

# HELPFUL PHRASES FOR POLST CONVERSATIONS

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## Introduction: Finding Out What the Patient/Family Understands

- Who would you like to be with you as we talk about your health and treatments?
- How have the last 3 months /6 months been for you/your family member?
- How have things been going for you at home? (In the past days, weeks, last few months)
- When you think about what lies ahead, what worries you the most?
- What is bothering you the most?
- When you think about the future, what do you hope for?
- What has your doctor told you about your illness/medical condition?
- What do you think is happening with your health?
- What brings you the greatest comfort right now?
- Can you share with me more about what you are thinking so we can work together?
- Many patients with your condition (COPD, cancer, etc.) think about the possibility of dying and have questions about this. Have you thought about this?
- What does a “good death” look like to you?
- I have information about your condition. Some patients want to know the details and others prefer to have me talk to someone else. What are your thoughts/preferences?
- What would you like us know about your cultural/spiritual beliefs to best take care of you and your family?

## Introducing POLST

- We want to document your treatment wishes should you become seriously ill.
- It's important to talk about your health and your wishes for medical care if you got really sick. We talk about this with everyone with serious illness. Your doctor, nurse practitioner or physician assistant will review what we talk about and answer your questions.
- You look really concerned. How are you doing?
- Refer to **The POLST Conversation** and **The POLST Cue Card** for more detailed information.

## Discussing Bad News or Difficult Situations

- Use warning words such as, “I am sorry...”, “I wish...”, “I had also hoped for...”, “If what we hope for does not happen... we also need to be prepared...”, “If your time were limited...”, “If your Dad could see his life now, what would he tell us?... What would he want?”
- Focus on what we can and will do: “Do everything possible to meet your needs...”, “Continue providing all appropriate medical treatments, but if his heart stopped, we would not do CPR. CPR will not fix his medical problems and can hurt him,” “Concentrate on maximizing comfort.”

## Concluding Discussion

- I can appreciate that this has been a difficult discussion.
- I can tell that this has been really hard for you. What can we do now that would be of help to you?

## Phrases to Avoid

- **There is nothing more we can do for you.**  
Patients and families may feel abandoned. Rather focus on what medical treatment can be provided. For example: “We are going to aggressively treat your pain and other symptoms. Our goal is for you to be as comfortable as possible.”
- **Would you like us to do everything possible? or Do you want us to do everything?**  
It is difficult to answer “no” to these questions for fear of not getting good care. Instead, it is important for the physician to make care recommendations to the patient and family. For example: “Based on your prognosis and your goal to be comfortable, I recommend we don’t do things that might cause you discomfort such as chest compressions or being put on a breathing machine. Instead, we will give you medicines to aggressively treat your pain and other symptoms.”
- **Should we withdraw care? or It is time to think about withdrawal of care?**  
These words lead to fear of abandonment. Instead, talk about a transition in the types of treatments that will best meet your goals of care. Talk about the burdens and benefits of different treatments.
- **Avoid talking in absolutes.**  
Instead, refer to hours to days; days to weeks; weeks to months. No one knows the exact moment that death will occur.

## POLST CONVERSATION POINTS: Key Information

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**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 or family member seems surprised by the POLST Conversation or questions “why do we need to talk about this?”** *We routinely talk to patients 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 at home or 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 you and your doctor, nurse practitioner or physician assistant, 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 medical 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?”** *No, completing a POLST form is voluntary.*

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, nurse practitioner or physician assistant can meet with you and your family for more discussion.*

When working with a Legally Recognized Decision-maker, or the family member designated as “Responsible Party”, it is important to remind them of the following key points:

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

- *Does your mom have an Advance HealthCare 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 decision-maker, 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).*

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

If someone chooses **DNR**, they can choose **any** option for medical interventions in Section B. A person can request Full Treatment, including ventilator/life support, 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-Focused Treatment or Selective Treatment in Section B. Attempt CPR requires Full Treatment.

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. The primary goal of Full Treatment is prolonging life by all medically effective means.*

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 on life-support?*

If the patient does not want their life prolonged with life-support, you can check the box, **"Trial Period of Full Treatment."**

Another alternative is **Selective Treatment**, with the goal of treating medical conditions while avoiding burdensome measures. 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.

**Selective Treatment** includes hospital evaluation and treatment, IV fluids, and cardiac monitoring if indicated, but **no** ventilator and **no** CPR.

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/NP/PA for additional discussion of this specific intervention.

**Comfort-Focused Treatment** is a choice where medical care is focused on the primary goal of maximizing comfort, rather than focused on medical procedures that may prolong life. Comfort-Focused Treatment is a choice for those with life-limiting illness that modern medicine cannot cure.

Comfort-Focused Treatment does **not** mean No Care. The goals of care are to manage pain and uncomfortable symptoms. Medications, oxygen, 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.

## **Ask, would you want to go to the hospital for evaluation and treatment?**

If “YES,” then check **Selective Treatment in Section B**.

If “NO,” then check **Comfort-Focused Treatment in Section B**.

For those who choose **Selective Treatment** 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 IV 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 **Selective Treatment in Section B**.

If the resident prefers treatment at the SNF, then mark **both Selective Treatment** and the box **Request transfer to hospital only if comfort needs cannot be met in current location**.

Another question to help a patient identify the choice between Selective Treatment and Comfort-Focused Treatment is to ask, “If you had a skin infection and the doctor thought you needed 2-3 days of IV antibiotics, would you go to the hospital for this treatment?” If patient said, “Yes, I would go to the hospital”, then choose Selective Treatment.

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



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

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

*Many patients 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, including feeding tubes", particularly after head or neck surgery, in hopes that their ability to swallow may improve. Some choose to be hand-fed foods with the best texture and thickness to help them swallow the best they can.*

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

Review POLST choices. If there are questions or concerns, tell the patient, we will set up a time for your doctor, nurse practitioner or physician assistant to talk with you more.

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

Check whether there is an AHCD. If yes, note the date of the document and the Healthcare Agent's name and phone number. If the AHCD is not available, encourage the patient/family to bring a copy to the doctor/hospital/SNF.

If patient and/or family have no questions, obtain signatures.

Note, the address is mailing address, not residential address (e.g. for patient living at SNF). Phone number is ideally a cell phone or number that can be accessed day or night.

For Registry Use box is a space for future POLST state registry use.

*We will have your doctor/NP/PA review and sign the form. The doctor/NP/PA will talk with you, if there is anything he/she wants to discuss more with you.*

You will complete the section on the back, Healthcare Provider Assisting with Form Preparation.

Be sure appropriate patient identifying information (Date of Birth, telephone numbers, etc.) are completed on both sides of the form. If no additional contact person, check "none."

- 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 is capable of making decisions – **always encourage completion of the Advance HealthCare Directive, in addition to POLST.** The Advance HealthCare Directive appoints the person who will make decisions on behalf of the person if they can no longer communicate their wishes. If the patient is in a SNF and completes an AHCD while at the SNF, a state ombudsman must witness the patient's signature on the AHCD.

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 for EMS 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.

*\*See SNF/Acute Care Hospital Model Policies regarding documenting POLST with the patient belongings.*

A Faxed physician/NP/PA signature is acceptable. Verbal orders may be obtained with follow-up signature by the physician/NP/PA in accordance with facility/community policy. Physician/NP/PA engagement in the POLST Conversation is essential, including those times when verbal orders are urgently needed.

Photocopies and Faxes of signed POLST forms are legal and valid.

Be sure to document POLST Conversation in the medical record.

Note the statement on the POLST, "Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid." It is good practice to complete the most current version when POLST is reviewed.