

Advance Care Planning (ACP) in Long-Term Care Facilities: Best Practice

1. **Introduction:** Individuals who require care in a long-term care facility (LTCF) have significant health changes that mandate advanced medical, nursing and care needs. Some of these health changes are transient and may improve. Many more individuals have chronic irreversible changes due to disease or injury. On average, the life expectancy for all LTCF residents at admission is about 2 years. While the goal is improvement or stabilization, it is more common to see decline and end-of-life changes in these frail individuals.

2. **Resident Goals of Care**
 - a. Many individuals have strong opinions and preferences about their medical care, where it is provided, and what they find acceptable at the end of life. These choices may be influenced by prior experience, theological beliefs, family input or other unique factors. Regardless of the source, these choices must be welcomed, understood, documented and honored for patient choice and autonomy.
 - b. Discussions about these choices are best done during times of health stability when the individual is able to participate and express care wishes. Decisions made during health crisis often cannot include the individual, or may be based more on emotions than rational recognition of health limitations, and can place great stress on decision-makers.
 - c. Therefore, **all LTCF residents** should have opportunity to: (based on decision-making capacity)
 - i. Discuss and understand their current health condition and prognosis
 - ii. Review or complete an advance directive, including a living will and/or healthcare power of attorney (if they retain decision-making capacity)
 - iii. Express their wishes and choices for future medical care during acute medical crisis, sub-acute medical change, and routine care.
 - iv. Document these choices and have them interpreted into medical orders that guide future care. If the individual wishes to limit future treatments, the Pennsylvania Orders for Life-sustained Treatment (POLST) document is a widely used tool to translate the individual's health care choices into practical medical orders.
 - v. Change their prior medical choices at any time, based on the current circumstances or change in perspective.

3. **Advance Care Planning (ACP):** ACP is the process by which individuals make and share decisions that guide their future health care, if they become unable to speak for themselves. Advance care planning documents are where these decisions are documented, in case the individual cannot participate in future decision-making.

4. Advance Care Planning documents

| | <u>Details:</u> | <u>Appropriate for:</u> |
|---|---|--|
| Healthcare Power of Attorney (HCPOA) | <ul style="list-style-type: none"> • A person appointed by another to serve as the individual's agent and to make health care decisions. Usually used only when the individual is unable to make decisions. • An individual may allow the designated HCPOA to make decisions at any time by informing the healthcare practitioner. This decision should be recorded in the medical record. | All LTC residents |
| Living will | <ul style="list-style-type: none"> • A statement of an individual's personal choices regarding life-sustaining treatment and other end-of-life care. • The living will becomes effective when the individual has an end stage medical condition, and is permanently unconscious or loses decision-making capacity. • The living will is NOT a medical order. | All LTC residents |
| POLST | <ul style="list-style-type: none"> • POLST is a translation of the individual's wishes for specific care into medical orders. It complements the living will, putting choices into actionable medical orders. • When future medical decisions are needed, it serves as a guide for discussion with an individual with intact decision-making. When decision-making capacity has been lost, it is a directive for the HCPOA or representative and healthcare team. | Medically frail individuals near end of life who wish to guide future medical treatments |

5. **Medical decision-maker:** If no agent is appointed as HCPOA by the individual, Pennsylvania law allows others to serve as a medical decision maker. Such a person is known as a health care representative and is often referred to as a surrogate decision-maker. Priority designation for designation of HCPOA is given in this order:

- a. Current spouse and adult child (of individual & another relationship)
- b. Adult child (of individual and current spouse)
- c. Parent
- d. Adult sibling
- e. Adult grandchild
- f. An adult who has knowledge of the individual's preferences and values

Per PA Act 169: <http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2006&sessInd=0&act=169>

6. Pennsylvania Orders for Life-Sustaining Treatment (POLST)

- a. **POLST appropriateness:** POLST discussions may be appropriate for:
 - i. Individuals who have advanced chronic progressive illness and/or frailty.
 - ii. Persons with acute medical illness that is likely irreversible, or associated with high burden of curative medical care.
 - iii. Individuals for whom medical providers would not be surprised if they were to die or lose decision-making capacity within 1-2 years.
- b. POLST completion is appropriate for the above individuals who choose to complete a POLST document.
- c. POLST is completed only after a discussion with the individual about current health conditions and treatment choices based on this understanding. If an individual is unable to participate, the discussion can occur with the HCPOA/representative. The POLST form serves only to document the discussion and choices, and should not be completed without this discussion.
- d. Physicians, physician assistants and CRNPs may facilitate the POLST conversation. Other disciplines, typically a nurse or social worker, may also engage residents in the POLST discussion.
- e. Once signed by a physician/nurse practitioner/physician assistant, and the individual (or HCPOA/representative when appropriate), the POLST becomes a medical order that follows the individual across care settings (i.e., LTC to emergency room to hospital to LTC).
- f. Completion of a POLST is always voluntary. Healthcare team input and POLST discussions should not be innately for or against life prolonging treatment or palliative care. It is only a tool to enable discussion, decision-making, and documentation of individual treatment preferences.
 - g. Individuals are encouraged to add comments on the POLST form to clarify POLST choices, declare goals of care, and establish unique wishes.

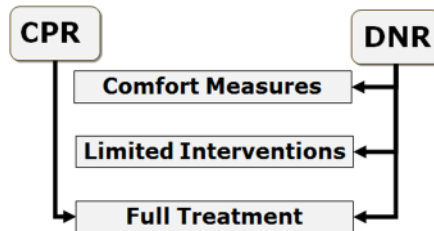
7. POLST clarifications

- a. If **“DNR”** is chosen in POLST section A:
 - i. This means that in a situation of cardiac arrest, with no pulse or breathing, the individual does not want resuscitation.
 - ii. “DNR” does **NOT** automatically exclude defibrillation, ventilation, hospitalization, or interventional medical care. Some individuals may want hospitalization for some illnesses, defibrillation for tachycardia, or ventilation for respiratory failure.
 - iii. An individual who chooses “DNR” may choose any of the medical interventions in section B (see graphic below).

b. If “CPR” is chosen in POLST section A:

- i. Then “Full treatment” must be chosen in Section B (Explanation: if a person wants CPR, they must be willing to receive cardiac life support interventions, which usually include intubation and care in the ICU.)
- ii. The individual may electively designate whether this “full treatment” should be provided for a limited amount of time (i.e., for 5 days), continued without specified limit, or deferred to choice of POA/representative.



c. Summary of medical interventions appropriate for both CPR and DNR choices:



8. Decision-making capacity (DMC) of the individual must be considered during the POLST discussion. The individual must show ability to reason, understand their health condition and choices, appreciate the implications of disease and choices, and then choose and communicate their wishes. These components must be present for full medical decision-making. The decision-making capacity assessment determines how the ACP discussion can occur and who should be included:

| If DMC assessment is: | Then the discussion process is: |
|------------------------------------|--|
| Full decision-making capacity → | Talk with individual. Engage HCPOA/representative if patient chooses |
| Limited decision-making capacity → | Discuss with individual & HCPOA/representative |
| No decision-making capacity → | Talk with HCPOA/representative |

POLST Do's & Don'ts

|  It is NOT appropriate to : |  It is appropriate to: |
|---|--|
| <u>Require</u> any individual to complete a POLST | Okay to <u>suggest and assist</u> |
| Establish a facility policy to <u>require</u> POLST completion for all residents | Okay to <u>offer</u> to all appropriate residents |
| <u>Incentivize</u> medical providers based on POLST completion or counting | Okay to incentivize advance care planning <u>discussions</u> and documentation |
| <u>Confuse</u> “cardiac arrest” with “respiratory arrest” in a patient with “DNR but FULL medical intervention” | Ventilation support may still be desired by the individual who is not in full cardiac arrest |
| <u>Assume</u> that a “DNR, comfort measures only” choice always means no hospitalization | Interventions for comfort are still appropriate. Examples: injuries like hip fracture, or lacerations |
| <u>Include</u> the POLST form in the LTC admission packet (conveys that it is just a paper completion formality). | Okay to provide introductions to the topic and subsequent conversations – brochures, videos like “POLST: When is the right time” or “Understanding POLST” |
| Discuss and complete a POLST document <u>only</u> with the HCPOA/representative of an individual who has <u>full</u> decision-making capacity | The HCPOA/representative may be included, with the permission of the resident. |
| Discuss and complete a POLST document <u>only</u> with an individual with <u>limited or no</u> decision-making capacity | Discuss if possible with the resident but confirm choices with HCPOA/representative |
| <u>Assume</u> that an individual with advanced or irreversible or terminal illness will choose a “DNR” status | Okay to inquire about their understanding of their illnesses, the ability to improve, and the likely benefit of medical intervention |
| <u>Assume</u> that POLST choices will stay the same | POLST is a guide based on decisions at a particular point. When time and medical circumstances allow, it should always be <u>confirmed</u> during subsequent medical changes |



9. Guidelines for use of POLST during LTCF stay:

New admission

- Information can be included in admission packet about upcoming ACP & POLST discussions – see drafted sample
- Medical provider or staff (per facility policy) discuss health status, advance care planning and POLST (if appropriate) with resident
- Inquire about previously completed advance directives. Review or request a copy for the LTC record. Inquire if choices are current. If there is no up-to-date LW and/or HCPOA, encourage and provide information for a new advance directive (if capable).
- Inquire about previously completed POLST documentation, and review prior wishes.
- If POLST is appropriate and desired by resident, it is completed based on discussion with resident, and signed by medical provider. When appropriate, completion of the POLST is encouraged during the initial visit or early during the admission.
- If the resident has limited or no decision-making capacity, the HCPOA/representative must participate in completing the POLST. If the HCPOA/representative is available only by phone, the POLST can still be completed by documenting the details of the phone call, date and name of the person giving verbal approval. The HCPOA/representative is requested to sign the POLST at their next visit.
- The POLST document should be located in a standardized and readily available location in the medical record
- Based on discussion and POLST, a medical order is entered on the chart. This should include some details and a date. It is preferred to use medical orders such as:
 - DNR for cardiac arrest, per POLST (date) (do not resuscitate)
 - DNH, per POLST (date) (do not hospitalize)
 - DNR/DNI, per POLST (date) (DNR, do not intubate)
 - DNR/Intubation ok, per POLST (date)
 - Full code & medical intervention, not POLST appropriate, per discussion (date)
- Avoid the use of the medical order of “no code”, due to the confusion over the meaning of “code”
- Recommended: enter an ACP entry in resident’s problem list in EHR or paper chart. A sample entry may include all of the following:
 - DNR, limited additional medical treatment, IVFs but no feeding tube, would accept antibiotics for comfort – per POLST 8/1/2018
 - Living will (10/1/2017) = no life prolonging measures in terminal setting
 - Healthcare POA (10/1/2017) = Sally Doe (daughter), then Peter Doe (son)

Acute medical change

- In addition to medical assessment, the medical provider and/or nursing staff should review previous ACP wishes and POLST choices during an acute medical change.
- If a serious life-or-death situation requires an immediate decision, the resident does not have decision-making capacity and the HCPOA/representative is not available --then follow current POLST wishes.
- In all other circumstances, the situation and options should be discussed with resident and/or HCPOA/representative (when appropriate).
- An alert and oriented resident with acute change should be offered all treatment decisions, using the POLST as a guideline:

“You appear to have a pneumonia that is not responding to treatment. We can consider admitting you to the hospital for IV antibiotics, IV fluids, and perhaps even short term use of a breathing machine. You previously said on your POLST that you did not want to go to the hospital or ever consider a breathing machine. What are your wishes now, based on your current illness?”
- The POLST should be used as a guideline for discussion with HCPOA/representative of an individual who has impaired decision-making capacity:

“Your mother is very ill. We are not sure if she can recover from this serious illness. It is possible to send her to the hospital for treatment attempts, but she and you had previously indicated on the POLST that she never wanted to go to the hospital. We can provide comfort treatments here, even if she is declining.”
- Prior to contacting the medical provider about a medical change, nursing staff should review prior ACP choices and POLST selections, and include this in the presentation to the provider:

“Mrs. Jones has lost all movement of left arm and leg, and is now unresponsive without signs of pain. Her POLST indicates DNR status, and a wish for comfort measures only. I have updated her HCPOA/representative who confirms these wishes.”

Stable or new chronic condition

- The POLST should be reviewed and confirmed with resident and/or POA following:
 - **Major medical change** (stroke, dementia dx, cancer dx, etc) – a change in condition should prompt a discussion to determine if the preferences of the individual have changed and if so, a new form should be completed and signed.
 - **Admission or readmission to facility**
 - **Annually** (if not done in past year) – facility policy should outline methodology for completing this. The discussion and review can be done by social work or other staff members.
- If there are no changes in the POLST, the form should be signed & dated by the reviewer (or the LTCF have a protocol for documenting the review)
- If there are changes in the previous POLST choices, a new form should be completed. The medical provider is required to review, date and sign the updated form.

Discharge to home or different level of health care

- Situation of improving health – if an individual had completed a POLST during a serious illness and subsequently significantly improves, to the point of discharging to home or a lower level of health care, they may no longer be appropriate for a POLST form (see 6a above). A discussion should occur with the resident about their condition and wishes. If their wishes have changed, the current POLST form should be voided (see 10 below).
- If the individual remains appropriate for a POLST form and they do not wish to change it, LTC staff must assure that the POLST form (or a pink copy on cardstock) accompanies the resident across the care settings.

10. Voiding a POLST form

- a. On the POLST form, a line should be drawn across sections A through E of the no longer valid form and “Void” should be written in large letters across the form. It should be signed and dated. Any associated orders in the medical record or entries in the individual’s problem list related to the voided POLST form should be deleted.
- b. The voided form should be kept as part of the archived medical record
- c. If the POLST has been digitally scanned, the EMR should allow the scanned document to be marked “void”, but not deleted.

11. Facility policy & procedure

- a. Establish a policy consistent with facility culture, practice and intended use
 - i. See “Model Policies Introduction” - <https://www.upmc.com/-/media/upmc/services/aginginstitute/partnerships-and-collaborations/documents/polst-model-policies.pdf>
 - ii. See “Recommended Policy Elements” - <https://www.upmc.com/-/media/upmc/services/aginginstitute/partnerships-and-collaborations/documents/polst-recommended-policy-elements.pdf>
 - iii. See PA POLST library in UPMC Institute of Aging site <https://www.upmc.com/services/aginginstitute/partnerships-and-collaborations/polst>
- b. LTC staff competency training
 - a. The LTC facility needs to assure that all staff that facilitate POLST discussions are trained and able to demonstrate the skill and knowledgeable required for the conversation.
 - b. Nursing staff should be educated in understanding the implications of POLST choices, using the document appropriately, and ethically guiding individuals and HCPOA/surrogates about options during acute and chronic illness.

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