Community Medical Center | RWJBarnabas HEALTH

ADMINISTRATIVE POLICY & PROCEDURES

Title:	Policy Number:
POLST - Practitioner Orders for Life Sustaining Treatment	**P-28C**

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PURPOSE:

The purpose of this policy is to define a process for Community Medical Center to follow when a patient presents with a Practitioner Orders for Life Sustaining Treatment, POLST Form. This policy also outlines procedures regarding the completion of a POLST Form by a patient in the hospital and the steps necessary when reviewing or revising a POLST Form.

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POLICY:

The POLST is a Physician MD or Advanced Practice Nurse APN order form that complements an Advance Directive or an individual's expressed wishes regarding life-sustaining treatment and resuscitation by converting those preferences into a comprehensive set of orders. It is designed to be a statewide mechanism for an individual to communicate his/her preferences about a range of life-sustaining and resuscitative measures. It is designed to be a portable, authoritative, and immediately actionable Physician/Nurse Practitioner Order consistent with the individual's preferences and medical condition, which will be honored across all treatment settings. Completion of the 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 Physician or Nurse Practitioner about the patient's medical condition, prognosis, and known treatment preferences. In

order for the POLST Form to be an immediate actionable order, a valid set of orders, the form must include the signature of the patient, or if the patient lacks decision-making capacity, the patient's legally recognized health care decision-maker, and the signature of the MD or APN. Back To Top

DEFINITIONS:

POLST - Practitioner Orders for Life Sustaining Treatment

APN - Advanced Practice Nurse Back To Top

RESPONSIBLE PERSONS:

Advanced Practice Nurses APNs
Physicians MDs Back To Top

EQUIPMENT:

New Jersey POLST Form Back To Top

PROCEDURE (Inclusive of Infection Control and Safety Aspects):

I. Patient in the Emergency Department ED with Completed POLST Form

1. During the initial patient assessment, the RN will document within the initial nursing assessment tool, the existence of the POLST Form.

2. The RN will communicate to the ED PHYSICIAN caring for the patient of the existence of the POLST Form.

3. POLST orders will be followed by the health care providers as a valid Physician Order until the ED Physician reviews the POLST Form and incorporates the content of the POLST into the care and treatment plan of the patient and Physician's Orders, as appropriate. The ED Physician/APN will document his/her review of the POLST in his/her progress note.

4. If the ED Physician/APN, upon review of the POLST and evaluation of the patient, determines that a new order is indicated, he/she will review the proposed changes with the patient and/or legally recognized health care decision-maker, if previously authorized by the patient, and issue a new order consistent with the most current information available about the patient's health status, medical condition, prognosis, treatment preferences, and goals of care. The ED Physician/APN will document the reasons for any deviation from the POLST in his/her progress note.

5. Discussions with the patient and/or the patient's legally recognized health care decision-maker regarding the POLST and related treatment decisions must be documented by the Physician/APN in his/her progress note.

6. A copy of the POLST Form, both sides, will be placed in the paper component of the Medical Record in the Advance Directives/Consents section and then scanned in to the permanent Medical Record 3M/Softmed.

7. Place the patient's identifying information label on the copy of the POLST Form in the upper right corner of the POLST copy and write the word **COPY** on the form and the date and time copied.

8. The current original POLST Form is to be returned to the patient or his/her representative prior to discharge or transfer from the ED. Back To Top

II. Patient Admitted with a Completed POLST Form

1. During the initial patient assessment, the RN will document within the initial nursing assessment tool the existence of the POLST Form.

2. The RN will communicate to the Admitting Physician caring for the patient of the existence of the POLST.

3. POLST orders will be followed by the health care providers as a valid Physician Order until the Admitting Physician reviews the POLST Form and incorporates the content of the POLST into the care and treatment plan of the patient and Physician's Orders, as appropriate. The Physician/APN will document his/her review of the POLST in his/her progress note.

4. The Physician or APN will complete any hospital approved and required order forms, such as DNR orders, if appropriate, and Physician Orders to reflect and make known the orders contained on the POLST Form.

5. If the Admitting Physician, upon review of the POLST and evaluation of the patient, determines that a new order is indicated, he/she will review the proposed changes with the patient and issue a new order consistent with the most current information available about the patient's health status, medical condition, treatment preferences, and goals of care. If the patient has lost decision-making capacity, the Physician **MUST** review any proposed changes to the POLST with the patient's legally recognized decision-maker if previously authorized by the patient to do so. The Physician/APN will document the reasons for any modification of the POLST in his/her progress note.

6. Discussions with the patient and/or the patient's legally recognized health care decision-maker regarding the POLST and related treatment decisions must be documented by the Physician/APN in his/her progress note. If goals of care have been changed related to changes in the patient's condition, a new POLST Form should be completed by the Physician/APN prior to the patient's discharge.

7. A copy of the POLST Form, both sides, will be placed in the paper component of the Medical Record in the Advance Directives/Consents section and then scanned in to the permanent Medical Record 3M/Softmed.

8. Place the patient identification label on the copy of the POLST Form in the upper right corner of the POLST copy and write the word **COPY** on the form and the date and time copied.

9. Because the current original POLST is the patient's personal property, the form is to be returned to the patient or legally authorized health care decision-maker.

10. If the patient is discharged or transferred by Emergency Medical Services EMS, ensure that the POLST Form is visible and accessible to the EMS Transport Staff. Back To Top

III. Completing a POLST Form with the Patient

1. If the patient, or, if the patient lacks decision-making capacity, the patient's legally recognized health care decision-maker, wishes to complete a POLST Form during a hospital admission, the patient's Physician or APN will be contacted. The Physician or APN will discuss goals of care with the patient or legally recognized health care decision-maker. The discussion should include information about the patient's Advanced Directive, if any, or other statements the patient has made regarding his/her preferences for end-of-life care and treatments. The benefits, burdens, efficacy, and appropriateness of treatment options and medical interventions should be discussed by the Physician or Nurse Practitioner with the patient and/or the patient's legally recognized health care decision-maker. A health care provider such as a Nurse or Social Worker can explain the POLST Form to the patient and/or the patient's legally recognized health care decision-maker. However, the Physician or APN is responsible for discussing treatment options with the patient or the patient's legally recognized health care decision-maker.

2. The above-described discussions will be documented in the Medical Record, dated, and timed.

3. The POLST Form is to be completed based upon the patient's expressed treatment preferences and medical condition. If the patient lacks decision-making capacity and the POLST Form is completed with the patient's legally recognized health care decision-maker, it must be consistent with the known desires of and in the best interest of the patient.

4. In order to be valid, the POLST must be signed by a Physician or APN, and by the patient, or if the patient lacks decision-making capacity, the legally recognized health care decision-maker.

5. The Physician or APN will complete any hospital approved and required order forms, such as DNR orders, if appropriate, and Physician Orders to reflect and make known the orders contained on the POLST Form.

6. Follow the instructions in Section II, #8 above for copying the POLST Form and putting it in the Medical Record.

7. Because the current original POLST is the patient's personal property, the form is to be returned to the patient or legally authorized health care decision-maker.

8. A copy of the POLST Form, both sides, will be placed in the paper component of the Medical Record in the Advance Directives/Consents section and then scanned in to the permanent Medical Record 3M/Softmed.

9. Be sure to indicate that the patient has a POLST on the Discharge Summary Form/Discharge Checklist.

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IV. Reviewing/Revising a POLST Form

1. Discussions about revising or revoking the POLST will be documented by the Physician/APN in his/her progress note including date and time. This documentation should include the essence of the conversation and the parties involved in the discussion.

2. It is permissible to access a closed Medical Record to gain access to an existing POLST Form. The Physician/APN should determine that this previous POLST Form represents the patient's most current expressed wishes.

3. The Attending Physician or APN and the patient may review or revise the POLST consistent with the patient's most recently expressed preferences at any time. In the case of a patient who lacks decision-making capacity, the Attending Physician or APN and the patient's legally recognized health care decision-maker may review the POLST, as long as it is consistent with the known desires of and in the best interest of the patient.

4. For a patient who had decision-making capacity at the time of the POLST completion, the legally recognized health care decision-maker may revise or revoke the POLST in collaboration with the Physician or APN, only if previously authorized by the patient on the original POLST Form.

5. During the acute care admission, care conferences, and/or discharge planning, the Physician or APN will review the POLST when there is a substantial change in the patient's health status, medical condition, or when the patient's treatment preferences change.

6. If the current POLST is no longer valid due to a patient changing his/her treatment preferences, or if a change in the patient's health condition warrants a change in the POLST orders, the POLST can be voided in accordance with Section IV, #2. To void a POLST, the Physician/APN should draw a line through Sections A through D and write **VOID** in large letters. Sign and date this line. This change will be documented by the Physician/APN in his/her progress note.

7. If a new POLST is completed, a copy of the original POLST marked **VOID** that is signed and dated will be kept in the Medical Record directly behind the current POLST and will become a part of the permanent Medical Record.

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V. Conflict Resolution

1. 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 govern.

2. If there are any conflicts or ethical concerns about the POLST, a bioethics consultation should be requested along with referrals to the Office of Risk Management in an effort to resolve the conflict.

3. During the conflict resolution process, consideration should always be given to:

   a) The Attending Physician's assessment of the patient'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 the POLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards;

   c) The patient's most recently expressed preferences for treatment and the patient's treatment goals.

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DOCUMENTATION:

A copy of the POLST Form will be kept in the Advance Directives/Consents section of the chart and the copy will be scanned in to the permanent Medical Record.

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REFERENCES:

New Jersey Senate Bill No. 2197

Practitioner Orders for Life Sustaining Treatment POLST—New Jersey

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ATTACHMENTS:
• New Jersey POLST Form

ORIGINAL DATE:	07/2013*
REVIEWED:	
REVISED:	2/17

***Approved by the Medical Executive Committee September 2013**

DEVELOPED BY (Local Policy Owner by Job Title):	
COMMITTEE APPROVALS:	Committee Name [Date]
SYSTEM STANDARDIZED DATE:	06/2013, 7/2013

SIGNATURE ON FILE

SIGNATURES

Michael Mimoso, MHSA, FACHE – President & CEO	Date
Yeshavanth Nayak, MD – Chief Medical Officer	Date
Jane O'Rourke, DNP, RN, NEA-BC, CENP – Chief Nursing Officer	Date

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

NEW JERSEY PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Follow these orders, and then contact Physician/APN. This Medical Order Sheet is based on the current medical condition of the person referenced below and his/her wishes stated verbally or in a written advance directive. Any section not completed implies full treatment for that section. Everyone will be treated with dignity and respect.

PERSON NAME (LAST, FIRST, MIDDLE) DATE OF BIRTH

A

GOALS OF CARE

(See reverse for instructions. This section does not constitute a medical order.)

B

MEDICAL INTERVENTIONS: *Person is breathing and/or has a pulse*

❑ **Full Treatment**. Use all appropriate medical and surgical interventions as indicated to support life. If in a nursing facility, transfer to hospital if indicated. See section D for resuscitation status.

❑ **Limited Treatment**. Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure. Generally avoid intensive care.

- ❑ Transfer to hospital for medical interventions.
- ❑ Transfer to hospital only if comfort needs cannot be met in current location.

❑ **Symptom Treatment Only**. Use aggressive comfort treatment to relieve pain and suffering by using any medication by any route, positioning, wound care and other measures. Use oxygen, suctioning and manual treatment of airway obstruction as needed for comfort. Use Antibiotics only to promote comfort. Transfer only if comfort needs cannot be met in current location.

Additional Orders:_____

C

ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:

Always offer food/fluids by mouth if feasible and desired.

❑ No artificial nutrition.

❑ Long-term artificial nutrition.

❑ Defined trial period of artificial nutrition.

D

CARDIOPULMONARY RESUSCITATION (CPR)

Person has no pulse and/or is not breathing

❑ Attempt resuscitation/CPR

❑ Do not attempt resuscitation/DNAR

Allow Natural Death

AIRWAY MANAGEMENT

Person is in respiratory distress with a pulse

❑ Intubate/use artificial ventilation as needed

❑ Do not intubate - Use O_2, manual treatment to relieve airway obstruction, medications for comfort.

❑ Additional Order (for example defined trial period of mechanical ventilation)_____

E

If I lose my decision-making capacity, I authorize my surrogate decision maker, listed below, to modify or revoke the NJ POLST orders in consultation with my treating physician/APN in keeping with my goals: ❑Yes ❑No

❑ Health care representative identified in an advance directive ❑ Other surrogate decision-maker

_____

Print Name of Surrogate (address on reverse) Phone Number

F

SIGNATURES:

I have discussed this information with my physician/APN.

Print Name_____

Signature_____

❑ Person Named Above

❑ Health Care Representative/Legal Guardian

❑ Spouse/Civil Union Partner

❑ Parent of Minor

❑ Other Surrogate

Has the person named above made an anatomical gift?

❑ Yes ❑ No ❑ Unknown

These orders are consistent with the person's medical condition, known preferences, and best-known information.

_____

PRINT Physician/APN Name Phone Number

_____

Physician/APN Signature (Mandatory) Date/Time

_____

Professional License Number

4/12/17

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

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HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

PRINT PERSON'S NAME (LAST, FIRST, MIDDLE) DATE OF BIRTH

PRINT PERSON'S ADDRESS

CONTACT INFORMATION

PRINT SURROGATE HEALTH CARE DECISION MAKER ADDRESS PHONE NUMBER

DIRECTIONS FOR HEALTH CARE PROFESSIONAL

COMPLETING POLST

- Must be completed by a Physician or Advance Practice Nurse.
- Use of original form is strongly encouraged. Photocopies and faxes of signed POLST Forms may be used.
- Any incomplete section of POLST implies full treatment for that section.

REVIEWING POLST

POLST orders are actual orders that transfer with the person and are valid in all settings in New Jersey. It is recommended that POLST be reviewed periodically, especially when:

- 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.

MODIFYING AND VOIDING POLST - *An individual with decision-making capacity can always modify/void a POLST at any time.*

- A surrogate, if designated in Section E on the front of this form, may, at any time, void the POLST Form, change his/her mind about the treatment preferences, or execute a new POLST document based upon the person's known wishes or other documentation such as an advance directive.
- A surrogate decision-maker may request to modify the orders based on the known desires of the person or, if unknown, the person's best interest.
- To void POLST, draw a line through all sections and write "VOID" in large letters. Sign and date this line.

SECTION A

What are the specific goals that we are trying to achieve by this treatment plan of care? This can be determined by asking the simple question: "What are your hopes for the future?" Examples include but not restricted to:

- Longevity, cure, remission
- Better quality of life
- Live long enough to attend a family event (wedding, birthday, graduation)
- Live without pain, nausea, shortness of breath
- Eating, driving, gardening, enjoying grandchildren

Medical providers are encouraged to share information regarding prognosis in order for the person to set realistic goals.

SECTION B

- When "limited treatment" is selected, also indicate if the person prefers or does not prefer to be transferred to a hospital for additional care.
- IV medication to enhance comfort may be appropriate for a person who has chosen "symptom treatment only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), or bi-level positive airway pressure (BiPAP).
- Comfort measures will always be provided.

SECTION C

Oral fluids and nutrition should always be offered if medically feasible and if they meet the goals of care determined by the person or surrogate. The administration of nutrition and hydration whether orally or by invasive means shall be within the context of the person's wishes, religion and cultural beliefs.

SECTION D

Make a selection for the person's preferences regarding CPR and a separate selection regarding airway management. A defined trial period of mechanical ventilation may be considered, for example, when additional time is needed to assess the current clinical situation or when the expected need would be short term and may provide some palliative benefit.

SECTION E

This section is applicable in situations where the person has decision-making capacity when the POLST Form is completed. A surrogate may only void or modify an existing POLST Form, or execute a new one, if named in this section by the person.

SECTION F

POLST must be signed by a practitioner, meaning a physician or APN, to be valid. Verbal orders are acceptable with follow-up signature by physician/APN in accordance with facility/community policy. POLST orders should be signed by the person/surrogate. Indicate on the signature line if the person/surrogate is unable to sign, declined to sign, or a verbal consent is given. Remind the person/surrogate that once completed and signed, this POLST will void any prior POLST documents.

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED

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