POLST for Hospice Providers
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- Please send requests for institutionally specific modifications to info@PolstIL.org.
• Note that this presentation provides clinical guidance for the POLST paradigm and should NOT be construed as medical nor legal advice.

• For answers to legal questions, check with your own organizational legal counsel.
By the end of this session, participants will be able to:

- Understand the POLST Paradigm and how patient wishes are determined and documented in a standard form
- Describe the relationship between a Power of Attorney for Healthcare and a POLST form, and when each is appropriate for patient completion
- Identify common errors when creating and reading the POLST medical order
- Understand how to access up-to-date POLST resources
The POLST Paradigm is a Process – Not a Form

Practitioner Orders for Life-Sustaining Treatment (POLST)

• The **POLST Paradigm** is the ideal approach to end-of-life planning. It promotes quality care through **informed** end-of-life conversations and **shared** decision-making.

• The **POLST form** is used to document the conversation. It should not be used as a check-box, or a replacement for an informed conversation between patients, families and providers.
Who is a POLST Form Designed for?

A POLST form is intended for:

- Someone who is seriously ill or frail

A POLST discussion is appropriate if:

- You would not be surprised if the person would die from their illness(es) within the next year
A growing body of published evidence supports the use of the POLST model as being superior to other advance directives for aligning patient wishes for treatment near the end of life with what actually transpires.

– Only 6.4% of patients who had a POLST form specifying Comfort Measures died in a hospital (some patients require hospitalization to receive adequate comfort care)
Evolution of the IDPH POLST Form

- **2000**: “Orange” DNR Form
- **2005**: IDPH Uniform DNR “Order Form”
- **2006**: IDPH Uniform DNR “Advance Directive”
- **2007**: IDPH Uniform DNR removed from title in the form
- **2013**: POLST Language Added
- **2015**: “Practitioners” Who Can Sign Medical Order are Expanded
- **2016**: IDPH Uniform “POLST form” DNR removed from title in the form
Benefits of POLST:

Promotes Patient-Centered Care

- POLST reduces medical errors by improving guidance during **life-threatening emergencies**
- Form accompanies patient from **care setting** to care setting
- In the **absence of a POLST form** first responders are required to offer **all medically available treatment**
- Use of the POLST form by patients is **entirely voluntary**
POLST Form and Advance Care Planning

POLST
- Is designed for those who with advanced illness or very frail – at any age.
- Medical order that documents wishes for treatment at this point in time; provides guidance to emergency medical personnel; usually completed in a medical setting.
- Can be signed by the patient’s decision maker if the patient lacks decision-making capacity.

Advance Care Planning
- Everyone 18 years and older is encouraged to have
- Legal document completed in advance of health issues that allows a person to:
  - make general statements about his/her healthcare wishes in the future, and
  - appoints a healthcare decision maker to speak on someone’s behalf.
Advance Care Planning Over Time

Maintain and Maximize Health, Choices, and Independence

**First Phase:**
Complete a PoA. Think about wishes if faced with severe trauma and/or neurological injury.

**Next Phase:**
Consider if, or how, goals of care would change if interventions resulted in bad outcomes or severe complications.

**Last Phase:**
End-of-Life planning - establish a specific plan of care using POLST to guide emergency medical treatments based on goals.

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**Healthy and Independent**

Document on Power of Attorney form

**Advancing Chronic Illnesses and Functional Decline**

**Multiple Co-Morbidities and Increasing Frailty**

Document on POLST form
Fragmentation of Care Near the End of Life In Illinois

Ave. of **34** Physician Visits in last 6 months of life

Ave. of **11** Different Physicians in last 6 months of life

Map 2.3. Variation, by State, in Average Number of Physician Visits During the Last Six Months of Life.

Map 2.4. Variation, by State, in the Percent of Decedents Seeing Ten or More Physicians During Their Last Six Months of Life.

THE DARTMOUTH INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE
The IDPH Uniform POLST Form in Illinois
3 Primary Medical Order Sections

A. CPR for Full Arrest
   • Yes, Attempt CPR
   • No, Do Not Attempt CPR (DNR)

B. Orders for Pre-Arrest Emergency
   • Full Treatment
   • Selective Treatment
   • Comfort Focused

C. Medically Administered Nutrition
   • Acceptable
   • Trial Period
   • None
The IDPH Uniform POLST Form
Practitioner Orders for Life-Sustaining Treatment

A
Cardio-Pulmonary Resuscitation (CPR)

B
Medical Interventions

C
Medically Administered Nutrition

D
Documentation of Discussion

E
Signature of Attending Practitioner

R
Reverse Side – Contains More Information and Instructions
There are multiple kinds of emergencies. This section only addresses a full arrest event (no pulse and not breathing), and answers “Do we do CPR or not?”
Up until recently, the form included “DNR” in the title and around the border.

Training needs to be ongoing to make sure all staff clearly understand patient can use POLST form to opt FOR CPR in case of cardiac arrest.
The IDPH Uniform POLST Form
Practitioner Orders for Life-Sustaining Treatment

- A: Cardio-Pulmonary Resuscitation (CPR)
- B: Medical Interventions
  - Medically Administered Nutrition
  - Documentation of Discussion
  - Signature of Attending Practitioner
- D: Reverse Side – Contains More Information and Instructions
Three categories defining the intensity of treatment when the patient has requested DNR for full arrest, but is still breathing or has a pulse.

- **Full** – all indicated treatments are acceptable
- **Selective** – no aggressive treatments such as mechanical ventilation
- **Comfort-Focused** – patient prefers symptom management and no transfer if possible

*Do Not Resuscitate does NOT mean Do Nothing*
• Use “Additional Orders” for other treatments that might come into question (such as dialysis, surgery, chemotherapy, blood products, etc.).

• An indication that a patient is willing to accept full treatment should not be interpreted as forcing health care providers to offer or provide treatment that will not provide a reasonable clinical benefit to the patient (would be “futile”).
If choosing “Attempt CPR” in Section A, Full Treatment is required in Section B.

Why?

If limited measures fail and the patient progresses to full arrest, the patient will be intubated anyway, thus defeating the purpose of marking Comfort or Selective.
Section “B”: Medical Interventions

Conversely, Selection of “Full Treatment” in Section B does NOT require “Attempt CPR” in Section A.

Why?

- Section B options are for Medical Emergencies aside from cardiac arrest.
- A person may wish to be intubated in case of Respiratory Distress, but would not want that treatment in the context of Cardiac Arrest (success rates may be very different in those different contexts!).
Section “B”: Comfort ALWAYS!

• Regardless of the option selected in section B, comfort care is always provided.

• To clarify: if a patient is choking, suction, manual treatment of airway, Heimlich maneuver would be implemented:

  **Choking is NOT COMFORTABLE!!**
Section “A” choices influence medical interventions in Section “B”

Section A
- Yes! Do CPR
- DNR: No CPR

Section B
- Full Treatment
- Selective Treatment
- Comfort-Focused Treatment

*Requires documentation of a “qualifying condition” ONLY when requested by a Surrogate.
<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Cardio-Pulmonary Resuscitation (CPR)</td>
</tr>
<tr>
<td>B</td>
<td>Medical Interventions</td>
</tr>
<tr>
<td>C</td>
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</tr>
<tr>
<td>R</td>
<td>Reverse Side – Contains More Information and Instructions</td>
</tr>
</tbody>
</table>
Medically Administered Nutrition can include temporary NG tubes, TPN, or permanent placement feeding tubes such as PEG or J-tubes.

A trial period may be appropriate before permanent placement, especially when the benefits of tube feeding are unknown, or when the patient is undergoing other types of treatment where nutritional support may be helpful.
The IDPH Uniform POLST Form
Practitioner Orders for Life-Sustaining Treatment

A. Cardio-Pulmonary Resuscitation (CPR)
B. Medical Interventions
C. Medically Administered Nutrition
D. Documentation of Discussion
E. Signature of Attending Practitioner
F. Reverse Side – Contains More Information and Instructions
The form can be signed by:

- The **patient**
- The agent with a **POAHC** (when the patient does not have decisional capacity)
- The designated Healthcare **Surrogate**
  - when the patient does not have decisional capacity and has no POAHC or applicable Advance Directive
Quick Refresher on Decision-Maker Priority

Start at the top and move down the list

1. **Patient**
   - Do not move on until patient has been evaluated by the attending physician who **documents the patient lacks decisional capacity** and is not expected to regain capacity in time to make this decision

2. **Power of Attorney for Healthcare**
   - Patient has completed and signed this Advance Directive

3. **Surrogate** (when you can’t speak to patient and no PoA)
   - Court-Appointed Guardian
   - Spouse/Civil partner
   - Adult children
   - Parents
   - Adult siblings
   - Grandparents/Grandchildren
   - Close Friend
Before turning to a POAHC or Surrogate, assess and document Decisional Capacity.

The patient may be able to make some decisions

- Patients who are minors should be offered the opportunity to participate in decision-making up to their level of understanding
- Studies consistently show that decisions made by others are more aggressive and not as accurate as what the patient would choose for him/herself.
Section “D”: Documentation of Discussion

• According to IDPH, “one individual, 18 years of age or older, must witness the signature of the patient or his/her legal representative’s consent... A witness may include a family member, friend or health care worker.”

• The witness CANNOT be the practitioner who signs the order.
When the form is completed by a person other than the patient, it should be reviewed with the patient if the patient regains decisional capacity to ensure that the patient agrees to the provisions.
The IDPH Uniform POLST Form
Practitioner Orders for Life-Sustaining Treatment

A. Cardio-Pulmonary Resuscitation (CPR)
B. Medical Interventions
C. Medically Administered Nutrition
D. Documentation of Discussion
E. Signature of Attending Practitioner
R. Reverse Side – Contains More Information and Instructions
The form can be signed by the (a) attending physician, (b) a licensed resident who has completed at least one year of training, (c) a physician assistant, or (d) an advanced practice nurse.

If more than one person shares primary responsibility for the treatment and care of the patient, any of those persons may sign the order.
The IDPH Uniform Form
Practitioner Orders for Life-Sustaining Treatment

- Cardio-Pulmonary Resuscitation (CPR)
- Medical Interventions
- Medically Administered Nutrition
- Documentation of Discussion
- Signature of Attending Practitioner

Reverse Side – More Information and Instructions
Completion of the form is always voluntary.

**THIS SIDE FOR INFORMATIONAL PURPOSES ONLY**

<table>
<thead>
<tr>
<th>Patient Last Name</th>
<th>Patient First Name</th>
<th>MI</th>
</tr>
</thead>
</table>

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, 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 you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

**Advance Directive Information**

I also have the following advance directives (OPTIONAL)

- Q Health Care Power of Attorney
- Q Living Will Declaration
- Q Mental Health Treatment Preference Declaration

Contact Person Name

<table>
<thead>
<tr>
<th>Contact Phone Number</th>
</tr>
</thead>
</table>

**Health Care Professional Information**

<table>
<thead>
<tr>
<th>Preparer Name</th>
<th>Preparer Title</th>
<th>Phone Number</th>
<th>Date Prepared</th>
</tr>
</thead>
</table>
Requirements for a Valid Form

- Patient name
- Resuscitation orders (Section “A”)
- 3 Signatures
  - Consent by patient or legally recognized representative
  - Witness
  - Practitioner
- Date
- All other information is optional
- **Pink** paper is recommended to enhance visibility, but color does not affect validity of form
Copies of POLST Form:

• Photocopies and faxes ARE acceptable.
  – Recommend making several copies of the POLST form
  – If EMS transports a patient they will take a copy of the POLST form for their records
  – This allows original to stay with the patient
Who Can Assist in Preparing the Form?

- Best practice suggests use of those trained in the POLST Conversation such as (among others):
  - Physicians
  - Social Workers
  - Nurses
  - Chaplains
  - Care Managers
  - Ethicists
  - Physician Assistants
  - Advance Practice Nurses
- Find an example of a POLST conversation at: http://www.uctv.tv/search-details.aspx?showID=18360
COMMON ISSUES & FREQUENTLY ASKED QUESTIONS
1. Signing practitioner **doesn’t have privileges** here
   - Orders may still need to be translated into specific institutional orders
   - Suggest using “Pt is DNR per POLST form” and have that order signed by assigned staff attending

2. Our clinicians have **never seen this patient** before
   - Law indicates POLST orders must be honored in all care settings
   - **Protected from liability** for following an POLST form in good faith
Potential System Concerns

Develop best practices for **storing, signing, scanning, and transmitting** document between care settings

- Process to review and audit POLST forms
- Standardized process for scanning into EMR *without taking the original from home*
- Process for getting practitioner signature on form and back to the patient quickly
- Consistent place to be displayed in patient home
- Encourage family to have multiple copies of form
Completing a POLST form is **VOLUNTARY**.

- LTC residents (non-rehab) do typically meet criteria for using the form.
- Some facilities have a policy requiring every patient document code status upon admission.
- While the POLST form may be used as a standard documentation tool to record the patient’s resuscitation wishes, the patient cannot be *required* to execute the form.
Can I Use POLST Just as a DNR or “Full Code” Form?

• Yes. Section A (requesting CPR or DNR) is only required section
  – However, If left blank, boxes could be filled in later, effectively creating a medical order that the practitioner is unaware of or may not agree with

• Cross out other sections and mark “No decisions made”
  – Makes it clear that patient did not address the subjects in the other sections – decisions can be made at a later date by creating a new form
Are Verbal Orders Acceptable?

Check with your own organizational policy, however, verbal orders are generally acceptable

- When patient is imminently dying, may be necessary for nurse to get order from practitioner over phone (TORB)

- Most organizations require the practitioner to sign the form within 24 hours of telephone order

- If EMS questions the validity, refer them to back of POLST form, which states that verbal orders are acceptable
What Should I do with an Older IDPH Form?

- Continue to **follow** older IDPH DNR Forms (may be called “IDPH DNR”; “IDPH Uniform DNR form”; “IDPH Uniform DNR Advance Directive”; “IDPH Uniform POLST form”)

- **Update** the older form to the new form when it is feasible.

- **Review** the form with the patient or legal representative when a change in the patient’s medical condition, goals, or wishes occurs
What happens if an agent with POAHC does NOT want staff to follow POLST Orders?

- Educate!
- It is the surrogate decision maker’s responsibility to honor the patient’s wishes.
- Extreme care should be exercised if the POAHC or Surrogate wishes to reverse the direction of care previously established by the patient
  - For example, the patient requested Comfort-Focused or Selective Treatment, but the POAHC or Surrogate wants Full Treatment
  - Changes to a form should be based on evidence of the patient’s wishes
- “Convince me.”
A Patient Has a POLST form Completed Incorrectly

Practitioner has added “DNI” to Part A

• Explain to patient and family that this does not make medical sense
• Explain to patient and family that this most likely will not be honored and may cause confusion for first responder
• Educate practitioner who completed the form incorrectly
• Complete a new form
The POLST Illinois Committee has created training tools including:

- Powerpoint presentations
- Guidance Document (in-depth overview)
- FAQ (healthcare and consumer)
- Key Points / Leave-behind

POLST Resources
www.POLSTil.org
POLST Resources

POLST Illinois information
info@POLSTil.org
1-855-765-7845
www.polstil.org

National POLST Program
www.polst.org
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Practitioner Orders for Life-Sustaining Treatment

Illinois Hospice & Palliative Care Organization
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physician orders for life-sustaining treatment

CHICAGO End-of-Life Care Coalition

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Expanding horizons in palliative, supportive & end-of-life care

Advocate Health Care
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The Retirement Research Foundation

University of Illinois at Chicago