Model Policy for Skilled Nursing Facilities

Physician Orders for Life Sustaining Treatment (POLST)

SUMMARY OF RECENT REVISIONS (March 29, 2010)

Following is a summary of the key revisions to the Model Policy for Skilled Nursing Facilities.

The Model P&P for Skilled Nursing Facilities (SNFs) was updated to reflect the All Facilities Letter (AFL) from the California Department of Public Health (CDPH) dated December 3, 2009, and address the importance of Advance Health Care Directives. The specific revisions may be found below:

***Revision**: <u>Section IV. Change in Patient Condition: Continuing Assessment and Reassessment</u> was added to the revised Model Policy to addresses the issues raised in the AFL.*

***Revision**. <u>Section III. Initiating a POLST, part 2</u> was added to stress the importance of determining whether a resident has an AHCD and ensuring that POLST and the AHCD are complementary.*

Model Policy for
SKILLED NURSING FACILITIES
Physician Orders for Life Sustaining Treatment (POLST)

Revised: March 29, 2010

PURPOSE

The purpose of this policy is to define a process for skilled nursing facilities to follow when a resident is admitted with a Physician Orders for Life Sustaining Treatment (POLST). This policy also outlines procedures regarding the completion of a POLST form by a resident and the steps necessary when reviewing or revising a POLST form.

PREAMBLE

The Physician Orders for Life-Sustaining Treatment (POLST) is a physician order form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders. It is designed to be a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be a portable, authoritative and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings.

The POLST form:

- Is a standardized form that is brightly colored and clearly identifiable[1];
- Can be revised or revoked by an individual with decisionmaking capacity at any time;
- Is legally sufficient and recognized as a physician order;
- Is recognized and honored across treatment settings;
- Provides statutory immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction or any other sanction to a healthcare provider who relies in good faith on the request and honors a POLST;
- Can be an alternative to the "Pre-Hospital Do Not Resuscitate," "Preferred Intensity of Care" and "Preferred Intensity of Treatment" forms[2], although POLST is more comprehensive in that it addresses other life-sustaining treatment in addition to resuscitative measures; and,
- Should be made available for residents who wish to execute a POLST form while in the nursing facility.

A health care provider is not required to initiate a POLST form, but is required to treat an individual in accordance with a POLST form. This does not apply if the POLST requires medically ineffective health care or health care contrary to generally accepted health care standards.[3]

A legally recognized health care decisionmaker[4] may execute, revise or revoke the POLST form for a resident only if the resident lacks decisionmaking capacity. This policy does not address the criteria or process for determining or appointing a legally recognized health care decisionmaker, nor does it address the criteria or process for determining decisionmaking capacity.[5]

While a health care provider[6] such as a nurse or social worker can explain the POLST form to the resident and or the resident's legally recognized health care decisionmaker, the physician is responsible for discussing the efficacy or appropriateness of the treatment options with the resident, or if the resident lacks decisionmaking capacity the resident's legally recognized health care decisionmaker.

Once the POLST form is completed, it must be signed by the resident, or if the resident lacks decisionmaking capacity the resident's legally recognized health care decisionmaker, AND the attending physician.

The POLST is particularly useful for persons who are frail and elderly or who have a compromised medical condition, a prognosis of one year of life or less, and/or a terminal illness. The POLST form should be executed as part of the health care planning process and ideally is a complement to a resident's advance directive. A POLST form may also be used by residents who do not have an advance directive. Completion of a POLST form should reflect a process of careful decisionmaking by the resident, or if the resident lacks decisionmaking capacity the resident's legally recognized health care decisionmaker, in consultation with the physician, about the resident's medical condition and known treatment preferences.

SKILLED NURSING FACILITY PROCEDURES[7]

I. Resident Admitted with a Completed POLST Form

1. The admitting nurse will note the existence of the POLST form on the admission assessment and review the form for completeness (e.g. signed by resident or legally recognized healthcare decisionmaker, and by a physician) and confirm with the resident, if possible, or the resident's legally recognized health care decisionmaker, that the POLST form in hand had not been revoked or superseded by a subsequent POLST form. A completed, fully executed POLST is a legal physician order, and is immediately actionable.

2. Once reviewed, the POLST should be copied, and the current original form placed in the front of the resident's chart, along with the resident's advance directive if he/she has one. As the resident moves from one health care setting to another, the original pink POLST and copies of the resident's advance directive should always accompany the resident.

3. Add the POLST form to the resident's inventory to ensure that when the resident is discharged or transferred, the current original POLST will be sent with the resident.

4. The order to "Follow POLST instructions" will be added to the resident's admitting orders for physician review. It is the attending physician's responsibility to review this order with respect to the resident's wishes and goals of care, within 72 hours of admission whenever possible. The physician will complete the review process by signing an order in the chart stating, "Follow POLST instructions." Thereafter, the orders will be renewed and reassessed on a periodic basis and as warranted by a change in the resident's health status, medical condition or preferences.

5. The POLST will be honored during the initial comprehensive assessment period (14 days) even if the attending physician has not yet formally reviewed the form. If "Do Not Attempt Resuscitation" is indicated on the POLST, follow the facility procedure for communication and documentation of DNR/DNAR.

6. POLST may replace the "Preferred Intensity of Care," "Preferred Intensity of Treatment," and "Pre-Hospital DNR/DNAR" forms, if consistent with facility policy.

7. If the POLST conflicts with the resident's previously-expressed health care instructions or advance directive, then, to the extent of the conflict, the most recent expression of the resident's wishes governs. *(See Section VI, "Conflict Resolution" for additional guidance.)*

8. A qualified health care provider[8], preferably a registered nurse or social worker, will conduct an initial review of the POLST with the resident, or if the resident lacks decisionmaking capacity the legally recognized health care decisionmaker, within the first required 14-day assessment period as part of the comprehensive assessment and care planning process.

9. If the resident, or when the resident lacks decisionmaking capacity the legally recognized health care decisionmaker, expresses concern or has questions about the POLST form, the attending physician or medical director will be notified as soon as possible to discuss any issues with the resident, or if the resident lacks decisionmaking capacity the legally recognized decisionmaker.

10. The initial review and discussion about continuing, revising or revoking the POLST should be documented in the medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.

II. Reviewing/Revising the POLST

1. The POLST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference, anytime there is a significant change[9] in the resident's condition, and at anytime that the resident, or if the resident lacks decisionmaking capacity the legally designated health care decisionmaker, requests it.

2. At any time, a resident with decisionmaking capacity can revoke the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or, after consultation with the resident's physician, a new POLST. The new POLST form must be signed by the physician and the resident and the revoked POLST must be voided.

3. If a resident decides to revoke the POLST form, the resident's attending physician should be notified and appropriate changes to the physician orders should be obtained as soon as possible to ensure that the resident's wishes are accurately reflected in the plan of care.[10]

4. If the resident lacks decisionmaking capacity and the legally recognized health care decisionmaker wants to consider revising or revoking the POLST form, he/she must consult the resident's physician before any change is made to the resident's POLST form.[11] The legally recognized health care decisionmaker, together with the physician, may revise the POLST only when the change is consistent with the known desires of and in the best interest of the patient. *(See also Section IV, "Change in Patient Condition: Continuing Assessment and Reassessment".)*

5. All discussions about revising or revoking the POLST should be documented in the resident's medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.

6. To void POLST, draw a line through the entire Section A through D and write "VOID" in large letters. The original POLST marked "VOID" should be signed and dated.

III. Initiating a POLST

1. If a resident, or if the resident lacks decisionmaking capacity the legally recognized health care decisionmaker, wishes to complete a POLST form during the resident's stay, provide a POLST form for the physician and the resident or the resident's legally designated health care decisionmaker to discuss, fill out and sign. Notify the resident's physician or the medical director that the resident, or the legally designated health care decisionmaker if the resident lacks decisionmaking capacity, wishes to discuss the treatment options on the POLST form.

2. During the admission process, facility staff should determine whether the resident has an advance health care directive. If an advance directive exists, obtain a copy and attach it to the POLST. Include these documents in the medical record. If the advance health care directive is not consistent with the resident's currently-expressed health care wishes and treatment instructions, then the most recent expression of the resident's wishes govern. *(See Section VI, "Conflict Resolution.")*

3. The physician should discuss the benefits, burdens, efficacy and appropriateness of treatment and medical interventions with the resident, or if the resident lacks decisionmaking capacity the resident's the legally recognized health care decisionmaker. A health care provider such as a nurse or social worker can explain the POLST form to the resident and/or the resident's legally recognized health care decisionmaker; however, the physician is responsible for discussing treatment options with the resident and/or the resident's legally recognized health care decisionmaker.

4. Follow facility procedures for issues brought to the physician's attention to ensure follow-up on the resident's request for a POLST.

5. Make a copy of the completed POLST form. Mark it as "COPY" with the date the copy was made. File the copy in the advance directive or legal section of the medical record. The current original POLST form is considered the property of the resident, and will be transferred with the resident upon discharge, so the copy is the only record that will remain with the facility.

6. Add the POLST form to the resident's inventory to ensure that the current original form is sent with the resident upon transfer or discharge from the facility.

7. Place the current original POLST form, along with a copy of the resident's advance directive (if he/she has one) at the front of the resident's physical chart.

IV. Change in Patient Condition: Continuing Assessment and Reassessment

1. It is recognized that in some resident care situations, a decline in status (medical, physical, mental, psychosocial) is an expected and unavoidable outcome. In these situations, when an expected change in condition occurs, it is generally <u>not</u> necessary to reassess POLST status when a resident has chosen comfort care and rejected life-prolonging measures. It is generally inappropriate to change POLST under these circumstances. However, the physician is ultimately responsible for the decision whether to modify POLST status.

2. Whenever a resident exhibits a sudden and/or marked adverse change in signs, symptoms and/or behavior, the attending physician must be notified,[12] regardless of the POLST instructions, or of whether the change was an expected outcome of the disease process. The physician will evaluate whether the current plan of care is effectively meeting the resident's treatment needs in light of his/her previously or currently expressed wishes.

3. Unless the resident requests otherwise, the family also will be notified of any marked and/or adverse changes in the resident's status as soon as possible.

4. The facility's plan of care for the resident will include continuing reassessment of the resident's needs to ensure that all appropriate and desired care is being provided to the extent possible.

5. Whenever there is a change of condition that renders the expressed treatment wishes of a patient medically ineffective, non-beneficial, or contrary to generally accepted health care standards[13] it reasonable to consider a change to the POLST status that would reflect an appropriate level of care. In this case the physician and the resident or, if the resident lacks decisionmaking capacity, the legally recognized health care decisionmaker, should consult on possible revisions to the POLST (*See Section II, Reviewing/Revising the POLST*).

V. POLST and the Medical Record[14]

1. The most current POLST in its original format should be the first page of the medical record.

2. If the resident has an advance directive, copies of it should be attached to the current original POLST in the front of the chart.

3. If the resident is transferred or discharged from the facility, the current original POLST must accompany the resident.

4. A fully executed, dated copy of the POLST, marked "COPY," should be retained in the medical record in the advance directive or legal section of the medical record. This copy should be on Pulsar Pink paper stock so it is readily recognizable when and if the current original is transferred with the resident.

5. All voided versions of the POLST, clearly marked "VOID," will be retained in the medical record.

6. Whenever the POLST is reviewed, revised, and/or revoked, this will be documented in the medical record by the physician and/or the health care provider(s) involved.

7. For facilities with electronic health records, the POLST should be scanned in and placed in the appropriate section of the health care record per facility policy.

VI. Conflict Resolution

If the POLST conflicts with the resident's health care instructions or advance directive, then, to the extent of the conflict, the most recent expression of the resident's wishes govern.

If there are any conflicts or ethical concerns about the POLST orders, appropriate facility resources – e.g., ethics committees, care conferences, legal, risk management or other administrative and medical staff resources – may be utilized to resolve the conflict.

During conflict resolution, consideration should always be given to: a) the attending physician's assessment of the resident's current health status and the medical indications for care or treatment; b) the determination by the physician as to whether the care or treatment specified by POLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and c) the resident's most recently expressed preferences for treatment and the resident's treatment goals.

ENDNOTES

[1] *Note: The official POLST form for California is approved by the Emergency Medical Services Authority. You can download a copy of the form for printing by going to the Coalition of Compassionate Care of California website at: www.coalitionccc.org.*

Wausau Pulsar Pink paper (65 lb. paper stock recommended) is the color used for the POLST form. It is important to use this specific color of pink paper so that the form can be photocopied and faxed. Although Pulsar Pink is the recognized and recommended color, the form remains valid if another color paper is used. A photocopy of the form is also valid.

[2] *Note: In order to promote consistency and efficiency of communication of a resident's wishes across treatment settings, we recommend that, for skilled nursing facility residents who have a POLST, that the POLST form replace the PIC, PIT, and Pre-Hospital DNR/DNAR for that resident.*

[3] California Probate Code §4781.2. (a) A health care provider shall treat an individual in accordance with a POLST form. (b) This does not apply if the POLST form requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution. (c) A physician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care decisionmaker, issue a new order consistent with the most current information available about the individual's health status and goals of care.

[4] Legally recognized health care decisionmaker includes the person's agent as designated by a power of attorney for health care, surrogate, conservator or closest available relative as described in California Probate Code §§ 4671, 4711, 1880, and *Cobbs v Grant*, 8 Cal3d 229, 244 (1972) respectively.

[5] *Note: Skilled nursing facilities should refer to their specific policies, the Health Care Decisions Law (Probate Code §§4600-4805), and relevant case law regarding determination of capacity, and of a legally recognized health care decisionmaker.*

[6] California Probate Code §4621. "Health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law of this state to provide health care in the ordinary course of business or practice of a profession.

[7] *Note: Individual skilled nursing facilities may adapt the model procedures in accordance with their existing structures and related policies.*

[8] "Qualified" means that they have had training in the purpose and use of the POLST form, and on the facility's policy regarding implementing or reviewing the POLST, including how to respond to questions from the resident and/or the resident's legally recognized health care decisionmaker regarding the specific interventions described on the POLST. And see 6 above regarding "health care provider."

[9] Significant change is defined in the Resident Assessment Instrument as "a decline or improvement in a resident's status that:

- will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting"
- impacts more than one area of the resident's health status: and
- requires interdisciplinary review and/or revision of the care plan."

[10] See 3 above.

[11] California Probate Code §4781.2(d). The legally recognized health care decisionmaker of an individual without capacity shall consult the physician who is, at that time, the individual's treating physician prior to making a request to modify that individual's POLST form.

[12] California Code of Regulations, 72311(a)(3)(B) and Health and Safety Code 1599.1(i).

[13] California Probate Code §4781.2. (a) A health care provider shall treat an individual in accordance with a POLST form. (b) This does not apply if the POLST form requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution. Also, California Probate Code §4735 states that: "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."

[14] *Note: Facilities should decide the most appropriate filing system for POLST depending on their specific medical records system and modify this model policy accordingly. The main considerations are: 1) that the most current POLST be available in a location of prominence in order to increase awareness of its existence and promote compliance, and 2) that the current original POLST must travel with the resident, so obtaining and filing of a copy is critical.*