Quality Assurance and Performance Improvement (QAPI)

A Toolkit for POLST in California's Skilled Nursing Facilities

Developed by the Coalition for Compassionate Care of California
with support from the California Health Care Foundation

COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

POLST CALIFORNIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

California Health Care Foundation

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COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

The Coalition for Compassionate Care of California is a statewide partnership of regional and statewide organizations dedicated to the advancement of palliative medicine and end-of-life care in California.
CoalitionCCC.org **CaPOLST.org**

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QAPI Toolkit for POLST in SNFs

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I. Introduction

This toolkit is designed to provide skilled nursing facilities with useful, QAPI-based tools which can be used to improve POLST utilization in California's nursing homes and assure that residents' end-of-life treatment wishes are understood, documented and followed.

Throughout the toolkit, look for the 🛠 symbol which identifies POLST-specific QAPI tools which are available in the Addendum section of this toolkit and online at www.caPOLST.org.

What is QAPI?

Quality Assurance (QA) is a process of meeting quality standards and assuring that care reaches an acceptable level. Skilled-nursing facilities often set QA thresholds to comply with regulations.

Performance Improvement (PI) is a pro-active and continuous study of processes to identify areas needing improvement and test new approaches to correcting persistent/systemic problems.

QA and PI combine to form QAPI, a comprehensive, data-driven, proactive approach to:

- Improve the quality of life, care, and services in nursing homes
- Identify opportunities for improvement
- Address gaps in systems or processes
- Develop and implement an improvement or corrective plan
- Continuously monitor effectiveness of interventions.

The Affordable Care Act of 2010 requires nursing homes to have an acceptable QAPI plan within a year of the promulgation of a QAPI regulation.

Five key elements provide the framework for nursing home QAPI:

- *Design and Scope* - Comprehensive, ongoing program which includes all departments and functions, as well as integration with the larger community, including hospitals, home health and hospice. QAPI plans address safety, quality of care, quality of life, resident choice and transitions. The focus is on person-centered care.

- *Governance and Leadership* - Stable, engaged and supportive leadership from boards/owners and executive staff.

- *Feedback, Data Systems and Monitoring* - Utilizes data and information from multiple sources, including residents & staff. Does not just respond to adverse events. Uses benchmarking and trends to look forward and address isolated issues before they become systemic.

- *Performance Improvement Projects* - Teams charter prioritized performance improvement projects (PIPs), focusing on high-risk, high volume, problem-prone areas. Incorporates a "Plan-Do-Study-Act" (PSDA) cycle.

- *Systematic analysis and systemic action* – PIPs incorporate root-cause analysis and systems thinking to institute systemic changes as needed.

With QAPI, nursing homes are being asked to incorporate a standardized process for ongoing performance improvement, and to develop a written plan to ensure accountability and sustainability for their improvement efforts.

This toolkit assumes that you have already developed an overall QAPI program for your facility and have identified POLST implementation or advance care planning as one of the "gaps" or areas of opportunity for improvement in your current processes.

Sample tools and suggestions for ensuring that your residents' treatment wishes regarding end-of-life care are respected and honored are provided throughout this document. These tools are designed to be used to in conjunction with other QAPI materials, such as CMS' *QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home*.

Why is Advance Care Planning in the Skilled nursing Setting Important?

Patients at the end of life too often receive care that is unwanted, inappropriate or futile. If patients are given the opportunity to discuss treatment options and share their thoughts well ahead of a medical crisis, many of these situations could be averted.

The goal of advance care planning is to ensure that patients' treatment wishes are known and respected, even if they lose capacity to communicate directly.

In the skilled nursing setting, advance care planning is fundamentally important because it:

- Supports patient-centered care
- Reduces unnecessary hospitalization and procedures
- Eases potential conflict and stress for patients, families and caregivers

Federal regulations for skilled nursing facilities recognize the benefits of advance care planning as indicated in *42 C.F.R. §483.25 Quality of Care.*

> *Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.*

Further, under F280-Resident Participation in Care-Planning, the regulations state:

> *A comprehensive care plan must be … prepared by an interdisciplinary team … and to the extent practicable, [with] the participation of the resident, the resident's family or the resident's legal representative.*

In Appendix PP of the *State Operations Manual,* the guidance to surveyors states:

> *"Advance care planning 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.*
>
> *…The ability of a dying person to control decisions about medical care and daily routines has been identified as one of the key elements of quality care at the end of life."*

What is POLST?

Physician Orders for Life Sustaining Treatment (POLST) is a form that clearly states what level of medical treatment a patient wants toward the end of life. Printed on bright pink paper, and signed by the patient *and* the physician, nurse practitioner or physician assistant, POLST helps give seriously-ill patients more control over their treatment. POLST also helps patients talk with their healthcare team and loved ones about their choices. In this way, POLST can help reduce patient and family suffering and make sure that patient wishes are known and honored.

POLST:

- Is a medical order
- It provides instructions regarding specific medical treatment
- It is legally binding across healthcare settings in California
- It is valid only if appropriately signed by the patient (or decisionmaker) AND a physician/NP/PA. (Note: As of January 1, 2016, California nurse practitioners and physician assistants acting under the supervision of a physician and within their scope of practice are authorized to sign POLST forms.)

POLST is designed to ensure that patients in frail health get the care they want and avoid care they do not want. Although anyone can complete a POLST, it is specifically designed for individuals of any age who have a chronic progressive illness, a serious health condition or are medically frail. A helpful tool for determining who would benefit from POLST is the question, "Would you be surprised if this patient died within the next year?"

POLST:

- Encourages communication between healthcare providers and patients
- Enables patients to make more informed choices
- Clearly communicates these decisions to healthcare providers.

As established in California in 2009 under Assembly Bill 3000, and updated in 2016 under Assembly Bill 637, key aspects of the POLST law include:

- There is only one standardized POLST form for the whole state.
- Completing a POLST is completely voluntary for patients. A facility cannot mandate completion of a POLST.
- While it is not mandated that a consumer complete a POLST, it is mandated that health care providers honor a POLST, even if the ordering physician/NP/PA does not have admitting privileges at the facility.
- Providers must follow POLST orders except if the orders are contrary to generally accepted healthcare standards or call for medically ineffective treatment.
- POLST law protects healthcare providers who comply in good faith with a patient's POLST requests.

POLST differs from the pre-hospital DNR in that it:

- Addresses other conditions as well as resuscitation.
- Provides context and focus for care.
- Is valid across all care settings.

If a nursing home resident does not want to go back to the hospital again or wants comfort-focused treatment, POLST should effectively prevent any unnecessary transitions.

POLST vs. Advance Health Care Directives (AHCD)

POLST does not replace the advance directive; the two documents should work together. POLST turns the values and wishes expressed in a person's AHCD into actionable medical orders that can be easily understood and followed by healthcare providers, including EMS.

AHCD vs. POLST: How they Differ	
AHCD	**POLST**
Who is it for? Any adult **What makes it legal?** Proper signatures. An ombudsman must serve as a witness if the AHCD is completed for a SNF patient. **Notarized?:** An option, but not required. **Guidance:** Can provide guidance on patient's treatment wishes **Agent:** Allows individual to appoint DPOA-HC/agent **Reasoning:** Choices based on possible medical conditions/goals of care	**Who is it for?** Very ill/frail, at any age **What makes it legal?** Proper signatures **Notarized?:** Not required **Guidance:** Considered a medical order valid across all care settings **Agent:** Cannot be used to name a DPOA-HC/agent. Can be completed by a legally-recognized decisionmaker if the patient lacks capacity. **Reasoning:** Choices based on patient's current medical conditions/goals of care

It is important to remember that POLST is not just a check-box form. When a POLST is appropriate, it should be completed in connection with an in-depth conversation (or conversations) between the patient and/or surrogate decisionmaker and health care provider regarding:

- The patient's current state
- The patient's and/or decisionmaker's understanding of their diagnoses
- Any threats to the patients wellbeing and function
- Expected trends and outcomes

As treatment options are discussed, the health care provider should share information about treatment:

- Benefits
- Burdens
- Likely results
- Alternatives

When working with patients on advance care planning, the health care provider should:

- Develop trust
- Listen closely
- Leverage the moment
- Use care conferences
- Involve both the resident and their family when possible
- Ensure that any documents completed are resident-driven
- Understand regulations, guidelines and policy regarding patient capacity
- Understand the family/surrogate's role in decision-making

Remember:

- POLST is <u>always</u> voluntary for patients
- POLST is not appropriate for all SNF patients
- POLST is not just a check-box form.
- POLST is not valid until signed by both the patient (or their decision-maker) AND the physician/NP/PA.
- POLST does not replace an AHCD.
- POLST should be re-visited with change of condition.
- POLST can be voided by patient (or their decisionmaker) at any time.

POLST is the natural product of a responsible, transparent conversation with a nursing home resident (and ideally, their family)—that includes prognosis, goals of care, and probable outcomes.

A skilled nursing facility with an effective POLST program:

- Takes the time to discuss goals of care and prognosis with every SNF resident and family
- Informs residents and/or decisionmakers of the differences between an advance directive and POLST.
- Encourages, but does not require, the creation of advance directive and/or POLST forms for all *appropriate* residents, and make copies for the chart.
- Creates and adheres to a process for getting copies of advance care planning documents into the hands of the patient's primary care physician (PCP).
- Sends the original POLST with patient when discharged home or to another setting, with instructions on the form's importance and where to keep the form.
- Educates residents, families, and nursing home staff so that informed decisions can be made.
- Empowers staff to discuss end-of-life concerns and issues with residents.
- Talks about the possibility of progressive illness and death openly and frequently with residents and their families, to the extent the residents and families are receptive to such conversations.
- Tracks POLST completion and employs a rigorous QAPI process to confirm that discussions are appropriate, forms are filled out correctly and patients' wishes are honored.

TOOLKIT

- POLST 2017 Form
- POLST SNF Cover Sheet
- Quick Reference: POLST in Nursing Homes
- Model POLST Policies & Procedures for SNFs

II. STEP-BY-STEP - POLST Performance Improvement Projects (PIPs)

If it has been determined that there are breakdowns in POLST implementation, you will need to develop a POLST-specific Performance Improvement Project (PIP) team. In order to be most effective, your POLST PIP team should utilize a standardized process for making improvements.

One of the best-known processes is PDSA – Plan, Do, Study and Act.

Plan

1. Select a POLST PIP leader/champion
    a. This can be anyone who has a passion for advance care planning or POLST.
    b. Choose someone who is expected and able to keep momentum despite setbacks and other factors that come up and distract.

2. Identify team members

Good advance care planning and POLST implementation crosses many departments, so your PIP team should be interdisciplinary. It may include:

a. Medical Director
b. Administrator
c. Director of Nursing
d. Nurse practitioners/physician assistants
e. Admissions Director/staff
f. Social Services Director/staff
g. MDS Nurse
h. CNAs
i. Residents

3. Define the mission

Determine all potential root cause(s) underlying the performance issues. Focus on systems and processes, not individuals. Systematic tools, such as the "Five Whys" or Fishbone Tool can help to dig down below the surface of an issue and help identify the root cause.

Five Whys: A simple but effective root cause analysis tool in which you state the problem, then ask "why", answer the question, then ask "why" again, and continue the process until you have drilled down to the root cause.

> Example: Data show that 10% of your patients had an incomplete POLST (not signed by either the physician/NP/PA or resident/surrogate) in their file.
>
> 1. Data show that resident files contain incomplete POLST forms. *Why?*
> 2. Staff may not know where "in process" POLST forms should be stored. *Why?*
> 3. Staff may be unaware of the policies and procedures for POLST. *Why?*
> 3. Current staff has not been trained on advance care planning and POLST. *Why?*
> 4. Regular training on advance care planning and POLST has not occurred. *Why?*
> 5. A regular schedule for training on advance care planning and POLST has not been created and followed.

TOOLKIT

- Assessing POLST Implementation in SNFs
- Fishbone Tool

4. Establish specific and measurable goals and objectives

Once you've clarified the problem and possible causes, you need to decide what changes need to be made in order to bring about improvements. In addition, you need to decide how you will measure the outcomes of your efforts. Be specific. Identify baseline performance measures, outcome measures, timelines and responsibilities. What will success look like?

TOOLKIT

- Goal Setting Worksheet

5. Determine what information is needed for the project and what collection tools you require.

This may include:

a. Resident charts
b. MDS reports
c. Survey reports (annual and complaints)
d. Resident/family surveys
e. Questionnaires for staff/physicians/nurse practitioners/physician assistants
f. Questionnaires for hospital case managers/ER physicians/ hospitalists/intensivists/palliative care specialists

Do

Implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring. If the change is significant, it may be best to test the change on a smaller scale first, and collect more data. Make sure your changes target the root causes you identified.

Study

Track and evaluate your progress. Compare baseline data with final outcomes. Use the data collection tools you identified to evaluate data and other input from staff, residents, families and related parties. Ask two basic questions: (1) Did it work? (2) If not, why? What did you learn as a result of this effort?

Act

After studying the results of your initial efforts, determine what actions will be taken next. Some questions to ask your team are:

- Which efforts were successful and which were not?
- Did the effort uncover any other opportunities for improvement?
- Did anything happen that we didn't expect?
- How can we spread the successful efforts?
- Are there any preparations which need to occur before full implementation?
- How will we plan for ongoing monitoring?

The final step in the PSDA cycle is sharing your success. Sharing and celebrating success supports the change process and encourages others to become a part of the process.

II. TOOLS:

POLST
Information & Resources

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

First follow these orders, then contact Physician / NP / PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document**.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing.*

If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	**Preparer Name** (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary**. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive**. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

UNDERSTANDING POLST
Physician Orders for Life-Sustaining Treatment
Key Facts About POLST for Residents and Family Members

POLST is a medical order that can help you get the care you want, and also protect you from getting medical treatments you DO NOT want. Before you complete a POLST you should know:

- **POLST is always voluntary.** Nursing homes and other health providers may include the POLST in their admission documents, but you are not required to complete a POLST form if you do not want one.
- **POLST is specifically designed for people who are elderly, seriously ill or medically frail.** Younger, healthier people may be best served by completing an advance directive instead.
- **When you make your treatment wishes known, you are relieving your family and friends from the stress of having to guess what care you might want in an emergency.**
- **POLST is a medical order. Medical personnel are required to follow POLST instructions** regarding CPR and other emergency medical care.
- **You should talk with your doctor or someone trained to discuss the POLST before filling out the form**. This conversation is very important and should cover your current overall health and how it might impact your treatment wishes and goals for your care.
- **It is very helpful to include your family members in the POLST conversation** so they also understand your health conditions and know your treatment wishes.
- **The POLST is not considered valid until it is signed by a physician, nurse practitioner or physician assistant AND you (or your designated decisionmaker).**
- **The original bright pink POLST form is yours, to travel with you** to different settings – home, assisted living, nursing facility or hospital. If you go home or to another care setting, the facility keeps a copy and the original pink POLST goes with you. Keep your POLST in an easy to find place in case of emergencies.
- **You only have to complete a new POLST if your treatment wishes change.** You should review your POLST regularly, but you do not need to make new POLST if you go to the hospital, move to another facility, or change doctors.
- **You can request different treatment or void the POLST form at any time, even verbally.** To void the form, draw a line through sections A through D, write "VOID" in large letters, then sign and date the line. Make sure your health providers have a copy of the voided form.
- **POLST does NOT replace an advance directive.** An advance directive is still the best way to appoint a legal healthcare decisionmaker, and is recommended for all adults, regardless of your age or current health. A POLST works together with your advance directive, providing more specific detail regarding treatment wishes and goals of care.

Please go to: http://www.capolst.org/ or call (916) 489-2222 for more information.

POLST MODEL POLICY | SKILLED NURSING FACILITIES

January, 2016

Purpose

The purpose of this policy is to define a process for skilled nursing facilities to follow when a resident is admitted with a Physician Orders for Life-Sustaining Treatment (POLST). This policy also outlines procedures regarding the completion of a POLST form for a resident and the steps necessary when reviewing or revising a POLST form.

Preamble

Physician Orders for Life Sustaining Treatment (POLST) is a form printed on bright pink paper that clearly states what level of medical treatment a patient wants toward the end of life. Signed by a patient (or their decisionmaker) and by a physician, nurse practitioner (NP) or physician assistant (PA), POLST helps give seriously ill patients more control over their treatment. POLST also helps patients talk with their healthcare team and loved ones about their choices. In this way, POLST can help reduce patient and family suffering and make sure that patients' wishes and goals of care are known and honored.

The POLST form:

- Is a standardized form that is brightly colored and clearly identifiable[i];
- Is always voluntary for the patient;
- Can be revised or revoked by an individual with decisionmaking capacity at any time;
- Is legally sufficient and recognized as a physician 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 on the request and honors a POLST;
- Can be an alternative to the "Pre-Hospital Do Not Resuscitate" forms[ii], although POLST is more comprehensive in that it addresses other life-sustaining treatments in addition to resuscitative measures and can request affirmative treatment as opposed to merely requesting withholding of resuscitation;
- Can be an alternative to the "Preferred Intensity of Treatment" (PIT) or "Preferred Intensity of Care" forms used in some skilled nursing facilities, although POLST is preferable because it is valid outside the walls of the facility and carries the full force of a physician's order; and
- Should be made available for seriously ill residents who wish to execute a POLST form while in the nursing facility.

A healthcare provider is not required by law to initiate a POLST form, but is required to treat an individual in accordance with a POLST form. This does not apply if the POLST requires medically ineffective health care or health care contrary to generally accepted healthcare standards.[iii]

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. The POLST form should be executed as part of the healthcare planning process and ideally is a complement to a resident's advance directive. A POLST form may also be used by residents who do not have an advance directive.

A legally recognized healthcare decisionmaker[iv] may execute, revise or revoke the POLST form for a resident only if the resident lacks decisionmaking capacity or at the request of a resident with capacity. This policy does not address the criteria or process for determining or appointing a legally recognized healthcare decisionmaker, nor does it address the criteria or process for determining decisionmaking capacity, which is generally the responsibility of the attending physician.[v]

While a healthcare provider[vi] such as a nurse or social worker can explain the POLST form to the resident/ decisionmaker, the responsibility for discussing the efficacy or appropriateness of the treatment options with the resident/decisionmaker lies with the physician, NP or PA.

Once the POLST form is completed, it must be signed by the resident or decisionmaker AND a physician, or by an NP or PA operating under the supervision of a physician.

Completion of a POLST form should reflect a process of careful reflection by the resident/decisionmaker, in consultation with the physician, NP or PA about the resident's medical condition and known treatment preferences.

Skilled Nursing Facility Procedures[vii]

I. Resident Admitted with a Completed POLST Form

1. A completed, fully executed POLST is a legal physician order, and is immediately actionable.
2. The admitting nurse will note the existence of the POLST form on the admission assessment and review the form for completeness (e.g. dated, signed by resident and/or legally recognized healthcare decisionmaker, and by a physician, nurse practitioner [NP] or physician assistant [PA], at least Section A completed).
3. It will be confirmed with the resident, if possible, or the resident's legally recognized healthcare decisionmaker, that the POLST form in hand has not been revoked or superseded by a subsequent POLST form or conflicting advance directive.
4. Once reviewed, the POLST will be copied, and the current original form placed in the front of the resident's chart, along with the resident's advance directive if he/she has one. If there is an electronic health record (EHR) and availability to scan and upload the POLST into the record or otherwise include it, the POLST should be incorporated into the EHR.
5. The POLST form will be added to the resident's inventory to ensure that when the resident is discharged or transferred, the current original POLST will be sent with the resident.
6. The order to "Follow POLST instructions" will be added to the resident's admitting orders for physician review. Specifics such as Do Not Resuscitate or No Tube Feeding may also be incorporated into the orders and recapitulations for increased clarity.
7. The attending physician will review this order by direct conversation with the resident and/or their decisionmaker, with respect to the resident's wishes and goals of care, within 72 hours of admission whenever possible.
8. The physician will complete the review process by signing an order in the chart stating, "Follow POLST instructions" and/or by writing the specific orders corresponding to those contained in the POLST.
9. The POLST will be honored during the initial comprehensive assessment period (14 days), even if the attending physician has not yet formally reviewed the form or discussed with the resident and/or their decisionmaker.
10. If "Do Not Attempt Resuscitation" is indicated on the POLST, follow the facility procedure for communication and documentation of DNR/DNAR.
11. POLST may replace the "Preferred Intensity of Care," "Preferred Intensity of Treatment," and "Pre-Hospital DNR/DNAR" forms, if consistent with facility policy.
12. If the POLST conflicts with the resident's previously-expressed health care instructions or advance directive, then, to the extent of the conflict, the most recent expression of the resident's wishes governs, in accordance with AB 3000. *(See Section VI, "Conflict Resolution" for additional guidance.)*

13. A qualified healthcare provider[viii], preferably a registered nurse or social worker, will conduct an initial review of the POLST with the resident, or if the resident lacks decisionmaking capacity, the legally recognized healthcare decisionmaker, within the first required 14-day assessment period as part of the comprehensive assessment and care planning process.
14. If the resident or their decisionmaker expresses concern or has questions about the POLST form, the attending physician/NP/PA will be notified as soon as possible to discuss any issues with the resident/decisionmaker. In situations where there are problems with communication between the resident/decisionmaker and their treating clinicians on this topic, the facility medical director should be notified and should intervene.
15. The initial review and discussion about continuing, revising or revoking the POLST will be documented in the medical record, including the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.
16. As the resident moves from one healthcare setting to another, the original pink POLST and copies of the resident's advance directive, when available, should always accompany the resident.

II. Reviewing/Revising the POLST

1. The POLST will be reviewed by the facility interdisciplinary team during the quarterly care planning conference, anytime there is a significant change[ix] in the resident's condition, and at any time that the resident/ decisionmaker requests it.
2. A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates an intent to revoke. Revocation should be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
3. If a resident decides to revoke the POLST form, the resident's attending physician should be notified and appropriate changes to the physician orders should be obtained as soon as possible to ensure that the resident's wishes are accurately reflected in the plan of care.[x]
4. A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.[xi] *(See also Section IV, "Change in Patient Condition: Continuing Assessment and Reassessment".)*
5. All discussions about revising or revoking the POLST must be documented in the resident'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. Older POLST forms with versions dated 10/1/2009, 4/1/2011 or 10/1/2014 are still valid.
7. The newest version of the POLST form should be used whenever a patient's POLST is updated.
8. To void POLST, draw a diagonal line through the entire Section A through D and write "VOID" in large letters. The patient/decisionmaker should then sign and date the VOID line. The original voided POLST should be filed in the medical record. <u>Voided POLST forms should not be discarded</u>.

III. Initiating a POLST

1. Completing a POLST form is always voluntary. It should not be a standard part of every skilled nursing facility admission process. Many nursing home residents may not be appropriate for POLST completion.
2. If a resident (or if the resident lacks decisionmaking capacity, the legally recognized healthcare decisionmaker) wishes to complete a POLST form, a POLST form will be provided for the physician, NP or PA and the resident/decisionmaker to discuss, fill out and sign.
3. The resident's physician, NP or PA will be notified that the resident/ decisionmaker wishes to discuss the treatment options on the POLST form.
4. Staff should determine whether the resident has an advance directive. POLST complements, but does not replace an advance directive. Facility staff should make a concerted effort to obtain a copy of the advance healthcare directive (AHCD). When available, review the AHCD to ensure consistency with the POLST, and update forms appropriately to resolve any conflicts. *(See Section VI, "Conflict Resolution.")*
5. A healthcare provider, such as a nurse or social worker, can explain the POLST form to the resident and/or the resident's legally recognized healthcare decisionmaker; however, the physician, NP or PA is responsible for discussing treatment options and goals of care based on the patient's current medical condition.
6. After the physician, NP or PA discusses treatment options and goals of care with the patient/decisionmaker, the POLST form should be completed and signed and dated by all parties. Physicians, NPs and PAs should not sign POLST forms on nursing home residents without confirming that the form accurately reflects the known wishes or, if wishes not known, the best interests of the resident.
7. POLST must be signed by the patient/decisionmaker AND by a physician or an NP or PA acting under the supervision of a physician to be valid.
8. Verbal (telephone) orders are acceptable with follow-up signature by the physician, NP or PA in accordance with facility policy, and a faxed version of POLST is also valid.
9. When a POLST is signed by an NP or PA, the name of the supervising physician should be noted on the back of the POLST form by the NP or PA. Signature of the supervising physician is not required. The supervising physician does not have to be the resident's attending physician of record in the nursing facility.
10. Follow facility procedures for any issues brought to the physician, NP or PA's attention to ensure follow-up.
11. Make a copy of the completed POLST form. Mark it as "COPY" with the date the copy was made. File the copy in the advance directive or legal section of the medical record. The current original POLST form is considered the property of the resident, and will be transferred with the resident upon discharge, so the copy is the only record that will remain with the facility in the chart upon discharge or transfer.
12. Add the POLST form to the resident's inventory to ensure that the current original form is sent with the resident upon transfer or discharge from the facility.

13. Place the current original POLST form, along with a copy of the resident's advance directive (if he/she has one) at the front of the resident's physical chart or in another prominent and easily accessible location.

IV. Change in Patient Condition: Continuing Assessment and Reassessment

1. It is recognized that in some resident care situations, a decline in status (medical, physical, mental, psychosocial) is an expected and unavoidable outcome. When an expected change in condition occurs, it is generally not necessary to reassess POLST status when a resident has chosen comfort-focused treatment and rejected life-prolonging measures. It is generally inappropriate to change POLST under these circumstances. However, the physician, NP or PA is ultimately responsible for the decision whether to modify POLST orders in conjunction with the resident and/or legally recognized decisionmaker.
2. Whenever a resident exhibits a sudden and/or marked adverse change in signs, symptoms and/or behavior, the attending physician must be notified,[xii] regardless of the POLST instructions, or of whether the change was an expected outcome of the disease process. The physician will evaluate whether the current plan of care is effectively meeting the resident's treatment needs in light of his/her previously or currently expressed wishes.
3. Unless the resident requests otherwise, the family also will be notified of any marked and/or adverse changes in the resident's status as soon as possible.
4. The facility's plan of care for the resident will include continuing reassessment of the resident's needs to ensure that all appropriate and desired care is being provided to the extent possible.
5. Revisions to the POLST should be considered whenever there is a change of condition that renders the expressed treatment wishes of a patient medically ineffective, non-beneficial, or contrary to generally accepted healthcare standards[xiii] . (*See Section II, Reviewing/Revising the POLST*).

V. POLST and the Medical Record[xiv]

1. The most current POLST, in its original version signed in ink, should be the first page of the medical record when that is feasible with the facility's chart format.
2. If the resident has an advance directive, copies should be attached in the same area as the current original POLST in the front of the chart.
3. If the resident is transferred or discharged home or to another care setting, the current original POLST should accompany the resident.
4. 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 medical record. Whenever possible, this copy should be on Ultra Pink paper stock so it is readily recognizable in the event that the current original is transferred with the resident.

5. All voided versions of the POLST, clearly marked "VOID," will be retained in the medical record.
6. Whenever the POLST is reviewed, revised, and/or revoked, the process will be documented in the medical record by the physician/NP/PA and/or the healthcare provider(s) involved.
7. For facilities with electronic health records, the POLST should be scanned in and placed in the appropriate section of the healthcare record per facility policy.

VI. Conflict Resolution

1. If the POLST conflicts with the resident's healthcare instructions or advance directive, then, to the extent of the conflict, the most recent expression of the resident's wishes govern.
2. If there are any conflicts or ethical concerns about the POLST orders, appropriate facility resources – e.g., ethics committees, care conferences, interdisciplinary team meetings, legal, risk management or other administrative and medical staff resources – may be utilized to resolve the conflict.
3. During conflict resolution, consideration should always be given to: a) the attending physician's assessment of the resident'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 POLST is medically ineffective, non-beneficial, or contrary to generally accepted healthcare standards; and c) the resident's most recently expressed preferences for treatment and the resident's treatment goals.

Endnotes

[i] *Note: The official POLST form for California is approved by the Emergency Medical Services Authority. You can download a copy of the form for printing by going to the California POLST website at www.CaPOLST.org or to the Coalition for Compassionate Care Website at www.CoalitionCCC.org.*

Mohawk BriteHue Ultra Pink paper (65 lb. paper stock recommended) is the color used for the POLST form. It is important to use this specific color of pink paper so that the form can be photocopied and faxed. Although Mohawk BriteHue Ultra Pink is the recognized and recommended color, the form remains valid if another color paper is used. A photocopy of the form is also valid.

[ii] *Note: In order to promote consistency and efficiency of communication of a resident's wishes across treatment settings, we recommend that, for skilled nursing facility residents who have a POLST, that the POLST form replace the PIC, PIT, and Pre-Hospital DNR/DNAR for that resident*.

[iii] California Probate Code §4781.2. (a) A health care provider shall treat an individual in accordance with a POLST form. (b) This does not apply if the POLST form requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution. (c) A physician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care decisionmaker, issue a new order consistent with the most current information available about the individual's health status and goals of care.

[iv] Legally recognized health care decisionmaker includes the person's agent as designated by a power of attorney for health care, surrogate, conservator or closest available relative as described in California Probate Code §§ 4671, 4711, 1880, and *Cobbs v Grant*, 8 Cal3d 229, 244 (1972) respectively.

[v] *Note: Skilled nursing facilities should refer to their specific policies, the Health Care Decisions Law (Probate Code §§4600-4805), and relevant case law regarding determination of capacity, and of a legally recognized health care decisionmaker.*

[vi] California Probate Code §4621. "Health care provider" means an individual licensed, certified, or otherwise authorized or permitted by law of this state to provide health care in the ordinary course of business or practice of a profession.

[vii] *Note: Individual skilled nursing facilities may adapt the model procedures in accordance with their existing structures and related policies.*

[viii] "Qualified" means that they have had training in the purpose and use of the POLST form, and on the facility's policy regarding implementing or reviewing the POLST, including how to respond to questions from the resident and/or the resident's legally recognized health care decisionmaker regarding the specific interventions described on the POLST. And see 6 above regarding "health care provider."

[ix] Significant change is defined in the Resident Assessment Instrument as "a decline or improvement in a resident's status that:

- will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting"
- impacts more than one area of the resident's health status: and
- requires interdisciplinary review and/or revision of the care plan."

[x] See 3 above.

[xi] California Probate Code §4781.2(d). The legally recognized health care decisionmaker of an individual without capacity shall consult the physician who is, at that time, the individual's treating physician prior to making a request to modify that individual's POLST form.

[xii] California Code of Regulations, 72311(a)(3)(B) and Health and Safety Code 1599.1(i).

[xiii] California Probate Code §4781.2. (a) A health care provider shall treat an individual in accordance with a POLST form. (b) This does not apply if the POLST form requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution. Also, California Probate Code §4735 states that: "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."

[xiv] *Note: Facilities should decide the most appropriate filing system for POLST depending on their specific medical records system and modify this model policy accordingly. The main considerations are: 1) that the most current POLST be available in a location of prominence in order to increase awareness of its existence and promote compliance, and 2) that the current original POLST must travel with the resident, so obtaining and filing of a copy is critical.*

RESOURCES | QUICK REFERENCE GUIDE ON POLST IN NURSING HOMES

POLST is Voluntary

Completing a POLST is always voluntary for the patient. (AFL 09-27, 10-25, 10-42, and 11-26.) Facilities cannot require that a resident have a POLST form. This means that facilities cannot require completion of a POLST form as a condition of admission.

MDS Section S

While MDS Section S requires facilities to report whether a resident has a POLST form, it does not require facilities to use POLST nor does it require an individual resident to have a POLST. Section S is used for data collection (not survey) purposes, thus accurate information is critical. If a resident does not have a POLST form, Section S should be completed to indicate so.

Signatures

A POLST isn't valid unless it is signed by (1) a physician, nurse practitioner or physician's assistant AND (2) the resident or, if the resident lacks capacity, the resident's legally recognized healthcare decisionmaker.

During the process of completion, the POLST may be put in the medical record with a note affixed to it stating that it is "in process" and what needs to occur for its completion. Once the form is completed and both signatures are obtained, it can be put in the medical record as a legally valid POLST.

Advance Directive

POLST complements a resident's Advance Directive. If a resident has a POLST and an Advance Directive, the two documents should be consistent. When filling out a POLST, staff should confirm whether the resident has an Advance Directive and, if so, obtain a copy of the Advance Directive and review it.

If the Advance Directive and POLST call for different medical treatment, the facility should confirm the resident's current wishes regarding medical treatment and then assist with completing new, up-to-date documents. Until a new document is completed, the facility should be guided by the resident's most current documented wishes.

Materials made possible by a grant from the California HealthCare Foundation

Completing POLST

Members of the healthcare team may help explain the POLST form and support residents in making decisions. These team members should have special training specifically on the POLST conversation before assisting with completion of a POLST.

Admission Packet

POLST should not be included in the admission packet. Doing so conveys the wrong message that completing POLST is simply a formality for admission and that admission staff are qualified to assist in completing POLST.

To the contrary, POLST should be completed only after a rich conversation between clinical staff or physician/NP/PA and the resident and their family members. POLST serves as documentation of that conversation.

Role of the Physician/NP/PA

POLST is a medical order. By signing POLST, the physician, nurse practitioner or physician assistant certifies that the orders on the form are consistent with the resident's medical condition and preferences.

It should be standard practice, before signing the form, for the physician/NP/PA to speak to the resident or, if the resident lacks capacity, the resident's legally recognized decisionmaker to confirm that the orders on the POLST are consistent with resident's medical condition and accurately reflect the resident's wishes.

Under no circumstances should a physician/NP/PA sign a POLST before it is filled out with the resident's identification and treatment preferences.

Who Is the Decisionmaker

The resident is the decisionmaker unless he/she lacks capacity.

Family members may act as a resident's surrogate decision maker only if the resident lacks capacity and has not designated an individual as his or her healthcare agent, or has specifically indicated that he/she would like family to make these decisions for him/her. If an incapacitated resident previously designated a healthcare agent, then POLST completion should be limited to that agent. Capacity is determined by a physician.

It is often helpful to include additional family members in the POLST conversation, even if they are not the decisionmaker, so they are aware of the resident's treatment choices.

Materials made possible by a grant from the California HealthCare Foundation

Role of Surrogates

When completing a POLST, legally recognized decisionmakers must make decisions that are consistent with the residents' personal preferences. Their job is to make the same treatment decisions the resident would make if the resident had capacity.

POLST on Transfer

The original POLST is to stay with the resident if the resident is transferred to an acute care hospital or another long-term care facility.

Who Would Benefit from POLST

Anyone can complete a POLST, but those who benefit most are patients who are medically frail, or suffer from serious or chronic, progressive illness.

In general, our healthcare system is designed to provide invasive, life-prolonging treatment, rather than treatment aimed at enhancing quality of life. Some residents, however, do not want invasive treatment. Research shows that POLST is the best tool available for ensuring that those residents, who do not want invasive treatment, will have their treatment preferences honored.

Residents Who Do Not Want POLST

Just because POLST is offered, however, does not mean a resident must complete one. No one is required to complete a POLST form. Facilities considering use of the POLST as a part of their routine care may want to use another form or format to document in the medical record the wishes of residents who don't want POLST.

How to Get More Training

The Coalition for Compassionate Care offers consulting services, webinars and training programs on POLST, advance care planning, ACP conversations and cultural diversity. Many communities also have local POLST/ACP coalitions which offer training. Learn more at www.CoalitionCCC.org.

This reference guide was developed by the Coalition for Compassionate Care of California in collaboration with the State Long-Term Care Ombudsman, California Association of Health Facilities, and California Association of Long-Term Care Medicine.

Materials made possible by a grant from the California HealthCare Foundation

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These fictitious case studies provide examples of possible citations resulting from facility-based breakdowns in advance care planning and POLST implementation.

POLST Case Study #1 – Incomplete POLST Leads to Failure to Ensure Patient's End of Life Choices are Honored

> ***F309***
> ***42 CFR 483.25 Quality of Care***
> *Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.*

Sample Department of Public Health investigation findings:

F309 - Citation Level G
Based on interview and record review, the facility failed to comply with the above requirement by not ensuring that Resident 1's advance directive and stated wishes related to end of life care were honored.

Resident 1, a 72 year-old male with dx of ESRD, DM, and CHF, was admitted to facility on 1/5/16 with diagnosis of pneumonia. Record review conducted on 3/14/16 indicated that Resident 1 was alert, oriented and was his own decisionmaker. He had required extensive assistance with his activities of daily living for several years due to stroke-related paralysis. Resident 1 had been living with his daughter and her family until 12/25/15 when he had been hospitalized for 10 days for treatment of pneumonia. On 2/14/16 at 0100 hours he was transferred from the SNF to the acute care hospital for treatment of acute respiratory distress and altered mental status. He was admitted from the ER, where he was intubated, to ICU at 0400 hrs. While in ICU, despite ventilator support and other aggressive treatment, his condition continued to deteriorate. On 2/18/16 he was removed from life support per his daughter's wishes and he expired on 2/19/16.

On 3/14/16 during a closed record review, a POLST form was found in Resident 1's chart that was signed by Resident 1 and dated 1/7/16. The physician signature line was blank. The POLST form indicated the following treatment selections:

- Section A: Do Not Attempt Resuscitation/DNR
- Section B: Comfort-Focused Treatment. Request transfer to hospital only if comfort needs cannot be met at current location.

Review of the SSD notes dated 1/7/16 stated the following: Discussion today with [Resident 1] and daughter regarding preferred intensity of care and goals for SNF stay. Resident stated during this interview that he was tired of struggling with his illnesses and felt that he had become a burden on his family. He stated that he "just want to end my days as comfortably as possible" and that he did not have a goal of getting back to his previous living arrangement with his daughter. Resident stated that he "had lived a good life, fought a good fight, and now just want to rest". A POLST form was initiated and after discussion with his daughter [Resident 1] indicated he did not want treatment other than symptom management for comfort. He said he did not want resuscitation or life sustaining measures and did not want to be transferred to the hospital. He declined a referral to a hospice."

A physician's note dated 1/8/16 contained a brief description of the findings of physical exam, and a statement to "continue treatment per MD orders". A review of the physician order sheet dated 1/8/16 revealed that the orders included a referral to physical therapy for evaluation, multiple medications, and a "Do Not Resuscitate" order. There were no orders related to the POLST form or the documented preferences identified on that form and described in the SSD note.

During an interview on 3/14/16 the SSD said that she recalled the conversation with Resident 1 and his daughter and that they had both stated they understood that the resident had the choice of full treatment, including therapy or hospice but that the resident stated he was "ready to die". The SSD stated that the daughter said she understood and supported whatever choice her father made. The SSD stated that she filled out the POLST with them and got the resident signature and then put the POLST form in the resident's chart for the physician's review and signature. She said that is the way the POLST forms are handled in their facility, and that she had also contacted the Ombudsman regarding assistance with an advanced directive for Resident 1. When asked if the physicians in this facility discuss POLSTs with residents and/or their decision-makers as part of the practice in this facility, she said "that is the plan but I am not sure it always happens".

On 3/14/15 Resident 1's daughter stated that the night that her father was transferred to the hospital she was not notified by the facility until after he had been picked up by EMS and was on his way. She said by the time she arrived at the hospital he had already been intubated and the ER physician was recommending urgent transfer to ICU. She stated that she knew her father did not want to go to the hospital or have aggressive treatment but at the time it all happened so fast that she felt confused and did not know what to do. She said that she had assumed that the facility staff would have honored her father's choices for end of life care in the SNF and did not understand why "he had to die with all those tubes".

Further review of Residents 1's record revealed that there was no advance directive in the chart, or care plan relating to the resident's stated preferences of comfort care and wish to not be transferred to the hospital.

POLST Case Study #2 – A record review reveals blank POLST forms pre-signed by physician in charts

F514
§483.75(l) Clinical Records
(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are--
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized.

Sample Department of Public Health investigation findings:

Citation Level F – Potential for harm and widespread

Based on interview and record review, the facility failed to ensure that each resident's records were complete and accurate and in compliance with professional standards for 5 out 20 sampled residents.

Findings include:

During an annual recertification visit on 8/10/15, a record review found 5 out of 20 resident records contained Physician's Orders for Life Sustaining Treatment (POLST) forms which were blank except for the physician's signature and the date of that signature.

Review of the facilities' Policy and Procedure entitled "POLST" revealed the following:

"Upon admission, all residents will be assessed to determine if they have an advance directive and/or have previously executed a valid POLST form. If the resident does not already have a valid POLST available, a blank form will be put into the record for completion by the physician within 3 days of admission unless the resident or their decision-maker decline to have a POLST.

1. During the admission assessment, the physician will explain the purpose of the POLST form and discuss the goals of care with the resident and/ or their authorized health care representative. If the authorized healthcare representative is unavailable and the resident is unable to make their own healthcare decisions, this conversation will be conducted as soon as possible either in person or by phone.

Following this discussion, the physician will complete and sign the POLST form, and the nursing or social services staff will review the form with the resident or their representative as soon as possible to obtain their signature and complete the form."

During an interview conducted on 8/10/15, Nurse 1 who identified himself as the charge nurse of the wing where the 5 residents resided, stated that he was not sure why the POLST forms were blank except for the MD's signature and date. He further stated that he did know the facility's process was to complete POLST forms, and would not know what the care preferences were for residents unless their chart was flagged for a "Do Not Resuscitate Order".

During an interview on 8/11/15 the director of nurses (DON) said that she was unaware of the incomplete POLSTs in these 5 residents' charts but stated that "the physicians don't always have time to talk to the residents about this kind of thing and so the nurses end up doing it."
When asked how the MD could sign a form indicating that they had verified the accuracy of the information with the resident when they had not had a discussion with them or their decision maker, the DON stated "They trust the nurses to talk to the residents."

During an interview on 8/12/15, Physician 1 stated that she does not usually discuss care preferences with her patients in SNFs unless they have questions. She said she does not "have time during my rounds for this kind of thing and the nurses handle it." She stated that sometimes she has signed the POLST form before they are filled out "so they are ready for the nurses." When asked if she was familiar with the facility's policy and procedure for POLST completion she said "no".

Assessing POLST Implementation

Potential Problems with POLST Implementation	Occurs How Often:				
	Very Often	Often	Occasionally	Rarely	Never
Interpreting the POLST to make treatment decisions					
Getting physicians/NPs/PAs to participate in POLST completion					
Getting physicians/NPs/PAs to sign a POLST form					
Physicians/NPs/PAs signing blank POLST forms					
Someone other than physician/NP/PA is co-signing form					
Getting SNF team to follow POLST orders					
Getting EMS to follow orders contained in the POLST					
Not receiving the original POLST back from other facilities					
Family disagreement with POLST content					
Family signed POLST for resident with capacity					
Patients/families not informed that POLST is voluntary					
Getting conservator or family of patient without capacity to complete and sign a POLST					
POLST does not match the resident's advance directive					
Family changed POLST to be inconsistent with resident's previously expressed wishes					
Receiving incomplete or incorrect POLST from another facility					
Incomplete or incorrect POLST form being filed in patient record					
Patient transferred to acute hospital against POLST orders.					
Non-medical staff are charged with having the POLST conversation					
Staff not trained in POLST conversation.					
POLST conversations are rushed or incomplete					
POLST conversation not being detailed in patient chart					
POLST orders not recorded in patient chart					
POLST orders not reviewed after significant change in patient condition					

Assessing POLST Implementation

Fishbone Diagram

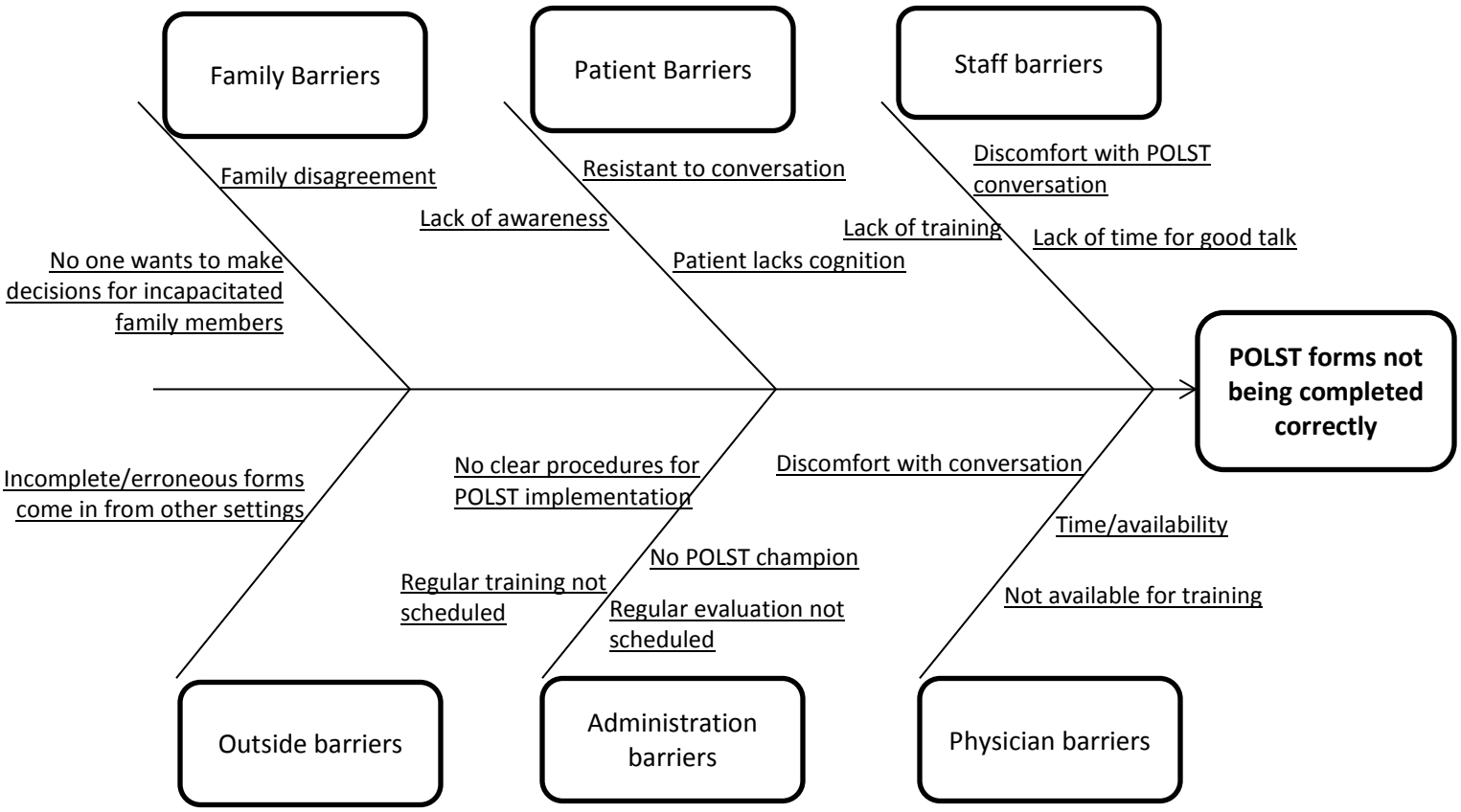
The "fishbone" diagram is a common cause and effect diagram and can be an effective tool for root cause analysis.

The problem or effect is displayed at the head or mouth of the fish. Possible contributing causes are listed on the smaller "bones" under various cause categories. This is best completed as a brainstorming exercise which includes team members who have personal knowledge of the processes and systems involved in the problem or event to be investigated.

How To Create a Fishbone Tool for Root Cause Analysis

1. Begin with a clearly stated problem or process to be considered. Write this in the box on the right, at the head of the "fishbone."
2. Draw a straight line (or spine) coming from the head.
3. Draw vertical lines above and below the spine.
4. Brainstorm to identify the major categories of factors that contribute to the problem. Put these in category labels above and below the spine.
5. Develop a list of causes or contributing factors for each category. Write these causes on the smaller lines.

An example is shown below.



Goal Setting Worksheet

Describe the problem to be solved?
Example: Non-actionable POLST forms are being filed in resident charts.

Use the SMART formula to develop a goal:

SPECIFIC

Describe the goal in terms of 3 'W' questions:

What do we want to accomplish?
All POLST forms filed in resident charts will be actionable (completed and signed by the physician/NP/PA and resident/decision-maker and dated.)

Who will be involved/affected?
Medical director Administrator Director of Nursing NP/PA Social Services Admissions MDS Coordinator

Where will it take place?

MEASURABLE

Describe how you will know if the goal is reached:

What is the measure you will use?
Number of resident charts with incomplete/non-actionable POLST forms reduced to zero.

Goal Setting Worksheet

What is the current data figure (i.e., count, percent, rate) for that measure?

What do you want to increase/decrease that number to?

ATTAINABLE

Defend the rationale for setting the goal measure above:

Did you base the measure or figure you want to attain on a particular best practice/average score/benchmark?

Is the goal measure set too low that it is not challenging enough?

Does the goal measure require a stretch without being too unreasonable?

Goal Setting Worksheet

RELEVANT

Briefly describe how the goal will address the business problem stated above.

TIME-BOUND

Define the timeline for achieving the goal:

What is the target date for achieving this goal?

Write a goal statement, based on the SMART elements above. The goal should be descriptive, yet concise enough that it can be easily communicated and remembered.

[Example: Reduce the number of POLST forms in long-term residents' files which are lacking patient signature, physician/NP/PA signature, or dates from 6 to 0 by June 30, 2016.]

QAPI TOOLKIT FOR POLST: Chart Audit Tool

QAPI - POLST CHART AUDIT TOOL

Chart No.	Name and DOB Correct Y/N	Chart Documentation of POLST Conversation:	Chart Documentation of Goals of Care: Y/N	POLST Discussed With: (Check all that apply)	Section A and B Correlate: Y/N	Current AHCD noted on POLST: Y/N	AHCD and POLST Correlate: Y/N	DPOA noted on POLST: Y/N	Provider Signature Present: Y/N	Provider Date Present: Y/N	POLST Signed By:
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator
				☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator ☐ Other:							☐ Patient ☐ Decisionmaker ☐ Parent ☐ Conservator

Chart Audit Tool - Measure/Indicator Collection and Monitoring

Definitions

Chart No.
This could be the actual chart number or another number related to the project. (Would not be reported as data, just accounting purposes)

Is Patient Name Present and Correct on POLST form: Y/N

DOB Correct: Y/N
Is patient's date of birth on form and correct?

Chart Documentation of POLST Conversation: Y/N
Is there any indication in the chart (other than on POLST form) that some form of discussion was had with patient and/or decisionmaker?

Chart Documentation of Goals of Care: Y/N
Indicates that an in-depth conversation was held. Includes mention of topics discussed, patient wishes and values and mentions goals of care. Indicates that choices where discussed and are consistent with patient values. A standard form can be used for this.

POLST Discussed With: (Check all that apply)
Indicates with whom the POLST was discussed.

Resident Has Capacity (Box Checked): Y/N

If Resident Has Capacity, Resident Signed POLST: Y/N

Section A and B Consistent: Y/N
Quality and accuracy metric indicating Section A and B are correlated. (e.g., no DNR with Full Treatment)

Current AHCD Status noted on POLST: Y/N
The POLST document indicates the existence of an AHCD

AHCD and POLST Concurrent: Y/N
Quality and accuracy metric indicating AHCD and POLST are consistent

DPOA noted on POLST: Y/N
Indicates that a legal DPOA is identified on the POLST

Provider Signature Present: Y/N
Indicates POLST signed by a physician, nurse practitioner or physician assistant

Provider Date Present: Y/N

POLST Signed By:
Indicates who (patient or decisionmaker) signed the POLST

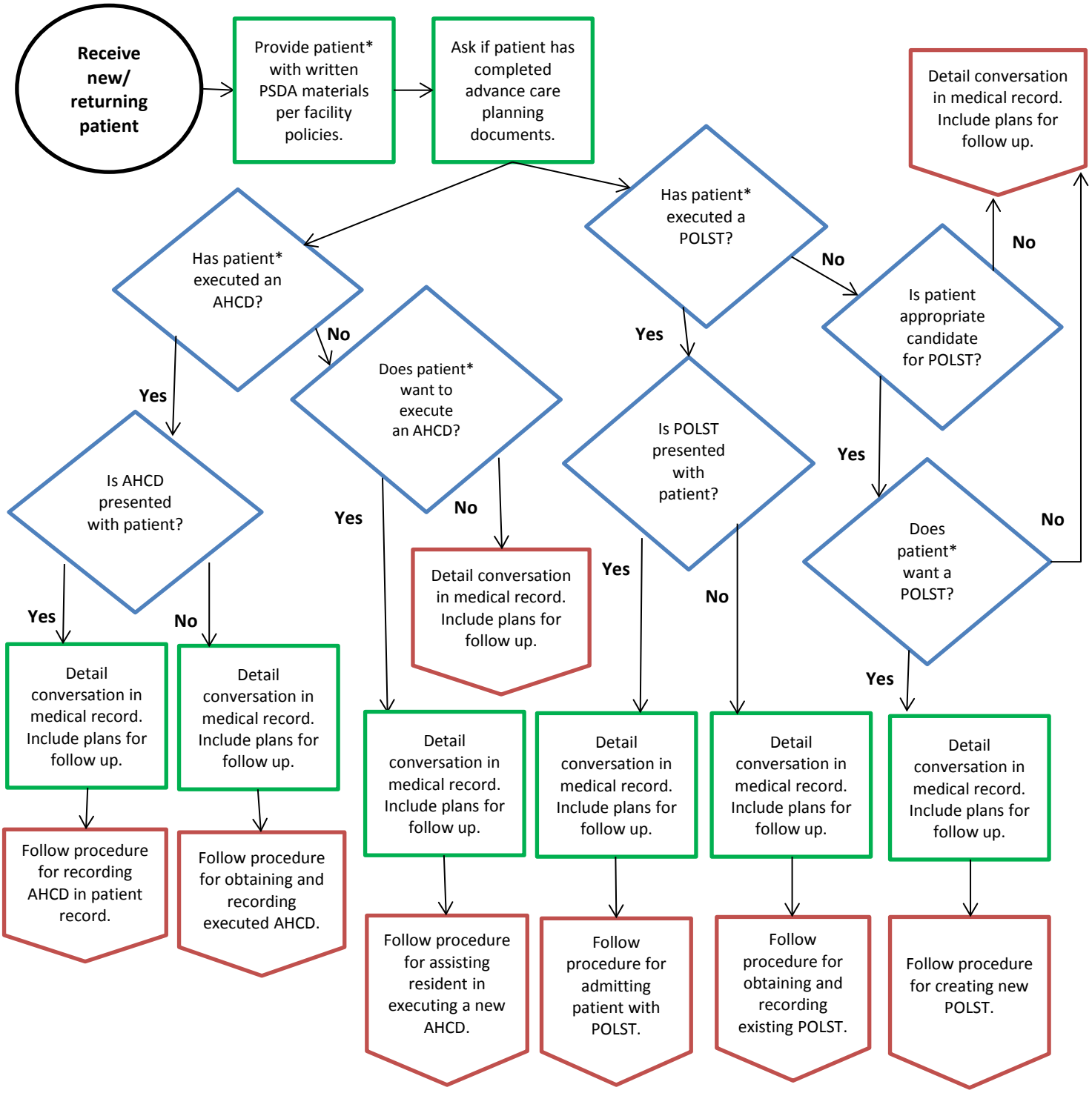
Healthcare Provider Assisting with Completion Identified (on back of form): Y/N
Is it clear who the person was?

Measure/Indicator Collection and Monitoring

What are we measuring (measure/indicator)?	When are we measuring this (frequency)?	How do we measure this (where do we get our data?)	Who is responsible for tracking on this measure?	What is our performance goal or aim?	How will data findings be tracked and displayed?
POLST discussed with new residents					
Invalid POLST forms in patient charts/ records					
Patients' POLST forms conflicting with their AHCD					
POLST forms are being reviewed with patient/decision-maker after significant change of condition.					
Patients' POLST forms being sent with them at discharge.					
POLST forms received back from other settings.					
POLST orders being followed correctly.					

POLST QAPI Toolkit

SAMPLE FLOWCHART - PSDA: ASSESSING PATIENT'S ADVANCE CARE PLANNING DOCUMENT STATUS AT ADMISSION OR RE-ADMISSION

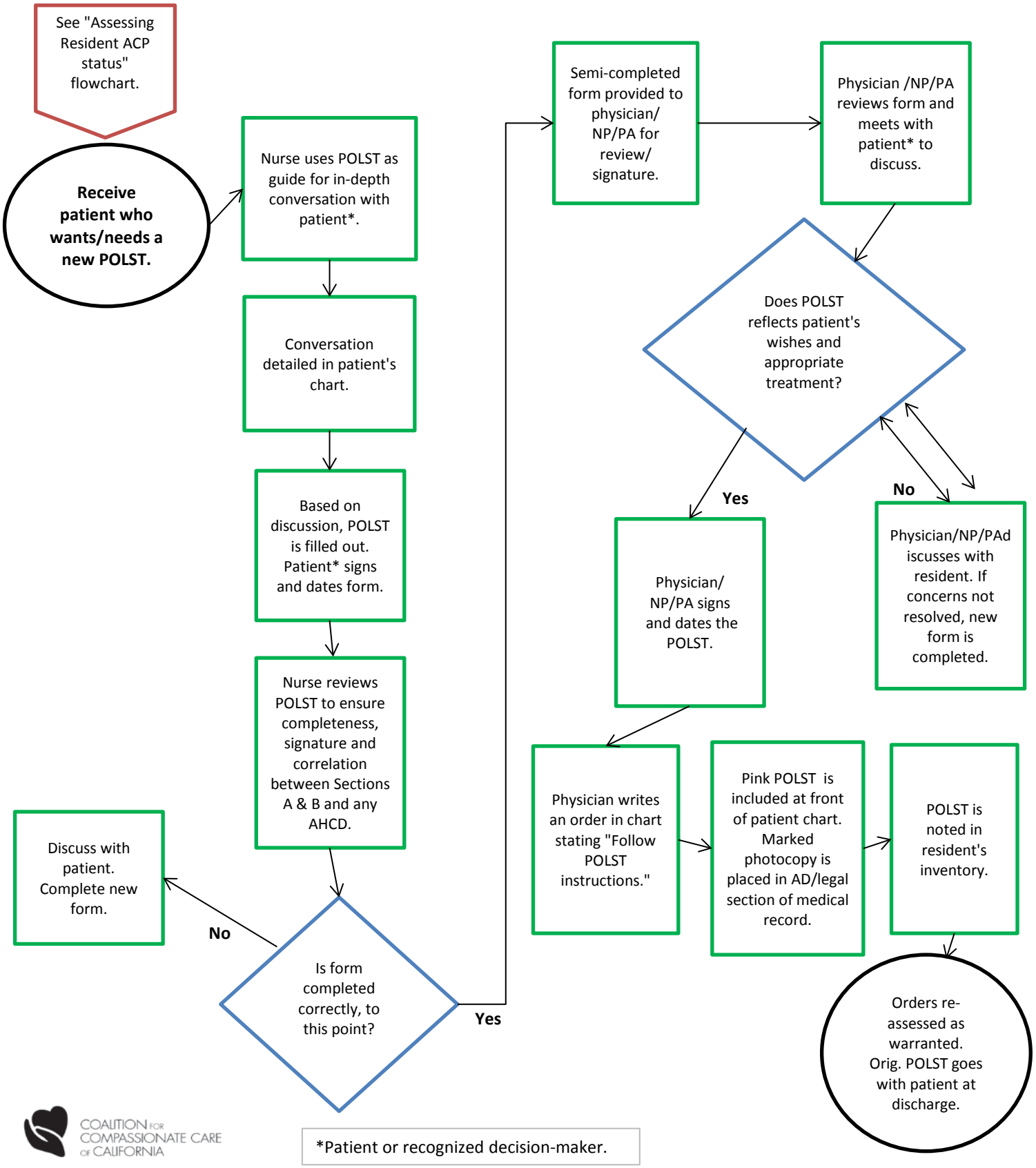


COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

*Patient or recognized decision-maker acting on patient's behalf.

POLST QAPI Toolkit

SAMPLE FLOWCHART - INITIATING A NEW POLST

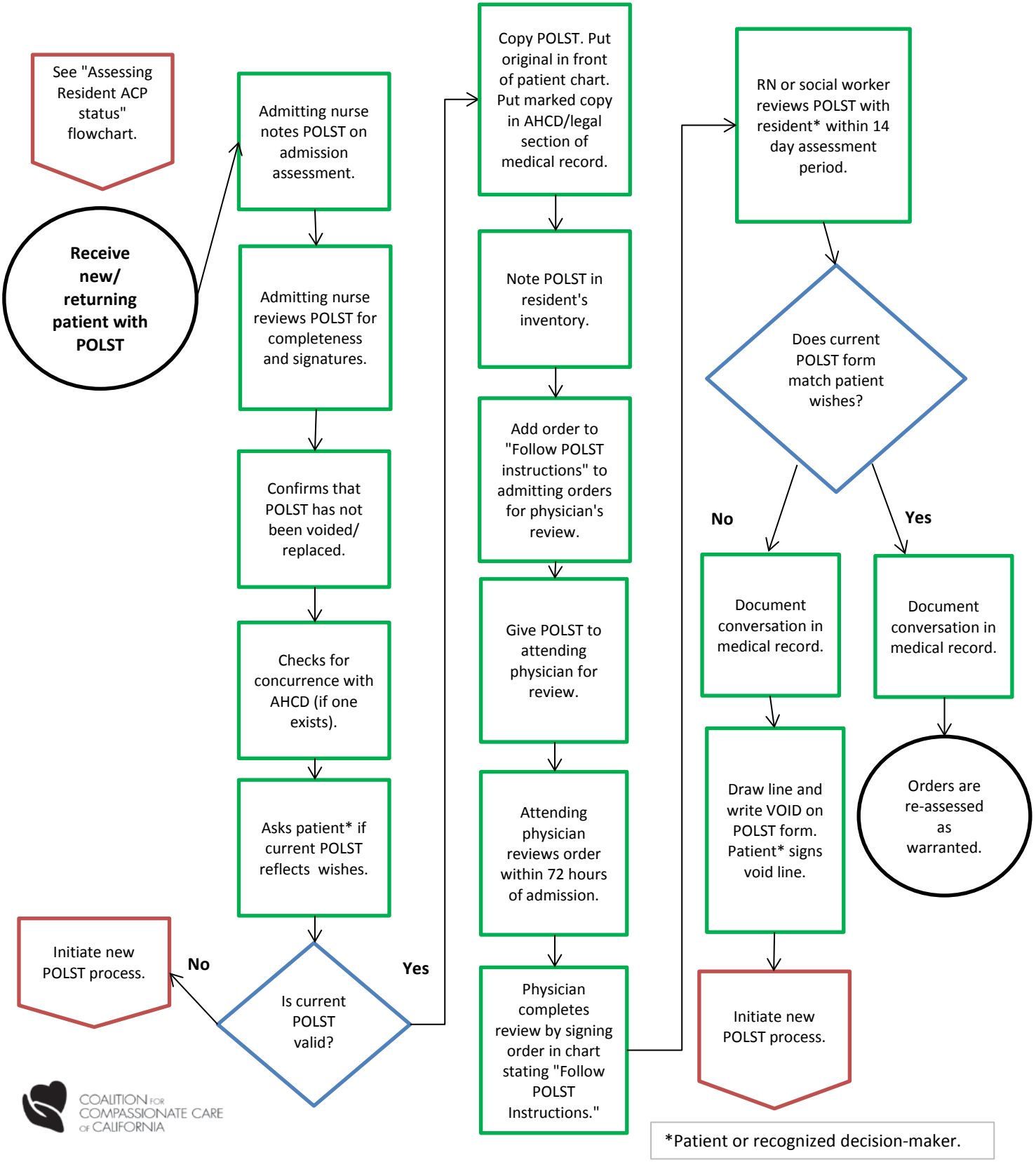


COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

*Patient or recognized decision-maker.

POLST QAPI Toolkit

SAMPLE FLOWCHART - NEW/RETURNING RESIDENT WITH PRE-EXISTING POLST



COALITION FOR COMPASSIONATE CARE OF CALIFORNIA

*Patient or recognized decision-maker.

Download the QAPI Toolkit for POLST in SNFs

The *QAPI Toolkit for POLST in SNFs* and all of the tools are available for download at http://capolst.org/wp-content/uploads/2017/06/POLST-QAPI-Toolkit_June2017.pdf.

Additional Resources for Advance Care Planning and POLST in Nursing Homes

www.caPOLST.org – POLST forms, resources and education
www.Coalitionccc.org - Advance care planning information, training and resources
http://csupalliativecare.org/programs/ Online palliative care courses for professionals
www.theconversationproject.org Consumer-focused tools/resources for advance care planning
www.prepareforyourcare.org Consumer-focused tools/resources for advance care planning
www.fivewishes.org - Advance health care directive
http://www.polst.org - National POLST Paradigm
www.practicalbioethics.org/resources/caring-conversations/free-downloads Consumer-focused information
www.aacn.nche.edu/elnec ELNEC for nurses
www.vitaltalk.org Conversations for clinicians
www.interact.fau.edu
www.americanbar.org/groups/law_aging/resources/health_care_decision_making.html

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Nursing Home Palliative Care Toolkit, September 2013, Revised June 2014, Healthcentric Advisors, http://healthcentricadvisors.org/wp-content/uploads/2015/01/NH-Palliative-Care-Toolkit_2014.pdf

The CMS QAPI Guide: What You Need to Know A Companion to QAPI at-a-Glance, Ohio Medicare Quality Improvement Organization, 2013, http://www.ohiokepro.com/shopping/pdfs/8772.pdf.

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How to Improve, Institute for Health Improvement, accessed September 15, 2015, http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx