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 (NP) or physician's assistant (PA) **AND** (2) the resident or, if the resident lacks capacity, the resident's legally recognized healthcare decision-maker.

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.

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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

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 decision-maker 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 Decision-maker

The resident is the decision-maker 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 decision-maker, so they are aware of the resident's treatment choices.

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Role of Surrogates

When completing a POLST, legally recognized decision-makers must make decisions that are consistent with the resident's 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.

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