

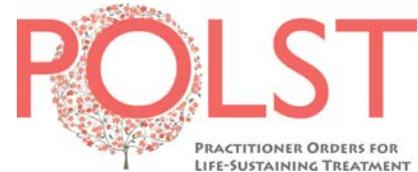


MODEL POLICY FOR HOSPICES

PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

PURPOSE

This policy defines a process for hospice providers to follow when a patient who is enrolled in hospice, or is considering enrollment, has a Practitioner Orders for Life-Sustaining Treatment (POLST) form. This policy also outlines procedures regarding the completion of a POLST form and the steps necessary when reviewing or revising a POLST form.



PREAMBLE

The Practitioner Orders for Life-Sustaining Treatment (POLST) is a physician or nurse practitioner (NP) order that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician/NP orders. It is used statewide for individuals to communicate their wishes about a range of life-sustaining and resuscitative measures. It is a portable, authoritative and immediately actionable physician/NP order consistent with the individual's wishes and medical condition, which shall be honored across treatment options.

THE POLST FORM:

- Is a standardized form that is brightly colored and clearly identifiable;
- Can be revised or revoked by an individual with decision-making capacity at any time;
- Is legally sufficient and recognized as a physician/NP 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 in honoring a POLST;
- Can be an alternative to some other forms, although POLST is more comprehensive than a Out-Of-Hospital DNR in that it addresses other life-sustaining treatment in addition to resuscitative measures; and
- Should be made available for patients who wish to execute a POLST form while enrolled in hospice.

The original form in its most current version must remain physically with the patient across all care settings.

A health care provider is not required to initiate a POLST form, but is required to treat an individual in accordance with his/her POLST form. This does not apply if the POLST requires ineffective medical care.

A legally recognized health care decision-maker may execute, revise or revoke the POLST form for a patient only if the patient lacks decision-making capacity and if the action is consistent with the expressed preferences of the patient. This policy does not address the criteria or process for determining or appointing a legally recognized health care decision-maker, nor does it address the criteria or process for determining decision-making capacity.

While a health care provider such as a hospice nurse or a hospice social worker can explain the POLST form to the patient and/or the patient's legally recognized health care decision-maker, the patient's physician/NP or nurse practitioner or the hospice physician/NP or nurse practitioner is responsible for



discussing any concerns or questions on the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks decision-making capacity, with the patient's legally recognized health care decision-maker.

Once the POLST form is completed, it must be signed by the patient, or (if the patient lacks decision-making capacity) the patient's legally recognized health care decision-maker, and the patient's physician/NP/PA or hospice physician/NP/PA.

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, which account for all hospice patients. The POLST form should be executed as part of the health care planning process and ideally complements a patient's advance directive. A POLST form may also be used by patients who do not have an advance directive. Completion of a POLST form should reflect a process of careful decision-making by the patient, or if the patient lacks decision-making capacity, the patient's legally recognized health care decision-maker, in consultation with the patient's hospice team, about the patient's medical condition and known treatment preferences.

It is possible that the preferences expressed in a POLST form may conflict with the principles and philosophy of hospice. Procedures listed below address this possibility, but the patient's hospice election (or a hospice election made by a patient's legally recognized health care decision-maker, if the patient lacks decision-making capacity) may be more recent than the patient's POLST form. In such cases, the patient's election of hospice should be considered the "most recent expression of the patient's wishes."



HOSPICE PROCEDURES

A. PATIENT CONSIDERING ENROLLMENT IN HOSPICE CARE

1. Prior to enrolling a patient in hospice care, hospice personnel should ask if the patient has completed a POLST form. If so, the hospice representative should request a copy of the POLST form and, while with the patient or the patient's legally recognized health care decision-maker, examine whether the patient's choices are consistent with, or in conflict with, the philosophy and procedures of the hospice program.
2. If the patient's choices are in conflict with hospice philosophy or procedures, the hospice personnel should use this as an opportunity to explain more fully to the patient the goals of hospice care – i.e., providing comfort to the patient and allowing natural death (which includes avoiding artificial, pharmaceutical or mechanical means of extending life)
3. If the patient prefers to abide by his/her choices on the POLST form that are in conflict with hospice philosophy or procedures (e.g., "Full Treatment"), the hospice should consider whether or not to admit the patient under those circumstances.
4. If the patient decides to change his/her decisions prior to admission to hospice, the hospice team should communicate those changes to the patient's physician/APN. The hospice team can assist the patient in authorizing a new POLST form or simply voiding the existing POLST form (see below).

B. HOSPICE PATIENT 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 the patient or legally recognized health care decision-maker, and by a physician/NP) and confirm with the patient, if possible, or the patient's legally recognized health care



decision-maker, that the POLST form in hand has not been revoked or superseded by a subsequent POLST form. A completed, fully executed POLST is a legal physician/NP order, and is immediately actionable.

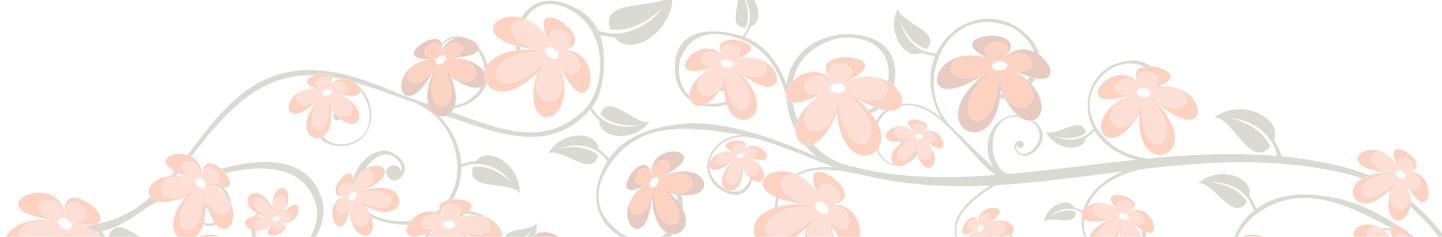
2. Once reviewed, the POLST should be scanned or copied, with a copy provided to the hospice marked 'COPY' and dated. The current original form is placed in the front of the patient's chart, along with the patient's advance directive if he/she has one. As the patient moves from one health care setting to another, the original POLST form and copies of the patient's advance directive should always accompany the patient.
3. Wherever the patient resides, the original POLST should be prominently displayed in an easily accessible and visible location.
4. The POLST may replace an "Out-of-Hospital DNR" form. Out-of-date "Out-of-Hospital DNR" forms should be clearly marked "VOID" and placed in the appropriate section of the hospice medical record. (See also Section V, POLST and the Medical Record.)
5. If the POLST conflicts with the patient's previously-expressed health care instructions or advance directive, then – to the extent of the conflict – the most recent expression of the patient's wishes governs. (See "Conflict Resolution" for further guidance.)
6. The existence of a POLST form should be documented within the first required assessment or as part of the comprehensive assessment and care planning process.
7. If the patient, or when the patient lacks decision-making capacity, the legally recognized health care decision-maker, expresses concern about the POLST form, or if there has been a significant change in the patient's conditions or wishes, then the patient's physician/NP or hospice physician/NP will be notified as soon as possible to discuss the potential changes with the patient or, if the patient lacks decision-making capacity, the legally recognized decision-maker.

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

C. REVIEWING/REVISING THE POLST

1. 1. The POLST will be reviewed by the hospice interdisciplinary team during the first interdisciplinary team meeting after the patient's admission to hospice and upon any request to do so by the patient or, if the patient lacks decision-making capacity, the legally designated health care decision-maker.
2. At any time, a patient with decision-making capacity can revoke the POLST form or change his/her mind about his/her treatment preferences by executing a written advance directive or, after consultation with the patient's physician/NP or hospice physician/NP, a new POLST. The new POLST form must be signed by the physician/NP and the patient and the revoked POLST must be voided. Should such changes conflict with hospice policy or procedures, the hospice team should discuss with the patient (or, if the patient lacks decision-making capacity, the legally designated health care decision-maker) the appropriateness of revoking the hospice election. Should the patient decline revocation, the hospice should consider discharging the patient from hospice care if the patient is now seeking curative and/or life-extending treatment.
3. If the patient decides to revoke the POLST form, the patient's physician/NP or hospice physician/NP should be notified and appropriate changes to the physician/NP's orders should be obtained as soon as possible to ensure that the patient's wishes are accurately reflected in the plan of care.





4. If the patient lacks decision-making capacity and the legally recognized health care decision-maker wants to consider revising or revoking the POLST form, he/she must consult the patient's physician/NP or hospice physician/NP before any change is made to the patient's POLST form. The legally recognized health care decision-maker, together with the physician/NP, may revise the POLST as long as it is consistent with the expressed preferences of the patient.
5. All discussions about revising or revoking the POLST should be documented in the patient'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 entirety of Sections A through E and write "VOID" in large letters. The original POLST marked "VOID" should be signed and dated.

D. INITIATING A POLST

1. If a patient or, if the patient lacks decision-making capacity, the legally recognized health care decision-maker, wishes to complete a POLST form while on service with hospice, obtain a POLST form for the physician/NP and the patient or the patient's legally designed health care decision-maker to discuss, fill out and sign. Notify the patient's physician/NP or the hospice physician/NP that the patient, or the legally designed health care decision-maker if the patient lacks decision-making capacity, wishes to discuss the treatment options on the POLST form.
2. Generally, the physician/NP should discuss the benefits, burdens, efficacy and appropriateness of treatment and medical interventions with the patient or, if the patient lacks decision-making capacity, the patient's legally recognized health care decision-maker. A qualified health care provider such as a hospice nurse or hospice social worker may also explain the POLST form to the patient and/or the patient's legally recognized health care decision-maker. The physician/NP should discuss any areas of concern with the patient and/or the patient's legally recognized health care decision-maker.

The completed POLST form must be signed by the physician/NP and the patient or, if the patient lacks decision-making capacity, the patient's legally recognized health care decision-maker.

3. Scan or make a copy of the completed POLST form, or request that the patient provide a copy of the POLST form. Mark the copy as "COPY" with the date the copy was made. File the copy in the advance directive or legal section of the medical record.
4. The current original POLST form is considered the property of the patient, and is to remain with the patient across all treatment settings, along with a copy of the patient's advance directive (if one exists), which should be placed at the front of the medical record.

E. POLST AND THE MEDICAL RECORD

1. The most current POLST in its original format will always be kept with the patient.
2. A copy of the POLST will be placed in the hospice chart (if one exists) at the place where the patient currently resides.
3. If the patient has an advance directive, copies of it should be attached to the current original POLST in the front of the chart.
4. If the patient is transferred, admitted to a facility, or discharged from hospice, the current original POLST form must remain with the patient.
5. 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 hospice medical record.
6. All voided versions of the POLST, clearly marked "VOID," should be retained in the medical record if available.
7. Whenever the POLST is reviewed, revised, and/or revoked, this will be documented in the medical record by the physician/NP and/or the health care provider(s) involved.
8. For hospices with electronic health records, the POLST should be scanned in and placed in the appropriate section of the health care record per facility/agency policy.



F. CONFLICT RESOLUTION

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

If there are any conflicts or ethical concerns about the POLST orders, appropriate hospice 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 assessment by the patient's physician/NP or hospice physician/NP of the patient's current health status and the medical indications for care or treatment; b) the determination by the physician/NP as to whether the care or treatment specified by POLST is medically ineffective, non-beneficial, or contrary to generally accepted hospice care standards; and c) the patient's most recently expressed preferences for treatment and the patient's treatment goals.

