The POLST Paradigm in Nursing Homes

Hand-out of presentation available:
http://clas.uiowa.edu/socialwork/nursing-home/webinars

1

The POLST Paradigm in Nursing Homes

Presenters
Jane Dohrmann
Nicole Peterson
Mercedes Bern-Klug

The University of Iowa

Hartford Change AGEnts Initiative Action Award

National Nursing Home Social Work Network
With support from the ***Retirement Research Foundation***

Iowa

3

Plan

- 50 minute presentation
- 15 minutes questions/answers

- Please use Q/A box (bottom right)
- Note the slide #
- Recording to be available on website:

http://clas.uiowa.edu/socialwork/nursing-home/webinars

4

Jane Dohrmann, MSW, LISW

- Director of **Honoring Your Wishes:** A Community-Wide Advance Care Planning Initiative
- Employed by Iowa City Hospice, a local non-profit hospice
- Promotes a systems-wide approach to advance care planning
- Respecting Choices Facilitator and Instructor
- Guides quality improvement projects

5

Nicole Peterson, DNP, ARNP

- Geriatric Nurse Practitioner/Lecturer- **HouseCalls** Faculty Practice at University of Iowa College of Nursing
- Provides primary care for residents in local long-term care facilities
- Teaches Gerontological Nursing for undergraduate nursing students
- Respecting Choices facilitator and instructor

6

Mercedes Bern-Klug, PhD, MSW

- Associate Professor in Social Work, University of Iowa
- Director, Aging Studies Program
- Researcher: Psychosocial issues related to advanced chronic illness
- Editor, *"Transforming Palliative Care in Nursing Homes: The Social Work Role"* (2010 – Columbia University Press)
- Co-founder: *National Nursing Home Social Work Network*

7

The POLST Paradigm

Jane Dohrmann, MSW, LISW

Objectives

- Describe the POLST paradigm
- Explain the rationale for POLST
- Discuss the extent to which POLST is available throughout the USA
- Explain the special usefulness of POLST in the nursing home setting
- Describe the ***Hartford ChangeAGEnt*** project currently underway
- Discuss preliminary findings from the project

9

POLST

- Physician Orders for Life-Sustaining Treatment
- Started in Oregon in 1991
- Turns health care preferences into medical orders
- Is more comprehensive than a DNR/CPR order
- May function as a DNR order

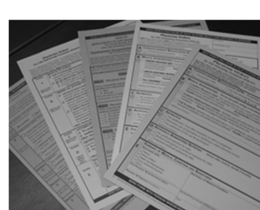
10

POLST

- Is a portable document that transfers with the individual from one setting to another
- Provides directions for providing or forgoing aggressive treatment
- Is considered to be a best practice standard of care for long-term care residents in assisted living centers and nursing homes

11

The POLST Form



Section A: CPR Decision

Section B: Goals of Care for Medical Interventions

12

California Physician Order for Life-Sustaining Treatment (POLST) effective 10.21.14

(Effective 10/1/2014)* replace that document.

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** ***If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.***

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B Check One — **MEDICAL INTERVENTIONS:** ***If patient is found with a pulse and/or is breathing.***

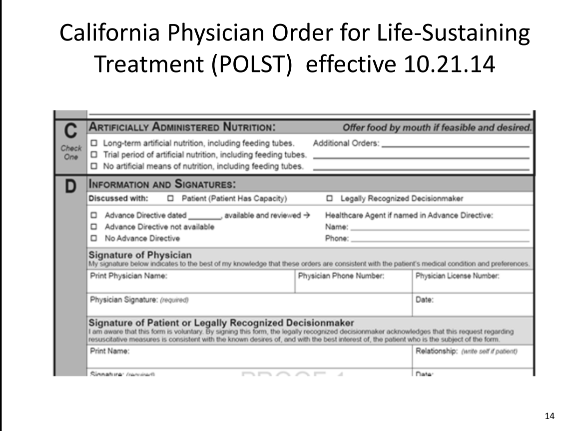
☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: ____________________

C — **ARTIFICIALLY ADMINISTERED NUTRITION:** ***Offer food by mouth if feasible and desired.***



California Physician Order for Life-Sustaining Treatment (POLST) effective 10.21.14

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** ***Offer food by mouth if feasible and desired.***

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: ____________
☐ Trial period of artificial nutrition, including feeding tubes.
☐ No artificial means of nutrition, including feeding tubes.

D — **INFORMATION AND SIGNATURES:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

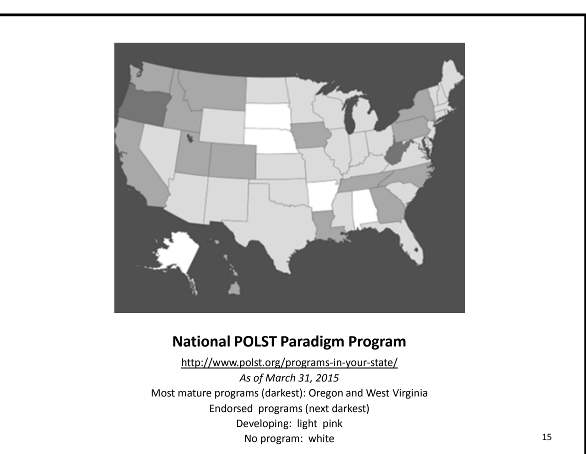
☐ Advance Directive dated ________, available and reviewed → Healthcare Agent if named in Advance Directive:
☐ Advance Directive not available Name: ____________
☐ No Advance Directive Phone: ____________

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name:	Relationship: *(write self if patient)*
Signature: *(required)*	Date:



National POLST Paradigm Program
http://www.polst.org/programs-in-your-state/
As of March 31, 2015
Most mature programs (darkest): Oregon and West Virginia
Endorsed programs (next darkest)
Developing: light pink
No program: white

"Compared with other advance directive programs, POLST more accurately conveys end-of-life preferences and yields higher adherence by medical professionals."

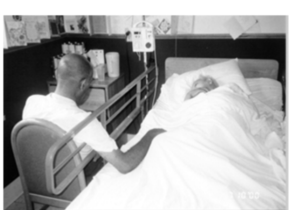
National Quality Forum (2006). ***A National Framework and Preferred Practices for Palliative and Hospice Care; Quality: A Consensus Report***. Washington, D.C.*: National Quality Forum*

POLST is recommended for:

- People with serious, life-limiting illnesses
- Frail
- Frail elderly
- People with chronic, critical illnesses

When is POLST appropriate?

Would I be surprised if this patient died in the next year?



Pattison, M., & Romer, A. L. (2001). Improving care through the end of life: Launching a primary care clinic-based program. *Journal of Palliative Medicine, 4*(2), 249-254.

IPOST

- Iowa Physician Orders for Scope of Treatment
- Enacted into law in 2012
- Iowa Code Chapter 144D

Facts about Advance Directives and IPOST

Advance Directives

- For all adults with decision-making capacity
- Future care
- Person completes form
- Health care proxy cannot complete
- Person responsible for up-dating & giving document to health care providers

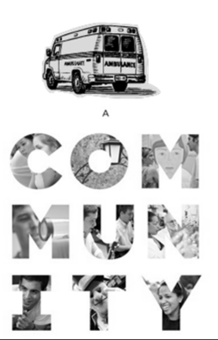
IPOST

- For seriously ill children & adults and the frail elderly
- Current and future care
- LIP & health care agent or patient sign form which results in a medical order
- Health care agent can complete with provider
- Individual, family or care center staff are responsible for presenting it in an emergency
- Provider is responsible for reviewing it with individual & family

The POLST Paradigm emphasizes:

- the importance of health care professionals facilitating advance care planning discussions
- engaging the health care agent
- promoting reflection of values, beliefs, and goals of care

Community-wide collaboration is crucial to POLST implementation



The POLST Paradigm emphasizes:

- thoughtfully reviewing options for care
- completing the medical order
- regularly reviewing choices
- honoring people's choices

When should a POLST form be reviewed?

- When the person is transferred from one care setting or care level to another, or
- When there is a substantial change in the person's health status, or
- When the person's treatment preferences change

Source: Iowa Physician Orders for Scope of Treatment (IPOST) 6/25/12

POLST in the Nursing Home

Nicole Peterson

Geriatric Nurse Practitioner

POLST translates the resident's wishes into actionable medical orders

- More comprehensive than just code status
- Can be specific to resident's needs
- High level of compliance with POLST documents and end of life care, 94% (Hickman et al, 2011)
- Sections not completed assume full treatment

Hickman, S.E., Nelson, C.A., Moss, A.H., Tolle, S.W., Perrin, N.A., & Hammes, B.J. (2011). The consistency between treatments provided to nursing facility residents and orders on the Physician Orders for Life-Sustaining Treatment form. *Journal of American Geriatrics Society, 59*(11), 2091-2099.

26

POLST documents are honored by all healthcare professionals

- POLST orders tell nurses what to do in the "middle of the night" scenarios
- EMS can follow POLST orders in the field
- Provide emergency department staff direction with patients they have not met before, or who may be transferred unconscious or in an altered mental state
- Iowa will honor POLST documents from other states

27

POLST provides clear instructions and improves communication

- 75% of HC providers felt POLST provided clear instructions about patient preferences (Schmidt et al 2004)
- 91% of HC providers feel POLST improved communication of patient preferences between patient and the healthcare team (Caprio, Rollins, Roberts, 2012)

Schmidt, T.A., Hickman, S.E., Tolle, S.W., & Brooks, H.S. (2004). The Physician Orders for Life-Sustaining Treatment program: Oregon Emergency Medical Technicians' practical experiences and attitudes. *Journal of American Geriatrics Society*, *52*(9), 1430-1434.

Caprio, A.J., Rollins, V.P., & Roberts, E. (2012). Health Care Professionals' Perceptions and Use of the Medical Orders for Scope of Treatment (MOST) Form in North Carolina Nursing Homes. *Journal of American Medical Directors Association*, 13(2), 162-168.

28

Role of the Licensed Independent Practitioner

- Review the resident's wishes and IPOST
- Elaborate on resident's goals and give specific information on expected disease trajectory
- Include the resident's wishes in documentation in the medical record
- Review/update IPOST with changes in resident's condition

29

POLST documents are easily accessible in the time of healthcare crisis

- Standard storage procedures
- Travel with resident
- Actions of healthcare providers following IPOST are upheld by IA state legislature

30

IPOST legislation

- Provides legal protection for healthcare providers following IPOST
- May transfer care to another if unwilling to carry out wishes identified on IPOST
- Death resulting from withholding or withdrawing life-sustaining procedures does not constitute suicide, homicide, or dependent adult abuse

31

IPOST Mission

To create a system
to honor the healthcare treatment
choices of individuals
through improved communication
across the healthcare continuum and
to promote community engagement in advanced care planning.

32

Hartford ChangeAGEnt Award:
Honoring the Care Wishes
of Nursing Home Residents

33

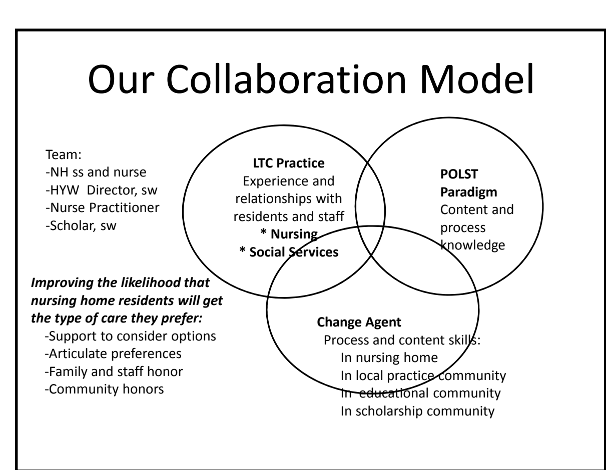
Hartford Change AGEnts Aims:

1) Enhance nursing home staff members' ability to engage residents and families in the advance care planning process including the POLST paradigm
2) Document nursing home residents' medical care preferences in the health care record
3) Develop an organization-wide protocol for securing, updating, and following IPOST
4) Complete audits to measure ACP & IPOST outcomes

34

What we are learning from our Hartford Change AGEnt Project

Mercedes Bern-Klug
John A Hartford Geriatric
Social Work Scholar



Systems Issues

- Staff did not anticipate that learning and incorporating the POLST paradigm would take much time, ***"We already ask about DNR"***
- Lesson learned from Dr. Nicole Peterson's research: The devil is in the details!
- Systems change can take time.

37

Hartford Project Implementation

- **Monthly team visits** – learning together
  - Education – law, literature, practice wisdom, Honoring Your Wishes
  - Support – empathy, brainstorming, normalizing
  - Building capacity:
- ***Record keeping***
- ***Train other staff***
- ***Residents***
- ***Families***
- ***Providers***

Support

- On-site
- Phone
- Email

39

Information in Medical Record

On IPOST form ***and*** in Medical Record.

40

Residents and Families

" I want CPR for her; I don't want her to choke to death"

"I don't want you to send me to the hospital and I want to be a full-code."

Nicole shares experience from a situation in a different city

41

Questions from Staff

- Sub-acute residents?
- Younger MI?
- Outings
  - Activities
  - Doctor appts

42

Other Providers:

- Importance of finding out what they want their role to be.

***Jane to discuss**:*

- Concerns about having a meaningful conversation
- Wanting to be included in the process
- "*More than a checklist*"
- Issues related to "verbal orders"
- Coordinating obtaining signatures outside of Nursing Home

43

Goal

People get the amount and type of care they want.

44

We did the best we could with what we knew.
Now we know better; now we must do better.
Maya Angelou

Your comments?

45