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POLST Is More Than a Code Status Order Form: Suggestions for Appropriate POLST Use in Long-Term Care

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A B S T R A C T

POLST (Physician Orders for Life-Sustaining Treatment) is a medical order form used to document preferences about cardiopulmonary resuscitation (CPR), medical interventions such as hospitalization, care in the intensive care unit, and/or ventilation, as well as artificial nutrition. Programs based on the POLST paradigm are used in virtually every state under names that include POST (Physician Orders for Scope of Treatment), MOLST (Medical Orders for Life-Sustaining Treatment), and MOST (Medical Orders for Scope of Treatment), and these forms are used in the care of hundreds of thousands of geriatric patients every year. Although POLST is intended for persons who are at risk of a life-threatening clinical event due to a serious life-limiting medical condition, some nursing homes and residential care settings use POLST to document CPR preferences for all residents, resulting in potentially inappropriate use with patients who are ineligible because they are too healthy. This article focuses on reasons that POLST is used as a default code status order form, the risks associated with this practice, and recommendations for nursing homes to implement appropriate use of POLST.

Physician Orders for Life-Sustaining Treatment (POLST) is used to document patient preferences as actionable medical orders to guide treatment decisions across settings. It is designed to be completed following a conversation between the patient and/or the patient's legal representative and a health care provider that ideally includes an exploration of goals, values, and treatment preferences. These preferences are documented as orders about cardiopulmonary resuscitation (CPR), medical interventions such as hospitalization, care in the intensive care unit, and/or ventilation, as well as artificial nutrition. A sample POLST form is contained in Figure 1.

National POLST is a nonprofit organization that provides support to state programs and oversees programs as well as form quality standards (www.POLST.org). As of April 2021, almost every state had a program based on the POLST model, although programs are run at the state level. As a result of this state-level oversight, naming conventions and programs vary. The POLST program is known by other acronyms, including POST (Physician Orders for Scope of Treatment), MOST (Medical Orders for Scope of Treatment), and MOLST (Medical Orders for Life-Sustaining Treatment)[1] (for simplicity, the acronym POLST will be used in this article). Minor state-level variations are permissible as long as they are consistent with program and form standards (eg, some POLST forms contain orders about antibiotics, whereas others incorporate this information into medical intervention orders).

POLST is intended for patients who are considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.[2] This focus helps make it possible to provide patients with tailored information about their diagnosis, prognosis, and treatment options, as well as the

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HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

National POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their 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 (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/_____ State where form was completed:_____

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired

☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Not discussed or no decision made (provide standard of care)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: | **Authority:**

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

✖ (required) | **Date** (mm/dd/yyyy): Required / / | **Phone # :** ( )

Printed Full Name: | **License/Cert. #:**

Supervising physician signature: ☐ N/A | **License #:**

Fig. 1. National POLST form.

National POLST Form – Page 2 *******ATTACH TO PAGE 1********

Patient Full Name:

Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

Full Name:	☐ Legal Representative ☐ Other emergency contact	Phone #: Day: ( ) Night: ( )
Primary Care Provider Name:		Phone: ( )
☐ Patient is enrolled in hospice	Name of Agency: Agency Phone: ( )	

Form Completion Information (Optional but helpful)

Reviewed patient's advance directive to confirm no conflict with POLST orders: (A POLST form does not replace an advance directive or living will)	☐ Yes; date of the document reviewed:_____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: _____

Professional Assisting Health Care Provider w/ Form Completion (if applicable): Full Name:	Date (mm/dd/yyyy): / /	Phone #: ( )

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

State Specific Info	For Barcodes / ID Sticker

Fig. 1. (*continued*).

likely outcomes of available interventions so POLST orders are both values-based and informed. It also helps ensure that decisions are made within the context of serious illness when the burdens and benefits of available treatments are more likely to be known.[3] POLST use is meant to be voluntary and patients should never be required to have a POLST.

POLST Use in Nursing Homes: Common Problems

POLST is used in nursing homes and residential long-term care settings across the country, likely in part reflecting the high proportion of POLST-appropriate patients within that care setting.[4] Research suggests POLST is used to guide the care of *hundreds of thousands* of geriatric patients throughout the United States. A California study found that almost half of all nursing home residents (n = 142,672) had a POLST form in 2011.[5] In Oregon alone, where POLST was originally developed, 46,345 POLST forms were submitted to a statewide electronic registry in 2020.[6]

However, several studies have documented problems with how POLST is used in nursing homes. In a recent study examining how well existing POLST orders reflect current preferences, only 44% of POLST forms were concordant with current treatment preferences, although concordance was higher for surrogates and when orders reflected preferences for comfort-focused treatment.[7] Interviews with residents and surrogates indicate that forms were often provided without adequate information and that POLST forms were not revisited when the resident experienced a change in condition.[8] These findings highlight program and policy issues with POLST use in nursing homes and are consistent with a series of studies that have identified issues with nursing home use, including staff difficulty understanding and explaining the form, discomfort with issues raised by the form, and problems using the form to guide treatment.[4,9]

One specific problematic practice that contributes to these difficulties is use of POLST as a universal code status order form to document CPR orders. In a recent National POLST survey of state POLST programs, almost half of program representatives who responded to the survey (15 of 33 or 45.4%) reported that POLST is at least sometimes used as a code status order form in their state and 9 (60%) of 15 who reported this occurs describe the practice as “very widespread” or “common” in their state (Vandenbroucke A. National POLST Paradigm [Personal Communication, March 2021]). POLST use as a code status form was also the topic of a recent point/count-point presentation at the 2021 annual meeting of AMDA — The Society for Post-Acute and Long-Term Care Medicine.[10]

POLST Is More Than a Code Status Order Form

Although POLST includes code status orders, it also includes orders addressing selected medical interventions that should be provided or withheld, irrespective of preferences related to CPR. The code status order directs response of nursing home staff and emergency medical responders when a nursing home resident’s heart and breathing stop. In the absence of additional information, code status is sometimes erroneously assumed to represent preferences for other kinds of treatments.[11] However, code status alone is not predictive of preferences for other kinds of interventions.[12–14] Importantly, POLST addresses this limitation of code status orders by including a broader range treatments that are highly relevant to long-term care residents with advanced serious illness or associated with end of life, such as preferences for hospitalization.[15]

Why POLST Is Erroneously Used as a Code Status Order Form

Nursing homes must ensure that residents are given the opportunity to participate in advance care planning and document their treatment preferences.[16,17] Although POLST includes medical orders for a range of interventions, some nursing homes are using POLST as the default mechanism for documenting code status orders on all residents. There are several rationalizations for this suboptimal practice. First, nursing homes commonly admit residents directly from the hospital and there is often a sense of urgency to document code status in the event that the resident experiences a medical crisis. Second, in contrast to code status orders documented solely in facility medical records, POLST is valid outside the nursing home setting and increases the likelihood that preferences will be known and honored by emergency medical responders in the event of a hospital transfer. Third, using a single tool to document code status simplifies training procedures and related policies for facilities, including storing and accessing orders in an emergency. Facilities may use POLST to avoid having multiple forms documenting code status in the chart, as a single form decreases the potential for conflicting orders and confusion during a medical crisis. Fourth, nursing homes are sometimes advised or directed to use POLST for code status by their corporate compliance nurses or surveyors who believe this is a more desirable practice or mistakenly believe that it is required.[18] Inadequate education about the broader role of POLST likely contributes to a poor understanding about the appropriate and intended population and goal of POLST.[19–21]

Problems Created by Using POLST as a Code Status Order

There are many reasons why using POLST as a code status order is a suboptimal, potentially harmful practice. When POLST is used primarily to document code status, there is increased likelihood that it will be inappropriately offered to residents who are not otherwise POLST appropriate. The potentially inappropriate group includes a growing population of younger residents with chronic mental illness and/or physical disability, and residents who are admitted for short-stay, post-acute rehabilitation following a hospitalization or procedure such as joint replacement.[18,21,22] Although some of these residents may be POLST appropriate, many are not, and they should not be offered POLST because they fall outside the intended population. It is problematic for otherwise healthy older adults to have a POLST form, as they may not have experience with the context of decision-making about specific interventions. Moreover, many of these patients expect to return to baseline, making it challenging to make informed decisions about the benefits and burdens of treatment options or even what treatment decisions may be relevant to their yet unknown health condition.[3]

For such relatively healthy patients, and even for many frail, chronically and seriously ill, POLST-appropriate patients who do not have specific preferences about initial treatment in the event of a sudden cardiac or respiratory arrest, there is no need to invoke POLST orders at all. In the absence of explicit orders for Do Not Resuscitate/Do Not Attempt Resuscitation (DNR/DNAR), the default treatment is always for full-code status, including CPR and intubation. A POLST form is therefore unnecessary for patients whose preference is to receive the most aggressive potentially life-sustaining treatment. Beyond being merely unnecessary, a full-code POLST in these situations can be harmful, because the implication of the full-code orders is that the patient wants the most aggressive and invasive treatments available, and to have their life prolonged until the last possible instant available through medical technology, no matter how dire the prognosis.

National POLST standards include the expectation that once executed, POLST forms do not expire unless the form is voided and a discontinuation of the orders is issued. Thus, a POLST form created as part of a short-stay rehabilitation encounter could resurface months or years later at a time when orders previously issued no longer reflect current preferences. This could result in goal-discordant care,

especially if the person no longer has decisional capacity.[7,23] At its worst, it will create a potential or actual conflict for health care providers and surrogates who may feel bound by what is documented. This problem is amplified in states with registries, where there is a greater risk these forms will be retrieved to guide treatments years after the form was signed with no reevaluation of goals, values, and preferences based on changes in the medical condition. Some have proposed adding an expiration date on all POLST forms, and some states' forms include an expiration date, but this creates the risk that residents who lose capacity may receive goal-discordant care if the form expires and can no longer be honored.[15] A patient may not remember to have a POLST renewed at the time of expiration, and it may be burdensome for some to navigate a visit with a health care providers just for this purpose, particularly for patients near the end of life.

A related problem associated with using POLST as a code status form is that it increases the likelihood that POLST will be presented as nonvoluntary because facilities must determine and document code status for all residents. A fundamental tenet of POLST is that it is always voluntary. This potential misuse of POLST creates confusion about its use in general and may lead to doubts about when and whether it should be honored in an emergency. This unnecessary mistrust of the form's value and efficacy may jeopardize the good that comes from honoring patient preferences, especially among vulnerable nursing home residents.

Finally, use of POLST as a code status order form may contribute to poor-quality discussions around POLST orders. Code status decisions are typically made close to the time of admission, when residents may be in their most weakened states or in early stages of recovery, or when advance care planning discussions may be difficult.[18,24] Completing POLST in these circumstances without the benefit of thorough advance care planning discussions about goals, values, and the burdens and benefits of treatment options jeopardizes a person-centered approach and may result in decisions being made prematurely, without adequate information, or perhaps without involvement of appropriate or desired decision-makers. The process should be designed to optimize resident/surrogate participation as much as possible. Further, if no orders are present in the other sections of POLST, it may be unclear whether there was a discussion and refusal to make other decisions or if the resident simply was not asked about anything other than code status. Marking all sections for full intervention without an explicit conversation to avoid leaving sections blank implies decisions were made when the intention may have been to simply reflect the default standard of care.

Implications for Practice, Policy, and Research

We have outlined several reasons that use of POLST as a code status order form is problematic. To prevent these problems, we recommend the following considerations for practice, policy, and research (see Table 1):

(1) Assess and identify which nursing home residents are eligible and appropriate for POLST: A process should be developed to identify which patients are POLST eligible, and it should only be offered to individuals who are considered to be at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty.
(2) Use alternate approaches to document and communicate code status: When POLST discussions cannot take place at the time of or immediately following admission, use a separate code status order and/or form to document preferences for CPR in the medical record rather than inappropriately substituting POLST as a code status order form.[25] Strategies to communicate code status could include: (a) placing a colored dot on the outside of the chart and/or room door with green symbolizing full code and red symbolizing DNR; (b) placing a sticker on the inside of the front cover of the chart that includes text in lieu of colors; (c) displaying code status *and* POLST orders on the electronic health record landing page; and/or (d) developing a facility-specific order sheet that is filled out when the POLST is completed.
(3) Review and revise specific policies for code status orders and appropriate use of POLST: If facilities have a policy to offer a POLST to all appropriate residents, it is important to ensure that the policy does not mandate completion and that there is clear guidance to assist health care providers in identifying appropriate residents. Just as residents have the right to refuse treatments, residents have the right to decline to have a POLST form completed. It is inappropriate to direct a resident to make decisions that they may not be ready to make or participate in advance care planning by suggesting it is required for nursing home admission. It is important to ensure that residents and their decision-makers know that if they choose not to discuss advance care planning, their treatment will default to full-code, full-treatment orders.[25]
(4) Conduct ongoing staff training about POLST: Develop and train staff in practices to increase awareness of POLST orders on file. Ideas include (a) routinely reviewing, confirming accuracy of, and emphasizing code status and POLST preferences during each interdisciplinary team meeting to increase awareness, as already required in the quarterly interdisciplinary team/care plan conference process;[26] and (b) referencing code status and POLST orders on daily rounding reports or other mechanisms for communicating important resident information with shift changes/clinical handoffs. Recognizing staff turnover and the interprofessional nature of POLST conversations, training

Table 1
Recommendations to Increase Appropriate POLST Use in Long-Term Care Settings

Problem	Recommendation	Rationale
Facility culture of urgency to document code status	• Develop and implement a process that incorporates both a strategy to document code status at admission and POLST on follow-up • Identify who is eligible and appropriate for POLST • Conduct ongoing staff training about POLST	Avoids use of POLST as a default code status order form by eliminating need at time of admission
Use of a single tool (ie, POLST form) to document code status	• Use distinct forms to document code status • Develop alternative strategies to communicate code status	A separate code status order form limits inappropriate or incomplete use of POLST
Nursing home companies or surveyors direct facilities to use POLST for code status	• Review and revise specific policies for code status orders and appropriate use of POLST • Leverage surveyors to promote appropriate POLST use	Need to ensure that POLST is not mandatory

should be offered on an ongoing basis and include all appropriate disciplines.

(5) Leverage state survey agencies and surveyors to promote appropriate POLST use: Nursing home state and federal surveyors should receive education about appropriate POLST use. Surveys should include an assessment that looks beyond whether all of the sections on the forms are completed, and includes the quality of the advance care planning conversation that health care providers shared with residents and/or family members, and accompanied the completion of the form when POLSTs are completed.

In conclusion, some of the growth in POLST use over the past 30 years includes the inappropriate use of POLST as a code status order form in nursing homes. Although there are multiple reasons for this practice and resulting risks, there are also opportunities for continuous practice improvement and education in nursing homes to implement appropriate use of POLST. Future research should focus on developing and evaluating effective implementation strategies of policies and practices to ensure safe and consistent use of POLST among appropriate nursing home residents, and use of alternative methods to designate code status and other treatment preferences among non–POLST-appropriate residents to avoid use of POLST as a default code status order form.

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