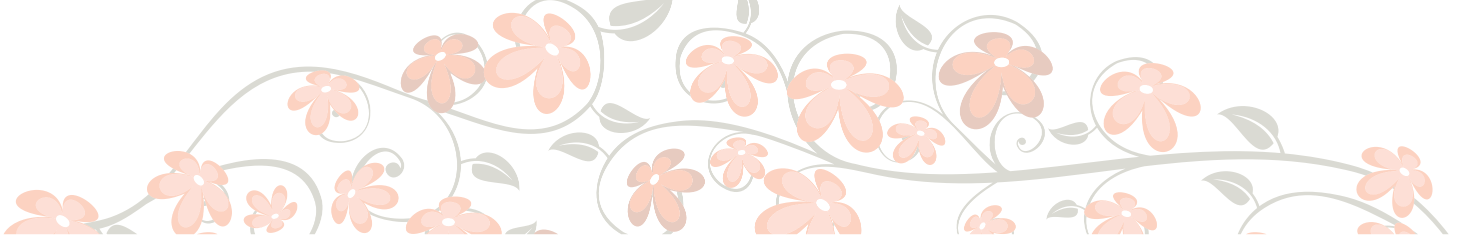


MODEL POLICY FOR NURSING HOMES & ASSISTED LIVING RESIDENCES

Practitioner Orders for Life-Sustaining Treatment (POLST)

SUBJECT: Practitioner Orders for Life-Sustaining Treatment (POLST)

PURPOSE

This policy defines a process for nursing homes and assisted living residences to follow when a person who resides in the nursing home or assisted living residence, or is considering residency, 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.

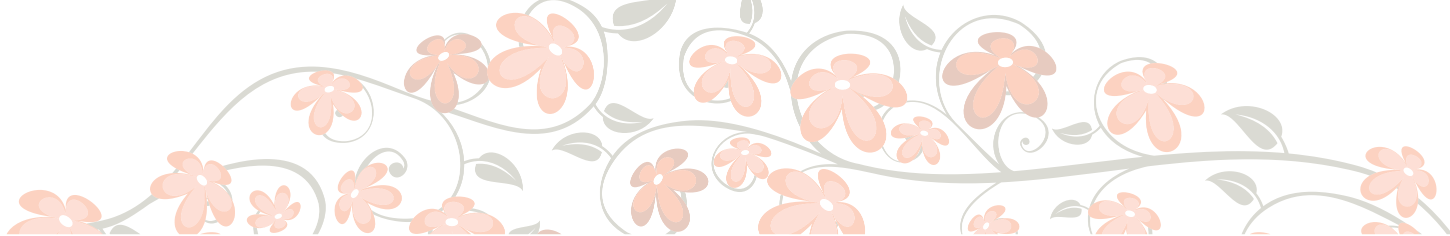
POLICY

It is the policy of ___(facility name)________________________ to support the rights of residents in making decisions regarding their care and treatment.

POLST is the Practitioner's Physician's Orders for Life-Sustaining Treatment. The POLST form is used by the physician or advance practice nurse to write orders that indicate what types of life-sustaining treatment the resident wants or does not want.

PROCEDURES

1. At the time of admission the facility will determine whether the individual has completed a POLST form.
2. The facility will review the existing POLST for completeness and confirm with the individual and/or with the individual's legally recognized health care decision-maker that the POLST form in hand has not been revoked or superseded by a subsequent POLST form.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. The facility will place the POLST form in the clinical record, along with the patient's advance directive if he/she has one. If the individual has an electronic health record, the POLST should be scanned in and placed in the appropriate section of the health care record per facility/agency policy.
3. If the individual does not have a POLST form at the time of admission, the facility will introduce POLST within 14 days of admission.
4. The attending physician or advance practice nurse will complete the POLST with the individual or the legally recognized health care decision maker, after discussing options for care.
5. The original POLST form will remain in the individual's clinical record
6. 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.
7. POLST forms will be reviewed annually and at the time of any significant change in the individual's condition, and at the individual's request.



8. 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 clinical record.
9. 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.
10. If the individual, or when the individual 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 individual's conditions or wishes, then the physician/NP will be notified within 24 hours to discuss the potential changes with the individual or, if the individual lacks decision-making capacity, the legally recognized decision-maker.
11. The initial review and any discussion about continuing, revising or revoking the POLST shall be documented in the clinical 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.
12. At each care conference, the interdisciplinary team will review the POLST with the individual/family to ensure that it matches the individual's wishes in light of the information discussed during the care conference. The individual. or when the individual lacks decision-making capacity, the legally recognized health care decision-maker, will be provided with information and resources as needed to affirm, update or revoke the POLST.

REVIEWING/REVISING THE POLST

1. At any time, an individual 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 their physician/NP, a new POLST. The new POLST form must be signed by the physician/NP and the individual and the revoked POLST must be voided.
2. If the individual decides to revoke the POLST form, their 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 individual's wishes are accurately reflected in the plan of care.
3. If the individual lacks decision-making capacityand the legally recognized health care decision-maker wants to consider revising or revoking the POLST form, he/she must consult the individual's physician/NP before any change is made to the 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 individual
4. All discussions about revising or revoking the POLST should be documented in the clinical 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.
5. 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 and placed in the clinical record.

CONFLICT RESOLUTION

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