How to Complete a POST Form
Physician Orders for Scope of Treatment

Guidance for Healthcare Providers

Developed by:

Tennessee End of Life Partnership Coalition

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Some of the included material was adapted from the Oregon Physician Orders for Life-Sustaining Treatment (POLST) and the La Crosse Medical Centers Advance Directive Task Force. The material is used and adapted with permission. Thanks and credit is given to the POLST Task Force for their work as well as the Oregon Center for Ethics in Health Care.
Introduction

Capable adults have a right to make their own healthcare decisions. In Tennessee Advance Directive documents like an Advance Care Plan (living will) or a Health Care Agent form (Power of Attorney for Healthcare) help adults communicate their healthcare treatment preferences when they would otherwise been unable to make such decisions. Unfortunately, the wishes expressed in the Advance Care Plan and Appointment of Health Care Agent documents are not always available because they do not clearly apply to a given situation, and cannot be utilized by non-physicians, e.g., by paramedics and first responders. Due to these reasons, those providing care in various settings may in good faith initiate or withhold treatment that may be medically inappropriate or contrary to the desires of a patient.

This document explains a method for patients to communicate decisions about cardiopulmonary resuscitation (CPR) and other treatments to prolong life. This method helps assure that preferences are available, clear, and utilized by all healthcare providers.

1. The POST has distinct advantages and disadvantages when discussing options with each patient.

**POST Document:**

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available to all patients/residents</td>
<td>Might not be available to emergency personnel in some circumstances</td>
</tr>
<tr>
<td>No personal discomfort</td>
<td></td>
</tr>
<tr>
<td>Deals with a range of treatments</td>
<td></td>
</tr>
<tr>
<td>Easy to maintain</td>
<td></td>
</tr>
<tr>
<td>No loss of privacy</td>
<td></td>
</tr>
<tr>
<td>Legal protection for emergency personnel</td>
<td></td>
</tr>
</tbody>
</table>

POST complements an Advance Care Plan (Living Will) and should be used to operationalize the directives of the Advance Care Plan (Living Will). It is recommended that patients with a life limiting illness have three (3) documents:

- POST (Physician Orders for Scope of Treatment)
- Appointment of Health Care Agent (Power of Attorney for health care)
- Advance Care Plan (Living Will)

The POST and information about it can be obtained from the Tennessee Department of Health’s website [www.tennessee.gov/health](http://www.tennessee.gov/health) or Tennessee End of Life Partnership’s website [www.endoflifetn.org](http://www.endoflifetn.org). Copies of this guide and the POST document.

Instructions on how to complete the POST document are contained in the following pages of this guide.
Implementing the Physician Orders for Scope of Treatment Document (POST)

Overview

The Physician Orders for Scope of Treatment (POST) document should be completed by the attending physician after discussion with the patient/resident or health care agent or surrogate decision maker regarding patient preferences. The document may be completed by other healthcare professionals under the direction of the attending physician. To be effective, the attending physician must sign the form and assume full responsibility for the accuracy of the recorded information.

The POST has five sections (A through E). The front side of the document is the “Physician Orders for Scope of Treatment” (Sections A-E). The other side of the form provides directions on how to complete, review, and use or change the physician orders.

The POST may be printed on any color of paper according to policy of the facility. The POST form may be downloaded from the TN Department of Health’s website www.tennessee.gov/health or at www.endolifecaretn.org.

<table>
<thead>
<tr>
<th>Physician Orders for Scope of Treatment (POST)</th>
<th>Patient’s Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right (“patient”). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.</td>
<td>First Name/Middle Initial</td>
</tr>
<tr>
<td>Date of Birth</td>
<td></td>
</tr>
</tbody>
</table>

Title and Patient/Resident Identification

The POST provides documentation of patient/resident preferences and provides life-treatment orders which reflect those values. In healthcare facilities, the POST should be the first document in the clinical record. In non-institutional settings, the form should be located in a prominent location. Care givers need to know where POST will be kept and be able to present it to emergency personnel upon arrival. The POST form should accompany the patient/resident upon transfer from one setting to another.
Section by Section Review of the POST Form

Physician Orders for Scope of Treatment (POST)

This section lists three different medical treatments or services including: Section A–Cardiopulmonary Resuscitation, Section B–Medical Interventions, Section C–Antibiotics, and Section D–Medically Administered fluids & Nutrition. Section E records the basis for the physician orders and with whom discussed. If the patient/resident requires treatment, the caregiver should first institute any emergency treatment orders recorded on the POST, and then contact the attending physician or nurse practitioner. Any order section that is not completed indicates that full treatment should be provided.

### Section A–Resuscitation

The Resuscitation section refers only to the circumstance in which the patient/resident is not breathing and/or has no pulse. This section does not apply to any other medical circumstances. For example, this section does not apply to a patient/resident in respiratory distress because he/she is still breathing. Similarly this section does not apply to a patient/resident who has an irregular pulse and low blood pressure because he/she has a pulse. For these situations, the caregiver should refer to Section B–Medical Interventions described below and follow the appropriate orders.

If the patient/resident wants cardiopulmonary resuscitation (CPR) and CPR is ordered, then the “Resuscitate” box is checked and full resuscitative measures should be carried out and 911 should be called.

If a patient/resident has indicated that he/she does not want CPR in the event of no breathing and/or no pulse, then the “Do Not Resuscitate (DNR)” box is checked. The patient/resident should understand that comfort measures will always be provided and no resuscitative efforts would be given.

<table>
<thead>
<tr>
<th>Section A Check One Box Only</th>
<th>CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and/or is not breathing.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Resuscitate (CPR)</td>
</tr>
</tbody>
</table>

When not in cardiopulmonary arrest, follow orders in B, C, and D.
Section B– Medical Interventions. Patient has pulse and/or is breathing.

This section refers to circumstances that are not covered in Section A and was developed in accordance with medical standard protocol. If full treatment is indicated and desired, the “Full Treatment” box is checked and 911 is called. However, if the patient/resident and physician determine that some limitation is preferred, then only one of the other boxes is checked. Caregivers will first provide the level of services ordered and then contact the attending physician or nurse practitioner. Comfort care is always provided regardless of indicated level of medical intervention treatment.

Comfort Measures Only indicates a desire for only those interventions that enhance comfort. In general, the patient/resident and physician/nurse practitioner would not want an EMS response unless necessary for patient comfort. The patient/resident would not expect to be transported to a hospital unless indicated later by the attending physician/nurse practitioner because acute care skills are needed to enhance comfort (e.g. to treat intractable pain). Oxygen, suction, and manual treatment of airway obstruction may be used as needed for comfort.

Limited Interventions includes comfort measures above and may include cardiac monitor and oral/IV medications. Transfer to a hospital if indicated, but no endotracheal intubation, advanced airway interventions, or mechanical ventilation or long-term life support measures. Usually no intensive care.

Full Treatment indicates all measures above plus endotracheal intubation, advance airway, and cardiovascular/automatic defibrillation. Transfer to hospital if indicated and includes intensive care.
Section C–Antibiotics

This section records the desired use of antibiotics. If there is no limitation, the attending physician/nurse practitioner checks the “Full Treatment” box. If limitation of antibiotics is desired, “No Antibiotics” box should be checked. There is also space for further instruction on the use of antibiotics. For example, a patient may want antibiotic treatment for a urinary tract infection but not pneumonia or no antibiotics except if needed for comfort. These types of specific limitations should be written on the “Other instructions” line.

Section D– Medically Administered Fluids & Nutrition

This section allows the physician or nurse practitioner to record patient/resident instructions regarding artificially administered fluids and nutrition for patients who cannot take fluids by mouth. If the patient/resident wants a long-term feeding tube of IV fluids, the “Long-term feeding tube/IV fluids” box is checked. If there are limitations ordered for artificially administered fluids and nutrition, either the “No feeding tube/IV fluids” box or the “Defined trial period of feeding tube/IV fluids” box is checked. Other instructions may also be specified.

Each column in the sections needs to be addressed and marked. Any column left blank will result in long term treatment.
<table>
<thead>
<tr>
<th>Section E</th>
<th>Discussed with:</th>
<th>The Basis for These Orders Is: (Must be completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Patient/Resident</td>
<td>□ Patient’s preferences</td>
</tr>
<tr>
<td></td>
<td>□ Health care agent</td>
<td>□ Patient’s best interest (patient lacks capacity or preferences unknown)</td>
</tr>
<tr>
<td></td>
<td>□ Court-appointed guardian</td>
<td>□ Medical indications</td>
</tr>
<tr>
<td></td>
<td>□ Health care surrogate</td>
<td>□ (Other) ________________________________</td>
</tr>
<tr>
<td></td>
<td>□ Parent of minor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Other: _______________ (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

**Section E–Basis for Orders / Discussed with**

Upon completion of the physician orders, the attending physician / health professional checks the box indicating with whom the orders were discussed with (i.e., patient/resident, healthcare agent, court-appointed guardian, or other). The attending physician then summarizes the basis for the orders in accordance with the medical indications and patient/resident treatment preferences. For example, the physician might write, “After thorough discussion with the patient and family, and in keeping with the current advance directive, the patient has indicated no desire for aggressive treatment. The above orders reflect this discussion.” At the bottom of the page, the physician **must** sign the form. The physician then prints his/her name and the time and date the orders were written. **If the physician does not sign the form it cannot be treated as a valid order and EMS personnel cannot limit EMS services.**

The bottom of the form includes a reminder that the form should accompany the patient/resident when transferred or discharged. It is very important that the form follow the patient. It allows the receiving facility to have the same information regarding the medical indication and patient/resident preferences for life-sustaining treatment and increases the likelihood that these orders will be respected in the new care setting.
Preferences have been expressed to a physician /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.

Name (print) | Signature | Relationship (write “self” if patient)
Surrogate | Relationship | Phone Number
Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Prepared

Signature of Patient, Parent of Minor, or Guardian / Health Care Representative / Surrogate

The POST form includes an educational comment for the patient/resident and/or surrogate/Health Care Agent. This section is intended to help patients/residents know whom the POST form is intended to serve and how the decisions were made. The patient/resident may sign this section indicating agreement with the orders, but the individual’s signature is optional but highly recommended. Some patients/residents may not be able to sign the form. If the form is prepared by someone other than the attending physician, the preparer is encouraged to record his/her signature, name, and time and date of preparation.

Contact information

This section has the contact information for the surrogate including name and relationship. The preparer of the form, if other than the physician, should document his/her name, title, phone number and date prepared.

Key Points include:

- POST is intended for people with advanced illness, chronic/terminal illness, and/or frailty.

- The POST treatment plan should show the patient’s wishes now in the patient’s current state of health and not future wishes for when their health may have deteriorated. These future wishes, if different than current wishes, are best documented on an Advance Care Plan form.

- The POST guides medical treatment and the plan of care, and can be changed if patient wishes. Goals change when more medical information is available.
• The Advance Directive is meant to document a patient’s future wishes and if the patient/resident is unable to make choices at any time, then the patient’s choices are made through the designated Health Care Agent/representative The Health Care Agent/ Power of Attorney for Health Care form designates who can speak for patient/resident when they cannot self-direct.

• Only the POST form is a medical order and it should always be kept up to date with the treatment plan that reflects the patient’s current choices.

How to Change the POST Document
The other side of the form tells you how to change the POST orders and when to review the order form.

Review of Physician Orders for Scope of Treatment (POST)
This section records the review of POST if patient/resident preferences or medical status change. The orders should also be reviewed by the attending physician or nurse practitioner (or designee) immediately after the patient/resident is transferred from one care setting to another. The outcome of the review should be recorded in the medical record.

Where Voided: The reviewer may also wish to record why the form was voided. With any change, the document should be voided by drawing a diagonal line and/or writing the word VOID across the front of the form with the date of voiding. After voiding the form, a new form should be completed reflecting the new medical indications and treatment wishes of the patient/resident. A voided form should be file in another part of the medical record.

Patient/Resident Preferences as a Guide for POST
The patient/resident has personal values that may be expressed orally, in writing (such as an advance directive) or by a surrogate, healthcare agent, or court-appointed guardian. We encourage you to attach copies of advance directives or guardianship documents to the POST form. The physician should carefully consider these individual preferences when completing and reviewing the scope of treatment orders. The POST should be reevaluated when the patient’s/resident’s preferences or medical status changes.

Revoking
A patient may orally revoke the POST at any time.

POST Use for Patients with Significant Physical Disabilities, Intellectual, Developmental Disabilities and/or Significant Mental Health Condition who are Now Near the End of Life

Special consideration is required when completing a POST form for a patient with significant physical disabilities, Intellectual, developmental disabilities, and/or a significant mental health condition. Patients in these groups have the right to both the highest quality of care for their chronic disability and for equally high quality care at the end of their life.
Unfortunately, many patients with disabilities experience inequities resulting in under-treatment and/or have their chronic health conditions mistaken for illnesses or conditions nearing the end of life. The challenge to the Health Care Professional is to discern when the patient is transitioning from a stable chronic disability to a terminal illness (see 1. Below). The POST form should not be used solely because a patient has a disability or mental illness.

**Evaluation of condition, capacity and identifying appropriate surrogate**

To ensure appropriate decisions are being made for the patient, the Health Care Professional must:

1) Determine if the patient has a condition that warrants POST form completion.
2) Determine if the patient has the capacity to contribute to his/her health care decisions, and
3) The patient has no decision-making capacity, then determine the appropriate surrogate. It should not be assumed that a patient lacks capacity solely because he or she has a cognitive or psychiatric disability.

**Assessment Process**

1. **Determine if the patient has a condition that warrants POST form completion.**

The physician or nurse practitioner can use several questions to determine if a POST form is warranted:

- Does the patient have a disease process (not just their stable disability) that is terminal;
- Is the patient experiencing a significant decline in health (such as frequent aspiration pneumonia);
- Is the patient in a palliative care or hospice program; and/or
- Has this patient’s level of functioning become more severely impaired as a result of a deteriorating health condition when intervention will not significantly impact the process of decline?

A POST form should be completed on the basis of a deteriorating irreversible health condition and not the stable disability.

* The “physician is not surprised if the person dies within the next year” indicator is not listed because many physicians overestimate the mortality of persons with significant disabilities, at times by decades.

2. **Determine if the patient has the capacity to make or contribute to his/her health care decisions.**

- A patient has decision-making capacity if he/she understands basic information, appreciates the consequences of a decision, evaluates the information rationally and can communicate a decision.
- People with disabilities have a wide range of abilities. Some can make simple health care decisions, some can make complex ones. Many have the capacity to appoint a health care representative.
- All patients should be given that opportunity to participate as much as their capacity will allow; individuals should either appoint a health care representative or provide input.
regarding who should be appointed and patients should be asked to provide input regarding their health care as much as possible.

- Even those who have little capacity frequently have expressed desires or wishes that should be respected in the decision-making process.

What if the patient never had capacity?
For those who have never had decision-making capacity, the process can be challenging. Frequently, family members, friends, and staff working with the patient can assist in determining the patient’s ability to understand and to communicate the information. If a patient’s capacity to make decisions remains unclear after discussing with family, close friends and direct care staff, Health Care Professionals should then seek consultation with a mental health professional.

3. Determine the appropriate surrogate.
Under Tennessee law, a health care representative can be:

- An adult appointed to make health care decisions for the individual under a health care agent or a power of attorney for health care
- A court appointed guardian or other person appointed by a court to make health care decisions for the individual, or;
- A person who has authority under the law to make health care decisions for the individual under end-of-life circumstances.

If the patient with a disability has decision-making capacity he/she may appoint a health care representative by completing the advance directive form. If a patient does not have decision-making capacity, then the Health Care Professional must rely on a surrogate.

Tennessee law defines the appointment surrogate:
If individual lacks capacity, has not appointed an agent, not designated a surrogate, and does not have a guardian, or whose agent, surrogate, or guardian is not reasonably available, a surrogate will be identified by the supervising health care provider.

Designated physician may make health care decisions for the patient after –
1. Consults with and obtains recommendations of an institution’s ethics mechanism
2. Obtains concurrence from second physician not directly involved in the patient’s health care nor having close ties to the designated physician

Reasons for Appointment:
- Knows patient’s wishes
- Demonstrates care and concern
- Knows patient’s best interest
- Visits patient regularly during illness
- Had regular contact with patient
- Engages in face-to-face contact with caregiver
- Available and willing to serve
- Participates in decision making process
Answers to Frequently Asked Questions

1. Can family members, present at the time a patient goes into cardiac arrest, override a POST signed by the patient and a physician that states DNR?

Family members cannot override a POST signed by a patient and physician that states “Do NOT Resuscitate.” The purpose of any type of advance directive, including the POST, is to allow an individual to express his own wishes for end-of-life care.

2. What if a person has a POST document but wants to travel from his or her residence?

a) The POST document is a state wide form and will be followed by emergency medical personnel.

b) The POLST document will need to be presented to emergency personnel if they are called. This means that this document will need to be taken with a person if they leave his or her residence. If the POST document is not presented, emergency medical personnel will start emergency care.

4. Will only patients who are DNR have a POST document?

No. Many long-term care facilities may chose to have a POST document on every resident. This approach would make sure that there would be no ambiguity about DNR status or the preference for their life-sustaining treatment. It would also make it routine to send a POST document with every patient when they are transported.

Comments or questions?
You may contact one of the members of the planning committee concerning the information in this document:

Jane Owen – Methodist Healthcare, Nurse Practitioner 608-791-9708

Eleanor Farber LCSW– Baptist Healthcare Advance Care Planner, Baptist Home Care & Hospice (901)767-6767

Judy Eads – Tennessee End of Life Partnership 615-289-4275

Criss Grant, Alexian Brothers PACE 423-495-9104 cgrant@alexianbrothers.net

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