

THE POLST CONVERSATION | POLST SCRIPT

“The POLST Script” provides detailed information in order to develop comfort and competence when facilitating a POLST Conversation.

The POLST Conversation utilizes realistic medical situations to determine patient treatment preferences and appropriate orders for each section of the POLST form; for example, *“If you suffered a heart attack and your heart stopped...”* frames the discussion for POLST Section A, Cardiopulmonary Resuscitation.

POLST Conversations may occur in a variety of settings, including:

- ❑ the doctor’s office
- ❑ during a family meeting in the acute care hospital
- ❑ on admission to a skilled nursing facility
- ❑ at home, with home health or hospice

POLST Conversations involve sensitive topics which may feel difficult for staff to discuss, especially if the staff has just met the patient and/or family. Understanding the patient and his/her values can help initiate the conversation. Taking the time to ask:

- ❑ *What is most important to you at this time in your life and in the future? or*
- ❑ *How do you feel things are going for you? Have you noticed any changes in the past few months? or*
- ❑ *What has your doctor told you? or*
- ❑ *I’d like to better understand what you hope for...*

Family meetings may also begin by:

- ❑ having everyone in the room introduce themselves and their relationship with the patient
- ❑ asking what the patient (or family) knows about the patient’s current medical condition

The POLST Conversation begins with explaining:

*It is important to talk about your health and some things that happen to people when they become critically ill. We talk about this with **everyone** with a serious illness.*

*I don’t think anything we talk about will happen to you soon, at least not in the very near future. But it is important to talk about it now, so that we know in advance what you want. **For a family member:** it is important to talk about it now, as things can happen quickly and we need to know what your loved one would want us to do in an emergency.*

If you are unsure how to answer anything we talk about or have questions, your physician, nurse practitioner (NP) or physician assistant (PA) can meet with you and your family for more discussion and to review our discussion. Be sure to record questions and to follow-up with patient's physician/NP/PA.

During the POLST Conversation, be aware of patient/family emotions and reactions:

- allow time for silence
- give time for reactions
- invite questions

Continue the POLST Conversation (POLST Section A):

Pretend you had a heart attack. You collapse and 911 – emergency services are called.

*You're unconscious, **not** able to talk. You are **not** breathing and your heart is not beating.*

You have died a natural death.

There is a medical procedure called CPR, cardiopulmonary resuscitation, which we can try.

*The truth is that CPR doesn't work well on older people, with bodies weakened by illness, like heart or lung problems or cancer. In very few cases, the heart can be made to beat again, but after a time of no circulation, there is a high chance of brain damage. Other complications of CPR include broken ribs and punctured lungs. Resuscitation **never** cures the original medical problems.*

For an older person with multiple medical problems or difficulty caring for themselves, there is less than 1% chance of living through CPR. Even for a relatively healthy person at a skilled nursing facility for short-term rehabilitation, if they survive CPR, less than 10% are alive after 60 days and those who live often have much worse disability and brain damage.

Some people say, "No, if I'm dead, let me die a natural death."

Other people may say, "If that is my only chance, then try the CPR."

If you have died a natural death, would you want us to try CPR?

If "No CPR", mark **Do Not Attempt Resuscitation**, then go to Section B, below.

If "YES, try CPR", then mark **Attempt Resuscitation**, and complete POLST Section B Medical Interventions by marking **Full Treatment**.

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

Then ask... *Let's say they did get your heart beating again. Usually, especially with older adults, you would not be up and about soon. You'll be in the intensive care unit on machines for life support, including a ventilator, to breathe for you.*

*If you **did not** get better over the next couple of weeks and you are **not** breathing well or your brain is **not** functioning well, there are special hospitals where people are on long-term life support machines.*

*Some people say they **don't** want their life prolonged if they are **not** getting better and are being maintained on machines. They want CPR tried, but "don't keep me on life support if the doctor doesn't think I'll get better."*

*If you do **not** want to be kept on life support if the doctor did not think you were getting better, we can check the box, "Trial Period of Full Treatment." The length of trial periods are not decided in advance, because the individual and the medical problems must be considered. The doctors caring for the patient will discuss the situation with the patient and/or family.*

POLST Section B: Medical Interventions

For those who say **Do Not Attempt Resuscitation** in Section A – continue with Section B...

Now we need to talk about how aggressively you would like us to be if you got very sick; for example, if you had a bad pneumonia, a high fever and started acting confused and you were taken to the emergency department. Sometimes your only chance of recovering is to have a ventilator, a life support machine, with a tube going down your throat which forces oxygen into your lungs.

You would be in the intensive care unit with nurses suctioning you, trying to get out the mucus. You would need to be kept sedated and your hands would likely be tied because the ventilator is uncomfortable and patients often try to pull the breathing tube out.

When people are strong in the first place and have no brain damage or memory problems, they usually get better in a few days.

For someone who is frail or has dementia, their ability to participate in activities or their memory often gets worse after being on the ventilator.

Would you want to be placed on the ventilator machine?

If "YES," then check **Full Treatment** in Section B. Then ask...

If you were on the ventilator and did **not** get better in a few days, would you want to be kept alive on the ventilator?

If “NO,” then check the box, “**Trial Period of Full Treatment**” in Section B.

If “NO ventilator,” discuss the following...

For people with some health problems who are doing well and are still able to do the activities they enjoy, if they got sick, some want to go to the hospital for evaluation and treatment, but they do not want to be put on the ventilator or have lots of intensive medical treatments.

There is also a small group of people with serious lung problems or congestive heart failure where the use of non-invasive positive airway pressure may be of benefit in delivering oxygen and assisting them to breathe easier. These are short-term, intense treatments which may require intensive care nursing.

When a patient asks, or for someone with severe lung disease or congestive heart failure, you may want to discuss the following:

Continuous Positive Airway Pressure (CPAP) and Bi-level Positive Airway Pressure (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 into the lungs and make the work of breathing easier. Some people find this uncomfortable, but it gives a chance for other treatments to work to improve the patient’s condition so that they can breathe easier on their own. These treatments require an alert and cooperative patient to be effective. The mask can only be removed for a few minutes at a time while it is used.

Selective Treatment might be chosen when the goal of care is treating medical conditions while avoiding burdensome measures.

Other people with advanced illness that we cannot cure, choose to have their care focused on making sure they are comfortable, not in pain, and not having to put up with uncomfortable symptoms, like nausea, shortness of breath, constipation, anxiety. Medical care focuses on promoting their comfort, but not going through medical treatments that will not cure their illness.

Food and fluids are offered by mouth as tolerated and feasible. 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. When needed, medicines are given to reduce lung congestion.

Care focused on comfort includes medicines to treat any symptoms, including shortness of breath, anxiety or suffering when someone is close to death.

The option of **Comfort-Focused Treatment** is for people with the goal of maximizing comfort, not continuing treatments to fix their illnesses. We would only request transfer to the hospital if we couldn't keep you comfortable (at home or in the SNF).

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**, ask...

If you got sick, like from a bad urinary tract infection or pneumonia, some people want to go to the hospital for evaluation and treatment. Other people want to avoid being transported to the hospital and 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 the 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 patients want treatment in the hospital for an acute illness or exacerbation or flare up of an existing illness like emphysema. Other patients 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 patient prefers treatment at the facility, then mark **both Selective Treatment and check the box Request transfer to hospital only if comfort needs cannot be met in current location**.

POLST Section C: Artificially Administered Nutrition

There is one other case to talk about – if you had a stroke, a part of the brain is damaged, and you can't talk or communicate with family and friends. Your ability to swallow may also be affected. Difficulty swallowing can also happen with advanced Alzheimer's or Parkinson's disease.

If you **cannot** talk with your family and friends, and you **cannot** swallow well, we **will** continue to hand feed you with the best food texture for you, and help you eat the best you can.

Or a feeding tube can be placed to provide artificial nutrition with medically-prescribed liquid formula. The artificial nutrition may **not** prolong your life, especially with Alzheimer's. Artificial tube feeding may be uncomfortable, and will **not** prevent a pneumonia or food from going into your lungs.

Some people 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. Many believe people do better with the human touch of hand feeding.

Would you want hand feeding to allow you to eat the best you can? Or would you want long-term artificial nutrition by a tube?

Complete Section C.

Note: Sometimes it feels uncomfortable to tell patients/families what a procedure can or cannot do, or what the risks are. But we need to be honest and give them all the information.

Patients and families **want** to know. When they know the realities of the disease process and the treatments available, including the benefits, limitations and risks, they can **make informed decisions**.

POLST Section D: Information and Signatures

Complete all demographic information for the patient, printing the patient's first, last and middle name and date of birth on front and back of POLST form.

Mark who POLST was discussed with (e.g., Patient, and/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 physician/hospital/SNF.

POLST will not be effective until the physician, nurse practitioner or physician assistant signs the form. 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.

Depending on who will be signing the POLST form (patient or their decision-maker), have that person complete the information at the bottom of the form (print name, relationship, mailing address, phone number), and then sign and date 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 the 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 the POLST Conversation and who participated in the conversation.

If a nurse practitioner or physician assistant signs the POLST form, the name of that person's supervising physician should be noted in the appropriate box on the back of the form. The supervising physician does NOT need to co-sign the POLST form.

On the back of the POLST form, the staff person helping to complete the POLST form needs to complete the section Healthcare Provider Assisting with Form Preparation, including their name, title, and facility phone number.

Then complete the Additional Contact section by writing the name, relationship to the patient, and phone number of the person (ideally a cell phone or number that can be accessed day or night). Check the box "None" if there is no additional contact.

Reinforce the importance of discussing their POLST decisions with other family members.

- ❑ Your family needs to know what type of medical care you want and what you don't want if you become very sick, or if your health declines and you become more weak and tired and less able to do the things you care about.
- ❑ You are giving your family a gift by telling them what you want and what you do not want. They can support you.
- ❑ If you were unable to talk, your family can state your choices, without feeling burdened or guilty.
- ❑ Talking opens the door for communicating about how everyone cares about you, and how everyone can support each other during serious illness.