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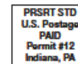

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Using POLST to Honor Your Patients' Treatment Wishes

By Marian Kemp, RN

Are you familiar with the Pennsylvania Orders for Life-Sustaining Treatment (POLST) form? The POLST is a document designed to help health care professionals honor the treatment wishes of their patients. POLST is used in states across the country as well as within all levels of care in this region, from acute care hospitals, to skilled nursing and long-term care, to hospice.

In Pennsylvania, Act 169 of 2006 mandated formation of a statewide advisory committee, the Patient Life-Sustaining Wishes (PLSW) Advisory Committee to examine the advisability and possible adoption of a standardized form such as Physician Orders for Life-Sustaining Treatment which was in use in other states. In October 2010 a standard POLST form, called the Pennsylvania Orders for Life-Sustaining Treatment (POLST) form that was recommended by that committee was approved. The use of the term "Pennsylvania" in the form name was to distinguish it from other state forms.

WHO IS POLST FOR?

The POLST form is recommended for persons who have advanced chronic progressive illness and/or frailty, those who might die in the next year or anyone of advanced age with a strong desire to further define their preferences of care in their present state of health. To determine whether a POLST form could be encouraged, clinicians may ask themselves, "Would I be surprised if this person died in the next year". If the answer is "No, I would not be surprised", then a POLST form is appropriate.

THE POLST CONVERSATION

The POLST process starts with a conversation, the key element of the process. An 8-step protocol has been designed to guide the discussion that is to occur between the health care professional and the patient or a legally designated decision-maker[1].

1. Prepare for the discussion
2. Begin with what the patient or family knows
3. Provide any new information about the patient's condition and values from medical team perspective
4. Try to reconcile differences in terms of prognosis, goals, hopes and expectations
5. Respond empathetically
6. Use POLST to guide choices and finalize patient/family wishes
7. Complete and sign POLST
8. Review and revise periodically

Effective communication between the patient or legally designated decision-maker and health care professionals ensures decisions are sound and based on the patient's understanding their medical condition, their prognosis, the benefits and burdens of the life-sustaining treatment and their personal goals for care.

Upon completion of the POLST form, it is signed by the physician, physician assistant2 or certified nurse practitioner and either the patient or the patient's legal decision-maker. In this respect, the requirement that patients or their legal decision-maker review and sign the form provides a safeguard for patients that the orders on the form accurately convey their preferences.

DOES THE POLST REPLACE AN ADVANCE DIRECTIVE?

No. The POLST is not intended to replace an advance health care directive document or other medical orders. It is recommended that people with advanced illness and/or advanced frailty have both an Advance Directive and a POLST form. The POLST process and health care decision-making works best when the person has appointed a health care agent to speak for them if they are unable to speak for themselves. A health care agent can only be appointed through an advance health care directive called a health care power of attorney. A good practice is to attach a copy of the advance health care directive to the POLST form.

A distinction between an advance directive and a POLST form is that a POLST form is a legal medical order and is completed by a health care professional after a discussion of end-of –life choices with a patient or his/her legal decision-maker. An advance directive is completed by an individual.

The POLST Form and educational materials are available through the website of The Aging Institute of UPMC Senior Services and the University of Pittsburgh, www.aging.pitt.edu/professionals/resources.htm.

[1] The 8-Step Protocol was originally developed for the MOLST Program of New York State. Program information is found at www.compassionandsupport.org

[2] In Pennsylvania, a physician assistant signature requires a physician co-signature within ten days.

Marian Kemp, RN, serves as POLST Coordinator, **Coalition for Quality at the End-of-Life (CQEL),** an organization concerned about the quality of care that is available to seriously ill people in western Pennsylvania. She is the contact for information on POLST and works to improve awareness of the value of the document. You can email her at papolst@verizon.net.