Washington POLST Clinician Toolkit

POLST Best Practices

This document explores best practices for the Washington POLST. These best practices have been selected to guide care, avoid common errors on the POLST, and support the development of systems for goal concordant care.

This document is one resource of the *Washington POLST Clinician Toolkit* and is intended to be used in conjunction with the other documents. To find the full *Washington POLST Clinician Toolkit*, please visit: https://www.honoringchoicespnw.org/polst-toolkit/ .

BASICS OF POLST USE FOR CLINICAL TEAMS
1. Completing a POLST is always voluntary.
2. POLST is a medical order: complete with medical oversight.
3. POLST is intended for people with a limited prognosis or high risk of harm.
ENSURE A PERSON-CENTERED APPROACH TO POLST
4. Initiate a goals of care conversation.
5. Discuss the diagnosis-specific implications of each decision.
6. Confirm concordance of decisions on POLST.
FINALIZE COMPLETION OF POLST
7. Ensure the POLST is signed and dated properly.
8. If appropriate, review preferences for medically assisted nutrition.
9. Ensure each POLST is recorded, stored, and accessible across settings.
CONFIRM A SYSTEM FOR USE OF POLST
10. Confirm policies to honor POLST.
11. Recognize POLST is intended primarily for Out-of-Hospital emergency care.

BASICS OF POLST USE FOR CLINICAL TEAMS

1. Completing a POLST is always voluntary.

Individuals should not be required, coerced, or otherwise compelled to have POLST and/or other advance care planning documents or conversations. It must remain their *choice* to engage in advance care planning and complete documents.

Best practices for promoting advance care planning include:

- Have policies and procedures to ask about and offer advance care planning to all individuals.
- Disease/Prognoses-specific goals of care conversations should be offered (NOT coerced or required) as standard of care for people with a serious illness.
- Offer goals of care conversations as standard of care for individuals with a serious illness.
- When appropriate, inform individuals about the role of POLST in making their wishes known and honored.
- Complete POLST as desired by the individual or their legal medical decision maker.
- Encourage conversations between the individual and those who matter to them, including their legal medical decision maker(s).
  - Assist in preparing the decision maker(s) to be advocates for the individual and increase their comfort with making future decisions.

2. POLST is a medical order: complete with medical oversight.

Ensure the POLST is completed under medical guidance. Encourage the individual to make an appointment to discuss the POLST, and invite those who matter to them, including legal medical decision maker(s), to attend the appointment.

The POLST is a medical order; as such, it should not be finalized without the guidance of a health care provider. Individuals may want to take the POLST home to discuss their decisions with those who matter to them, including those who will act as a legal medical decision maker(s). A follow-up appointment should be set up between the individual and the health care provider (MD, DO, ARNP, PA-C) for final review of their decisions and to complete the form with the proper signatures and date.

3. POLST is intended for people with a limited prognosis or high risk of harm.

POLST is intended for individuals with serious life-limiting medical conditions or advanced frailty. Examples of medical conditions in which a POLST should be considered (not a complete list):

- Severe Heart Disease
- Metastatic Cancer or Malignant Brain Tumor
- Advanced Lung Disease
- Advanced Renal Disease
- Advanced Liver Disease
- Advanced Frailty
- Advanced Neurodegenerative Disease (e.g., Dementia, Parkinson's Disease, ALS)[i]

POLST should be offered if you would not be surprised if the individual died in the next 1-2 years or if the individual would be potentially harmed by, or their overall condition worsened by, aggressive invasive measures, including cardiopulmonary resuscitation (CPR).

Healthy adults, including many individuals over the age of 65, are not the intended audience for the POLST; these individuals should have advance directives.

ENSURE A PERSON-CENTERED APPROACH TO POLST

4. Initiate a goals of care conversation.

The best way to know if POLST is 'right' for an individual is to have a high-quality goals of care conversation with them.

The skill of having a high-quality goals of care conversation, including an empathic delivery of prognostic information is invaluable in supporting individuals with serious illness. These conversations will help the individual and their legal medical decision maker understand how their medical condition may impact the outcome of medical interventions.

For more information about a goals of care conversation, see *Washington POLST Clinician Toolkit - Goals of Care*.

5. Discuss the diagnosis-specific implications of each decision.

The POLST Toolkit Completion Guide addresses the process of reviewing the CPR decision and the level of medical interventions that may be offered in an emergency. It is important to review and discuss the implications of each decision, given their medical condition, with the individual or the person making decisions on their behalf.

The decision on the level of medical intervention (Section B) is used when the patient is alive but in distress. Discuss this decision, and the implications of each level of care, before completing Section A.

It is important the individual understands that CPR is only initiated when there is no heartbeat and no breathing (i.e., they have died due to vital functions ceasing).

6. Confirm concordance of decisions on POLST.

It is important that an individual's decisions on the POLST reflect their values and preferences with consideration to their overall health status. In addition, the decisions in Sections A and B must be in alignment. Together these sections should reflect a plan of care that will be actionable by emergency responders and others providing care.

If an individual's heart and breathing stop and they have indicated "Attempt Resuscitation/CPR" on their POLST form, it is important that they understand that this includes all the following interventions to attempt resuscitation: defibrillation, chest compressions, and artificial ventilation.

By indicating "Attempt Resuscitation/CPR." Emergency Medical Services will perform the standard of care, which includes all the advanced resuscitation methods above and any other interventions that may be useful in an attempt to restore life.

Choosing "Yes-Attempt Resuscitation/CPR" but placing limits on this, including the choices of "Selective Treatment" in Section B is not recommended.

- First responders are trained to do everything possible that may be helpful, even if the odds of survival are very low. If an individual wants to limit which measures are started or how long they are attempted, this can be noted in bold print in the box above Section A.

7. Ensure POLST is signed and dated properly.

A valid Washington POLST requires two signatures:

- The signature of the health care provider who is verifying it as a medical order. Qualified signing health care providers include MDs, DOs, ARNPs, and PA-Cs.

  AND

- The signature of the individual with decision-making capacity or their legal medical decision maker as determined by guardianship, durable power of attorney for health care (DPOA-HC), or a person authorized to give health care informed consent per chapter 7.70.065 RCW.

Like all medical orders, each signature must be accompanied by the printed name and date. The POLST is not valid unless all appropriate dates and signatures are completed in Section C.

Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility.

See *Washington POLST Clinician Toolkit - POLST Completion Guide* for how to properly change the effective date upon a review of a completed POLST.

8. If appropriate, review preferences for medically assisted nutrition.

Medically assisted nutrition is not considered part of EMS' standard of care for medical interventions. However, goals of care conversations may include discussions about preferences for medically assisted nutrition and other life sustaining interventions. If the individual has capacity to indicate their preference regarding medically assisted nutrition, these may be captured in this section of the POLST and should also be reflected in their advance directives.

If the individual no longer has decision making capacity, a legal medical decision maker can indicate a preference here, either based on the individual's known preferences or based on what is in their best interest, under the guidance of the health care provider.
It is best practice to address the differences in function and expected outcomes of medically assisted nutrition as a time-trial, short term, or prolonged intervention.

(instructions for this section continued on next page)

Preferences on medically assisted nutrition do not serve as actionable orders like those found in Sections A and B. This section is intended to guide care in a hospital or other inpatient setting.

The actionable orders on the POLST will remain valid if this section is not addressed/discussed.

9. Ensure each POLST is recorded, stored, and accessible across settings.

Everyone in your clinical setting should be trained to ensure that POLST is properly stored and accessible in the EHR, in personal health records, and if possible, in shared directories or repositories. By taking responsibility for proper storage of the POLST, health care professionals can help ensure goal concordant care.

Ensure that the original POLST and additional copies are given to the individual and/or their legal medical decision maker(s), as well as any additional supportive people who may be called or are likely to be present in an emergency. POLST is intended to travel with the individual to ensure it is available to emergency medical services, if needed.

Typical places POLST can be kept:

- On a refrigerator, or a prominent bulletin board in the main living area, or near the phone with other emergency documents and numbers. (Some like to keep in Freezer. Advise that a note be on the outside of the freezer door: *POLST in freezer*)
- Pictures and other virtual copies can be taken and kept on phone, or other device.
- Bracelets can be ordered to indicate POLST is available. Lifeline.org

It is also the responsibility of all health care team members to ensure the most recent POLST is accessible and shared across the care continuum. This includes, but is not limited to, specialists, primary care, hospitals, SNF, and EMS (if possible).

Original and copies of the POLST on paper remain the gold standard for ensuring that EMS can follow POLST orders. Digital images, such as pictures on a cell phone, are also encouraged.

CONFIRM A SYSTEM FOR USE OF POLST

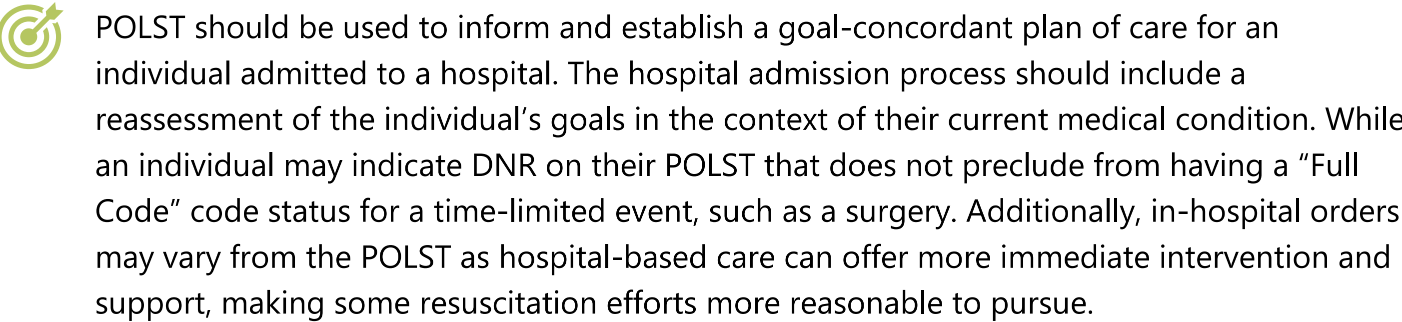
10. Confirm policies to honor POLST.

Best practices for POLST policies include:

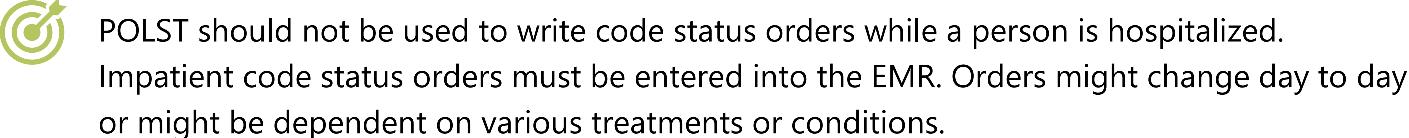
- Addressing how the POLST will be stored and retrieved during an emergency.
- Reinforcing the rights of the individual to have advance care planning, including completion of a POLST, while acknowledging that the process is voluntary and free from coercion or threat of losing care or benefits.

11. Recognize POLST is intended primarily for Out-of-Hospital emergency care.

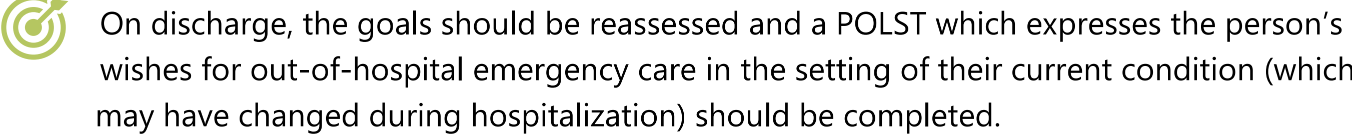
POLST is primarily intended to guide out-of-hospital emergency care provided by EMS providers or other health care providers.



POLST should be used to inform and establish a goal-concordant plan of care for an individual admitted to a hospital. The hospital admission process should include a reassessment of the individual's goals in the context of their current medical condition. While an individual may indicate DNR on their POLST that does not preclude from having a "Full Code" code status for a time-limited event, such as a surgery. Additionally, in-hospital orders may vary from the POLST as hospital-based care can offer more immediate intervention and support, making some resuscitation efforts more reasonable to pursue.



POLST should not be used to write code status orders while a person is hospitalized. Impatient code status orders must be entered into the EMR. Orders might change day to day or might be dependent on various treatments or conditions.



On discharge, the goals should be reassessed and a POLST which expresses the person's wishes for out-of-hospital emergency care in the setting of their current condition (which may have changed during hospitalization) should be completed.

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[i] National POLST. Intended Population & Guidance for Health Care Professionals. https://polst.org/wp-content/uploads/2020/03/2019.01.14-POLST-Intended-Population.pdf#:~:text=Intended%20Population%20%26%20Guidance%20for%20Health%20Care%20Professionals,life-limiting%20medical%20condition%2C%20which%20may%20include%20advanced%20frailty. 2019 Jan 14.