Pennsylvania
POLST
Pennsylvania Orders for Life-Sustaining Treatment
A Participating Program of National POLST

Pennsylvania Orders for Life-Sustaining Treatment

A Best-Practice Guide for Long-Term-Care Providers

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Dr. Kraybill advocates that when possible, all Long-Term-Care (LTC) residents have the opportunity to make decisions for treatment that will, or will not, be provided as the end of life nears. The optimal time for such decision making is during times of health stability when the individual is able to participate and express care wishes. Decisions made during a health crisis often cannot include the individual, or may be based more on emotions than rational recognition of health limitations, and can place great stress on decision-makers.

Dr. Kraybill developed the documents found in this guide to serve as teaching tools for an understanding of the many aspects of the advance care planning process, with emphasis on POLST. The tools are detailed and recommended for use in all LTC facilities in Pennsylvania.

A major objective is to provide information so those who facilitate, complete or follow POLST orders always use POLST appropriately.

The guide includes the following materials

A. **Advance Care Planning (ACP) in Long-Term Care Facilities: Best Practice**:
   A broad overview of ACP and POLST that includes:
   1. Introduction
   2. Resident's Goals of Care
   3. Advance Care Planning
   4. Advance Care Planning Documents
   5. Medical Decision-maker
   6. Pennsylvania Orders for Life-Sustaining Treatment (POLST)
   7. POLST Clarification
   8. Decision-making Capacity
   9. Guidelines for use of POLST during LTC stay
   10. Voiding a POLST form
   11. Facility policy & procedure

B. **POLST Do's and Don'ts**: Intended to help reinforce important facts, make users aware of common misconceptions and avoid errors associated with the POLST process.

C. **Patient and Resident Family Form**: A handout for LTC facilities to include in their admission packet about upcoming ACP and POLST discussions. It can be personalized with the facility name.

D. **POLST Preparation Questionnaire**: A questionnaire for the resident (with decisional capacity) or HCPOA/representative to start them thinking about the upcoming ACP discussion and possible choices. The goal is to start a thought process, and give a takeoff point for the medical staff member who initiates the discussion.

Special thanks to Dr. Kraybill for his long support of POLST and his significant contribution to the continuing goal to improve the POLST process in our state.

Pennsylvania Orders for Life-Sustaining Treatment (POLST) educational materials and the POLST form are available through the PA POLST website:

www.papolst.org

Users should download and print the form on Pulsar Pink stock

(#65) POLST inquiries can be sent to **info@papolst.org**

Advance Care Planning (ACP) in Long-Term Care Facilities: Best Practice

1. **Introduction:** Individuals who require care in a long-term care facility (LTCF) have significant health changes that mandate advanced medical, nursing and care needs. Some of these health changes are transient and may improve. Many more individuals have chronic irreversible changes due to disease or injury. On average, the life expectancy for all LTCF residents at admission is about 2 years. While the goal is improvement or stabilization, it is more common to see decline and end-of-life changes in these frail individuals.

2. **Resident Goals of Care**
    a. Many individuals have strong opinions and preferences about their medical care, where it is provided, and what they find acceptable at the end of life. These choices may be influenced by prior experience, theological beliefs, family input or other unique factors. Regardless of the source, these choices must be welcomed, understood, documented and honored for patient choice and autonomy.
    b. Discussions about these choices are best done during times of health stability when the individual is able to participate and express care wishes. Decisions made during health crisis often cannot include the individual, or may be based more on emotions than rational recognition of health limitations, and can place great stress on decision-makers.
    c. Therefore, **all LTCF residents** should have opportunity to: (based on decision-making capacity)
        i. Discuss and understand their current health condition and prognosis
        ii. Review or complete an advance directive, including a living will and/or healthcare power of attorney (if they retain decision-making capacity)
        iii. Express their wishes and choices for future medical care during acute medical crisis, sub-acute medical change, and routine care.
        iv. Document these choices and have them interpreted into medical orders that guide future care. If the individual wishes to limit future treatments, the Pennsylvania Orders for Life-sustained Treatment (POLST) document is a widely used tool to translate the individual's health care choices into practical medical orders.
        v. Change their prior medical choices at any time, based on the current circumstances or change in perspective.

3. **Advance Care Planning (ACP):** ACP is the process by which individuals make and share decisions that guide their future health care, if they become unable to speak for themselves. Advance care planning documents are where these decisions are documented, in case the individual cannot participate in future decision-making.

4. Advance Care Planning documents

	Details:	Appropriate for:
Healthcare Power of Attorney (HCPOA)	• A person appointed by another to serve as the individual's agent and to make health care decisions. Usually used only when the individual is unable to make decisions. • An individual may allow the designated HCPOA to make decisions at any time by informing the healthcare practitioner. This decision should be recorded in the medical record.	All LTC residents
Living will	• A statement of an individual's personal choices regarding life-sustaining treatment and other end-of-life care. • The living will becomes effective when the individual has an end stage medical condition, and is permanently unconscious or loses decision-making capacity. • The living will is NOT a medical order.	All LTC residents
POLST	• POLST is a translation of the individual's wishes for specific care into medical orders. It complements the living will, putting choices into actionable medical orders. • When future medical decisions are needed, it serves as a guide for discussion with an individual with intact decision-making. When decision-making capacity has been lost, it is a directive for the HCPOA or representative and healthcare team.	Medically frail individuals near end of life who wish to guide future medical treatments

5. Medical decision-maker: If no agent is appointed as HCPOA by the individual, Pennsylvania law allows others to serve as a medical decision maker. Such a person is known as a health care representative and is often referred to as a surrogate decision-maker. Priority designation for designation of HCPOA is given in this order:

a. Current spouse and adult child (of individual & another relationship)
b. Adult child (of individual and current spouse)
c. Parent
d. Adult sibling
e. Adult grandchild
f. An adult who has knowledge of the individual's preferences and values

Per PA Act 169: http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2006&sessInd=0&act=169)

6. Pennsylvania Orders for Life-Sustaining Treatment (POLST)

a. **POLST appropriateness:** POLST discussions may be appropriate for:
    i. Individuals who have advanced chronic progressive illness and/or frailty.
    ii. Persons with acute medical illness that is likely irreversible, or associated with high burden of curative medical care.
    iii. Individuals for whom medical providers would not be surprised if they were to die or lose decision-making capacity within 1-2 years.
b. POLST completion is appropriate for the above individuals who choose to complete a POLST document.
c. POLST is completed only after a discussion with the individual about current health conditions and treatment choices based on this understanding. If an individual is unable to participate, the discussion can occur with the HCPOA/representative. The POLST form serves only to document the discussion and choices, and should not be completed without this discussion.
d. Physicians, physician assistants and CRNPs may facilitate the POLST conversation. Other disciplines, typically a nurse or social worker, may also engage residents in the POLST discussion.
e. Once signed by a physician/nurse practitioner/physician assistant, and the individual (or HCPOA/representative when appropriate), the POLST becomes a medical order that follows the individual across care settings (i.e., LTC to emergency room to hospital to LTC).
f. Completion of a POLST is always voluntary. Healthcare team input and POLST discussions should not be innately for or against life prolonging treatment or palliative care. It is only a tool to enable discussion, decision-making, and documentation of individual treatment preferences.
g. Individuals are encouraged to add comments on the POLST form to clarify POLST choices, declare goals of care, and establish unique wishes.

7. POLST clarifications

a. If "DNR" is chosen in POLST section A:

i. This means that in a situation of cardiac arrest, with no pulse or breathing, the individual does not want resuscitation.

ii. "DNR" does **NOT** automatically exclude defibrillation, ventilation, hospitalization, or interventional medical care. Some individuals may want hospitalization for some illnesses, defibrillation for tachycardia, or ventilation for respiratory failure.

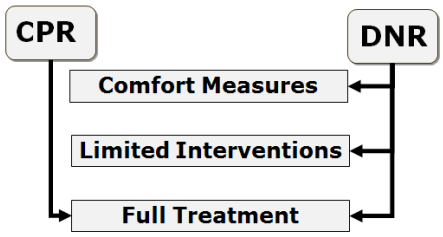
iii. An individual who chooses "DNR" may choose any of the medical interventions in section B (see graphic below).

b. If "CPR" is chosen in POLST section A:

i. Then "Full treatment" must be chosen in Section B (Explanation: if a person wants CPR, they must be willing to receive cardiac life support interventions, which usually include intubation and care in the ICU.)

ii. The individual may electively designate whether this "full treatment" should be provided for a limited amount of time (i.e., for 5 days), continued without specified limit, or deferred to choice of POA/representative.

c. Summary of medical interventions appropriate for both CPR and DNR choices:



8. Decision-making capacity (DMC) of the individual must be considered during the POLST discussion. The individual must show ability to reason, understand their health condition and choices, appreciate the implications of disease and choices, and then choose and communicate their wishes. These components must be present for full medical decision-making. The decision-making capacity assessment determines how the ACP discussion can occur and who should be included:

If **DMC assessment** is:	Then the **discussion process** is:
Full decision-making capacity →	Talk with individual. Engage HCPOA/representative if patient chooses
Limited decision-making capacity→	Discuss with individual & HCPOA/representative
No decision-making capacity →	Talk with HCPOA/representative

9. Guidelines for use of POLST during LTCF stay:

New admission

- Information can be included in admission packet about upcoming ACP & POLST discussions – see drafted sample
- Medical provider or staff (per facility policy) discuss health status, advance care planning and POLST (f appropriate) with resident
- Inquire about previously completed advance directives. Review or request a copy for the LTC record. Inquire if choices are current. If there is no up-to-date LW and/or HCPOA, encourage and provide information for a new advance directive (if capable).
- Inquire about previously completed POLST documentation, and review prior wishes.
- If POLST is appropriate and desired by resident, it is completed based on discussion with resident, and signed by medical provider. When appropriate, completion of the POLST is encouraged during the initial visit or early during the admission.
- If the resident has limited or no decision-making capacity, the HCPOA/representative must participate in completing the POLST. If the HCPOA/representative is available only by phone, the POLST can still be completed by documenting the details of the phone call, date and name of the person giving verbal approval. The HCPOA/representative is requested to sign the POLST at their next visit.
- The POLST document should be located in a standardized and readily available location in the medical record
- Based on discussion and POLST, a medical order is entered on the chart. This should include some details and a date. It is preferred to use medical orders such as:
    - DNR for cardiac arrest, per POLST (date) (do not resuscitate)
    - DNH, per POLST (date) (do not hospitalize)
    - DNR/DNI, per POLST (date) (DNR, do not intubate)
    - DNR/Intubation ok, per POLST (date)
    - Full code & medical intervention, not POLST appropriate, per discussion (date)
- Avoid the use of the medical order of "no code", due to the confusion over the meaning of "code"
- Recommended: enter an ACP entry in resident's problem list in EHR or paper chart. A sample entry may include all of the following:
    - DNR, limited additional medical treatment, IVFs but no feeding tube, would accept antibiotics for comfort – per POLST 8/1/2018
    - Living will (10/1/2017) = no life prolonging measures in terminal setting
    - Healthcare POA (10/1/2017) = Sally Doe (daughter), then Peter Doe (son)

Acute medical change

- In addition to medical assessment, the medical provider and/or nursing staff should review previous ACP wishes and POLST choices during an acute medical change.
- If a serious life-or-death situation requires an immediate decision, the resident does not have decision-making capacity and the HCPOA/representative is not available --then follow current POLST wishes.
- In all other circumstances, the situation and options should be discussed with resident and/or HCPOA/representative (when appropriate).
- An alert and oriented resident with acute change should be offered all treatment decisions, using the POLST as a guideline:

  "You appear to have a pneumonia that is not responding to treatment. We can consider admitting you to the hospital for IV antibiotics, IV fluids, and perhaps even short term use of a breathing machine. You previously said on your POLST that you did not want to go to the hospital or ever consider a breathing machine. What are your wishes now, based on your current illness?"
- The POLST should be used as a guideline for discussion with HCPOA/representative of an individual who has impaired decision-making capacity:

  "Your mother is very ill. We are not sure if she can recover from this serious illness. It is possible to send her to the hospital for treatment attempts, but she and you had previously indicated on the POLST that she never wanted to go to the hospital. We can provide comfort treatments here, even if she is declining."
- Prior to contacting the medical provider about a medical change, nursing staff should review prior ACP choices and POLST selections, and include this in the presentation to the provider:

  "Mrs. Jones has lost all movement of left arm and leg, and is now unresponsive without signs of pain. Her POLST indicates DNR status, and a wish for comfort measures only. I have updated her HCPOA/representative who confirms these wishes."

Stable or new chronic condition

- The POLST should be reviewed and confirmed with resident and/or POA following:
  - **Major medical change** (stroke, dementia dx, cancer dx, etc.) – a change in condition should prompt a discussion to determine if the preferences of the individual have changed and if so, a new form should be completed and signed.

  - **Admission or readmission to facility**
  - **Annually** (if not done in past year) – facility policy should outline methodology for completing this. The discussion and review can be done by social work or other staff members.
- If there are no changes in the POLST, the form should be signed & dated by the reviewer (or the LTCF have a protocol for documenting the review)
- If there are changes in the previous POLST choices, a new form should be completed. The medical provider is required to review, date and sign the updated form.

Discharge to home or different level of health care

- Situation of improving health – if an individual had completed a POLST during a serious illness and subsequently significantly improves, to the point of discharging to home or a lower level of health care, they may no longer be appropriate for a POLST form (see 6a above). A discussion should occur with the resident about their condition and wishes. If their wishes have changed, the current POLST form should be voided (see 10 below).
- If the individual remains appropriate for a POLST form and they do not wish to change it, LTC staff must assure that the POLST form (or a pink copy on cardstock) accompanies the resident across the care settings.

10. Voiding a POLST form

a. On the POLST form, a line should be drawn across sections A through E of the no longer valid form and "Void" should be written in large letters across the form. It should be signed and dated. Any associated orders in the medical record or entries in the individual's problem list related to the voided POLST form should be deleted.
b. The voided form should be kept as part of the archived medical record
c. If the POLST has been digitally scanned, the EMR should allow the scanned document to be marked "void", but not deleted.

11. Facility policy and procedure

a. Establish a policy consistent with facility culture, practice and intended use
    i. See "Model Policies Introduction" - https://www.upmc.com/-/media/upmc/services/aginginstitute/partnerships-and-collaborations/documents/polst-model-policies.pdf
    ii. See "Recommended Policy Elements" - https://www.upmc.com/-/media/upmc/services/aginginstitute/partnerships-and-collaborations/documents/polst-recommended-policy-elements.pdf

iii. See PA POLST library in UPMC Institute of Aging site https://www.upmc.com/services/aginginstitute/partnerships-and-collaborations/polst

b. LTC staff competency training
    a. The LTC facility needs to assure that staff that facilitate POLST discussions are trained and able to demonstrate the skill and knowledgeable required for the conversation.
    b. Nursing staff should be educated in understanding the implications of POLST choices, using the document appropriately, and ethically guiding individuals and HCPOA/surrogates about options during acute and chronic illness.

POLST Do's & Don'ts

 **It is NOT appropriate to :**	 **It is appropriate to:**
Require any individual to complete a POLST	Okay to suggest and assist
Establish a facility policy to require POLST completion for all residents	Okay to offer to all appropriate residents
Incentivize medical providers based on POLST completion or counting	Okay to incentivize advance care planning discussions and documentation
Confuse "cardiac arrest" with "respiratory arrest" in a patient with "DNR but FULL medical intervention"	Ventilation support may still be desired by the individual who is not in full cardiac arrest
Assume that a "DNR, comfort measures only" choice always means no hospitalization	Interventions for comfort are still appropriate. Examples: injuries like hip fracture, or lacerations
Include the POLST form in the LTC admission packet (conveys that it is just a paper completion formality).	Okay to provide introductions to the topic and subsequent conversations – brochures, videos like "POLST: When is the right time" or "Understanding POLST"
Discuss and complete a POLST document only with the HCPOA/representative of an individual who has full decision-making capacity	The HCPOA/representative may be included, with the permission of the resident.
Discuss and complete a POLST document only with an individual with limited or no decision-making capacity	Discuss if possible with the resident but confirm choices with HCPOA/representative
Assume that an individual with advanced or irreversible or terminal illness will choose a "DNR" status	Okay to inquire about their understanding of their illnesses, the ability to improve, and the likely benefit of medical intervention
Assume that POLST choices will stay the same 	POLST is a guide based on decisions at a particular point. When time and medical circumstances allow, it should always be confirmed during subsequent medical changes 

Name: _____ Date: _____

POLST Form and Your Wishes for Care at (Facility Name)

- Do you care about the types and amount of medical care you receive?
- Do you have opinions about your medical care now and in the future?
- If you become ill, is it important that the right person make choices for you?

……. If **YES**, then you should make and complete **advance care planning** now. Facility staff can provide information on how to access to necessary forms."

What is advance care planning? Advance care planning (ACP) is the process by which individuals make decisions to guide their future health care, if they become unable to speak for themselves. It is designed specifically for a situation where you are unable to make or communicate your choices. It requires understanding of your health and thoughtful discussions about your medical care.

What does advance care planning include?

- Living will - a statement of choices regarding life-sustaining treatment if you have an end stage medical condition, and are unable to participate in decisions. It is recommended for everyone.
- Healthcare power of attorney - a person appointed by you to make your medical decisions if you are unable to do so. It is recommended for everyone.
- POLST (Pennsylvania Orders for Life-sustaining Treatment) **–** a translation of your medical wishes into specific medical orders that implement your choices now and in the future. It is suggested for people with serious illness – see details below.

Does (Facility Name) use the POLST form? Yes, we will talk with you and the people you wish to include in the conversation about your wishes for care and the POLST form.

Tell me more about the POLST form.

The POLST Form is a document that helps doctors, nurses, healthcare facilities and emergency personnel honor your wishes regarding life-sustaining treatments in emergency situations.

The POLST form is voluntary and recommended for patients:

- whose health care professional would not be surprised if they died within 1-2 years; or
- who are at an increased risk of experiencing a medical emergency based on their current medical condition and who wish to make clear their treatment preferences, including about CPR, mechanical ventilation, ICU; or
- who have had multiple unplanned hospital admissions in the last 12 months, typically coupled with increasing frailty, decreasing function, and/or progressive weight loss.

If you have an advance directive/living will, a POLST form is still recommended.

The POLST form includes information about:

- preferences for resuscitation
- treatments for medical conditions
- preferences on the use of antibiotics
- preferences for artificially administered fluids and nutrition

Name: _____ Date: _____

The POLST form is completed by a healthcare provider after discussion with you or your legal decision-maker. It is then signed by the doctor/nurse practitioner/PA and you or your legal decision-maker. It then becomes a medical order that is understood and followed by other healthcare professionals.

Can you explain some of the words on the POLST?

- Cardiopulmonary Resuscitation (CPR) - attempts to restart breathing and the heartbeat of a person whose heart has stopped and is not breathing. Typically this involves "mouth-to-mouth" breathing and forceful pressure on the chest. It can also involve electric shock or a plastic tube being placed in the throat to assist breathing.
- Mechanical Ventilation/Respiration - the pumping of air in and out of the lungs through a tube in the throat. Used when a person is not able to breathe on his or her own.
- Do Not Attempt Resuscitation (DNR) – this is a choice not to accept interventions such as CPR or mechanical ventilation when there is no heartbeat or breathing. This usually results in end of life. Most ethicists agree that this is not a deliberate choice to end life, but rather the acceptance of a natural death in someone who is life-threateningly ill.
- Comfort Measures - Care undertaken with the primary goal of keeping a person comfortable, rather than prolonging life. A person who requests "comfort measures only" on the POLST would be transferred to a hospital only if needed for his or her comfort.
- Intravenous (IV) Fluids - Fluids administered through a small plastic tube directly into a vein, typically on a short-term basis.
- Artificial Nutrition - when a patient can no longer eat or drink by mouth, it is possible to give liquid food through tube.
- Tube Feeding - Short-term basis: Fluids and liquid nutrients can be given through a tube in the nose that goes to the stomach. Long-term basis: a tube inserted through a surgical procedure directly into the stomach through the abdominal wall.

What happens if I go to the hospital or transfer elsewhere? The POLST remains with and travels with you between care settings, home, hospital, long-term care or any other facility.

Can I change my mind about my POLST choices? Yes, at any time! The POLST form is a guide for future decisions, and does not lock you in to that choice. You can change it tomorrow, or make a different choice at the time of a future illness. It should be reviewed and updated at least yearly to make sure it still reflects your current wishes.

Does the POLST replace my future decisions or my POA/representative? No! If you become ill and are still alert, we will discuss your options with you, and you can decide. If you are unable to participate in decisions, we will contact your POA if possible, and they can decide. It is best to discuss your POLST choices with your POA/representative, since it helps them honor your choices.

Where is the POLST form kept? The form is kept in the medical chart. If you are discharged, we will send the POLST with you.

Does this mean I won't receive treatment and medications for pain control? NO!! We will always seek to manage pain with medications or other treatments.

Why can't I just wait until I have a medical change before deciding? Often medical illness will affect your alertness and ability to make good decisions. It is hard to make good decisions in the middle of a crisis – it is usually best to describe your overall wishes when your health is stable. It is also a great gift to your POA/representative if you can give guidance on your wishes.

Name: _____ Date: _____

Preparation for a Discussion about Advance Care Planning and POLST Form

A (Facility Name) staff member or medical provider will talk with you about your current health condition, your medical treatments, and your wishes for future medical care. You can help prepare for this discussion by considering the following questions. It is often helpful to discuss these questions with your family or medical decision-maker. This paper is only your initial thoughts, and NOT your final choices. You can discuss any question or concerns that you have about your health condition or treatment during the meeting with a staff member of medical provider.

1. Have you previously completed advance care planning documents?				
	Living will	Yes No	Have you already provided a copy?	Yes No
	Healthcare Power of Attorney	Yes No	Have you already provided a copy?	Yes No
	POLST (pink paper)	Yes No	Have you already provided a copy?	Yes No

2. When you consider your medical and physical health, would you say it is:		
	◯	Improving, or a has good chance of improving
	◯	Stable and about the same
	◯	Declining, and not clear if it will improve

3. As you think of your current and future medical care, which <u>best</u> describes your wishes?		
	◯	Do everything possible to prolong life, even if I am very ill and need major treatments.
	◯	Try to maintain my health with simpler treatments, if they are not major or uncomfortable or risky (antibiotics, medications, IV fluids, x-rays, hospitalization, etc.). Talk with me before starting major or uncomfortable treatments.
	◯	Provide treatment only for my comfort. Do not give interventions only to extend life. Do not send me to the hospital if I am comfortable.

Name: _____ Date: _____

Preparation for a Discussion about Advance Care Planning and POLST Form

4. If you have a life-threatening event, and your heart stopped, and you were not breathing (this means you are very ill and likely to die soon): If this happens, do you want immediate emergency efforts to attempt to prolong life (a code blue)? This often requires shocking the heart, pushing very hard on your chest, and placing a breathing tube into your lungs.				
	◯ YES	How long should this continue?	◯	Briefly – less than 30 minutes to see if I respond
			◯	At least until I get to the hospital
			◯	Indefinitely, if there is any chance of improvement
	◯ NO			

5. Would you accept treatment in the hospital, if that was required to keep you alive?	
	Yes No

6. Would you accept treatment in an intensive care unit, if that was required to keep you alive?	
	Yes No

7. Would you <u>ever</u> accept any of the following specific treatments?		
	Yes No	IV fluids
	Yes No	Antibiotics
	Yes No	Feeding tube – in the nose or through the abdomen
	Yes No	Kidney dialysis

8. If you were unable to make health care decisions, who do you feel would best represent your wishes?	
	Name_____