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Disclaimer

• Note that these slides are developed as 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
- Recognize the importance of healthcare staff being properly educated regarding interpreting POLST forms during emergencies and other relevant circumstances
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.

POLST Programs – are how states are implementing the POLST Paradigm.

POLST Form – the form used by a state to document a person’s wishes. POLST is a set of concrete Medical Orders that must be followed by healthcare providers.
Who is a POLST Form Designed for?:

Is intended for persons of any age for whom death within the next year would not be unexpected (the “Surprise Question”)

• This includes patients with advanced illness or frail elderly

• POLST is not intended for persons with chronic, stable disability, who should not be mistaken for being at the end of life.
National POLST Paradigm Programs

No Program (Contacts)

Endorsed Programs

Regionally Endorsed Program

Developing Programs

Programs That Do Not Conform to POLST Requirements

www.polst.org

*As of May 2016
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.
• Recent study on the relationship between what POLST orders are selected and where people ultimately die. 18,000 death records (2010-2011) reviewed from Oregon’s electronic POLST registry

• Relationship between options selected on the POLST form and where people die:
  – 6.4% of patients who had a POLST Form specifying Comfort Measures Only treatment wishes died in a hospital
  – 22.4% for patients who wished for Limited Additional Interventions died in a hospital
  – 44.2% of patients whose POLST specified wishes for Full Treatment died in a hospital
  – 34.2% of patients without a POLST Form died in a hospital

(Fromme, Erik, et.al., “Association Between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and In-Hospital Death in Oregon”, JAGS, Vol. 62, No. 7, July 2014, pp 1246–1251.)
Evolution of the IDPH POLST Form

- **“Orange” DNR Form**
- **2000**
- **2005**
- **2006**
- **2007**
- **2013**
- **2015**
- **2016**

- **POLST Language Added**
- **“Practitioners” Who Can Sign Medical Order are Expanded**
- **IDPH Uniform DNR “Order Form”**
- **IDPH Uniform DNR “Advance Directive”**
- **IDPH Uniform “POLST form”**
The POLST Paradigm:

Allows patients to choose all possible life-sustaining treatment, selected life-sustaining interventions, or comfort-focused care only.
Benefits of POLST in Illinois

Promoting 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

- 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.
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
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
<table>
<thead>
<tr>
<th>A</th>
<th>Cardio-Pulmonary Resuscitation (CPR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Medical Interventions</td>
</tr>
<tr>
<td>C</td>
<td>Medically Administered Nutrition</td>
</tr>
<tr>
<td>D</td>
<td>Documentation of Discussion</td>
</tr>
<tr>
<td>E</td>
<td>Signature of Attending Practitioner</td>
</tr>
<tr>
<td>R</td>
<td>Reverse Side – Contains More Information and Instructions</td>
</tr>
</tbody>
</table>
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?”

**NOTE!** Patients can use this form to say YES to CPR, as well as to refuse CPR.
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

- Cardio-Pulmonary Resuscitation (CPR)
- Medically Administered Nutrition
- Documentation of Discussion
- Signature of Attending Practitioner
- Reverse Side – Contains More Information and Instructions
The language was changed to better reflect actual conversations which generally begin with offering maximal medical treatment, before moving to any restrictions the patient/family may wish to place on treatments.
Section “B”: Medical Interventions

Do Not Resuscitate does NOT mean Do Nothing

- 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
- 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.
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/mechanically ventilated 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.*
• 85 year-old gentleman admitted from home through ED with severe pneumonia
• The patient is increasingly hypoxic and may be confused
• Patient refuses the vent x3.
• There is a DNR order on the chart.
• The physician feels DNR does not apply to potentially reversible conditions and begins full resuscitation.
85 year-old gentleman admitted from home through ED with severe pneumonia

The patient is increasingly hypoxic and may be confused

Patient refuses the vent x3.

There is a POLST form on the chart.

Comfort-focused treatment is marked for medical interventions. Intensive symptom management is started; mechanical ventilation is not initiated.
A 59 year-old woman being treated for breast cancer arrives at the ED with sepsis.

In the ICU, she is on oxygen and maxed-out on pressors.

She has a DNR order on the chart.

Staff are concerned they are violating the patient’s wishes.
• A 59 year-old woman being treated for breast cancer arrives at the ED with sepsis.
• In the ICU, she is on oxygen and maxed-out on pressors.
• She has a POLST form on the chart.
• Selective treatment is marked for medical interventions. Staff can feel comfortable they are honoring the patient’s wishes.
• 67 year-old gentleman presents with **chest pain and SOB**.
• He is in pain and confused.
• The cardiologist wants to take him for a **cardiac cath** and possible stent.
• The patient’s nurse calls the physician to inform her that the patient has a **DNR order** on the chart.
• There is confusion whether the patient would want to be **sent for the procedure** anyway.
67 year-old gentleman presents to ED with chest pain and SOB.

He is in pain and confused.

The cardiologist wants to take him for a cardiac cath and possible stent.

The patient’s nurse calls the physician to inform her that the patient has a POLST form on the chart.

Full treatment is marked for medical interventions. He is immediately sent for the recommended treatment.
Consent needs to be obtained to change an existing DNR order to full code, even during a procedure

- Discuss appropriateness of DNR in light of procedure and objectives
- If suspended, specify length of time
- Inform procedurists of code status
Some institutions have created orders to better capture the distinction of these categories, such as DNR-Comfort, DNR-DNI, or DNR-Full Treatment.

Hospitals are NOT required to complete this form when writing in-hospital DNR orders for the first time.

- Complete an IDPH Uniform POLST form if the patient/legal representative wishes to continue DNR code status or limit emergency medical interventions after discharge.
Of 25,000 people in Oregon...

Yes to CPR (28%)  

No CPR: DNR (72%)

½ of the DNR group wanted hospitalization and some level of treatment for medical emergencies

½ of the DNR group wanted only comfort measures for medical emergencies


Full treatment
Limited treatment
Comfort Only
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
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.
Of 25,000 people in Oregon…

CPR group
- Long-Term feeding tube: 18%
- Time-limited Trial: 22%
- No feeding tube: 60%

DNR group
- No feeding tube: 74%
- CPR: 2%
- Time-limited Trial: 24%

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 **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
  - a parent of a minor child is a surrogate
  - a guardian is also a surrogate
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
Decisional Capacity
It’s not all or nothing

• Before turning to a POAHC or Surrogate, assess and document Decisional Capacity.
• The patient may be able to make some decisions even if s/he can’t make all 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.
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 same practitioner as the one 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.
Adults with a completed POLST form are also encouraged to complete a Power of Attorney for Health Care (POAHC).

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.
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.
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
- Photocopies and faxes **ARE** acceptable.
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:
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.
1. Signing practitioner **doesn’t have privileges** here
   - Orders still must 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

3. Developing best practices for **storing, locating**, and transmitting document between care settings
   - Institutions should standardize where the document is located so that it is easily available during an emergency, but also protects the patient’s privacy
Completing a POLST form is **voluntary.**

- Using a POLST form is a practical way to capture both medical orders and patient preferences, **but cannot be required**
- Residents typically meet criteria for using the form
- All staff should be trained regarding how to find and interpret form in an emergency.
Can I Use POLST Just as a DNR or “Full Code” Form?

- Yes - Section A (requesting CPR or DNR) is the only required section
- Cross out other sections and mark “No decisions made”
  - 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
  - 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
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
POLST is a Process, Not a Form
The form is a documentation tool.

• POLST should not be used as a check-box form, or as a replacement for an informed conversation between patients, families and providers to:
  – Identify goals of treatment.
  – Make informed choices.
• The conversation should be documented in the medical record, along with a copy of the completed POLST 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
Training Programs for Having POLST Conversations

• Coalition for Compassionate Care of California: capolst.org Includes on-line 3 hour course; webinars; on-site trainings

• Respecting Choices program, Gundersen Health System (Lacrosse, Wisconsin) : respectingchoices.org On-site trainings; train-the-trainers’ local trainings
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POLST Illinois
Practitioner Orders for Life-Sustaining Treatment
THANK YOU!

Polstil.org (Illinois)
Polst.org (National)

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