

The POST Form

Physician Orders for Scope of Treatment

Guidance for Tennessee
Health Care Professionals

Developed by:

Tennessee End of Life Partnership
Tennessee POST Program

Revised July 2015

www.endoflifecaretn.org

Parts of this booklet were adapted from materials prepared by the Oregon Physician Orders for Life-Sustaining Treatment (POLST) Task Force, the La Crosse Medical Center Advance Directive Task Force, and the Programs of All-Inclusive Care for the Elderly (PACE) of the United States Department of Health and Human Services, and are used by permission. Thanks is given to each of these organizations for their prior work.

How To Use This Document

Part I of this document provides basic information about the Physician Orders for Scope of Treatment, commonly known as the POST form. It describes how POST works in patient care and how it should be used.

Part II of this document describes how to complete the form section by section, as well as specific considerations for certain sections. It also includes a section of frequently asked questions.

Part I

Introduction

Physician Orders for Scope of Treatment (POST), is an important form used in an approach to end of life planning that encourages conversation between patients, their loved ones, and their health care providers about CPR and other types of care the patient wants at the end of his or her life. When successful, these conversations can be converted to medical orders that are recorded in the POST form, which is designed to help health care professionals recognize and honor the patient's treatment wishes. The purpose of a POST form are to:

- Promote the patient's¹ autonomy by creating medical orders that reflect the patient's current treatment preferences
- Facilitate appropriate treatment by emergency medical services (EMS) personnel, emergency medicine and other health care professionals, as applicable
- Assist parents of minor children, guardians of seriously ill minors, and other persons to express what they believe to be in the patient's best interests when the patient's wishes are not known.

The POST is a medical order, and not an advance directive.² Nevertheless, it can and should be completed in advance. It provides a way for patients and their surrogates, through their health care providers, to communicate decisions about CPR and other treatments that may prolong life. The POST form helps assure that patient preferences are available, clear, and respected by all health care providers.

How POST Works

The current standard of care in the United States requires emergency and medical personnel, in the absence of a medical order limiting treatment, to make every attempt to save a person's life. This may entail advanced cardiac life support, including cardio-pulmonary resuscitation (CPR), endotracheal intubation, and cardiac defibrillation, based on standard protocols. A POST form can countermand some of these automatic treatments when a

¹ "Patient" is used throughout this booklet to indicate a child or adult inpatient or outpatient or a resident of a nursing or community based care facility.

² An advance directive is a patient's expression of his or her wishes, which then must be implemented by the health care provider in order to take effect. See advance directives heading below.

decision has been made that they offer no benefit. The POST alerts medical personnel about the patient's treatment preferences.

POST transforms a patient's treatment plan and goals of care into **medical orders** that apply when a patient cannot communicate his or her wishes and no surrogate is available to speak on the patient's behalf. Emergency medical responders and health care professionals must follow these orders unless there is new information from a patient or appropriate surrogate. Once completed, the POST is the order set for these treatments that can and should be recognized and followed anywhere in Tennessee. If any section of the form is not completed, standing orders will normally dictate full treatment unless and until countermanded by other orders.

Because each person has the right to make his or her own health care decisions, POST is **always voluntary**. It is intended to allow patients with serious illness or frailty to record their choices for medical treatment. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, the patient's treatment wishes may change, in which case POST can and should be changed to reflect new preferences and treatment choices.

To assure that patient preferences for limited treatment are given effect, the POST form must be readily available to medical personnel. The POST form should be clearly visible in a patient's home (for example on the refrigerator, in the medicine cabinet, or near the patient's bed), and should accompany the patient whenever transferred or discharged. They should be clearly visible in the patient's medical record as well. Orders on the POST form are the medical orders for the treatments described within them.

The POST form and information about it can be obtained from the Tennessee Department of Health's web site, <http://tn.gov/health/article/advance-directives> or the Tennessee End of Life Partnership's website, <http://endoflifecaretn.org>.

Relationship Between POST and Advance Directives

An "advance directive" is a written instruction given by the patient that either appoints another person to make health decisions for the patient or states the patient's health care preferences, or both. POST complements an advance directive and should be used to operationalize some of the choices made by the patient in an advance directive (see *Guidance on Advance Health Care Directives*). In Tennessee, a variety of advance directive documents are currently in use including:

- "Advance Directive for Health Care" (English and Spanish versions available at <http://endoflifecaretn.org/>)
- Commercially available forms such as "Five Wishes" (available at: <http://www.agingwithdignity.org/five-wishes.php>, cost \$5.00)

- Forms surviving from the 1990s, called “Living Will,” and “Durable Power of Attorney for Health Care.”
- Advance directives can also be custom crafted by attorneys to suit the patient’s needs.

Any of these forms can help healthy adults communicate their future treatment wishes.

POST and advance directives work together in advance care planning to ensure the patient’s wishes are followed. The POST form is **not** intended to replace an advance directive, but can be used for seriously ill patients, even if they do not have an advance directive. It is recommended that patients with a life-limiting illness have two (2) documents:

- Advance directive that includes appointment of a health care agent (also called a power of attorney for health care)³ and scenario-based treatment directives
- POST (Physician Orders for Scope of Treatment)

Who Should Have a POST?

POST is not for everyone, but is designed for seriously ill or frail patients who wish to limit treatment in some way. To determine whether a POST should be considered, clinicians should ask themselves:

- "Would I be surprised if this patient died or lost decision-making capacity in the next year"? If the answer is, "No I would not be surprised," then a goals-of-care discussion and advance care planning with POST is appropriate to consider.
- Each treatment on the form should be evaluated and discussed based on what, if any, benefit it has for the patient.

Use of the POST form to limit treatment is **not appropriate** for patients with stable medical or functional disabilities, who have many years of life expectancy. (See page 9: *POST Use for Patients with Significant Physical Disabilities, Intellectual or Developmental Disabilities and/or Significant Mental Health Condition at Near the End of Life*). If a patient has a strong preference regarding medical interventions, such as wanting limitations on the use of artificially administered nutrition, the patient should be encouraged to complete an advance directive. A POST is not to be used as the sole documentation of this wish.

³ The old “Living Will” form alone does not do this. A patient who has only a Living Will can use forms available at <http://endoflifecaretn.org> to appoint an agent and/or replace the Living Will, or may wish to consult an attorney for assistance.

Discussing POST with the Patient

A key component of the POST program is thoughtful advance care planning conversations between health care professionals and patients and those close to them. In these conversations, patients are informed of their treatment options so they can determine what they do and do not want based on their personal beliefs and current state of health. If they wish, their health care professional completes a POST form based on the patient's expressed treatment preferences. When filling out a POST form always specify who the "other" is and their relationship to the patient (Section D of the form). Participants in the discussion might include:

- Patient (even if the patient lacks capacity or is a minor);
- Parent of minor;
- Court-appointed guardian;
- The health care agent/representative as appointed in an advanced directive;
- Legally recognized surrogate when the patient lacks capacity. It is imperative when working with a surrogate to make sure that you are working with the appropriate legal surrogate. Refer to your health care facility's policy and/or Provider Identification of Surrogate form. (See Guidance for Health Care Surrogate Selection)
- Surrogate for patient with developmental disabilities or significant mental health condition (Note: Special requirements for completion. See page 9: *POST Use for Patients with Significant Physical Disabilities, Intellectual or Developmental Disabilities and/or Significant Mental Health Condition at Near the End of Life*).

Form Completion and Signature

The POST form may be prepared by any health care professional. To be valid, the form must be signed by a physician, or at discharge from a hospital or long term care facility by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by the physician in accordance with facility/community policy. The preparer should fill out the health care professional information on the front of the form. The professional who signs the POST form is assuming **full responsibility** for the medical orders and attests that these orders are an accurate reflection of the patient's current treatment preferences.

Patient or Surrogate Signature

Tennessee is one of a few states that does not require the patient or surrogate to sign the POST form. However providers are strongly encouraged to have the patient or surrogate, as appropriate, sign it, due to increasing concerns about Tennessee POST forms not being honored in states requiring patient signatures.

Storage/Location of Completed POST Forms

In institutional settings, POST forms should be easily accessible in the clinical record, usually the first document. In EMR systems, linkage to the patient header and one-click access is recommended. In non-institutional settings, it is recommended that the POST be

attached on the **front** of the kitchen refrigerator, in the patient's medicine cabinet, or near the patient's bed. Care givers need to know where the POST will be kept and need to 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.

Transferring a Patient with a POST

For patients in institutional settings, the original POST should accompany the patient upon transfer from one setting to another. A copy of the POST form should be kept in the individual's medical record. HIPAA permits disclosure of POST orders to other health care professionals across treatment settings. Copies of the POST form may be honored by EMS and other health care professionals.

Honoring a POST Form

Sometimes a patient is evaluated in a setting with a POST created elsewhere (e.g., where the patient comes to the hospital emergency department from home). In such cases, the patient will often have a POST form signed by an appropriate provider who is not on staff of the facility. Tennessee law allows physicians and other health care providers to honor POST orders that have been executed by a health care professional (physician, nurse practitioner, clinical nurse specialist, or physician assistant) who does not have admitting privileges at the hospital or health care facility where the patient is being treated. Health care facilities are also required to honor specific orders contained in the POST. The POST form itself can serve as the order set, or new orders consistent with those on the POST form can be written, per facility policy.

Specifically for first responders, the Board for Licensing Health Care Facilities has defined the Emergency Medical Technicians (EMT) and Para-Medic Scope of Practice so that Tennessee-certified First Responder or EMT are required to comply with POST forms appropriately executed if signed on discharge from a hospital or long term care facility (by a physician, nurse practitioner, clinical nurse specialist, or physician assistant).

Dealing with Disputes Regarding a POST

Sometimes disputes arise regarding an existing POST for a patient who no longer has decision-making capacity. These disputes may center on who has decision-making authority and/or what the decision(s) should be. Typically a family member is requesting treatment changes that are inconsistent with the existing POST.

For emergency responders, resolution should begin by clarifying the family's understanding of the treatment decisions recorded on the POST form, obtaining medical advice, if possible, and then if conflict still exists transporting to a hospital to allow for more time to thoughtfully address the conflict. For organizations and hospitals, if a family dispute arises concerning the validity of a POST, you should follow your organization's policies

regarding surrogate decision-making and/or conflict resolution. Some organizations offer ethics consultation. Organizational policy may also require that disputed treatments be continued (or not stopped or started) until the family dispute is resolved. Some disputes may require legal advice.

Revising a POST Form

The health care professional taking responsibility for the patient's care should review and update the POST orders as needed based on the patient's medical condition and treatment preferences.

The POST form should be reviewed periodically and on the occurrence of any one or more of the following events:

- The patient is transferred from one care setting or care level to another
- There is a substantial change in the patient's health status
- The patient's goals of care and/or treatment preferences change

The orders contained in a current and valid POST must be followed by EMS and other care givers unless and until reviewed and changed by authorized persons.

While POST orders remain valid even when the physician signing the form no longer practices in Tennessee (e.g., the physician relocates, retires, license suspended or revoked, or dies), new orders should be obtained.

Revoking or Voiding a POST

A patient with capacity, or the health care agent/representative of a patient without capacity, can revoke the POST form (verbally or in writing) and request alternative treatment. The current form should be made void by marking a line through sections A through D and writing "VOID" in large letters. This should also be followed if the POST is replaced or becomes invalid.

Documentation

The attending physician or other health professional should summarize the basis for the orders in accordance with the medical indications and patient/resident treatment preferences in the medical record. 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. A POST was completed and orders given to reflect this discussion."

Special Considerations

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 for a patient in these groups. Like all people, these patients have the right to the highest quality of care for their chronic disability and for equally high quality care at the end of their lives. Unfortunately, many patients with disabilities experience inequities resulting in under treatment and/or have their chronic health conditions mistaken for illnesses or conditions near 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. POST should not be used solely because a patient has a disability or mental illness.

Evaluation of Condition and Capacity, and Identifying the 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 decision-making capacity; and
- (3) If the patient lacks decision-making capacity, then determine the appropriate surrogate.

It should not be assumed that a patient lacks capacity solely because he/she has a cognitive or psychiatric disability.

Assessment Process

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

Several questions may be helpful to determine whether or not a POST form is warranted⁴:

- Does the patient have a disease process (not just 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?
- Has this patient's level of functioning become more severely impaired as a result of a deteriorating health condition, where 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 stable disability.

⁴ The "physician will not be 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 often also 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. Patients should either appoint a health care representative or provide input regarding who should be appointed, and should be asked to provide input regarding their health care whenever possible.
- Even those who have little capacity frequently have expressed desires or wishes that should be respected in the decision-making process.

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 seek consultation with a mental health professional.

POST can also be used to clarify treatment orders for children with serious illnesses. For children, custodial parents and guardians have the authority and responsibility to consent or refuse consent to health care for minors who are unable to consent for themselves.

Part II

Section by Section Review of the POST Form

Overview

The POST form provides documentation of patient/resident preferences and treatment orders which reflect their values related to life-sustaining treatment. In health care facilities, the POST form 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.

The front side of the form is the “Physician Orders for Scope of Treatment” (Sections A-D). The other side provides directions on how to complete, review, use, or change the orders. Any order section that is not completed indicates that full treatment should be provided for that section until clarification is obtained.

The POST form should be completed by the attending physician after discussion with the patient/resident, health care agent, or surrogate decision maker regarding patient preferences. The document may also be completed by other health care professionals at the direction of the attending physician. To be valid, the POST form must be signed by a physician, or at discharge from a hospital or long term care facility it can be signed by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by a physician in accordance with facility/community policy.

The POST form may be printed on any color of paper according to policy of the facility. It can be downloaded from the Tennessee Department of Health’s website, or from the Tennessee End of Life Partnership at <http://endoflifecaretn.org/>.

Physician Orders

Side one of the POST form lists three different medical treatment sections:

- A - Cardiopulmonary Resuscitation
- B - Medical Interventions
- C - Artificially Administered Nutrition

Title and Patient/Resident Identification

Tennessee Physician Orders for Scope of Treatment (POST, sometimes called POLST) 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, <u>first</u> follow these orders, <u>then</u> contact physician.	Patient’s Last Name
	First Name/Middle Initial
	Date of Birth

provides orders for situations that are not covered in section A.

- **Choose Comfort Measures Only** – when the patient's goals are to maximize comfort and avoid hospitalizations unless necessary to ensure his/her comfort needs are met. The treatment plan is to maximize comfort through symptom management. If appropriate, consider a palliative care or hospice referral, e.g., a patient with widely metastatic cancer wishes no further intervention and to die in his/her home .
- **Choose Limited Treatment** – when the patient's preferences reflect a desire to be hospitalized if needed, but avoid mechanical ventilation and generally avoid ICU care. Some patients may want hospitalization and treatments for reversible conditions or exacerbations of their underlying illness with the goal of restoring them to their current state of health, e.g., hospitalization for dehydration or pneumonia.
- **Choose Full Treatment** – if all life-sustaining treatments are desired including use of intubation, advanced airway intervention, mechanical ventilation, cardioversion, transfer to hospital, and use of intensive care, as indicated, with no limitation of treatment.
- Additional clarifying orders can be written in “Other Instructions” in applicable sections. For example in section B and additional instruction might be: "ICU treatment for sepsis but no intubation/mechanical ventilation for respiratory failure."
- Health care professionals should first administer the level of medical interventions ordered by the POST and then contact the physician.

Additional Considerations with Sections A and B

Section A is designed to guide response when a person with a POST is in cardiopulmonary arrest. Section B is designed to guide care in an acute situation when the person is not in cardiopulmonary arrest. Although these sections are designed to apply in different situations, there are some combinations of section A and B orders that are not clinically feasible and others that may cause confusion.

It is possible, for example, for a POST to have orders for DNR in Section A, and Full Treatment in Section B. Some patients with advanced illness might want all measures, including intensive care treatment and temporary life support such as mechanical ventilation, but would not want to be resuscitated if these attempts fail and their heart stops.

However, it is not medically feasible to Attempt Resuscitation in Section A and Comfort Measures Only in Section B. Patients with an order to attempt resuscitation should not also have an order for Comfort Measures Only. It is likely that patients requesting this combination

of orders do not understand that the intention of Comfort Measures Only (and DNR) is to allow natural death. Further discussion is warranted to determine their goals of care. If this is the patient's wish, then POST is not recommended for them.

POST forms with Section A designating CPR, and Section B Limited Treatment, can also be medically problematic. Few persons with advanced illness or frailty can successfully be resuscitated. Rates vary by diagnosis and location but are likely less than 3% for POST-appropriate patients who arrest outside of a hospital. Patients or their surrogates should be aware that for those who survive, intubation and ventilation are standard parts of resuscitation. The few who have a return of circulation will likely be intubated and transported to the hospital. From the emergency department they will be admitted to an intensive care unit, unless the patient's surrogate provides new information about the goals of care (revoking the current POST).

If the patient wishes to avoid mechanical ventilation in Part B but at the same time wants CPR (when he/she has no pulse and is not breathing), the health care professional signing the POST form should clarify the patient's understanding of CPR to ensure he/she is aware that CPR often includes intubation and often people are on a ventilator following CPR.

As noted earlier, the POST form should reflect the patient's preferences for care based on his or her **current** condition. To illustrate, two separate patients with advanced COPD may have similar responses to a discussion about their wishes regarding resuscitation: "I want you to try everything, but I don't want to end up a vegetable or be kept alive on a machine." This statement necessitates further exploration of the patient's wishes. For example:

- **Patient #1:** After further discussion regarding prognosis, what CPR entails, and the likelihood of CPR restoring the patient to a quality of life acceptable to her, Patient #1 might decide that she wants all measures which might maintain and extend life, as well as all measures to potentially restore life in the event of a cardiopulmonary arrest. However, if at any future time Patient #1's medical condition required ongoing mechanical ventilation to maintain life she would not want life support measures. To reflect this patient's goals, her POST form should be completed as follows: Section A: Attempt Resuscitation/CPR; Section B: Full Treatment. Patient #1 should also complete an advance directive to indicate her **future** treatment preferences.
- **Patient #2:** After further discussion, Patient #2 might clarify that he wants all measures short of intubation and mechanical ventilation to maintain and or restore life to his current condition, and does not want anyone to attempt resuscitation in the event of loss of pulse and respirations. Patient #2's POST form should be completed as follows: Section A: Do Not Attempt Resuscitation/DNR; Section B: Limited Treatment.

Remember, the patient' preferences regarding medical interventions may change based on

his/her evolving medical condition, or simply because he/she changes his/her mind. The POST form should be updated as soon as a health care professional is aware of a change in the patient's preferences, as these are medical orders that will be acted on by EMS and other medical personnel.

It is very important to document the patient's goals of care and details of the discussion on which the orders are based, who was present for the discussion, and what the plan is in the medical record. This is helpful if the validity of the POST form is questioned, and may provide reassurance and comfort for decision makers and other loved ones.

Should You Transfer Patients with “Comfort Measures Only” Orders?

“Comfort Measures Only” orders suggest that the patient prefers not to be transferred to a hospital unless comfort needs cannot be met in the current location. Sometimes it is necessary to transfer patients to a hospital to control their symptoms. Examples include pain management, wound care (control of bleeding, cleaning, wound closing, and dressing, as needed to optimize hygiene and comfort), and stabilization of a fracture by splinting and/or surgery (with the goal to control pain).

When a patient is transferred, the POST form should **always** be sent with the patient. Information explaining that the specific goals of care have not changed and a specific outline of the treatments for which the patient is being transferred must be conveyed. Direct communication with the receiving health care team about the treatment plan assures that the patient’s wishes are respected and comfort maximized as a patient moves from one care setting to another. Comfort care is always provided regardless of the indicated level of treatment.

Section C– Medically Administered Nutrition

<p>Section C</p> <p><i>Check one</i></p>	<p>ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.</p> <p><input type="checkbox"/> No artificial nutrition by tube</p> <p><input type="checkbox"/> Defined trial period of artificial nutrition by tube.</p> <p><input type="checkbox"/> Long-term artificial nutrition by tube.</p> <p><i>Other Instructions:</i></p>
---	---

Instructions regarding artificially administered nutrition for patients who cannot take food by mouth can be recorded in this section. If the patient/resident wants a long-term feeding tube, the “Long-term artificial nutrition by tube” box is checked. If there are limitations ordered for artificially administered nutrition, either the “No artificial nutrition by tube” box or the “Defined trial period of feeding tube” box is checked. Other instructions may also be specified.

Section D—Basis for Orders / Discussed with

Section D <i>Must be Completed</i>	Discussed with: <input type="checkbox"/> Patient/Resident <input type="checkbox"/> Health care agent <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Health care surrogate <input type="checkbox"/> Parent of minor <input type="checkbox"/> Other: _____ (Specify)	The Basis for These Orders Is: (Must be completed) <input type="checkbox"/> Patient’s preferences <input type="checkbox"/> Patient’s best interest (patient lacks capacity or preferences unknown) <input type="checkbox"/> Medical indications <input type="checkbox"/> (Other)
--	---	---

Upon completion of the treatment orders, Section D must be completed by checking the box(es), indicating with whom the orders were discussed, i.e., patient, health care agent, surrogate, or court appointed guardian. If the patient lacks capacity but participated in the conversation, the patient/resident box may still be checked, but a box below related to who is making decisions must also be checked. For both options on the line below, the full name of the individual and his/her relationship to the patient should be provided.

When a patient lacks capacity, it is essential to discuss POST orders with the correct surrogate(s). It is important that that signing providers know how to identify the appropriate decision makers. (See Guidance for Health Care Surrogate Selection)

Physician/NP/CNS/PA and PATIENT OR SURROGATE SIGNATURE

Physician/NP/CNS/PA Name (Print)	Physician/NP/CNS/PA Signature <small>(NP/CNS/PA Signature at Discharge)</small>	Date	MD/NP/CNS/PA Phone Number
Signature of Patient, Parent of Minor, or Guardian/Health Care Representative 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 agent/ surrogate.			
Name (print)	Signature	Relationship (write “self” if patient)	
Agent/Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

At the bottom of the page, the POST must be signed by a physician, unless the patient is being discharged from a hospital or long term care facility. Then the form can be signed by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). The provider

then prints his/her name and writes the time and date the orders were written. **If the form is not signed it cannot be treated as a valid order and EMS personnel cannot limit EMS services.**

Tennessee is one of a few states that does not require the patient or surrogate to sign the POST form. However it is strongly recommended to have the patient or surrogate, as appropriate, sign the form, due to increasing concerns about Tennessee POST forms not being honored in states requiring patient signatures. Documentation of the discussion in the patient/resident chart in addition to them signing will also help alleviate those concerns.

Side 2 of the POST Form

Directions for Health Care Professionals

Common questions related to completing, using and reviewing the POST form are described in this section.

Key points include:

- The POST form should reflect patient's preferences, patient's best interest, and medical indications
- Photocopies and faxes of signed POST forms are valid and legal
- Oral Fluids must always be offered if medically feasible.

The bottom of the instructions on the back page includes a reminder that the form should accompany the patient when transferred or discharged. It is very important that the POST form follow the patient. It allows the receiving facility to have the same information regarding the medical indications and patient/resident preferences for life-sustaining treatment and increases the likelihood that the physician orders will be followed in the new care setting.

Frequently Asked Questions

1. Can family members who are present at the time a patient goes into cardiac arrest override a Do Not Attempt Resuscitation (DNR) order that has been recorded on a POST form signed by the patient and physician?

- a. No, family members cannot override a DNR or any other treatment decisions on a POST form signed by a patient and physician.
- b. Like advance directives the POST form is meant to express the patient's wishes when they cannot.
- c. POST is different in that it is a set of medical orders from the patient's physician.

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

- a. The POST form is a state wide document and that must be followed by emergency medical and other health care personnel. At one time it was called the “Universal DNR” to convey the idea that it applies everywhere.
- b. The POST document should be presented to emergency personnel if called.
- c. This means that the POST form will need to be taken with the patient if he/she leaves his/her residence.
- d. If the POST form is not presented, emergency medical personnel will start emergency care.

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

No. Some long-term care facilities may choose to have a POST form on file for every resident. However, they cannot require a resident to make decisions about life sustaining treatment. Remember that the POST form is voluntary and no resident can be forced to have one.

Comments or questions?

POST Program Contact Information

Tennessee End of Life Partnership, LLC
711 Shenandoah Drive
Brentwood, TN 37027
Phone: 615-289-4275
Fax: 615-246-2773
<http://endoflifecaretn.org>