

## Conversation Points/Key Information

**POLST Conversation Points/Key Information** contains additional information, with questions and answers to facilitate comprehensive, meaningful POLST Conversations. Reading this material is essential:

- to fully understand POLST,
- to answer questions patients and families may ask,
- to learn key methods to facilitate difficult conversations.

If a patient/resident or family member seems surprised by the POLST conversation or questions “why do we need to talk about this?” *We routinely talk to patients/residents about their goals for medical care. Or, if talking with family, you can say, We routinely talk to family members about what their loved one’s wishes for medical care would be if he/she could talk with us now. Or, It’s important to know your loved one’s wishes because sometimes people become sick very fast and we need to know what their treatment wishes are.*

*I’d like to better understand:*

- *what you know about your condition,*
- *what your family knows about your wishes,*
- *what you hope for,*
- *what is most important to you at this time in your life and in the future.*

*Let’s talk some more about this:*

- *What do you love to do? What do you enjoy?*
- *What gives your life meaning?*
- *What is your overall goal for your care – for example, to live life as long as possible, or to live your last days with comfort and dignity?*
- *What medical treatments do you want or not want?*

*We’ll talk about goals of care today and at regularly scheduled meetings with you and your family.*

If someone needs more help in understanding POLST: *The POLST, Physician Orders for Life-Sustaining Treatment, is a tool for this important discussion of your wishes for medical care.*

*For people with serious health conditions, or who are older, or in fragile health, the POLST describes a plan of care which reflects the person’s wishes for their health care during serious illness or the last stages of an illness.*

*The POLST is signed by your doctor and is a medical order that communicates your wishes for medical care to other doctors, nurses and emergency medical personnel so that they know and can honor your wishes.*

*We encourage you to complete a POLST to make certain that your wishes for care in the future are known and respected.*

- *The POLST makes clear what medical care you would or would not want if you are ill and unable to speak for yourself.*
- *The POLST provides a doctor's order so that other healthcare staff (Emergency Personnel, nurses, other doctors) can follow your plan.*
- *The POLST form stays with you if you are moved between medical care facilities or home.*
- *The POLST increases the chance that you can live the rest of your life as you wish.*

If someone asks "Do I have to complete a POLST?" *Although you do not have to complete a POLST, we encourage it.*

Review key benefits of POLST:

- *Without a POLST, emergency (ambulance) staff, nurses and hospital doctors do not know your treatment wishes.*
- *The POLST allows you to state what you do want, as well as what type of medical care you do not want, and to state the intensity of medical treatment you want.*
- *Without a POLST, you will receive all possible treatments, whether you want them or not, even if they might not help you, and even if the treatment causes pain or problems or complications.*
- *You can change your POLST if your treatment preferences change. If your health status changes significantly, either getting better or worse, you and your doctor can discuss changing your POLST.*

During the POLST discussion, what do you do if questions arise about specific medical issues or medical prognosis, or any question that you cannot answer? *If you are unsure how to answer any of the choices on the POLST or have questions, your doctor can meet with you and your family for more discussion.*

When working with a Legally Recognized Decisionmaker, or the Family Member designated as Responsible Party, it is important to remind them of the following Key Points:

If the patient/resident cannot communicate his/her wishes for medical care, the family is asked to make decisions based on what the patient/resident would have wanted if he/she could speak for themselves.

- *Does your mom have an Advance Health Care Directive or other document stating her wishes?*
- *Has your mom talked about what her treatment wishes or values would be if she got very sick and was unable to talk with us or care for herself?*
- *What would she tell us to do if she could talk to us now?*
- *As the decisionmaker, your job is to make choices that your mom would have made, if she could speak to us now.*

**POLST Section A: More details about CPR**

*There are three areas we will discuss. You may have thought about what you might want if you have died a natural death, such as from a heart attack. Your heart is not beating and you are not breathing. An intense medical intervention, called CPR, Cardiopulmonary Resuscitation, can be attempted.*

*People often have an unrealistic expectation of CPR because of what we see on TV. CPR nearly always works on TV. In real life, CPR is not very effective, especially for people with more than one medical problem or who cannot function independently and require long-term nursing care.*

*CPR attempts to restart breathing and heartbeat by “mouth to mouth” breathing, forceful pressure on the chest to try to restart the heart, and may use electrical shock (called defibrillation.) CPR usually requires putting a plastic tube (about the size of 2 to 3 fingers) down the throat, into the windpipe (intubation) and using a machine to push air in and out of the lungs (mechanical ventilator or respirator).*

*Do Not Attempt Resuscitation, or DNR, is a medical order not to attempt resuscitation because the patient does not want to endure the procedure or because CPR is not likely to help the patient.*

*Why do patients choose DNR? Resuscitation may help a healthy person. Unfortunately, success with resuscitation is not good for people with a serious medical condition or with more than one medical condition.*

*If they live, these people can have broken ribs, punctured lungs, or brain damage after resuscitation. Resuscitation does not ensure that the person will have the same quality of life if they survive. Resuscitation never cures the original medical problems.*

*Even for a relatively healthy patient, after CPR, less than 10% are alive after 60 days. Those who survive often end up with significantly greater disability and brain damage.*

*If patient/resident or family is unsure or has questions about CPR, refer discussion and follow-up to physician.*

*If someone chooses DNR, they can choose any option for medical interventions in Section B. A person can request full hospital interventions, including ventilator care, but No CPR if they die a natural death and their heart stops beating and they are not breathing.*

*If someone chooses Attempt CPR, then Section B automatically requires Full Treatment. It is not acceptable to choose Attempt CPR and Comfort Measures Only or Limited Additional Interventions in Section B. Attempt CPR requires full treatment in the acute care hospital.*

*It is OK to acknowledge that this is a difficult discussion and that many people don't want to talk about what happens if they become very ill: “I know this is a difficult discussion, but it is so important.”*

**POLST Section B: More information on Medical Interventions**

*The next section of POLST addresses the type of medical care you choose if your condition worsens or you have a sudden medical problem.*

*For example, if you became very sick from pneumonia, some people would choose to have everything done in the hospital, including intubation, the placement of a breathing tube and use of a mechanical ventilator or respirator.*

*For people with healthy lungs and generally good health, usually 4 to 5 days on a ventilator and other treatments allows their lungs to improve. A ventilator causes significant discomfort and anxiety, and you will need medications to make you sleepy and more comfortable; your hands may need to be tied down.*

*The choice for Full Treatment includes intubation, mechanical ventilation and intensive care.*

An important question to ask those who choose Full Treatment is:

*If you were not getting better and the doctor thought your chances of good recovery were poor, would you want to be kept alive with aggressive medical treatments?*

If the patient does not want their life prolonged with aggressive medical treatments, you can write in Additional Orders, Defined Trial Period. Do not prolong my life if I am not expected to recover.

*Another alternative is Limited Additional Interventions. Some people choose not to endure being on a ventilator and the discomfort and anxiety of all the medical procedures, often because they are frail and elderly. People with lung disease or life-limiting chronic illness may choose not to have the ventilator.*

*Limited Additional Interventions includes hospital evaluation and treatment, IV fluids, and cardiac monitoring if indicated, but does not use intubation.*

If someone asks for details about non-invasive positive airway pressure, CPAP or BiPap:  
*For people with serious lung problems or congestive heart failure, the use of non-invasive positive airway pressure may help deliver oxygen and assist them to breathe easier. These are short-term, intense treatments, which usually require intensive care nursing. CPAP and BiPAP use a tightly fitting mask which usually covers both the mouth and nose to prevent air leakage. This is connected to a ventilator machine which uses positive pressure to push more oxygen down into your lungs. Some people find it uncomfortable, but it gives a chance for the other treatments, like antibiotics, to work. It can only be removed for a few minutes at a time while it is used. CPAP and BiPAP require an alert and cooperative patient to be effective. Use of this treatment would be discussed with you or your family at the time.*

You can also refer the patient or family to their doctor for additional discussion of this specific intervention.

*Comfort Measures Only is a choice where medical care is focused on the main goal of keeping you comfortable, rather than focused on medical procedures that may prolong life. Comfort care is a choice for those with life-limiting illness that modern medicine cannot cure.*

*Comfort care does not mean No Care. The goals of care are to manage pain and uncomfortable symptoms. Medications, oxygen, positioning, wound care and other measures to relieve pain and suffering are used. Food and fluids are always offered.*

*When the body is shutting down, the person does not need or benefit from additional food and fluids. Extra fluids are retained in the lungs and as swelling in the body. The goal is to avoid retaining too much fluid in the body. When needed, medicines are given to reduce lung congestion. Comfort measures include medicines to treat any shortness of breath, anxiety or pain when someone is in the last stages of dying. Medicines do not hasten death, but help keep someone comfortable and prevent suffering during their last days and hours of living.*

*Would you want to go back and forth to the hospital for evaluation and treatment?*

If “YES,” then check Limited Additional Interventions in Section B.

If “NO,” then check Comfort Measures Only in Section B.

For those who choose Limited Additional Interventions and are living at a Skilled Nursing Facility (SNF): *If you got sick, like from a significant urinary tract infection or pneumonia, some people want to go to the hospital for evaluation and treatment, and some people want to avoid being transported back and forth to the hospital. Some people would prefer to be treated at the SNF, with the treatments that the SNF can provide.*

Discuss what additional interventions the SNF can provide, i.e. if SNF can administer short-term V fluids or IV medications, or give intramuscular antibiotics if needed for an infection. Discuss if the SNF can monitor oxygen levels and give oxygen and hand-held nebulizer treatments, etc.

*Some SNF residents want treatment in the hospital for an acute illness or exacerbation or flare up of an existing illness like emphysema. Other residents would like to be treated at the SNF, in “their home,” with the treatments provided by the SNF, and only go to the hospital if they have uncontrolled pain or other symptoms like bleeding or a broken bone.*

*Would you prefer to go to the hospital for treatment?*

If “YES,” then mark Limited Additional Interventions in Section B. If the resident prefers treatment at the facility, then mark **both** Limited Additional Interventions and the box Do Not Transfer to hospital for medical interventions. Transfer if comfort needs cannot be met in current location.

If patient or family is unsure of option for Section B, refer discussion and follow-up to physician.

### **POLST Section C:**

This section refers to determining the use of antibiotics. Introduce with “antibiotics may require a conversation on how they may be used”. Some patients may decide they prefer not antibiotics and wish other measures be used to relieve any symptoms. Some patients choice may be to use antibiotics if it would mean life could be prolonged.

Another group of patients may choose to determine use or limitation of antibiotics when infection occurs, with comfort being a goal.

### **POLST Section D: Artificially Administered Nutrition, additional information**

*Food and fluids are always offered by mouth if desired and feasible.*

*Many patients/residents with a severe stroke, or end-stage Parkinson's or dementia /Alzheimer's, have lost the ability to talk and communicate and may lose the ability to swallow well. A natural occurrence at the end of life is the loss of appetite and loss of ability to take in and use nutrition. During the dying process, the body cannot metabolize and use fluids. People do not feel hungry and are not “starving”. During this time, forcing fluids through artificially administered nutrition, often causes more suffering by increasing swelling, fluid retention and fluid in the lungs.*

*It is controversial if giving nutrition by a feeding tube near the end of life may be beneficial or if it is actually harmful. Feeding tubes can be harmful because they can cause pneumonia, ulcers, swelling and infections.*

*Tube feedings do not prevent pneumonia. Tube feedings have not been shown to prolong life in dementia or other chronic, life-limiting illnesses.*

*Hand feeding may provide equal or better benefits, and offers a personal touch that does not happen with medically administered fluids and liquid nutrients. Food and fluids are always offered for comfort and enjoyment.*

*Some people choose to try to prolong their life by having medically-prescribed formula given through a tube in the nose that goes into the stomach or through a tube placed directly into the stomach (by a surgical procedure). Some may choose a “trial period of artificial nutrition by tube”, particularly after head or neck surgery, in hopes that their ability to swallow may improve. This is also sometimes called a “Defined Trial Period” or “Time-Limited Trial.” Some choose to be hand-fed foods with the best texture and thickness to help them swallow the best they can.*

### **POLST Section E: Information and Signatures**

Review POLST choices. If there are questions or concerns, tell the patient, *We will set up a time for your doctor to talk with you more.*

Check who POLST was discussed with – patient with capacity or legally recognized Decision-maker.

If patient and/or family have no questions, obtain signatures. *We will have your doctor review and sign the form. Doctor \_\_\_ will talk with you, if there is anything he/she wants to discuss more with you.*

You will complete the section on the back, Health Care Provider Assisting with Form Preparation, and date the form.

Be sure appropriate patient identifying information (Date of Birth, decision-maker, telephone numbers, etc.) are completed on both sides of the form.

- If the conversation with the decision-maker was by telephone, write decision-maker name per telephone conversation.
- The decision-maker can sign during their next visit to facility, or if the decision-maker is not local, a copy of POLST can be filed in the chart and POLST can be Faxed or mailed to the decision-maker to sign and return (send with stamped, addressed return envelope).
- In the medical record, document that the POLST conversation was with decision-maker.

If the patient/resident is capable of making decisions – always encourage completion of the Advance Health Care Directive, in addition to POLST. The Advance Health Care Directive appoints the person who will make decisions on behalf of the person if they can no longer communicate their wishes

The original POLST:

- Goes with patient to SNF or to the acute care hospital via Emergency Medical Services.
- Is kept in patient chart.
- Goes with patient at discharge to another facility or to home.
- Is kept in an easily accessible location in the home (e.g., on the refrigerator or posted on a wall near the bed).

The POLST and AHCD can be kept in a plastic sleeve for protection. A copy of the POLST form is also placed in the patient's medical record at the hospital or SNF, and in the clinic medical record.

A Faxed physician signature is acceptable. Verbal orders may be obtained with follow-up signature by the physician in accordance with facility/community policy. Physician engagement in the POLST conversation is essential, including those times when verbal orders are urgently needed. and Faxes of signed POLST forms are legal and valid.