

# Nevada POLST Post

## Spring 2018



### **POLST Webinars - Schedule Online**

As announced in our last issue, Nevada POLST is now offering Webinar training. There are two versions of training. The Overview training (1.5 hrs), covers the full Nevada POLST Program. The Update training (1 hr) focuses on the 2017 legislative changes to the program and the Nevada POLST form.

We offer nursing and social work CEU credits for both courses. We have had several requests for physician and administrator continuing education credits, but unfortunately, the fees required of Nevada POLST to provide such credits are prohibitive for Nevada POLST.

Evaluation comments indicate that participants have found the training helpful:

"I'll share this information with our providers to be sure the POLST forms are completed correctly."

"I found the step-by-step completion information very helpful."

"The suggestions for starting the POLST conversation . . . great!"

"The material was valuable for people with experience as well as for those who have not had much training."

"I will use the information on a regular basis."

"It was helpful to know who can and cannot change a POLST."

May training dates are available now on our [website](#) with each month's webinars posted by the 15th of the preceding month. Should you have any questions regarding our courses or credit, please contact [Sally Hardwick](#).

### **New Reno POLST Pick-Up Location**

For those in the Reno area who would rather pick up their POLST forms avoiding shipping charges, please note the new location:

*Dini Townsend Hospital, 480 Galletti Way, Building D, Sparks, NV 89431*

Use the main entrance to Dini Townsend and go to the front

### **Helping Patients Find Their Voice**

*The following is an excerpt from "The Power of Words: The Importance of Defining and Documenting Goals in Patient-Centered Care" - The California State University Institute for Palliative Care and Care Excellence: Case Management Education. The entire e-book can be found [here](#).*

Many patients will not easily be able to articulate who they are, exactly what they need, and the specific steps that will help them achieve these goals.

Asking directly for what one needs is a difficult task that many people feel uncomfortable doing, particularly in health care. Patients are typically put into a submissive position in a hierarchical system where they are expected to "follow the doctor's orders" instead of speaking up for themselves. Additionally, patients' symptoms and existential distress may impede their ability to focus on what they need.

For these reasons, the expertise and experience of a transdisciplinary care team becomes critically important to guiding these discussions.

Various team members can help patients and families navigate their choices based on their experience helping other patients.

Clinicians can draw from their knowledge and experience to help patients and families define what is possible given the specific disease trajectory, symptoms, insurance constraints and intricacies of the medical system.

The palliative team may need to give patients and families suggestions, or "fill in the links" as patients try to articulate their needs. Team members must be careful to avoid coloring the patients' choices with their own values in a paternalistic manner.

Although it can be hard to articulate, most people know what is important to them and what gives their life meaning, purpose and joy. Many times, it just takes the guidance and focused attention of palliative care clinicians to help patients voice who they are and what really matters.

### **Empower People with Their Own Goals**

Completing the [Who-What tool](#) (click the link to be taken to this very valuable, easy tool) helps patients and families anchor their health care choices to what is important to them as individuals.

Establishing goals can empower patients with a sense of control and personal satisfaction during a time when their illness often makes life feel out of control. Setting goals also helps patients maintain their hope and motivation by pushing them forward and keeping themselves at the center of every decision.

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### **POLST Resources**

The Nevada POLST website offers many helpful tools for health care providers and their patients. In this issue we feature some videos. Videos often are easier for patients to watch and understand than are printed materials. You might suggest the following videos to your patients or their loved ones:

[What is a Living Will or Advance Directive](#) - It explains why a POLST is necessary to avoid resuscitation outside of a hospital.

[What is a Health Care Power of Attorney](#)

[What is a Do-Not-Resuscitate or DNR Order](#)

desk. Health Services campus; use the main entrance to Dini Townsend and go to the front desk.

Be sure to [place your order online](#) first, to assure your forms are available and ready when you arrive.

## Helping Patients Find Their Voice (cont. from pg. 1)

As patients move along the disease trajectory and experience physical and functional changes, their goals may also change. Specific treatments or settings of care that they were hoping for might no longer be feasible given new constraints with who they are.

Changes in goals are completely acceptable - we can never forget that human beings are at the center of any illness. As long as the patient is keeping themselves at the center of their decisions, it should be celebrated that the patient is a human being who is inherently complex and capable of growth and change.

Just because a person has a serious illness, does not mean that they stop learning and changing. In fact, many times it is the experience of the illness itself that pushes people to grow and evolve into a stronger individual with a truer sense of self and priorities than they were before they got sick.

### Conclusion

Discussing and documenting patients' goals of care is one of the most powerful ways that clinicians can empower patients to control the circumstances of their life...and their death.

By using the [Who I Am and What I Need tool](#), clinicians can move advance care planning conversations beyond the traditional work of completing Advance Directives, to helping patients define who they are and what goals and values will guide their care.

Focusing on who patients really are, and what they need, reminds us that palliative care is a privilege and a calling...to work with people who are infinitely more than a set of symptoms or a disease.

For more information about the sponsoring organizations of the e-book from which this was excerpted, refer to [The California State University Institute for Palliative Care](#) and [Care Excellence - Case Management Education](#).

## Avoiding Objections to Following POLST Orders

Nevada POLST has received several calls and questions regarding how to handle family who are objecting to providers following Nevada POLST orders. There are several ways to address this challenge.

### Legal Considerations

First, remember that the POLST is not only a medical order, but is supported by Nevada statute. As such, NRS 449.694.5 states, "The Board shall prescribe a ... POLST form, which...is intended to be honored by any provider of health care who treats the patient in any health-care setting, including, without limitation, the patient's residence, a health care facility or the scene of a medical emergency."

Furthermore, NRS 449.695.1 states that "a provider of health care shall comply with a valid Provider Order for Life-Sustaining Treatment form, regardless of whether the provider of health care is employed by a health care facility or other entity affiliated with the physician, physician assistant or advanced practice registered nurse who executed the POLST form."

Secondly, there are specific people who are legally allowed to revoke or change the POLST of another person. *Only* the patient's Durable Power of Attorney for Healthcare (DPOA-HC) as established by an Advance Directive or a legally designated guardian, may change the POLST of a patient who now lacks decisional capacity. If a patient completed a POLST and a family member or other person wants to over-ride the orders of a POLST, but that person is not legally designated as their DPOA-HC or legal guardian, then a health care provider legally must follow the current orders of a POLST unless they have reason to believe the POLST is illegitimate.

Third, National POLST has informed us that they are aware of 5 lawsuits nationally involving POLST programs. Every one of them was for wrongful life...failing to follow POLST orders for Comfort Measures, or in Nevada's current language, Comfort-Focused Treatment.

### An Informed Consent Process

Unlike an Advance Directive that may have been completed by a patient themselves or with their attorney, a POLST form is completed with a health care professional during a conversation that explains what each of the choices mean and their implications for that specific patient. Patients have an opportunity to ask questions and discuss their choices. It provides an informed consent from the patient.

### How to Handle an Objection

Many of these encounters can be avoided by not questioning the POLST itself. There have been several reports of providers making comments such as, "We have a POLST for [your loved one], would you like me to follow it?" Remember, this is a medical order supported by Nevada statute. In addition, one of the purposes and proven benefits of documents such as Advance Directives and POLST forms is to relieve family of making a difficult decision for their loved one, and avoiding the certain guilt of that decision. It is not appropriate to ask permission to follow a patient's POLST order.

A better approach is to state, "We have a document that states what [your loved one] would like at this point, so I will be following his/her wishes." Such a matter-of-fact approach usually curtails any objection.

However, if there is still an objection, allow the patient's loved one(s) to express their anguish, but keep calm and explain the process of completing a POLST. That the patient had decisional capacity, that the options were explained to them in terms of the patient's specific health status and what each option would mean for that patient. Then, what we suggest is to ask, "This may have been one of the last decisions your loved one was able to make, are you comfortable over-riding their wishes?" In our experience, the person objecting accepts the process and the objection is eliminated.

Nevada POLST is still a relatively new program, but as we all become more familiar with it and experience its benefits, we can expect fewer such challenges.

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