**Date Form Prepared**

Signature of Provider: *My signature below indicates to the best of my knowledge that these orders are consistent with the medical conditions and preferences of the patient.*

Signature of Physician, PA, or APRN (required)	**Printed Name of Physician, PA or APRN**

Date and Time	*Provider Phone Number*

Signature Section: Signatures should be entered as follows:

- Patient or decision makers signatures **are required** for it to be valid
- Provider signature is also **required** for form to be valid
- If form is not completed by the provider, it is important that the name of the person completing the form is filled in so any concerns or inconsistencies may be addressed.
- The person preparing the form should be trained in the appropriate use of the POLST document as well as how to have POLST conversations

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POLST forms, envelopes and bracelets may be ordered from:

Department of Public Health and Human Services
EMS & Trauma System Section
(406) 444-3895
emsinfo@mt.gov

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

http://bsd.dli.mt.gov/license/bsd_boards/med_board/polst.asp *Revised 3/2014*

Montana Provider Orders For Life-Sustaining Treatment (POLST)

THIS FORM MUST BE SIGNED BY A PHYSICIAN, PA or APRN IN SECTION D TO BE VALID

If any section is NOT COMPLETE:
Provide the most treatment included in that section

EMS: If questions/concerns, contact Medical Control.

Patient's Last Name:

Patient's First Name:

Date of Birth:

Male ☐ Female ☐

Section A
Select only one box

Treatment Options: If patient does not have a pulse and is not breathing:

☐ **Attempt Resuscitation (CPR)**

☐ **Do Not Attempt Resuscitation (DNR)**
(Allow Natural Death)

If patient is not in cardiopulmonary arrest, follow orders found in sections **B** and **C**

Section B
Select only one box

Treatment Options: If patient has a pulse and/or is breathing:

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

☐ **Limited Additional Interventions:** In addition to the care described above, use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions or mechanical interventions. May consider use of less invasive airway support such as CPAP or BiPAP. *Transfer to hospital if indicated for treatment or comfort. Generally Avoid Intensive Care.*

☐ **Full Treatment:** In addition to the care described above, use intubation, advanced airway interventions, mechanical ventilation and cardioversion as indicated. *Transfer to hospital if indicated. Include Intensive Care.*

Other Instructions: _____

Section C
Select only one box

Artificially Administered Nutrition: (Offer food and fluid by mouth if feasible and/or desired)

☐ **No Artificial Nutrition by Tube.**

☐ **Defined trial period of Artificial Nutrition by Tube. Specifically:** _____

☐ **Long Term Artificial Nutrition by Tube.**

Section D
Select box(es)

Discussed With:

☐ **Patient** ☐ **Health Care Agent or Decision-Maker** ☐ **Court Appointed Guardian**

☐ **Other** _____

By signing below, the decision-maker acknowledges that these orders are consistent with the known desires of the patient.

Signature of Patient or Decision-Maker (required)	**Printed Name**	**Relationship if not Patient**

Name of Person Preparing Form	**Phone Number of Preparer**	**Date Form Prepared**

Signature of Provider: *My signature below indicates to the best of my knowledge that these orders are consistent with the medical conditions and preferences of the patient.*

Signature of Physician, PA, or APRN (required)	**Printed Name of Physician, PA or APRN**

Date and Time	*Provider Phone Number*

FORM SHALL ACCOMPANY PATIENT WHENEVER TRANSFERRED CARE LEVELS OR TO HOME
Use of the original form is strongly encouraged. Photocopy, fax or electronic copies of signed POLST forms are legal and valid.