The POLST Paradigm in Nursing Homes

Hand-out of presentation available: http://clas.uiowa.edu/socialwork/nursing-home/webinars

The POLST Paradigm in Nursing Homes

Presenters
Jane Dohrmann
Nicole Peterson
Mercedes Bern-Klug

National Nursing Home Social Work Network
With support from the Retirement Research Foundation

Iowa

Plan

• 50 minute presentation
• 15 minutes questions/answers
• Please use Q/A box (bottom right)
• Note the slide #
• Recording to be available on website: http://clas.uiowa.edu/socialwork/nursing-home/webinars

Jane Dohrmann, MSW, LISW

• Director of Honoring Your Wishes: A Community-Wide Advance Care Planning Initiative
• Employed by Iowa City Hospice, a local non-profit hospice
• Promotes a systems-wide approach to advance care planning
• Respecting Choices Facilitator and Instructor
• Guides quality improvement projects

Nicole Peterson, DNP, ARNP

• Geriatric Nurse Practitioner/Lecturer-HouseCalls Faculty Practice at University of Iowa College of Nursing
• Provides primary care for residents in local long-term care facilities
• Teaches Gerontological Nursing for undergraduate nursing students
• Respecting Choices facilitator and instructor
Objectives

- Describe the POLST paradigm
- Explain the rationale for POLST
- Discuss the extent to which POLST is available throughout the USA
- Explain the special usefulness of POLST in the nursing home setting
- Describe the Hartford Change AGEnt project currently underway
- Discuss preliminary findings from the project

POLST

- Physician Orders for Life-Sustaining Treatment
- Started in Oregon in 1991
- Turns health care preferences into medical orders
- Is more comprehensive than a DNR/CPR order
- May function as a DNR order

The POLST Form

Section A: CPR Decision
Section B: Goals of Care for Medical Interventions
California Physician Order for Life-Sustaining Treatment (POLST) effective 10.21.14

National POLST Paradigm Program
http://www.polst.org/programs-in-your-state/

As of March 31, 2015:
Most mature programs (darkest): Oregon and West Virginia
Endorsed programs (next darkest)
Developing: light pink
No program: white

POLST is recommended for:

- People with serious, life-limiting illnesses
- Frail
- Frail elderly
- People with chronic, critical illnesses

“Compared with other advance directive programs, POLST more accurately conveys end-of-life preferences and yields higher adherence by medical professionals.”


When is POLST appropriate?

Would I be surprised if this patient died in the next year?
IPOST

- Iowa Physician Orders for Scope of Treatment
- Enacted into law in 2012
- Iowa Code Chapter 144D

Facts about Advance Directives and IPOST

Advance Directives
- For all adults with decision-making capacity
- Future care
- Person completes form
- Health care proxy cannot complete
- Person responsible for updating & giving document to health care providers

IPOST
- For seriously ill children & adults and the frail elderly
- Current and future care
- LIP & health care agent or patient sign form which results in a medical order
- Health care agent can complete with provider
- Individual, family or care center staff are responsible for presenting it in an emergency
- Provider is responsible for reviewing it with individual & family

The POLST Paradigm emphasizes:

- the importance of health care professionals facilitating advance care planning discussions
- engaging the health care agent
- promoting reflection of values, beliefs, and goals of care

Community-wide collaboration is crucial to POLST implementation

When should a POLST form be reviewed?

- When the person is transferred from one care setting or care level to another, or
- When there is a substantial change in the person's health status, or
- When the person's treatment preferences change

Source: Iowa Physician Orders for Scope of Treatment (IPOST) 6/25/12
POLST translates the resident’s wishes into actionable medical orders

- More comprehensive than just code status
- Can be specific to resident’s needs
- High level of compliance with POLST documents and end of life care, 94% (Hickman et al, 2011)
- Sections not completed assume full treatment

POLST provides clear instructions and improves communication

- 75% of HC providers felt POLST provided clear instructions about patient preferences (Schmidt et al 2004)
- 91% of HC providers feel POLST improved communication of patient preferences between patient and the healthcare team (Caprio, Rollins, Roberts, 2012)

POLST documents are easily accessible in the time of healthcare crisis

- Standard storage procedures
- Travel with resident
- Actions of healthcare providers following IPOST are upheld by IA state legislature

Role of the Licensed Independent Practitioner

- Review the resident’s wishes and IPOST
- Elaborate on resident’s goals and give specific information on expected disease trajectory
- Include the resident’s wishes in documentation in the medical record
- Review/update IPOST with changes in resident’s condition

POLST documents are honored by all healthcare professionals

- POLST orders tell nurses what to do in the “middle of the night” scenarios
- EMS can follow POLST orders in the field
- Provide emergency department staff direction with patients they have not met before, or who may be transferred unconscious or in an altered mental state
- Iowa will honor POLST documents from other states

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IPOST legislation

- Provides legal protection for healthcare providers following IPOST
- May transfer care to another if unwilling to carry out wishes identified on IPOST
- Death resulting from withholding or withdrawing life-sustaining procedures does not constitute suicide, homicide, or dependent adult abuse

IPOST Mission

To create a system to honor the healthcare treatment choices of individuals through improved communication across the healthcare continuum and to promote community engagement in advanced care planning.

Hartford Change AGEnts Aims:

1) Enhance nursing home staff members’ ability to engage residents and families in the advance care planning process including the POLST paradigm
2) Document nursing home residents’ medical care preferences in the health care record
3) Develop an organization-wide protocol for securing, updating, and following IPOST
4) Complete audits to measure ACP & IPOST outcomes

What we are learning from our Hartford Change AGEnt Project

Mercedes Bern-Klug
John A Hartford Geriatric Social Work Scholar

Our Collaboration Model
Systems Issues

- Staff did not anticipate that learning and incorporating the POLST paradigm would take much time, "We already ask about DNR"

- Lesson learned from Dr. Nicole Peterson’s research: The devil is in the details!
- Systems change can take time.

Hartford Project Implementation

- Monthly team visits – learning together
  - Education – law, literature, practice wisdom, Honoring Your Wishes
  - Support – empathy, brainstorming, normalizing
  - Building capacity:
- Record keeping
- Train other staff
- Residents
- Families
- Providers

Support

- On-site
- Phone
- Email

Information in Medical Record

On IPOST form and in Medical Record.

Residents and Families

"I want CPR for her; I don’t want her to choke to death"

“I don’t want you to send me to the hospital and I want to be a full-code.”

Nicole shares experience from a situation in a different city

Questions from Staff

- Sub-acute residents?
- Younger MI?
- Outings
  - Activities
  - Doctor appts
Other Providers:

- Importance of finding out what they want their role to be.

*Jane to discuss:*

- Concerns about having a meaningful conversation
- Wanting to be included in the process
- "More than a checklist"
- Issues related to "verbal orders"
- Coordinating obtaining signatures outside of Nursing Home

Goal

People get the amount and type of care they want.

We did the best we could with what we knew.
Now we know better; now we must do better.

*Maya Angelou*

Your comments?