Nevada POLST Post

Summer 2019

POLST: The 7 Deadly Sins - In this issue the 1st of 7

In the next few issues we will be excerpting passages from *POLST:Avoid the Seven Deadly Sins* discussing the most common improper uses of the POLST as presented by Charlie Sabatino, Esq. in *Bifocal*, a publication of the American Bar Association.

> Because the POLST form is such a powerful tool in directing care and treatment, its improper use poses an equally powerful risk of undermining person-centered, informed decision-making at the end of life if the form does not truly reflect their informed preferences.
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> **Deadly Sin #1**: **Using POLST with people who are too healthy**.
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> POLST is for individuals with a serious illness or frailty whose health care providers would not be surprised if they died within the next year or so. It is also an entirely voluntary option for patients. The specificity of the medical orders contained in a POLST order set are justified by the proximity between the patient's current condition and the critical care decisions likely to be faced by patients in the here and now. Using the form further "upstream," such as for patients who reach a specific age or for all patients who enter a nursing home, eliminates the connection between the orders and immediate medical circumstances and forces patients to address increasingly hypothetical rather than known circumstances.
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> One illustration of the immediacy of POLST comes from a study of advance care planning in LaCrosse, Wisconsin, which found that among a sample of 400 decedents, advance directives were completed an average of 3.8 years before death versus an average of 4.3 months for POLST forms.[1] In another study, death certificates of 18,285 Oregon decedents were matched to the state's POLST registry. The study found that the median interval between POLST completion and death was just 6.4 weeks.[2]
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> The error that some nursing homes have fallen into is that of using POLST forms for all or most residents, possibly because they are required to document the code status of all residents. The POLST Paradigm is far more than a documentation of code status. Its misuse with residents who enter a nursing home for short-term rehabilitation puts them in the position of having to make decisions about a range of premature and out-of-context interventions inappropriate to their situation. Moreover, the expectation that all residents should have a POLST form undermines its voluntary nature.
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> For these "healthier" residents, nursing homes need to find a distinct way to document code status.

A few notes on Deadly Sin #1from Nevada POLST:

A POLST is a patient's treatment preferences in their *current* state of health. It is *not* an *advance* directive expressing what a patient may want in the event they have a change of health status. Therefore, it is not appropriate for all patients because most patients change their preference as their health status declines.[3,4] Therefore, as a patient's health status changes, their POLST should be reviewed.

In instances where code status is required for admission, but the patient is not a POLST profile patient, we recommend using whatever protocol was used prior to the existence of Nevada POLST.

1. Hammes BJ, BL Rooney, and JD Gundrum (2010). "*A Comparative, Retrospective, Observational Study of the Prevalence, Availability, and Specificity of Advance Care Plans in a County that Implemented an Advance Care Planning Microsystem*." Journal of the American Geriatrics Society, 58(7):1249-55.
2. Zive DM, EK Fromme, TA Schmidt, JNB Cook, and SW Tolle (2015). "*Timing of POLST Form Completion by Cause of Death*." Journal of Pain and Symptom Management, 50(5) 650-58.
3. Ditto PH, Jacobson JA, Smucker WD, et al. (2006). "*Context Changes Choices: A Prospective Study of the Effects of Hospitalization on Life-Sustaining Treatment Preferences*." Sage Journal. Found at:mhttps://journals.sagepub.com/doi/abs/10.1177/0272989X06290494.

Meet our New Board of Directors

At this year's annual Board of Director's meeting, Nevada POLST welcomed two new board members and reorganized its officers.

Kristine Strand, BSN, RN. REMSA-Care Flight Clinical Services and Quality Manager brings her expertise in emergency medical services (EMS) and her years as an emergency department nurse to our board. Kristine has already begun her work with and for Nevada POLST. She is encouraging her staff and administration to take our Nevada POLST Overview webinar and is working on Provider Education with two other board members, **Mary-Ann Brown**, MSN CHPCA GCHCE HEC-C, Director of Palliative Care for Renown Health, and **John Hardwick**, MD an Emergency Medicine physician who brings his experience working with POLST in both Oregon and Illinois.

Jenifer Ausiello, DNP, APRN, AGNP-C, ACHPN has her own practice and works in palliative care at Dignity Health, Las Vegas. Jenifer will be joining **Peggy Ewald**, RN, CCM, Director of Clinical Services at Geriatric Specialty Care, and **Sally Hardwick**, MS, founder of Nevada POLST presenting online webinars and in-person trainings.

Peggy Ewald continues as our Chair. However, other officers have changed. **Sally Hardwick** is now Vice-Chair, **John Hardwick** is Treasurer and **Patti Pollina**, APRN, ACHPN, NP-C who works on the Admissions Transitions Optimization Program (ATOP) at Comagine (previously HealthInsight) and and runs the Conversations Matter Workgroup on ACP in Las Vegas is our Secretary. Other board members, not previously mentioned, are **Steven L. Phillips**, MD. President of Geriatric Specialty Care, and **Peter Reed**, PhD, MPH, Director of Sanford Center for Aging, University of Nevada, Reno School of Medicine.

Our plans for next year are to advance its standing at the national level, increase Nevada POLST training and initiate systems to better track the appropriate use and honoring of Nevada POLST.

4. Fried TR, Byers, AL, Gallo WT, et al. (2006). "*Prospective Study of Health Status Preference and Changes in Preferences Over Time in Older Adults*." *Arch Inter Med.* 2006;166(8):890-895.

ACEP Guidelines for POLST use in the Emergency Department.

In April of last year, the governing body of Emergency Medicine, the American College of Emergency Physicians, published a policy statement regarding POLST and the treatment of patients presenting with a POLST form. This policy offers a good overview of the POLST, how Emergency Physicians should interpret POLST preferences, how to respond to confounding completion of a POLST form and the legal protections offered for compliance with a POLST order.

Click to read the entire to the ACEP POLST policy.

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POLST Q & A

Q: *If a VA provider is not licensed in Nevada, can they sign a Nevada POLST*?
A: VA providers, because they are federal employees may practice in any state regardless of state of issue of their medical license. But, because POLST and other state-authorized portable orders (SAPO) are authorized by state law, it is state law that governs who may sign the orders. Nevada law requires that the provider be licensed in Nevada, so a VA provider who does not have a Nevada license is not authorized to sign a Nevada POLST form. However, this requirement is the responsibility of the signing provider, not the provider accepting the patient. If a provider or facility receives a POLST, as long as Section D (patient capacity) and the required signatures and information in Section E are complete, the provider may assume the validity of the POLST order. Signing a POLST fraudulently can result in significant legal jeopardy.

Q: *Our provider sends the POLST form home with patients for them to complete, then signs the form when they return it. Who should be listed as the Preparer on Side 2*?
A: The POLST should ONLY be completed by healthcare personnel. The POLST is a medical order; medical orders and prescriptions should NEVER be written by the patient! The POLST requires an informed consent to allow treatment choices; the risks and benefits, alternatives and likely outcomes of choices should be explained before a patient or, if the patient lacks decisional capacity, their representative or surrogate complete a POLST.

Q: *What is the difference between a healthcare representative and patient surrogate*?
A: Both of these, as applied to Nevada POLST, are legal terms. A **healthcare representative** is one the following: the patient's Durable Power of Attorney for Healthcare (aka Agent), the parent of a minor or the patient's legal guardian. These people may create, change or void a POLST of a patient who has lost decisional capacity. A **healthcare surrogate** is explained under the section "Completing a POLST" on the back of the current Nevada POLST. Surrogates are listed in order of authority, so, for example, a cousin has no authority if an adult sibling is present and willing to complete a POLST. A surrogate may only change or void a POLST that they themselves created for the patient, not a POLST created by the patient or their healthcare representative.

How Does EMS Respond to Comfort Focused Treatment?

When EMS responds to a patient with a POLST indicating Comfort Focused Treatment on their Nevada POLST form, should they transport the patient? It depends.

If the patient has arrested, responders should focus on the family. Reassure them that their loved one's values and wishes are being honored. If the patient was on hospice, remind the family that hospice must be contacted.

If the patient is actively dying reassure the family that the unusual breathing, elimination and other signs are normal. If the patient is not a hospice patient and the process is prolonged longer than the team can spend with the patient, and family is not able to care for the dying patient, the patient may be transferred to acute care. However, it is imperative that the patient's POLST be transferred with the patient to assure the patient does not receive care beyond comfort measures.