REGION 11 CHICAGO EMS SYSTEM POLICY	Title: Advanced Directives and POLST
	Section: Patient Care
	Approved: EMS Medical Directors Consortium
	Effective: June 1, 2023

ADVANCED DIRECTIVES AND POLST

I. HEALTH CARE AGENT/POWER OF ATTORNEY FOR HEALTH CARE (POAHC)

A. Illinois law allows persons to appoint an agent to make health care decisions for the patient in the event that the patient is unable to make his or her own medical decisions. The person chosen by the patient to make these decisions is called the "agent." An agent is appointed by the patient via a document called a "power of attorney for health care." The agent can ask you to withdraw or withhold medical care of the patient.

B. A health care agent has no authority if the patient himself or herself is alert and able to articulate consent to treatment or transport. If the patient is alert and consents to treatment, continue to treat the patient, even if thereafter the patient is unable to communicate with you. In such situations, the health care agent has no authority over the treatment of the patient.

C. In a situation where someone represents to you that they have power of attorney to make medical decisions for the patient, EMS personnel should do the following:

1. Begin treatment of the patient.

2. As soon as it is practical, ask the agent for the power of attorney form and examine the form to determine if the agent's name appears on the form as agent and ask the agent to verify that his/her signature appears on the form. Review the form to see what decision-making authority has been given to the agent.

3. Notify medical control as indicated of the confirmed presence of a health care agent and follow the instructions of the agent per the authority granted in the power of attorney form unless instructed otherwise by medical control.

4. If you have doubt as to the identity of the agent, the extent of the authority of the agent, or if communications with medical control cannot be established, continue treatment of the patient and document the situation.

II. LIVING WILLS AND PATIENT SURROGATES

Illinois law allows terminally ill patients to instruct their health care providers, either directly with a living will or indirectly through a patient surrogate, on their treatment in near death situations. However, the technical requirements of these laws make them difficult for field use. Therefore, Region 11 EMS personnel shall not follow the instructions contained in a living will or given by any person representing to be a surrogate for the patient unless instructed otherwise by medical control.

III. IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For the purpose of this policy, the POLST decision making process and form are defined as medical orders by a physician or practitioner for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. These orders provide guidance during life threatening emergencies and must be followed by all healthcare providers.

A. The IDPH Uniform POLST Form was revised in September 2022 and is detailed below. Prior versions of the DNR/POLST Form are still valid.

B. The sections of the POLST Form are defined as follows:

1. Section A of the POLST Form references "Orders for Patient in Cardiac Arrest." This section notes if the patient wishes to have resuscitation/CPR attempted or if they prefer medical providers "Do Not Attempt Resuscitation (DNAR)."

2. Section B of the POLST Form references "Orders for Patient Not in Cardiac Arrest." This section has three treatment options with the goal of maximizing comfort regardless of which treatment option is selected.

    a. **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments**. Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
    b. **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
    c. **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptoms management. Allow natural death. Use medication by any route as needed. Use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.**

3. Section C of the POLST Form references "Additional Orders or Instructions." These orders are in addition to those in the above sections and includes language that EMS protocols may limit emergency responder ability to act on orders in this section.

4. Section D of the POLST Form references "Orders for Medically Administered Nutrition".

5. Section E of the POLST Form references documentation of the discussion of the form and signatures of the patient or legal representative.

6. Section F of the POLST Form references the printed name, signature, and date of the patient's Qualified Health Care Practitioner.

C. Region 11 EMS personnel are permitted to follow a valid POLST Form regarding medical care in a life-threatening clinical event. This includes situations for patients in long-term care facilities, with hospice and home-care patients, and with patients who arrest during interhospital transfers or transportation to or from home.

D. A valid POLST Form will contain at least the following information:

1. Name of the patient.

2. "Orders for Patient in Cardiac Arrest" - Section A option selected.

3. Signature of patient or legal representative as defined on the form:

   a. Parent of minor
   b. Agent under Power of Attorney for Health Care (POAHC)
   c. Heath care surrogate decision maker

4. Name and signature of the patient's Qualified Health Care Practitioner.

5. Date.

E. If the POLST Form does not have the required items completed on the form, the form is not valid for prehospital use.

F. In situations with a POLST Form, EMS providers should do the following:

1. Verify the form contains the criteria for a valid POLST Form as listed above.

2. Make a reasonable attempt to verify the identity of the patient (for example, identification by another person or an identifying bracelet) named in a valid POLST Form.

3. Contact medical control as needed to discuss the situation and advise them of the presence of a POLST Form, along with the description of any specific treatments as defined in the POLST Form.

4. If the order is valid, follow the terms of the POLST Form. Document all information from the POLST Form on the patient care report.

5. If there is any doubt as to the validity of the POLST Form, treat the patient and contact medical control. Document the situation in the patient care report.

G. Voiding or revoking a POLST Form:

1. A patient with decision making capacity can void or revoke the POLST Form and/or request alternative treatment.

2. Changing, modifying, or revising a POLST Form requires completion of a new POLST form.

H. Digital copies (including on a cell phone or tablet) and photocopies, including faxes, on any color paper are legal and valid. POLST Forms with e-signature are legal and valid.

I. EMS and healthcare providers should honor any completed POLST Form that is formally authorized by a state or territory within the United States, as well as the National POLST Form (http://polst.org/national-form/).

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*		
Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)	

A *Required to Select One*

ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.

- ☐ **YES CPR**: **Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)
- ☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

B *Section may be Left Blank*

ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

- ☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
- ☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
- ☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C *Section may be Left Blank*

Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D *Section may be Left Blank*

ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

- ☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.
- ☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.
- ☐ No artificial nutrition or hydration desired.

E *Required*

Signature of Patient or Legal Representative. *(eSigned documents are valid.)*

X Printed Name ***(required)*** | Date _____

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

X

Relationship of Signee to Patient:		
☐ Patient ☐ Parent of minor	☐ Agent under Power of Attorney for Health Care	☐ Health care surrogate decision maker (See Page 2 for priority list)

F *Required*

Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

X Printed Authorized Practitioner Name ***(required)***	Phone _____
Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.* **X**	Date ***(required)*** _____

****THIS PAGE IS OPTIONAL – use for informational purposes****		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT