

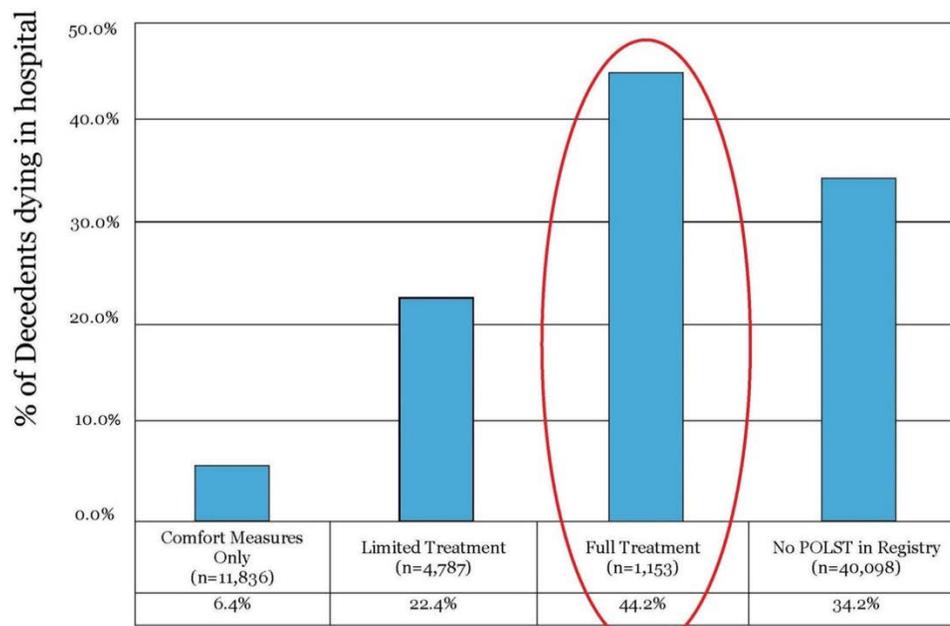
Oregon POLST Task Force Recommendation for Patient Transfer Forms

Is it possible that by completing orders for full treatment on those who are “too healthy” to have a POLST form that we ultimately increase their rate of in hospital death?

In a study of those who died in Oregon in 2010 and 2011, those with POLST orders for comfort measures only had a very low rate of death in the hospital (6.4%). According to Fromme et al. (2014), “The association with numbers of deaths in the hospital suggests the end-of-life preferences of people who wish to avoid hospitalization as documented in POLST orders are honored.”

Furthermore, those with orders for full treatment were more likely to die in the hospital than those with no POLST form in the Oregon POLST Registry.

Patient’s preferences recorded as medical orders on a POLST Form and how those orders match with death in the hospital



JAGS: Fromme et al 2014 62: 1246-1251

The Oregon POLST Task Force (OPTF) recommends integrating a standard code status section on hospital transfer forms as a way of improving Physicians Orders for Life-Sustaining Treatment (POLST) Form completion, which ultimately improves the appropriate use of POLST forms.

In order to meet the needs across the continuum of care, we focused on two issues:

- Facilities need to record code status
- Healthy patients should not be required to complete POLST forms to address facility need for code status documentation

The OPTF recommends the following language be included on hospital transfer forms:

Code Status
<input type="checkbox"/> Full Code (No POLST needed)
<input type="checkbox"/> No Code (Complete POLST form as applicable, NOT required)

The stories of Ethel and Ralph are available to help educate health professionals on when a POLST form should and should not be offered, see page 2.

When a POLST Form Should and Should Not Be Offered

When POLST should have been offered at discharge

At 84 years old, Ethel Weiss* lived independently but was having increasing difficulty living alone. She was short of breath with activity, weaker and falling at times. Several months prior to surgery Ethel sustained a small stroke. After much consideration and at the suggestion of her cardiologist, she underwent a recommended aortic valve replacement surgery. She hoped to improve her quality of life and ability to continue to engage in activities she enjoyed – having lunch with friends and spending time with family and new grandbabies.

After surgery, Mrs. Weiss told her family, “If I had known it would be this hard, I wouldn’t have had the surgery.” Her recovery was slow. At eight days post-surgery she was discharged to a rehab facility. It was a late Saturday morning when Mrs. Weiss arrived at the skilled nursing facility (SNF). She had a cardiac arrest 30 minutes after her arrival to the SNF. 911 was called and CPR was initiated. On the floor, in the middle of the hall at the SNF, EMTs tried to resuscitate Ethel. The code was in process as she was transferred back to the same hospital from which she had just been discharged. In the emergency department, medical personnel continued to try to resuscitate Ethel until family said she wouldn’t want the resuscitation. Upon confirming surrogate authority on her advance directive, the doctor immediately stopped CPR.

In retrospect her family wondered why no Physicians Orders for Life-Sustaining Treatment (POLST) was completed upon Ethel’s discharge from the hospital.

When POLST should not have been offered at discharge

Ralph Jacobson*, a healthy 76 year old male, was referred for short term care following a right total knee replacement for inpatient OT/PT rehab for 2 weeks. Mr. Jacobson is admitted to a rehab facility on the evening shift. His daughter-in-law, “Sarah” (a health care professional who was very knowledgeable about POLST) was present to provide support and help navigate the health care system. Sarah reports the following story: This was an unexpected admission as the pre-op plan was to return home and have immediate outpatient OT/PT at a location close to her parents’ home and the appointments were already established (his wife is able to assist) and the patient and family weren’t informed about the orthopedist’s recommendation for inpatient rehab until the day before discharge.

Sarah reports that shortly after arrival at Windy Oaks Rehab the evening nursing administrator gave her a POLST form to complete. Sarah asked if it was meant for her father-in-law, as she felt he did not fit the medical requirements to be offered POLST orders and was concerned that his physician was not present and had not had a conversation with him. Sarah was told in order to stay at Windy Oaks Rehab facility that Mr. Jacobson had to have a POLST form on record, regardless of his current advanced directive (but also asked that his wife bring in a copy). The administrator commented that the facility medical director would be in the next morning and he needed to have the completed POLST form available. Sarah reviewed the POLST with her father-in-law and identified his desires for CPR and Full Treatment the evening of admission and the SW/case manager required that he sign it.