

Module 4 – 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/resident and their 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/resident
- ❑ asking what the patient (or family) knows about their 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 doctor can meet with you and your family for more discussion and your doctor will review our discussion. Be sure to record questions and to follow-up with patient's/resident's doctor.

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**. 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 or respirator to breathe for you.

If you did not get better over the next 4 to 5 days 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 wanted CPR tried, but “don’t keep me on life support if the doctor doesn’t think I’ll recover”.

Would you want to continue to have machines keep your body alive, dependent on life support treatments?

*Or... if you do not want to be kept on life support if the doctor did not think you were getting better, we can write in Additional Orders, **“Defined Trial Period. Do not keep me on prolonged life support.”***

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 respirator or ventilator, a 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 we'd need to make sure you didn't try to pull it 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 write Defined Trial Period. Do not keep me on prolonged life support” in Additional Orders, Section B.

If “NO Ventilator,” ask...

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.

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. (Limited Additional Interventions)

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.

Comfort measures include medicines to treat any shortness of breath, anxiety or suffering when someone is close to death.

*The option of **Comfort Measures Only** focuses on care to keep you comfortable. We would only send you to the hospital if we couldn't keep you comfortable here. (Comfort Measures Only)*

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, ask...

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. Other people want to avoid being transported back and forth 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 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.

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 thickened food and you can eat as 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. 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. Many believe people do better with the human touch of hand feeding.

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

Complete Section C.

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 Decisionmaker).

Check whether there is an AHCD. If yes, note the date of the document and the Health Care 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.

Print the physician’s name who will sign the form. POLST will not be effective until the physician signs the form. 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.

Depending on who will be signing the POLST form (patient or their decisionmaker), have that person complete the information at the bottom of the form (print name, relationship, address, phone numbers), and then sign and date the form.

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

- In the medical record, document that the POLST conversation was with decisionmaker.

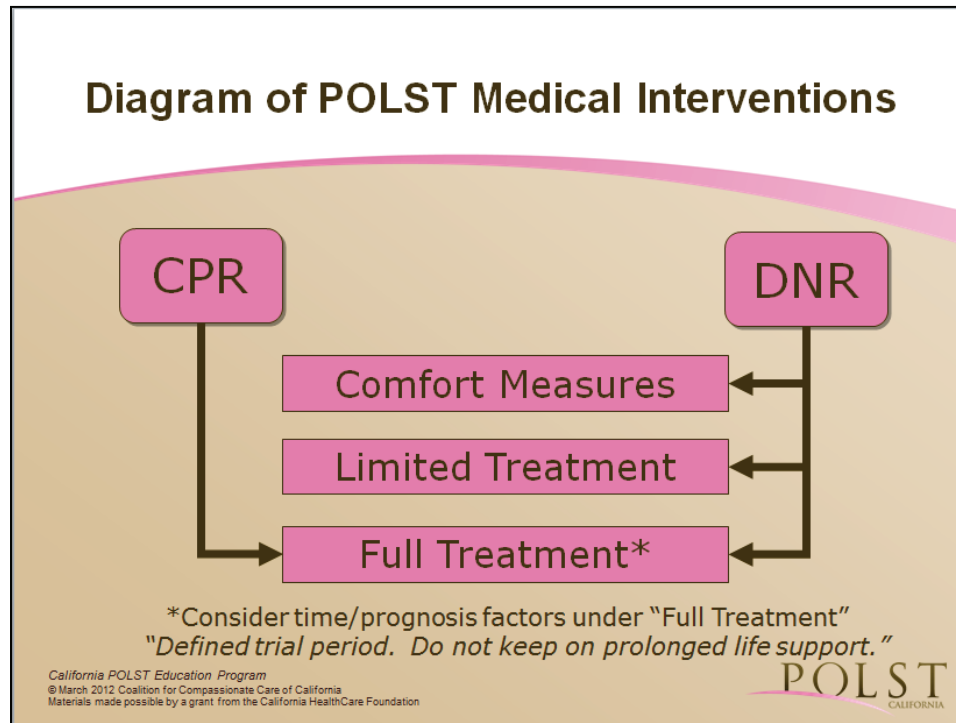
On the back of the POLST form, the staff person helping to complete the POLST form needs to complete the section Health Care Provider Assisting with Form Preparation, including their name, title, and facility phone number.

Then complete the Additional Contact section by writing the name, relationship to the patient, and phone number of the person (a cell phone number is helpful too).

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.*

Diagram of POLST Medical Interventions



Look at Section A: Attempt Resuscitation/CPR - what does the POLST form say under Attempt Resuscitation/CPR? Answer: Section B – Full Treatment required.

If a patient wants Attempt CPR, he/she must be willing to undergo the treatments listed in Section B: Full Treatment. Read the care described in Full Treatment. Full treatment includes all the elements necessary for attempting resuscitation.

If the patient chooses Do Not Attempt Resuscitation / DNR (Allow Natural Death), the patient may choose any of the three choices in Section B: Medical Interventions.

A patient choosing Full Treatment is requesting aggressive medical treatments. When the patient dies a natural death (no pulse and not breathing), then he or she does not want anyone to attempt or start CPR.

When a patient chooses Full Treatment, it is important to discuss the severity of their illness and what they would want if they were not getting better. The POLST Conversation includes discussion regarding long-term intensive medical treatment. Ask the patient, *If you did not get better and the doctor thought your chances of a good recovery were poor, would you want to be kept alive on the ventilator?*

If the patient does not want to be kept on life support, Defined Trial Period. Do not keep me on prolonged life support can be written in Section B: Additional Orders.

It is not acceptable to request Attempt Resuscitation/CPR in Section A and Comfort Measures Only or Limited Additional Interventions in Section B.

You can remind patients/families that comfort is important for everyone's treatment.

POLST Cue Card

It's important to talk about your health and what can happen if you get really sick. We talk about this with everyone with a serious illness. If you're unsure how to answer anything we talk about or if you have questions, your doctor can talk more with you. *(You can explore: How do you feel things are going for you? Have you noticed any changes in the past few months? I'd like to better understand what you know about your condition? What is your overall goal for your care; for example, to live as long as possible, or to live your last days with comfort and dignity?)*

POLST documents your wishes for your care in critical medical situations. POLST becomes medical orders after you and your doctor sign it and obligates the medical system to follow these orders. Your choices should be based upon knowledge of your medical condition, the likelihood that you will respond to these medical treatments, and your preferences. If your medical situation changes, or if your wishes and thinking change, POLST orders may also be changed.

SECTION A: Cardiopulmonary Resuscitation (CPR) *If not in cardiopulmonary arrest, follow orders in Sections B & C*

The first section of POLST has to do with the specific situation in which your heart completely stops, you are not breathing, are not awake, and you have died a natural death. We can try a medical procedure, Cardiopulmonary Resuscitation (CPR). Unfortunately, CPR almost never works on older people. When this happens to people who have multiple medical problems or who have difficulty in caring for themselves, they have less than a 1% chance of living through CPR. If this happens to a healthier person, their chance of surviving CPR is less than 10%. There is a significant chance of worse disability and brain damage in those who survive. Resuscitation never cures the original medical problems.

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

- YES** – Mark Attempt Resuscitation/CPR and →Go to Section B
- NO** – Mark Do Not Attempt Resuscitation/DNR (Allow Natural Death) and →Go to Section B

SECTION B: Medical Interventions

For patients who marked Attempt Resuscitation/CPR on Section A:

- Mark Full Treatment on Section B and →Continue...

Let's say they did get your heart beating again. You will be in the ICU on a ventilator. If you did not get better and your doctor thought your chances of a good recovery were very poor, **would you still want to be kept alive on the ventilator?**

- YES** – Do nothing else in Section B. →Go to Section C
- NO** – If your doctor does not think you are going to make a good recovery, we can write in Additional Orders, ***“Defined Trial Period. Do not keep me on prolonged life support.”*** (Additional Orders Section B). →Go to Section C

For patients who marked No CPR on Section A:

Let's talk about if you got really sick, for example a bad pneumonia, and you needed a ventilator. The ventilator machine is not comfortable; you would need to be kept sedated and often restrained. For people with healthy lungs and generally good health, most get better in four to five days. People with multiple problems or who are medically frail may choose not to be on a ventilator to avoid the discomfort and anxiety of all the medical procedures. Because their chances of dying are higher, they will likely be much weaker and more debilitated if they do survive.

If you were really sick would you want to be placed on the ventilator?

- YES** – Mark *Full Treatment* and →Continue...

If you are on the ventilator and not improving, and your doctor thinks your chances of a good recovery are very poor, **would you want to be kept alive on the ventilator?**

- YES** – Do nothing else in Section B. →Go to Section C
- NO** – If your doctor does not think you are going to make a good recovery, we can write in Additional Orders, ***“Defined Trial Period. Do not keep me on prolonged life support.”*** (Additional Orders Section B). →Go to Section C
- NO** – →Continue...

Most patients want us to treat them in the hospital if we feel that is necessary. However, some patients with advanced illness who we cannot cure and who have gotten very weak find it difficult to be sent to the Emergency Department, get poked with needles and moved back and forth by the hospital staff, and no longer want to go to the hospital at all. These patients, who feel that the hospital no longer helps them, will tell us to treat them in the SNF with whatever means are available there. Other patients will tell us to actively focus on keeping them comfortable if they have gotten that sick and allow them to die without starting treatment to prolong their life. **What do you think is best for you?**

- Mark *Comfort Measures Only* in Section B for patients choosing comfort measures
- Mark *Limited Additional Interventions* in Section B for patients wishing to be hospitalized
- Mark *Limited Additional Interventions* AND *Do Not Transfer* in Section B for patients wishing treatment to be only in the facility and not in the acute care hospital

→Go to Section C

SECTION C: Artificially Administered Nutrition

There is one other case to talk about – if in the future you have a bad stroke and you can’t talk or communicate. Your ability to swallow may also be affected. Difficulty swallowing can also happen with advanced Alzheimer’s or Parkinson’s Disease.

We will continue to hand feed you with thickened food and you can eat as best you can. Or, a feeding tube can be placed to provide artificial nutrition with medically-prescribed liquid formula. Artificial nutrition may not prolong your life, especially if you have dementia. Artificial feeding may be uncomfortable, and will not prevent pneumonia or keep food from going into your lungs. Some may choose a defined trial period of artificial nutrition by tube, particularly after head or neck surgery, in the hopes that their ability to swallow may improve. Many believe people do better with the human touch of hand feeding. **Would you want hand feeding to allow you to eat as best as you can, or would you want artificial nutrition by a tube?**

- HAND FEEDING** – Mark *No artificial means of nutrition, including feeding tubes*
- TUBE FEEDING** – Mark *Long-term artificial nutrition, including feeding tubes*
- TUBE FEEDING FOR A TIME** – Mark *Trial period of artificial nutrition, including feeding tubes*

REVIEW POLST CHOICES. If you have questions or need more information, we will help coordinate time for more discussion with your doctor. If patient is capable of decisionmaking, always encourage completion of AHCD, particularly to name a healthcare decisionmaker.

POLST Cue Card – Short Version

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 will review what we talk about and answer questions. Encourage AHCD.

Take time to ask... How do you feel things are going? Have you noticed any changes in the past weeks, months? What has your doctor told you about your medical condition? What do you hope for with your care? What do you enjoy doing? What is important to you? What gives your life meaning?

POLST records your wishes for medical care if you are seriously ill; becomes medical orders after you and your doctor sign. Form goes with you to hospital. POLST can be changed if your condition changes or your treatment wishes change.

Section A: Cardiopulmonary Resuscitation/CPR *Introduce with, "If you had a bad heart attack..."*

CPR is attempted only if the heart has stopped beating, you are not breathing, not awake and have died a natural death. Unfortunately, CPR almost never works on older people. Of the rare times people live thru CPR, most will be on ventilator (life support) for a period of time and may still die. For those who survive, many have worse disability and brain damage. CPR never cures the original medical problem.

→ **If you die a natural death, would you want us to try CPR?** Yes – Section B is Full Treatment (Ask about Ventilator Trial.)

Section B: Medical Interventions *Introduce with, "If you got really sick, for example, you had a bad pneumonia..."*

There are different treatment options for serious illness. **We always take care of comfort needs.** With aggressive medical care, say you needed a ventilator to help you breathe, the machine is not comfortable and pain and sedating/calming medicines are needed. Recovery time after intensive treatments is often long and difficult.

- **Full Treatment: All medical treatment options.** You can ask to stop if doctor thinks you are not going to make good recovery and treatments are just keeping you alive. We can write "*Full treatment for trial period*" on Additional Orders.
 - **Limited Additional Interventions: Hospital care, but no ventilator, no intubation.** May use non-invasive positive pressure breathing mask. Patients often choose **not** to have major surgery or treatments with long, difficult recoveries.
 - **Comfort Measures Only:** Some patients with illness we cannot cure, want us to care for them by treating all symptoms and pain, focusing on comfort. The patient chooses **not** to start treatments to try and cure medical problems because they do not want to prolong their life. Medicines to promote comfort, like antibiotics for bladder infection, can be given.
- **What do you think is best for you?** *For SNF patients, Limited Interventions,* ask if they want hospital transfer or treatment at SNF with transfer to hospital only if required to meet comfort needs.

Section C: Artificially Administered Nutrition *Introduce with, "If you had brain damage from a bad stroke or severe dementia or Alzheimer's and you cannot speak for yourself, cannot swallow food and are not expected to recover (or may take months to recover). Food is offered by mouth if possible and desired. We will continue to hand feed you with the best texture of food and help you eat as best you can. Or a feeding tube can be placed to give artificial nutrition with medically prescribed formula. Careful feeding by hand can be just as effective and some believe the human touch is better. There is little evidence that artificial tube feeding helps people with advanced dementia. Artificial tube feeding may be uncomfortable, does not prevent pneumonia, and can cause swelling and infections. Artificial tube feeding can be helpful in specific situations like cancer of the mouth or throat, and some may choose a *trial period*, in hopes that their ability to swallow may get better.*

→ **Would you want hand feeding to allow you to eat as best you can, or would you want long-term artificial nutrition by tube?**

Review POLST choices. Questions – coordinate time with doctor. Complete signatures. Document the conversation.

POLST Conversation Documentation Tool

Patient: _____ **DOB:** _____

POLST discussed with: _____
(name and relationship) *(name and relationship)*

Patient is ___ capable of medical decisionmaking.
 Patient is ___ **not** capable of medical decisionmaking (per physician order).

Patient has Advance Health Care Directive (AHCD) naming _____ as decisionmaker.

Or: ___ No AHCD, but decisionmaker/responsible party is: _____ **Or:** ___ No named decisionmaker.
(name and relationship)

Patient Goals: Discuss with patient and/or other family and friends present: ask what is important to you; what do you like to do? How do you feel things are going? Have you noticed any changes in the past weeks/months? What has the doctor told you about your medical condition? What do you hope for with your care?

The following components of the POLST Conversation have been discussed and patient preference is checked (if known):

___ **CPR** is utilized when a patient has died, is not breathing and has no heartbeat. CPR is rarely successful in patients with multiple chronic diseases or those who require 24 hour care. CPR may result in severe disability including brain damage if the heartbeat is able to be restored. *Medical example: a massive heart attack.*

___ **Full Treatment** includes using ventilators (life support), major surgery and possibly other aggressive treatments. These treatments are often uncomfortable and are likely to cause further complications. If successful, a patient may live longer, but often has to undergo a long, difficult recovery. *Example: pneumonia needing a ventilator.*

___ **Limited Treatment** includes hospital treatments, but avoiding ventilators (life support) and other treatments which are difficult for a patient to endure. Option is available for treatment at the skilled facility and transfer only if required to meet comfort needs. *Example: treating pneumonia in skilled facility or at hospital without a ventilator (life support).*

___ **Comfort measures** means choosing a plan of treatment for the time in which a patient faces serious illness. This plan focuses on treatments that provide comfort, and chooses **NOT** to have treatments that are meant to cure illness and prolong life. *Example: serious pneumonia is treated with oxygen and medications to help with shortness of breath, but NOT being hospitalized and using other treatments aimed at curing the pneumonia.*

___ **Artificial Nutrition** as discussed in POLST is a treatment choice to be considered if a patient has become disabled and can no longer communicate and cannot swallow. Careful hand feeding with optimal food texture or choice of medically prescribed formula by tube. *Example: serious stroke or severe Alzheimers.*

Patient or family concerns: _____

Staff concerns (i.e., comprehension, capability to act for patient, potential conflicts): _____

Dr. _____ notified of questions or concerns. **Staff signature:** _____ **Date:** _____

Physician notes (optional): _____

Physician signature: _____ **Date:** _____

Helpful Phrases for POLST Conversations

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?

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 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 hoped 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...” “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.

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 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 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: 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 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 to talk with you more.*

Check who POLST was discussed with – patient with capacity or legally recognized decisionmaker.

Check whether there is an AHCD. If yes, note the date of the document and the Health Care 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.

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, decisionmaker, telephone numbers, etc) are completed on both sides of the form.

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

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. 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 policy regarding documenting POLST with the patient belongings.

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.

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

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Demonstration of a POLST Conversation

The following POLST Conversation is an example of a straight-forward discussion between a staff person and a recently admitted resident who is at the skilled nursing facility for rehabilitation. This simple conversation will help staff feel more comfortable with the flow of the POLST Conversation after reading or seeing a demonstration.

It is recognized that some discussions are more complex or time-consuming, and questions can occur during any conversation which will need referral to the resident's physician. After questions are answered, either the doctor or the staff may complete the POLST form.

Staff Person: Mrs. James, thank you for your patience as we have done so much paperwork in the last few days. There is still another important discussion for us to have. I know you are here for physical therapy after your hip surgery. Do you have any other medical problems the doctor has talked with you about?

Resident: Oh yes, I have lung problems; you know I smoked for over 60 years, but I quit four days ago! And I did have colon cancer four years ago.

Staff Person: I saw that the doctor has you on the nicotine patch. I'm glad you have stopped smoking. Falling and breaking your hip, surgery and having physical therapy are not easy. As you go through your therapy, what are your goals for the next few weeks?

Resident: I want to get home and be able to take care of my four dogs. I have always taken care of myself and I want to be independent and capable again.

Staff Person: And our goal is to help you build your strength and go home. I'd like to spend a few minutes talking about what you might want in the future, if you got very sick. We talk about this with everyone with chronic or 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 we know in advance what you would want. If you are unsure how to answer anything we talk about or have questions, your doctor can meet with you and your family for more discussion.

Resident: This is really hard to talk about, but I know it's important.

Staff Person: It is important for us to understand your values and what you would want us to do if something happens to your health. This is the POLST form, which stands for Physician Orders for Life-Sustaining Treatment. It allows us to document your wishes for your medical care, if in the future, you had a serious illness. We're going to talk about some things that could happen, to be sure we honor your wishes.

Pretend you have a heart attack. You collapse and you're unconscious. 911 is called. The emergency medical services staff check you and find you are not breathing and your heart is not beating. You have died a natural death. There is a medical procedure called CPR that we can try. We forcefully push on your chest and insert a breathing tube.

Unfortunately, CPR almost never works on older people. 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, after CPR, less than 10% survive and those who live often have worse disability and brain damage. Other complications of CPR include broken ribs and punctured lungs. CPR never cures the original medical problems.

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

Resident: If that is my only chance, then try CPR.

Staff Person: I will check Attempt Resuscitation/CPR. Since you chose CPR, we must choose Full Treatment in the Medical Interventions section, which includes being in the intensive care unit on a ventilator, the machine forcing air into your lungs.

Resident: Wait, why can't they just try the CPR for awhile and stop it if I don't look so good?

Staff Person: When you choose to try CPR, you will receive intensive medical care for several days to see how your body responds. Is that OK with you?

Resident: Yes.

Staff Person: Let's say they did get your heart beating again. You will 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 four to five days, you are not breathing well or your brain is not functioning, some people say they do not want their life prolonged if they are dependent on life support treatments.

Would you want to be kept on life support if the doctor did not think you were getting better?

Resident: I wouldn't want to be on those machines forever if I'm not getting better.

Staff Person: (showing resident) I understand. We can communicate this to doctors by writing under Additional Orders, "Trial Period. Do not keep me on prolonged life support."

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 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 thickened food and you can eat as best you can. Or, a feeding tube can be placed to provide artificial nutrition with liquid formula. There is very little evidence that artificial nutrition by tube is helpful for people who have advanced dementia. Artificial tube feeding may be uncomfortable, and will not prevent a pneumonia or food from going into your lungs. Many believe people do better with the human touch of hand feeding. Artificial nutrition by tube can be helpful if there is cancer of the mouth or throat. It can be used for a trial period.

Would you want hand feeding to allow you to eat as best as you can or would you rather have artificial nutrition by a tube?

Resident: I wouldn't want tubes to feed me.

Staff Person: So we'll check the box, "No artificial means of nutrition."

Let's review your POLST choices. [Go over POLST form and review choices with the patient.] Next if you could sign here, we will have your doctor review your choices and sign the form also. The form will stay on your medical chart here, but if you ever need to go to the hospital it will go with you. When you are discharged to your home, you will take the form with you. You will also take it with you if you had to go back to the hospital by car or ambulance.

The goal is to be sure all of your health care providers understand your wishes. We also need to talk with your family about your choices. We will review the POLST at certain times to be sure your wishes are still the same. If you ever want to change your choices or if your condition changes, you and your doctor can change your POLST form.

Thank you for taking the time to discuss your choices with me.

Cultural & Spiritual Awareness

The POLST conversation involves a rich dialogue incorporating goals of care, wishes during critical illness, and patient and/or family awareness of their medical condition. Cultural and spiritual awareness and sensitivity is vital during these discussions. We must also acknowledge that:

- Each of us probably will never fully understand the many cultural and spiritual beliefs of our patients/residents,
- We cannot assume that a patient/resident or family shares identical values and beliefs simply based on their ethnicity or culture,
- We need to explore and respect the individual values, spiritual beliefs and cultural traditions of each patient/resident and their family.

Although meeting the diverse needs of our patients/residents and their families is a challenge, our role provides a unique opportunity to assist and support others during critical times of illness and dying. We must acknowledge and appreciate that many cultural and spiritual beliefs differ from our own. We need to actively encourage others to share their thoughts and feelings in order to build understanding and trust, and to enhance communication. When conflict arises, we need to use effective communication techniques to understand the issues and build bridges to provide effective care.

As we facilitate the POLST conversation, we should not make assumptions about anyone's cultural or spiritual beliefs, but we need to:

- Ask the patient/resident or their family, *What do you know about your condition?*
- Ask, *How much do you want to know?*
- Ask, *Is there anyone that you want to be here as we talk? Or, Is there someone that you want me to talk with?*
- Ask, *Do you have an Advance Health Care Directive naming your decisionmaker if you are unable to talk with us sometime in the future?*
- Acknowledge feelings and encourage discussion – *I am so sorry. How can I help you? Or, What is most important to you at this time?*

Using the “Facilitating Care Conferences & Family Meetings – Cue Card” will help during discussions (Module 5).

To introduce and assess an individual's spiritual or religious beliefs, the "FICA" tool can be helpful. Ask the following questions to explore patient and family preferences:

Faith: *Do you consider yourself to be a religious or spiritual person?*
Or, *What do you believe in that gives meaning to your life?*

Importance and Influence: *How important is your faith (or religion or spirituality) to you?*

Community: *Are you a part of a religious or spiritual community?*

Address or Application: *How would you like me, as your healthcare provider, to address these issues in your health care?*

Or, *How can we assist you in your spiritual care?*

Or, *How might these things apply to your current situation?*

FICA was created by Christina Pulchalski, MD, George Washington School of Medicine and Health Services; www.mywhatever.com/cifwriter/library/70/4966.html

Many additional resources exist to build cultural awareness and competence, including:

Control and End-of-Life Care: Does Ethnicity Matter?

Deborah L. Volker, RN, PhD; American Journal of Hospice and Palliative Care.

2005; 22(6): 442-446; www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1460576

The Explanatory Model

James Hallenbeck, MD; David E. Weissman, MD; EPERC Fast Fact #26;

www.eperc.mcw.edu/fastFact/ff_026.htm

The National Resource Center on Diversity in End-of-Life Care; www.nrcd.com

Taking a Spiritual History, (acronym SPIRIT)

Bruce Ambuel, PhD; EPERC Fast Fact #19; www.eperc.mcw.edu/fastFact/ff_019.htm

Mrs. Lee's Story, a 16-page booklet written in Chinese and English addressing end-of-life issues that concern Chinese elders and their families.

Center for Healthcare Decisions; www.chcd.org/contact-purchasepubs.htm

Patient Information Guide

Supplement to POLST Consumer Brochure

POLST (Physician Orders for Life-Sustaining Treatment) is a form to record your wishes for the types of medical care you want if you become seriously ill. Your doctor or another healthcare provider will be going over the POLST form with you.

Please read the POLST brochure and the information below. Each section of the POLST form is explained. Once you discuss the medical treatment you would want in these situations, both you and your doctor sign the POLST form.

When the POLST form is signed, your wishes become medical orders. This means they must be followed by other doctors, nurses and the emergency team. Your POLST form stays with you if you move from one healthcare setting to another.

A POLST form can be updated if your condition changes, or if your treatment wishes change.

Take POLST with you whenever you go to the hospital. If you are admitted to the hospital, the POLST form stays with you (or in your chart). When you leave the hospital, the POLST form goes with you.

Completing a POLST helps to make certain that your wishes for care will be respected by all healthcare staff. POLST is recognized throughout California and used in many other states. It is important to talk with your family about your POLST choices.

Review each section of POLST:

SECTION A

___ Cardiopulmonary Resuscitation (CPR) is attempted only when a patient's heart has completely stopped. The patient has no heartbeat, is not breathing, is not conscious, and has died a natural death. CPR includes pumping on the chest and trying to shock the heart. Broken ribs from CPR are common in older patients.

CPR is unsuccessful in almost 100% of patients in nursing homes. Of the rare cases of people who do survive CPR, most will be on a ventilator (life support, using a breathing machine to force air into the lungs) for a period of time and still may die. Brain damage occurs in at least half of the patients who initially survive CPR.

People who choose CPR may think “If it doesn’t work, then I’m no worse off than not trying – I will die either way. So even if there is a high chance of broken ribs and brain damage I want you to try CPR. It’s my only chance.”

Other people choose No CPR because they feel, “It’s such a small chance that CPR will work and I’ll probably be sick for a long time. If I’ve died, then let me go peacefully.”

SECTION B

Medical Interventions is about hospital treatment options for serious illness. In each of these options, the comfort needs of patient must be taken care of. When aggressive medical treatments are used, the patient often will require more pain and sedative (“calming”) medications. Recovery time after intensive treatments is often long and difficult.

If a patient becomes suddenly ill, treatment options are:

Comfort Measures Only focuses on keeping the patient comfortable by treating pain and symptoms. The patient chooses not to start treatments that attempt to *cure* new, serious medical problems because they do not want to prolong life. The patient may choose treatment when the goal is to decrease pain and discomfort; for example, taking antibiotics for a bladder infection in order to relieve discomfort.

Limited Additional Interventions includes transfer to the hospital for care if necessary. The patient chooses not to use ventilators (life support, forced breathing machines.) The patient who chooses this option also will usually choose not to have major surgery or treatments that involve significant pain, or heavy sedation, or long and difficult recovery times.

Full Treatment includes aggressive treatment using all medical treatment options if needed. The patient who chooses the “Attempt Resuscitation/CPR” option above will receive Full Treatment. The patient can express their wish to

stop these treatments if the doctor believes that the patient is not going to make a good recovery, and the treatments are just keeping them alive. We can write “Full treatment for trial period” under Additional Orders.

Some patients will think, “If I end up in ICU on life support, I know that it will be a tough fight, but I do think my body will be strong enough to get through. It may be a long recovery, but I’m ready to face it, and I want to try”

Others may be thinking, “It’s not a guarantee that life support treatment will work, and if it does, it still sounds like I will be weaker than I am, sicker, and needing help for a long time, and I don’t want to be that way. You can treat me in the hospital, but don’t put me on life support.”

Patients may also feel, “My body is really tired. Next time I get sick, even a little bit, I don’t want to be treated, even if it something that you think I would be able to get better from. Make sure I’m comfortable – that’s what I really want.”

SECTION C

Artificially Administered Nutrition is about situations (such as brain damage from a stroke or severe dementia) in which a patient cannot speak for themselves and cannot swallow food and is not expected to recover, or may take months to recover.

Food is always offered for comfort and enjoyment. Or the patient may be fed through a tube. Careful feeding by hand can be just as effective and some believe the human touch is better. There is very little evidence that artificial feeding by tube is helpful for people who are ill because of very advanced dementia. Artificial tube feeding does not prevent pneumonia. Feeding tubes can cause pneumonia, swelling and infections. Artificial tube feedings can be helpful in some very specific situations, such as cancer of the mouth or throat.

A patient may say “That’s no quality of life...No feeding tubes!”

Another patient may think, “My beliefs are that if there is a medical means to keep my body alive, then I want to have those means used.”

Key Points:

- Talk with your family about your wishes
- Complete an Advance Health Care Directive to name your decisionmaker

Caring for the POLST Form:

- Keep POLST in an obvious place in your home, such as on the refrigerator or with your medicines
 - POLST and your Advance Health Care Directive can be kept together in a plastic cover
- Take POLST with you to the hospital
 - EMS (emergency medical service team) will take POLST with you during ambulance transfers between home or skilled nursing facility and the hospital
- Take POLST with you when you leave the hospital