Physician’s Order for Life Sustaining Treatment (POLST)

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Learning Objectives

- Review history of POLST and LTC
- Review the Department of Health-Nursing Care Quality Assurance Commission Advisory Opinion on the POLST
- Review steps facilities should take to honor the POLST
- Discuss recommendations for facility policy and procedure development or update relating to the POLST form
- Discuss the Washington State Medical Association/POLST Task Force video for caregivers. The video provides caregivers with the what, when, where, and how the POLST form is applied.
The POLST was originally created to guide emergency medical services (EMS) personnel in emergency situations. The POLST was created to allow EMS staff to honor a person’s wishes through a medical order and exempts them from liability when doing so. In 2012, a Dear Provider letter from DSHS regarding the POLST read, “Since the POLST is intended for emergency medical personnel, there are issues related to legal immunity for others to follow the POLST directions.” Various legislative efforts to add caregivers to the list of those immune have failed.
What is a POLST?

- A POLST is a portable medical order form that summarizes a person’s wishes for end of life treatment and describes code directions.
- The POLST is intended to complement, not replace an advance directive.
- A POLST turns a person’s wishes in the advance directive into medical orders which may be followed by healthcare providers.
- A valid POLST must be signed by an authorized healthcare provider (ARNP, physician, or physician assistant) and the resident/representative.
Four Sections of the POLST

- Section A identifies CPR or DNAR/Allow Natural Death
- Section B identifies what action to take if the person has a pulse and/or is breathing and includes oxygen, suctioning, IV fluids, airway support, intubation, mechanical ventilation, etc.
- Section C includes signatures
- Section D identifies non-emergency medical treatment preferences including whether the person wants to receive antibiotics, medically assisted nutrition and hydration, and dialysis.
The Advisory Opinion Covers Section A Only
Purpose of the POLST

- To improve communication of a person’s decisions to accept or decline medical intervention and life-sustaining treatment in any healthcare setting and to ensure these decisions are honored when the person cannot communicate.

- A POLST is intended to go with a resident from one healthcare setting to another to ensure the resident receives care consistent with their healthcare decisions.
A POLST may apply in many settings, including but not limited to the following:

- Assisted living facilities
- Skilled nursing facilities
- Adult family homes
- Personal, residential homes
- Hospitals
- Hospices
- Correctional facilities
- Schools
A POLST is Voluntary

- A POLST is not mandated by law and a facility cannot require a resident to have a POLST.

- Facilities MUST ask upon admission whether a resident has made an advance directive.

- The Federal Patient Self-Determination Act (PDSA) prohibits facilities from conditioning care on whether or not a resident has an advance directive.
  - The PDSA definition of advance directives includes a variety of advance directive documents, including a POLST.
WAC 388-78A-2600 Policies and Procedures Assisted Living Facilities are required to have policies and procedures in place

The assisted living facility must develop, implement and train staff persons on policies and procedures to address what staff persons must do:

- When a resident stops breathing or a resident's heart stops beating, including, but not limited to, any action staff persons must take related to advance directives and emergency care; and
- In response to medical emergencies.
May facilities refuse to honor the POLST?

Yes.

The Natural Death Act, RCW 70.122 allows health care facilities to refuse to participate in withholding or withdrawing life-sustaining treatment due to moral or ethical objections.
Residents must be informed upon admission of the facility’s policies and procedures surrounding implementation of advance directives and the POLST.

If a facility objects to honoring a POLST directive, they are required to assist the resident/family in transferring the resident to a facility that is willing to honor the POLST order if the resident so desires.
How is a POLST created?

- The resident or his/her legal surrogate decision maker and the authorized healthcare provider should discuss information to assure the POLST reflects the resident’s wishes.
- POLST must be signed by a physician/ARNP/PA-C and resident, or his/her surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.
- Any incomplete section of POLST implies full treatment for that section.
- The POLST is a set of medical orders. The most recent POLST replaces all previous orders.
This POLST should be reviewed periodically whenever:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person’s health status, or
- The person’s treatment preferences change.
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial

Date of Birth

Gender

Medical Conditions/Patient Goals:

Agency Info/Sticker

A. CARDIOPULMONARY RESUSCITATION (CPR):
   - Person has no pulse and is not breathing.
   - CPR/Attempted Resuscitation
   - DNAR/Do Not Attempt Resuscitation (Allow Natural Death)

Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

B. MEDICAL INTERVENTIONS:
   - Person has pulse and/or is breathing.

   - COMFORT MEASURES ONLY
     - Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort.
     - Patient prefers no hospital transfer: EMS contact medical control to determine if transport indicated to provide adequate comfort.

   - LIMITED ADDITIONAL INTERVENTIONS
     - Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BIPAP).
     - Transfer to hospital if indicated. Avoid intensive care if possible.

   - FULL TREATMENT
     - Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
     - Transfer to hospital if indicated. Includes intensive care.

   Additional Orders (e.g. dialysis, etc.)

C. SIGNATURES:
   - The signatures below verify that these orders are consistent with the patient’s medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

   Discusses with:
   - Patient
   - Parent of Minor
   - Guardian with Health Care Authority
   - Spouse/Other as authorized by ODC 720.362
   - Health Care Agent (POA/HC)

   PRINT — Physician/ARNP/PA-C Name
   Phone Number

   PRINT — Physician/ARNP/PA-C Signature (mandatory)
   Date (mandatory)

   PRINT — Patient or Legal Surrogate Name
   Phone Number

   X — Patient or Legal Surrogate Signature (mandatory)
   Date (mandatory)

   Person has:
   - Health Care Directive (living will)
   - Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed POLST forms are legal and valid. Make copies for records.
What Medical Orders Are Included in a POLST?

The POLST is divided into four sections:
Section A identified what action to take if the resident is not breathing and does not have a pulse.
- CPR (Attempt Resuscitation) or
- DNAR (Do Not Attempt Resuscitation)/Allow Natural Death
Section B identifies what action to take if the resident has a pulse and/or is breathing

- Use of Oxygen
- Suctioning
- Intravenous Fluids
- Airway Support
- Advanced Interventions such as intubation, mechanical ventilation, and other intensive care related procedures
Section C

Signatures

- The signatures verify that the orders are consistent with the patient’s medical condition, known preferences and best known information.

- If signed by a surrogate, the resident must be decisionally incapacitated and the person signing is the legal surrogate.
Section D identifies non-emergency medical treatment preferences including:

- Antibiotics
- Medically assisted nutrition
- Medically assisted hydration
- Dialysis
The Nursing Commission received a formal request from the DSHS as to whether current standards of practice for NACs, NARs, and C-HCAs allow them to follow doctors orders to independently implement a “no code” or “No CPR” order; including a POLST.
Physician’s Order for Life Sustaining Treatment (POLST): Scope of Practice for Registered Nurses, Licensed Practical Nurses, and Nursing Assistants

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The Advisory Opinion concluded the following:

- The Nursing Commission supports honoring resident choices about end of life planning and following medical orders implementing resident decisions.
- Subjecting residents to unwanted medical treatment is contrary to best practices and nursing principles.
- The Nursing Commission concludes that RNs and LPNs may follow a valid POLST in ANY setting.
The NCQAC determines that a Nursing Assistant-Certified (NAC), Nursing Assistant-Registered (NAR), and other “unlicensed assistive personnel (UAP) MAY FOLLOW the instructions in SECTION A of the POLST indicating, “Attempt Resuscitation-Perform Cardiopulmonary Resuscitation (CPR)” or “Do Not Attempt Resuscitation (DNAR)-Allow a Natural Death” by providing nursing care and using nursing judgment during an emergency.

- An unresponsive resident or a resident without a pulse is considered an emergency situation.
The Nursing Commission does NOT have the authority to define scope of practice for Certified-Home Care Aides (C-HCAs).

- However, the advisory opinion does include the term “UAP” which may apply to C-HCAs.

- The Secretary of Health has the authority to write rules defining the scope of practice for C-HCAs.
Nursing assistants may follow orders in Sections B and D of a valid POLST under the direction and supervision of a RN or a LPN.
Nurses and nursing assistants should be aware that following a POLST is similar to carrying out any other medical order---there is no legal immunity (except for emergency responders) and healthcare providers are accountable for following the standard of care.

The Washington Natural Death Act provides immunity for caregivers following an advance directive (RCW 70.122.051). If the advance directive and POLST are consistent, caregivers should have legal immunity when following a POLST order.

If there is no advance directive, caregivers should honor the POLST order as they would follow any other medical order.
What is a UAP?

- According to the Department of Health Nursing Commission, caregivers that hold a nursing assistant credential (NAC or NAR) may work under that credential or work as “unlicensed assistive personnel” (UAP).
- If a NAC or NAR is working under the supervision of a RN or a LPN, they are working under their credential.
- If a NAC or NAR is working without the supervision of a nurse, according to the Department of Health the NAC or NAR is working as a UAP.
  - Since the nursing commission does not have oversight authority for C-HCAs, they did not comment on this credential.
This does not mean that an UAP does not need to still meet the necessary qualifications and training required in an assisted living facility.
- **Supervision** is defined by the Department of Health as providing guidance and evaluation for the accomplishment of a nursing task or activity with the initial direction of the task or activity; periodic inspection of the actual act of accomplishing the task or activity, and the authority to require corrective action.

- **Indirect supervision** means the nurse who is providing supervision is not on the premises, but has given written or oral instructions for the care and treatment of the resident (WAC 246-840-010(22)(c)).
Nursing Assistants (NAC or NAR) and other UAP may NOT perform tasks that require nursing judgment EXCEPT IN EMERGENCY SITUATIONS.

The Nursing Commission has determined that nursing assistant core competencies include vital signs and proficiency with CPR. Because nursing assistants may take vital signs, they may independently determine if a resident has no pulse.
A nursing assistant or other UAP may use nursing judgment to assess if the resident is unresponsive or has no heartbeat.

A nonresponsive resident with or without a heartbeat is an emergency situation even though death may be expected.

The Nursing Commission has determined that a nursing assistant or other UAP should follow Section A of the POLST order to either provide CPR or provide comfort care while allowing a natural death.
Sections B and D of the POLST may indicate medical interventions outside the scope of a nursing assistant.

Sections B and D may contain tasks that, in conjunction with facility policy and resources and other necessary regulations, may be nurse delegated depending on the specific situation.

Sections B and D should be honored to the highest ability possible either through direct care or coordination of that care.
- According to the Nursing Commission opinion, it is within the scope of practice for an ARNP, RN, or a LPN to determine or pronounce death.

- It is NOT within a nursing assistant’s scope of practice to determine or pronounce death.
Recommendations

- Facilities need to develop policies and procedures regarding advance directives and POLST.

- Ensure the existence of advance directives and/or POLST are a part of residents' negotiated service agreements.

- Facilities should ensure the POLST is reviewed with all transfers and significant changes in resident condition.

- Direct that any discussions regarding significant changes to a resident’s POLST include the resident’s medical provider, the resident, and/or the legal surrogate decision maker.
Recommendations

- Assisted living facilities need to ensure that staff are trained regarding the facility’s policies/procedures, and have knowledge of residents’ wishes regarding life sustaining treatment.

- Policies and procedures need to address where and how information regarding residents’ POLST and advance directive information is maintained and communicated.

- Staff education needs to include how to recognize and respond to medical emergencies, such as choking, anaphylaxis, and significant injuries.
What does a caregiver/nurse do if the resident has a POLST saying NO CPR and the family member demands the caregiver initiate CPR?

- A competent resident or legal surrogate decision maker may always change their medical treatment decisions and request alternative treatment.
- However, in an emergency situation it may be difficult to determine whether or not the family member is the legal surrogate decision maker.
- Facilities need to establish policies and procedures to address these situations and discuss with staff their expectations of the staff to support and advocate for the residents’ POLST directives.
Is nurse delegation required in order for a NAC, NAR, or UAP to follow a POLST Part A?

Delegation is **not** required for a nursing assistant (NAC, NAR, or UAP) to follow Part A of the POLST form.
Can a nursing assistant (NAC, NAR, UAP) follow a POLST, Section A if a nurse is not directing or supervising the resident’s care?

Yes, in community based settings, such as an assisted living facility, personal care is given by nursing assistants with or without nurse direction or supervision. The nursing assistants need to have training regarding the facility’s policies and procedures and may implement Section A of the POLST.
What if a resident stops breathing due to an accident, such as choking?

- If a resident’s heartbeat stops during a witnessed choking incident or other accident, perform basic first aid measures per standard training.

- Each resident’s negotiated service agreement should include details specifying if the POLST DNAR order applies in all circumstances. The POLST should include a note in Section A stating “DNAR-No exceptions” initialed by an authorized provider if indeed the resident does not want CPR for any reason. Direct caregivers and supervisors should be familiar with the details of each resident’s plan of care and POLST directives.
What should a caregiver do if they initiate CPR on a resident and then determine the resident has a POLST indicating “DNAR?”

If a resident’s POLST order indicates no CPR, CPR should not be initiated. In the event that CPR is erroneously initiated, CPR should be discontinued if no pulse is detectable.
Policy and Procedure Considerations

- Where the POLST is stored
- How often/when the POLST is reviewed
- What to do if a resident does not have a POLST form
- Steps to take in a medical emergency (choking, allergic reaction, etc.) REGARDLESS OF RESIDENT’S CODE STATUS

- Steps to take when a resident does not have a pulse/respiration and:
  - Does not have a POLST form
  - Has a POLST form that instructs DNAR
  - Has a POLST form that instructs CPR
  - Is on hospice

- Steps to take if CPR is started, then a no code order is discovered
What Resources are Available?

- The Washington State Medical Association (WSMA) in conjunction with the Washington State POLST Taskforce has developed a video entitled, **POLST for Caregivers: Honoring POLST in Private Homes and Residential Care Settings**. This video provides caregivers with the what, when, where and how the POLST form is applied.

- This video was created by a team of experts convened by the WSMA, the Washington State POLST Task Force and DSHS, and was made possible by a grant from The Retirement Research Foundation through the National POLST Paradigm Task Force.
The video is accessible by direct link [https://vimeo.com/127507151](https://vimeo.com/127507151). This goes to a page on the Washington State Medical Association’s Vimeo account where the video lives. From this page the viewer can view the video as full screen and can share via social media.

The video has been embedded on the WSMA POLST Web page, [www.wsma.org/polst](http://www.wsma.org/polst), under ‘Educational resources.’
Next Steps

- WHCA & DSHS are developing a one hour CE for ALFs to train staff in conjunction with the POLST video for caregivers. It will cover:
  - Facility-specific policies and procedures
  - Expectations of the caregiver relating to the POLST
  - Interactive trouble-shooting scenarios
- A train-the-trainer will be part of this CE
- Should be available by Winter Conference (February 2016)
Additional Resources

- Washington State Hospital Association (206) 281-7211
- Washington State Medical Association website:
  

- Resources and video are available in Spanish on the WSMA website
Washington State Department of Health
Office of Community Health Systems
EMS & Trauma Section
(360) 236-2841, (800) 458-5281

http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/PhysiciansOrdersforLifeSustainingTreatment

Department of Health-NCQAC Advisory Opinion and FAQs

http://www.doh.wa.gov/Portals/1/Documents/6000/POLST.pdf

www.doh.wa.gov/Portals/1/Documents/6000/FAQ-POLST.pdf
Contacts

The volunteer health professionals below are willing to help answer any questions you might have regarding POLST.

- **Bruce Smith, MD**, (bruce.smith@regence.com), physician perspective
- **Sharmon Figenshaw, ARNP, CHPN**, (shar@dslnorthwest.net), hospice/palliative care perspective
- **Cattie Holstein, EMS & Trauma Supervisor, Dept. of Health, EMS Section & Trauma Prevention**, (catie.holstein@doh.wa.gov), emergency medical service perspective
- **Graham Short**, (gfs@wsma.org), for questions regarding the management of the statewide POLST program
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