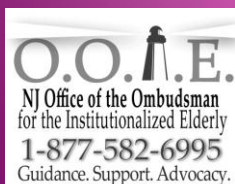


# HOW POLST & ADVANCE CARE PLANNING CAN IMPROVE QUALITY OF CARE

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## OBJECTIVES

- ◉ Cultivate an understanding of various components of advance care planning.
- ◉ Cultivate an understanding of the importance of advance care planning, in particular POLST to residents and staff.
- ◉ Develop and implement a plan to make advance care planning an integral part of person-centered care in the facility.
- ◉ Develop and implement a plan for having advance care planning conversations with residents and family members.

## OVERVIEW

## ADVANCE CARE PLANNING IS GOOD CARE

- ◎ Tool for enacting person-centered care.
  - CMS: “The advance care planning process is an integral aspect of the facility’s comprehensive care planning process and assures re-evaluation of the resident’s desires on a routine basis and when there is a significant change in the resident’s condition.”
- ◎ Person-centered care
  - “Person before the task”
  - Resident choice
  - Empowering caregivers to honor resident choice
- ◎ Resident-directed care
  - Promotes resident choice in all aspects of life

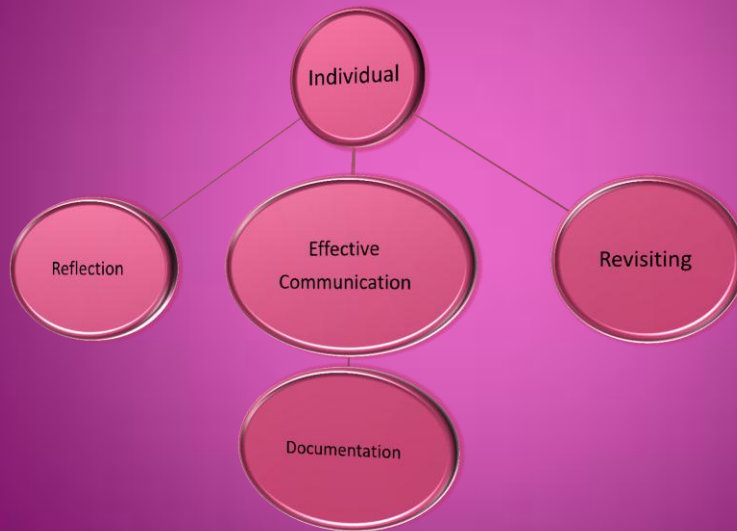
## COMMUNITY VIEWS ON ACP

- Many people think it's important, however.....;
- Few have done it;
- Surrogates are poorly prepared to act (don't understand what the patient wants);
- Forms are difficult to understand when filling out;
- Forms not written in a way that is useful to health care proxy;
- People change: AD written when 55 and healthy, now 75 and have COPD
- Forms aren't accessible (not with HCP, even given to HCP not accessible when needed);

## COMMUNITY BARRIERS TO ACP

- Denial (society and individuals)
- Time
- Health care system often confusing
- Lack of awareness
  - How it can help
  - How to facilitate conversation
  - HCP's awareness of individuals' expression
  - What medical all means (CPR, AHN, Palliative Care)
- ACP not for me (not until sick or did one already)
- Cultural Differences (cultural humility/cultural competency)

## COMPONENTS OF SUCCESSFUL ACP



## HEALTH CARE PROXY – AD

### ◎ How to Pick a Proxy

- Is the person willing to take on the role?
- Is the person willing to listen to and understand individuals' goals, values, and beliefs for future health care decisions?
- Can the person make decisions under difficult and stressful situations?
- Can the person follow your wishes even if they are different than their own?
- Will the person be available?

## COMMUNICATION : HEALTH CARE PROVIDER

- ◎ Individual/resident
  - What a person understands/experiences about their disease
- ◎ Health care provider
  - Diagnosis-to determine the identity of (a disease, illness, etc.) by a medical examination
  - Prognosis-a opinion about how/if someone will recover from (a disease, illness, etc.)
  - Goals of Care
  - All possible treatment options
  - Benefits/burdens of various treatments
  - Role of palliative care and hospice

## COMMUNICATION: GOALS & CONCERNS

- ◎ What an individual hopes for, what he or she fears, what makes life worth living
  - Activities
  - Fears/concerns (breathing, pain, family strife)
  - Where individuals want to be
- ◎ Focus: Longevity, maintenance, comfort
- ◎ Every person is different and that must be valued
- ◎ Goals and values change

## REVISITING

- ◎ First, if you don't have one – NOW or when you turn 18
- ◎ The 5 Ds:
  - Decade
  - Death of a loved one
  - Divorce
  - Diagnosis
  - Decline

## DOCUMENTS

# DOCUMENTATION

- ◎ Advance Directives
  - “Living Will”
  - “Health Care Proxy”
- ◎ DNRs/DNHs/DNIs
  - Do Not Hospitalize
  - Do Not Resuscitate
  - Do Not Intubate
- ◎ POLST: Practitioner Orders for Life-Sustaining Treatment

# ADVANCE DIRECTIVES



## DNRS/DNHS/DNIS

- ⊙ DNRS/DNHS/DNIs are orders written by doctors or advanced practice nurses (in collaboration with doctors) that are made part of a resident's medical record
- ⊙ Do not travel across medical settings
- ⊙ "One Hit Wonders"

## MYTHS & MISCONCEPTIONS ABOUT AD

*THESE ARE NOT TRUE*

- ⊙ Financial POA = health care proxy
- ⊙ Once an individual names a proxy they lose control
- ⊙ DNR = Living will
- ⊙ Advance directive = don't treat
- ⊙ Only older/sick people need advance directives



## POLST

- ⦿ Here -February 2013
- ⦿ Patient is not mandated to fill one out
- ⦿ One-page, green medical order filled out by individual & HCP (signed by both)
- ⦿ Works across all settings (EMS)
- ⦿ Can address a number of issues-CPR,ANH,AR use of antibiotics and Goals of Care

## POLST

- ⦿ ABOUT NOW
- ⦿ Modification/Revocation
  - Individual with DMC can change/revoke POLST at any time or request alternative treatment to what is on POLST
- ⦿ Surrogates
  - Can sign based on known preferences or, if they are unknown, best interest
  - May modify/revoke if patient authorized
- ⦿ Most recent verbal or written directive of patient governs

# POLST FORM

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROFESSIONALS AS NECESSARY

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

*Follow these orders, then contact physician/APP. This Medical Order Sheet is based on the current medical condition of the person referenced below and their 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 \_\_\_\_\_

<b>A</b>	<b>GOALS OF CARE</b> (See reverse for instructions. This section does not constitute a medical order.)	
<b>B</b>	<b>MEDICAL INTERVENTIONS:</b> Person is breathing and/or has a pulse <input type="checkbox"/> <b>Full Treatment:</b> 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). <input type="checkbox"/> <b>Limited Treatment:</b> Use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use noninvasive positive airway pressures. Generally avoid intensive care. <input type="checkbox"/> Transfer to hospital for medical interventions. <input type="checkbox"/> Transfer to hospital only if comfort needs cannot be met in current location. <input type="checkbox"/> <b>Symptom Treatment Only:</b> 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 nasal treatment of airway obstruction as needed for comfort. Use Antibiotics only to provide comfort. Transfer only if comfort needs cannot be met in current location. Additional Order: _____	
<b>C</b>	<b>ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION:</b> Always offer food/fluids by mouth if feasible and desired. <input type="checkbox"/> No artificial nutrition. <input type="checkbox"/> Delayed end period of artificial nutrition. <input type="checkbox"/> Long-term artificial nutrition.	
<b>D</b>	<b>CARDIOPULMONARY RESUSCITATION (CPR)</b> Person has no pulse and/or is not breathing <input type="checkbox"/> Attempt resuscitation/CPR <input type="checkbox"/> Do not attempt resuscitation/DNR/Do Not Attempt Resuscitation	<b>AIRWAY MANAGEMENT</b> Person is in respiratory distress with a pulse <input type="checkbox"/> Intubate/Use artificial ventilation as needed <input type="checkbox"/> Do not intubate - Use O2, manual treatment to relieve airway obstruction, medications for comfort.
<b>E</b>	If I lose my decision-making capacity, I authorize my surrogate decision maker noted below to modify or revoke these NJ POLST orders in consultation with my treating physician/APP. Health care representative identified in an advance directive. Other surrogate decision maker: <input type="checkbox"/> Yes <input type="checkbox"/> No First Name of Surrogate (indicate on reverse) _____ Phone Number _____	
<b>F</b>	<b>SIGNATURES:</b> I have discussed this information with my physician/APP. Signature: _____ <input type="checkbox"/> Person Named Above <input type="checkbox"/> Health Care Representative/Legal Guardian <input type="checkbox"/> Spouse/Closest Union Partner <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Other Surrogate: _____	Has the person named above made an anatomical gift? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown These orders are consistent with the person's medical condition, known preferences and best known information. PHYS: (Physician/APP Name) _____ Phone Number: _____ Physician/APP Signature (Mandatory) _____ Date/Time: _____ Professional License Number: _____

1/2/14 **SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED**

## POLST

### Initial POLST

- ☉ Seriously ill with life-threatening illness
- ☉ Advanced frailty with significant weakness & difficulty with ADLs
- ☉ May lose capacity to make their own health care decisions within the year
- ☉ Strong preferences for EOL care
- ☉ Chronically ill individuals who have frequent health care system contact
- ☉ Individuals who reside in LTCF

### Revisiting POLST

- ☉ Transferred to a different care setting
- ☉ Experiences a significant change in health status
- ☉ Changes his or her treatment preferences
- ☉ Changes his or her primary care provider

## DIFFERENCES BETWEEN AD & POLST

Advance Directive	POLST
All Adults	People w/Advanced Illness
Future Care/Condition – IF, THEN	Current care/condition - NOW
Individual & 2Witnesses/1 Notary	Individual/Surrogate & Doctor/APN
Names surrogate	Doesn't name surrogate
Legal Document – Requires Interpretation	Medical Order – Immediately Actionable
Any Setting	Medical Setting
Individual/Med. Records	Original w. Individual/Copy in Medical Records
Not operational in field (EMS)	Operational in field (EMS)
Transportable	Transportable
Limited to certain situations	Not limited by situation or place
Loss of capacity	No loss of capacity

## OUTCOMES

<u>Benefits of facility ACP</u>	<u>Consequences of No ACP</u>
<ul style="list-style-type: none"> <li>Reinforces to residents that health care needs will be met</li> <li>If critical event happens, won't be first time thinking about issues</li> <li>Avoid conflict among family/staff</li> <li>Strengthen relationships</li> <li>Reduced stress and anxiety for proxies and staff</li> <li>Reduce unnecessary hospital transfers</li> <li>Improved quality of care</li> <li>Increased satisfaction with care</li> </ul>	<ul style="list-style-type: none"> <li>Possible deficiencies in survey</li> <li>More aggressive intervention (feeding tube) or insufficient intervention (pain)</li> <li>Imposes stress on staff b/c of inability to constructively deal with grief/loss and time to sort through ethical complexities</li> <li>No matter what decision made, family/HCP live with uncertainty, resulting in lasting distress</li> </ul>

## EFFECTIVE ADVANCE CARE PLANNING

### ACP IS NOT:

- A single document
- A one-time thing
- A checklist of various medical interventions
- About how a person wants to die

### ACP IS:

- Communicating, reflecting, documenting, and revisiting
- A process
- A reflection of an individuals' goals and values and how that connects to their health
- About how a person wants to live

## FACILITY IMPLEMENTATION

## INITIAL ACP QUESTIONS FOR THE FACILITY

- ◉ Does the admission packet reflect information about current forms of ACP?
- ◉ Does the intake form provide space for POA, AD, and/ or POLST?
- ◉ What is the facilities standard practice for revisiting ACP documents?

## ACP PROCESS FOR THE FACILITY

- ◉ Staff are trained and supported about ACP/GOC; how to deal ethics dilemmas, with death/dying of residents.
- ◉ Ensure resident and family are fully informed of (1) resident's medical condition, (2) prognosis and range of possible outcomes (hope for best, prepare for worst) and (3) common medical interventions (CPR, ANH)
- ◉ Residents have the opportunity to express wishes about GOC and desired medical interventions clearly.
- ◉ Facility has policies and procedures in place to document, communicate, and honor wishes of residents.

## KEYS TO SUCCESS

- ⊙ Trust, communication & relationships
- ⊙ Individual understands health care status, diagnosis, prognosis, possible care/treatment options.
- ⊙ Opportunity to reflect on goals/values in conjunction with health status
- ⊙ Opportunity to clearly articulate goals/values/wishes
- ⊙ Individuals know they have choices/understand ALL the choices/treatment options and burdens/benefits
- ⊙ Involvement of IDT and all relevant facility/care provider knows who the proxy is and what articulated wishes are and all are ready to advocate

## OPPORTUNITIES FOR ACP IN FACILITIES

- ⊙ Admission (and within a couple of weeks)
- ⊙ Care conferences
- ⊙ When there is a change in resident's condition
- ⊙ When a resident or family member raises it ("I've lived my life; I'm ready to go")
- ⊙ The Conversation(s)

### Things to Keep in Mind:

- Listening is key – empathetic and reflective
- No one communication strategy
  - Tailor to the disease trajectory
  - Tailor to needs/communication style of individual/family
- Must work from where person is & where willing to go
  - A lot of education will likely be needed
- Process that happens over time
- MUST COMMIT to ensure preferences are honored

## THE CONVERSATION

### ◎ Prepare

- Review resident's goals & values, medical condition & prognosis, any ACP docs, resident's capacity, identify key family members and/or health care proxy if necessary
- Create the space: private, enough time, turn off cell – give full attention
- Be mindful to use simple language and respond empathetically
- Have tissues

## THE CONVERSATION

### ◎ Discussion

- Describe purpose of meeting
- Identify spokesman if not resident and there is one
- Assess resident's current state of mind, comfort level
- Ask what resident/family understand of condition and prognosis
- Talk about ACP – what resident has, what ACP is
- Ask about resident's goals of care, values, wishes
- Go more in-depth about condition and prognosis and clarify any areas of confusion

## THE CONVERSATION

- Discuss possible interventions (use of antibiotics, CPR, ANH) and palliative care or hospice
- Discuss/fill-out any medical orders; encourage filling out advance directive
- ◎ Ending the Discussion
  - Ask: What do you understand about what we've talked about? (Not do you have any questions.)
  - Explain will always have provide comfort
  - Offer to have a follow-up meeting if necessary and explain will revisit whenever needed

## WHAT YOU CAN DO

- ◎ Do It Yourself
- ◎ Get Comfortable with Dying as a Part of Life
- ◎ Get Your Family and Friends To Do It
- ◎ Assess What Your Facility Is Doing
- ◎ Talk to the Ombudsman for Assistance
- ◎ Talk with Residents & Family
- ◎ Engage with Regional Ethics Committee
- ◎ Attend to Yourself



## RESOURCES

### Tools for Developing a Facility Plan

- ◎ POLST
  - [njha.com/polst](http://njha.com/polst)
- ◎ Coalition for Compassionate Care of California
  - <http://coalitionccc.org/nursing-homes.php>
- ◎ Advancing Excellence in America's Nursing Homes
  - Goal 6 – Advance Care Planning  
[http://www.nhqualitycampaign.org/star\\_index.aspx?controls=resByGoal](http://www.nhqualitycampaign.org/star_index.aspx?controls=resByGoal)

## RESOURCES

### Tools that May Help Have the Conversation

- ◎ INTERACT II
  - <http://www.interact2.net/tools.html>
- ◎ Hospice & Palliative Nurses Association TIPS Sheets
  - <http://www.hpna.org/DisplayPage.aspx?Title=TIPS>
- ◎ American Hospice Foundation: Medical Issues to be Considered in Advance Care Planning
  - <http://www.americanhospice.org/articles-mainmenu-8/advance-care-planning-mainmenu-9/46-medical-issues-to-be-considered-in-advance-care-planning>

## RESOURCES

### Advance Care Planning Tools

- ◎ The Conversation Project
  - <http://theconversationproject.org/>
- ◎ Engage with Grace
  - <http://www.engagewithgrace.org/>
- ◎ 5 Wishes
  - <http://www.agingwithdignity.org/five-wishes.php>
- ◎ Caring Conversations
  - <http://practicalbioethics.org/resources/caring-conversations.html>
- ◎ American Bar Association
  - [http://www.americanbar.org/groups/law\\_aging/publications.html](http://www.americanbar.org/groups/law_aging/publications.html)
- ◎ Your Life Your Choices
  - [http://www.rihlp.org/pubs/Your\\_life\\_your\\_choices.pdf](http://www.rihlp.org/pubs/Your_life_your_choices.pdf)



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