Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION
Olympia, Washington

TITLE: POLST AND PALLIATIVE CARE FOR RESIDENTS OF RHCs — POLICY 17.01

Authority:

RCW 7.70.065	*Informed Consent - Persons Authorized to Provide for Patients who are not Competent - Priority*
RCW 11.92.043(5)	*Guardianship - Powers and Duties of Guardian or Limited Guardian - Additional Duties*
Chapter 70.122 RCW	*Natural Death Act*
RCW 71A.20.050	*Superintendents - Secretary's Custody of Residents*
42 CFR Part 418	*Hospice Care*
RCW 70.126.030	*Hospice Care - Provider, Plan, Services Included*
WAC 246-335-015	*In-Home Services Agencies - Definitions*
WAC 246-335-020	*In-Home Services Agencies - License Required*
WAC 246-335-085	*Hospice Plan of Care*
WAC 182-551-1000 through 1330	*Alternatives to Hospital Services*
In re Grant, 109 Wn.2d 545, (1987)	
Patient Self-Determination Act (OBRA 1990, P.L. 101-508)	

PURPOSE

This policy establishes principles and procedures for clients who are appropriate for palliative care or physician orders for life-sustaining treatment (POLST) status while residing in a Residential Habilitation Center (RHC) operated by the Developmental Disabilities Administration (DDA).

SCOPE

This policy applies to all staff working at the RHCs.

DEFINITIONS

Cardiopulmonary resuscitation (CPR) means the process of keeping the heart pumping and the blood oxygenated through external means, including chest compressions, electric shock, and artificial breathing, whether performed by a layperson or emergency medical personnel.

DNR/DNAR means "do not resuscitate" or "do not attempt resuscitation (allow natural death)". This is the same as no CPR.

Guardian means someone appointed by a judge in a legal proceeding to make health care decisions for another person who is incapable of making their own decisions or who cannot do so responsibly per RCW 7.70.065.

Hospice care or hospice program means items and services provided to a terminally ill individual, generally in the individual's place of residence, by or under the direction of a hospice agency. It is "a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care" per 42 CFR §418.3. Hospice care is palliative rather than curative.

Hospice agency means an organization licensed as a hospice agency by the Department of Health and approved as a "Medicaid-approved hospice agency" by the Health Care Authority. Hospice services are provided by a licensed provider other than the RHC.

Hospice plan of care means the written document created by a hospice agency describing the assessment of an individual's needs and the services required to meet those needs. The hospice plan of care should include all the elements listed in WAC 246.335.085.

Incurable and irreversible condition means an illness or disease that, based on reasonable medical judgment, will soon cause death or for which the application of CPR, intubation, or other life sustaining measures will only prolong the process of dying or will create a greater risk of death than the condition itself.

Informed consent means consent given by a person to receive treatment with an understanding of the risks and benefits involved. An individual who can understand the risks and benefits of treatment can provide informed consent for his or her own treatment. If a person is not competent to give informed consent for health care that person's guardian and/or other persons as defined in RCW 7.70.065 may provide informed consent on the person's behalf.

Interdisciplinary team (IDT) means the group of individuals that represents the professions, disciplines or services that are relevant to identifying a client's needs and designing programs to meet those needs. See 42 CFR 483.440(c). The IDT also includes the client/guardian or family members, and may include professionals from outside the RHC. The IDT may go by different names depending on the facility.

Medical provider means a medical doctor (M.D.) licensed under Chapter 18.71 RCW or a doctor of osteopathy (D.O.) licensed under chapter 18.57 RCW in the State of Washington. For the purposes of this policy, this term also includes Physician Assistants-Certified (PACs) and Advanced Registered Nurse Practitioners (ARNPs).

Palliative care means "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice" per 42 CFR §418.3.

Palliative Care Plan means the care plan developed by the IDT to carry out all elements described in this policy as they relate to providing services for the client residing in an RHC.

Physician Orders for Life Sustaining Treatment (POLST) means a legal document that specifies the type of care a person would like in an emergency situation. The goal of a POLST is to effectively communicate the wishes of seriously ill patients to limit life-sustaining medical treatment.

POLST/Palliative Care verification form/checklist is a checklist signed by the IDT to verify all elements of discussion are completed and sent to the guardian and available family members. It is not THE POLST, nor do all IDT members or family members sign the POLST.

POLICY

A. Persons living in RHCs must receive routine and emergency health services and other rehabilitative services appropriate to their needs and consistent with the expressed preferences of each person, or their legal guardian if the person has one.

B. To protect a person's legal rights and ensure that person participates in decision making regarding medical care and treatment, the RHCs must provide written information to adult clients and guardians at the time of admission and at other appropriate times concerning a person's legal right to participate in decisions regarding their medical care, including the right to accept or refuse medical or surgical treatment.

C. When an RHC resident develops an incurable and irreversible condition that significantly impacts the resident's quality of life, the facility must discuss end-of-life choices with the resident, guardian, and family. In particular, the facility must discuss the concepts and availability of palliative care, hospice services, and POLSTs. These discussions may involve RHC staff and external providers (such as a resident's personal medical provider), depending on the issue, but these discussions and the identity of the participants must be properly documented in the resident's records.

D. An RHC resident who has an incurable and irreversible condition may benefit from palliative care provided by the RHC or by a licensed hospice agency provided in coordination with the RHC plan of care. See W120 (42 CFR §483.410(d)(3); F500 42 CFR §483.75(h)). The choice to receive services from a licensed hospice agency is entirely the option of the resident or an individual authorized under RCW 7.70.065 to provide informed consent on the client's behalf if one has been appointed. If the resident or an individual authorized under RCW 7.70.065 to provide informed consent on the

client's behalf so chooses, the resident may also be discharged to and reside at a hospice facility with care provided entirely by the outside provider.

E. When a resident of an RHC has an incurable and irreversible condition, a completed POLST for that resident must be honored by all staff of an RHC.

PROCEDURES:

A. **Identifying the Need for a POLST**

When a client, or an individual authorized under RCW 7.70.065 to provide informed consent on the client's behalf, requests a POLST, the following steps must be taken:

1. Two medical providers must confirm that the client has an incurable and irreversible condition. One of the medical providers must be a RHC employee or contractor and the other must not be directly employed by or contracted with the RHC.

2. The client, guardian, or an individual authorized under RCW 7.70.065 to provide informed consent on the client's behalf completes Parts A and B (and D if appropriate) of the Washington State Medical Association POLST form with the Medical Provider, indicating whether CPR or other medical interventions should be performed in the event the client has no pulse or stops breathing. If the DNAR box on the form is checked, the form needs to be accompanied by a letter or progress note from the non-state physician stating that CPR would not be beneficial to the client and should not be performed under any circumstances.

3. An IDT meeting is convened to discuss the POLST and ensure the client's rights are protected. The IDT should include the client (if able), guardian, family, RHC medical staff or Primary Care Provider (PCP), any outside medical providers (if he or she has one), and hospice representative (if there is one).

4. All required information must be included on the form. That information is recorded on DSHS 13-909, *POLST and Palliative Care Verification* form, by the Habilitation Program Administrator (HPA), Case Manager Registered Nurse (CM/RN) or Patient Care Coordinator (PCC). This link is available on the DSHS DDA intranet website only.

5. The completed DSHS 13-909, *POLST and Palliative Care Verification* form, and supporting documentation is sent to the DDA Assistant Secretary or designee for final approval and a Prior Approval request is entered into CARE. In the event that the DDA Assistant Secretary or designee does not approve the POLST as written, a meeting will be scheduled by the DDA Assistant Secretary or designee with the relevant attendees of the IDT meeting to clarify and resolve concerns.

6. After the DDA Assistant Secretary or designee has approved the POLST, the POLST form and supporting documents are placed in the client's chart. The POLST form must be at the very front of the chart.

7. All staff who work with the client must be informed of the POLST and trained on how to implement it.

8. A review of the POLST must occur at the annual plan of care meeting and whenever:

    a. The client has transferred from one care setting or care level to another;

    b. There is substantial change in the client's health status; or

    c. The client's treatment preferences change.

9. The client or an individual authorized under RCW 7.70.065 to provide informed consent on the client's behalf may cancel the POLST at any time either verbally or in writing. Changes to the POLST plan or form (other than minor clerical edits) require repetition of steps 3. through 7. above.

10. Responsibility for ensuring that the POLST is properly implemented is as follows:

    a. Client's PCP or designee:

        1) Obtains appropriate medical consultations and presents relevant medical data (including diagnosis and results of consultations) to the client or an individual authorized under RCW 7.70.065 to provide informed consent on the client's behalf and the IDT;

        2) Participates in the IDT meetings and ensures the client and guardian/family are fully informed;

        3) Carries out the POLST and maintains appropriate orders and documentation; and

        4) Updates the client, or an individual authorized under RCW 7.70.065 to provide informed consent on the client's behalf and IDT regarding any significant changes that affect the POLST.

    b. HPA, CM/RN or PCC

        1) Coordinates guardian/family contacts and convenes meetings;

2) Completes DSHS 13-909, *POLST and Palliative Care Verification* form, updates the IHP and changes to care plans; and

3) Ensures proper notification of affected parties and ensures that required approvals are timely obtained.

c. Nursing and Attendant Counselor Manager.

1) Ensures training of direct care staff and other nursing staff of the POLST and how to follow it.

2) Alerts the PCP of any changes in the client that may affect the POLST.

11. For all other requests to withhold CPR (such as CPR being contraindicated for a person with severe brittle bones), the facility submits an Exception to Policy (ETP) request for approval.

12. The facility submits the POLST request via a Prior Approval in CARE to the Central Office Residential Habilitation Center (RHC) Program Manager for review and to obtain approval from the Deputy Assistant Secretary or designee.

13. The Administration recognizes the urgency of responding to requests to withhold CPR. Once all documentation is submitted by the RHC to the Central Office RHC Program Manager, the Administration will make every effort to process this request in the shortest possible timeframe, not to exceed two (2) working days upon receipt of all information required under this policy. This includes the required statement from the person's physician (per Procedures, Section A-2. of this policy).

B. Palliative Care

The level of care the client continues to receive will be adjusted based on the evolving needs and desires of the client, guardian, and the family. The IDT shall follow standard IHP procedures in updating the care plans as needed and required under current policies and procedures.

C. Hospice Care

If the client, or an individual authorized under RCW 7.70.065 to provide informed consent on the client's behalf, wish to engage hospice care by a licensed agency, the IDT will coordinate with that agency as described under Policy section "D" above.

EXCEPTION

None.

SUPERSESSION

DDA Policy 9.04
Issued November 30, 2004

Approved: */s/ Donald Clintsman* Date: October 15, 2016
Deputy Assistant Secretary
Developmental Disabilities Administration

Attachment A: Washington State Medical Association POLST Form 4/2014
Attachment B: DSHS 13-909, *POLST and Palliative Care Verification* form

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment

Last Name - First Name - Middle Initial

Date of Birth ___ ___ ___ Last 4 #SSN ___ ___ ___ ___ Gender M F

FIRST follow these orders, **THEN** contact physician, nurse practitioner or PA-C. The POLST form is always voluntary. The POLST is a set of medical orders intended to guide medical treatment based on a person's current medical condition and goals. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Medical Conditions/Patient Goals:

Agency Info/Sticker

A Check One — CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

☐ CPR/Attempt Resuscitation ☐ DNAR/Do Not Attempt Resuscitation (Allow Natural Death)

Choosing DNAR will include appropriate comfort measures and may still include the range of treatments below. When not in cardiopulmonary arrest, go to part B.

B Check One — MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no hospital transfer:** *EMS contact medical control to determine if transport indicated to provide adequate comfort.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). **Transfer** *to hospital if indicated. Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer** *to hospital if indicated. Includes intensive care.*

Additional Orders: (e.g. dialysis, etc.) _____

C SIGNATURES: The signatures below verify that these orders are consistent with the patient's medical condition, known preferences and best known information. If signed by a surrogate, the patient must be decisionally incapacitated and the person signing is the legal surrogate.

Discussed with:
☐ Patient ☐ Parent of Minor
☐ Guardian with Health Care Authority
☐ Spouse/Other as authorized by RCW 7.70.065
☐ Health Care Agent (DPOAHC)

PRINT — Physician/ARNP/PA-C Name | Phone Number

X Physician/ARNP/PA-C Signature ***(mandatory)*** | Date ***(mandatory)***

PRINT — Patient or Legal Surrogate Name | Phone Number

X Patient or Legal Surrogate Signature ***(mandatory)*** | Date ***(mandatory)***

Person has: ☐ Health Care Directive (living will) ☐ Durable Power of Attorney for Health Care

Encourage all advance care planning documents to accompany POLST

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Revised 4/2014

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

Washington State Medical Association WSMA — Physician Driven Patient Focused

Washington State Department of Health

See back of form for non-emergency preferences ▶

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Other Contact Information (Optional)

Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

D NON-EMERGENCY MEDICAL TREATMENT PREFERENCES

ANTIBIOTICS:

☐ No antibiotics. Use other measures to relieve symptoms. ☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal.

MEDICALLY ASSISTED NUTRITION:

Always offer food and liquids by mouth if feasible.

☐ Trial period of medically assisted nutrition by tube. (Goal: _____)
☐ No medically assisted nutrition by tube. ☐ Long-term medically assisted nutrition by tube.

ADDITIONAL ORDERS: (e.g. dialysis, blood products, implanted cardiac devices, etc. Attach additional orders if necessary.)

X Physician/ARNP/PA-C Signature	Date
X Patient or Legal Surrogate Signature	Date

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

Completing POLST

- The POLST is usually for persons with serious illness or frailty.
- Completing a POLST form is always voluntary.
- The POLST must be completed by a health care provider based on the patient's preferences and medical condition.
- POLST must be signed by a physician/ARNP/PA-C and patient, or their surrogate, to be valid. Verbal orders are acceptable with follow-up signature by physician/ARNP/PA-C in accordance with facility/community policy.

Using POLST

Any incomplete section of POLST implies full treatment for that section.

This POLST is valid in all care settings including hospitals until replaced by new physician's orders.

The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

The POLST does not replace an advance directive. An advance directive is encouraged for all competent adults regardless of their health status. An advance directive allows a person to document in detail his/her future health care instructions and/or name a surrogate decision maker to speak on his/her behalf. When available, all documents should be reviewed to ensure consistency, and the forms updated appropriately to resolve any conflicts.

SECTION A:
- No defibrillator should be used on a person who has chosen "Do Not Attempt Resuscitation."

SECTION B:
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

SECTION D:
- Oral fluids and nutrition must always be offered if medically feasible.

Reviewing POLST

This POLST should be reviewed periodically whenever:
(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

A competent adult, or the surrogate of a person who is not competent, can void the form and request alternative treatment.

To void this form, draw line through "Physician Orders" and write "VOID" in large letters. Any changes require a new POLST.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND ORIGINAL FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Photocopies and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST visit www.wsma.org/polst.

OVER ▶

Attachment B: POLST and Palliative Care Verification Form

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DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
PHYSICIAN'S ORDER FOR LIFE SUSTAINING TREATMENT

POLST and Palliative Care Verification

CLIENT NAME	BIRTHDATE
DSHS NUMBER	LIVING UNIT

RHC NAME
☐ Lakeland Village ☐ Yakima Valley School ☐ Fircrest School ☐ Rainier School

1. Fill in the dates in the second column as items A through J are completed. Attach copies of original documents: statements of need, requests, and endorsements.	
a. Guardian request for POLST (when appropriate)	DATE
b. Statement for Qualifying Condition to allow POLST from Primary Care Physician or designee	
c. Community physician statement for Qualifying Condition	
d. Legal guardian completed POLST	
e. IDT ad hoc for POLST	
f. Immediate family notification (if indicated)	
g. Superintendent endorsement for POLST	
h. DDA Assistant Secretary or designee approval	
i. Documents filed in chart	
j. Update face sheet, burial plans and staff in-servicing	

2. Record the names of members of the team.	**3. Signature of team member** **Date**
PHYSICIAN	
REGISTERED NURSE	
PSYCHOLOGIST	
GUARDIAN	
ATTENDANT COUNSELOR MANAGER	
HABILITATION PLAN ADMINISTRATOR	
OTHER	
OTHER	

POLST AND PALLIATIVE CARE VERIFICATION
DSHS 13-909 (10/2016)