POLST: Promise and Pitfalls in Skilled Nursing Centers

The National POLST Paradigm is dedicated to creating portable medical orders that reflect patients' wishes for specific treatment.

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Advance care planning is vitally important for nursing center residents, many of whom are seriously ill and nearing the end of life. Advance care planning helps clarify priorities and wishes for medical care, and should lead to patients receiving the kinds of treatment they want to get—but not being subjected to treatments that they don't want or that won't help them.

The National POLST Paradigm is devoted to a specific paradigm, creating portable medical orders reflecting a patient's wishes for certain treatment, to help seriously ill or frail patients ensure that they'll receive the level of treatment they want.

Ensuring Treatment

The POLST movement dates back to the early 1990s, where it began as a grass roots movement in Oregon to help ensure that patients received treatment that was in line with their desires. Today almost all of the states in the United States have POLST programs at various levels of implementation, although there are a dozen or so different names (including MOLST, MOST, POST).

The National POLST Paradigm is working toward reducing variation among POLST forms and processes, helping eliminate reciprocity concerns and building consensus among how the POLST Paradigm should be integrated into technology, such as electronic medical records, health information exchanges, and registries so these orders may be easily accessed by first responders and other health care providers. Some such registries already exist.

A Team Process

The acronym historically has denoted Physician Orders for Life-Sustaining Treatment, but the National POLST Paradigm is now moving away from the original meaning and just retaining the word POLST because it is familiar to many people.

The reasons include emphasizing that not just physicians are involved but that the entire POLST process, from goals of care conversation to completion of the form, is a team process; that other licensed health care professionals are able to sign the form; and that the term "life-sustaining treatment" is somewhat value-laden: It seems to imply that placing a feeding tube in a person with advanced dementia or doing cardiopulmonary resuscitation (CPR) on a 75-pound nonagenarian with advanced cancer would in fact be "life-sustaining."

It's important to note that POLST orders are meant to reflect the end result of diligent, careful, detailed conversations between the health care team and the patient (and/or surrogates). A POLST form should never be just a check-box form that is part of a pile of admission documents, and it should not be completed in a cursory manner. This is a life-and-death document, and it needs to be treated that way.

POLST has been exceptionally useful in skilled nursing centers. Since all residents must be given the right to formulate advance directives under federal regulations and since it is important for staff to know what a resident would want in case of a change of condition or life-threatening emergency, POLST forms can be a great tool to memorialize these wishes for seriously ill or frail residents—and to translate them into actionable medical orders that are valid not just within the four walls of the center, but out in the community and in the hospital.

Before POLST, the time spent having advance care planning discussions with residents, and the orders given in the nursing center's chart, would essentially disappear once the resident was discharged.

With POLST, residents can be given their form (a portable medical order) to take home and place on their refrigerator or bedpost, and many nursing centers also take the initiative to get POLST forms transmitted to residents' physician offices and local hospitals.

Making Wishes Clear

But some nursing centers are using POLST as a code status document for all residents; this is inappropriate. (Note: There may be locations where it is a requirement in nursing centers, but such policies violate National POLST Paradigm principles.) One criterion for POLST appropriateness is that the health care professional would not be surprised if the patient died in the next one to two years. People who want usual care, and who are not seriously ill, frail, or nearing the end of life should not even be offered POLST orders.

Here's why: Of course, default treatment for every resident—if there is no clear guidance to the contrary—is that CPR is performed, the patient is sent to the hospital, and providers do whatever they can to prolong life. A POLST form is not needed to do that, and when POLST is completed for patients who want "usual" care based on their current condition, but who would want their treatment changed in the face of a new condition or different prognosis, it creates a potentially difficult and unnecessary conflict.

When people lose decisional capacity (whether due to dementia or to another medical condition), most would want a surrogate (family member, agent, proxy) to make decisions on their behalf based on what is going on now, based on known wishes—and if exact wishes are not known, then based on their values and beliefs (substituted judgment).

False Implications

When a POLST form was completed previously that requested CPR and full treatment, it carries the (usually) false implication that the patient wanted his or her life prolonged at all costs, no matter what the situation. So a family member is now placed in a position of "going against" the patient's previously stated wishes that applied to their earlier, healthier state.

This can create problems for the health care team and for the resident's loved ones and ultimately can result in patients being given care that truly goes against what they would have wanted in a particular situation—potentially causing severe suffering.

Certainly some seriously ill patients do want their lives prolonged at all costs, using all technology available, no matter how dire their situation—and those patients are appropriate to complete POLST orders indicating those wishes, including their wishes not to have others change the orders even if their condition deteriorates.

For a majority of patients, and even for healthy younger people, it is strongly advised to create a medical power of attorney and to ensure that the agent named in the directive is a person who knows their wishes and will advocate for them.

Even though it may be inconvenient as far as workflow for a nursing center to have two different pathways to document code status (or end-of-life wishes), that is probably the best way to respect the residents' values and ensure that clinicians are not creating situations that wind up doing more harm than good.

For residents who want usual care based on their current status—including CPR, intubation, and other aggressive resuscitative measures—an internal form (such as Preferred Intensity of Treatment) should suffice. This type of form can be offered to all admissions and used as a code status document. For those who want limits on their treatment, and for those who want their lives prolonged at all costs regardless of prognosis or functional status, a POLST should be offered in addition.

Nursing centers are entrusted with the precious lives of over a million Americans, and it is their critical duty to ensure that providers can help them make informed decisions about their end-of-life care. POLST order sets are an important tool to help respect residents' wishes, but they are not for everyone. Advance health care directives, on the other hand, are for everyone—and should be strongly encouraged.