Geriatric Nursing 36 (2015) 21–24

Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com

Feature Article

Nurses' knowledge and comfort levels using the Physician Orders for Life-sustaining Treatment (POLST) form in the progressive care unit

Nancy N.H. McGough, PhD, RN [a,*], Barbara Hauschildt, MSN, RN, NE [a], Deene Mollon, PhD(c), RN, NE-BC [a], Willa Fields, DNSc, RN, FHIMSS [a,b]

[a] 3 East Progressive Care Unit, Sharp Grossmont Hospital, 5555 Grossmont Center Drive, La Mesa, CA 91942, USA
[b] School of Nursing, San Diego State University, San Diego, CA, USA

ARTICLE INFO

Article history:
Received 19 May 2014
Received in revised form
1 September 2014
Accepted 8 September 2014
Available online 16 October 2014

Keywords:
POLST
Progressive care unit
End-of-life
Evidence-based practice

ABSTRACT

Many patients are admitted to the hospital with an active Physician Orders for Life-sustaining Treatment (POLST) Form; however, not all registered nurses (RNs) are familiar with the form or comfortable with initiating a discussion about end-of-life care. Evidence indicates that an education program increases RNs' knowledge and utilization of the POLST form. The purpose of this evidence-based practice project was to answer the question: among the RNs in a progressive care unit (PCU), does implementing a formal evidence-based practice POLST program compared to current practice increase RNs' knowledge and comfort level using the POLST form? A pre-post education survey was used. Results indicated a POLST education program increased PCU RNs' knowledge and comfort level in using the POLST form. It is recommended to include POLST form education for PCU RNs in workplace education programs.

Introduction

The majority of Americans say it is extremely important to be comfortable and pain free when approaching death.[1–3] Medicare beneficiaries received an average of 21 days of hospice care in the last 180 days of their life.[4] The majority of Americans prefer a natural death, in a familiar environment, with loved ones, and without interventions to prolong life or delay the dying process.[1–3] During the last 180 days of life, 15% of Medicare beneficiaries spent more than seven days in the intensive care unit where they received aggressive, life prolonging medical treatments. Approximately 42% of them saw more than ten physicians, suggesting intense medical interventions.[4] A discrepancy exists between end-of-life wishes and the actual care a patient receives.

There are multiple reasons explaining the gap between a patient's wishes and the care they received during their last six months of life. Factors such as race,[5,6] culture,[6] and age[7] affect the likelihood a patient's end-of-life treatments will be in accordance with their preferences. Barriers exist for discussions among health care providers, patients, and their families about end-of-life care. Barriers include time for health care providers to spend with a patient[8] and inadequate training for health care providers in end-of-life care discussions.[9] Even when these discussions occur, a patient's wish might not be documented or followed through by other health care providers in a different health care setting.[8,10] The Physician Orders for Life-sustaining Treatment (POLST) form complements an advanced directive to ensure the patient's preferences about end-of-life care are followed in any health care setting. The purpose of this evidence-based education program was to increase progressive care unit (PCU) registered nurses' (RNs') knowledge and comfort levels using the POLST form.

Background

The POLST form was initiated in 1991 when a group of medical ethicists in Oregon noted patients' preferences for end-of-life care were not consistently honored.[11] A new tool, the POLST form, was developed to facilitate end-of life communication between a patient and health care providers, translate patients' end-of-life goals into medical orders and ensure patients' wishes are honored across health care settings.[11,12] POLST is specifically for patients who have life-limiting illnesses and are in the last year of their life.[11] Currently, 16 states have implemented a similar legal provider order form documenting parameters for life-sustaining treatment and 27 more states have programs in development.[12]

Although the POLST form has been established or is being developed in most states with the same core concepts, the form goes by different names and under different legislation regulations

* Corresponding author. Tel.: +1 619 740 4840; fax: +1 619 740 4257.
E-mail address: nien-hsien.mcgough@sharp.com (N.N.H. McGough).

0197-4572/$ – see front matter © 2015 Elsevier Inc. All rights reserved.
http://dx.doi.org/10.1016/j.gerinurse.2014.09.001

in different states.[13] Besides POLST, for example, Delaware, Maryland, Massachusetts, New York, Ohio and Rhode Island use medical orders for life-sustaining treatment (MOLST); Idaho, Indiana, South Carolina, Tennessee, Virginia and West Virginia use physician orders for scope of treatment (POST) and Alaska, Colorado, Kentucky, New Mexico and North Carolina use medical orders for scope of treatment (MOST).[13] In some states (California, Georgia, Illinois, Kansas, Missouri, Nevada, New York, Tennessee and West Virginia), only physicians can sign and validate the POLST form. However, other states (Colorado, Iowa, Idaho, Maryland, Massachusetts, Minnesota, Montana, New Jersey, North Carolina, Oregon, Rhode Island, Utah, Vermont and Washington) extend the authority to sign the POLST to nurse practitioners or physician assistants.[13] Based on California law AB 3000 (Statutes 2008, Chapter 266), although nurses are unable to sign the POLST form, nurses are able to initiate a discussion on the content of the POLST form.

Three core tasks need to be accomplished between health care providers and a patient when using a POLST form in the state of California.[12] First, health care providers (e.g. physician, RN, social worker) need to discuss preferred end-of-life medical interventions such as resuscitation, antibiotics, intubation, and tube feedings with their patient. Second, health care providers need to document the patient's choices on the POLST form, which is then signed by the patient and physician. Although the POLST form was initially a bright pink document so it could be recognized easily within a stack of patient medical records, it does not need to be pink to be valid. The physician's signature authenticates the POLST form into actionable physician orders, which then can be followed by other health care providers at any location at any time. Third, the POLST form accompanies the patient when transferring between health care settings such as a skilled nursing facility (SNF) or acute care hospital. Health care providers are bound by the orders in the POLST form. Patients admitted to the hospital with a POLST form are less likely to receive unwanted or medically ineffective treatment and have less patient and family suffering when compared to patients who had only an advanced directive.[14]

Due to the size and ethnic diversity in California, the POLST form was implemented through local community coalitions which focused on promoting its usage in SNFs.[15] In 2007, the California HealthCare Foundation collaborated with the Coalition for Compassionate Care of California and funded seven community coalitions to perform grassroots education and training about POLST form usage. In 2008, additional eleven community coalitions were funded.[15] In 2009, California law AB 3000 (Statutes 2008, Chapter 266) required physician orders in a POLST form[16] to be followed by health care providers. Based on the report from Wenger et al, 82% of California SNFs educated their staff about the form, and 80% of the SNFs' residents completed a POLST form after admission.[15]

San Diego County is one of the POLST community coalitions regions. More and more SNF residents were transferred to the acute care hospital with a POLST form. However, many of the RNs in these hospitals were not familiar with how to use this form and not comfortable in talking to the patients or their families about the end-of-life care content in the POLST form.

Sharp Grossmont Hospital is a 536-bed acute care hospital in East San Diego County, California. There are more than 35 SNFs in this geographic area. This project took place in two of the hospital's 33-bed PCU. The majorities of patients are admitted through the emergency department and have congested heart failure (CHF), chronic obstructive pulmonary disease (COPD), pneumonia, gastrointestinal bleed or alcohol withdrawal. The units are staffed with nine RNs, three nursing assistants, one resource RN, one charge RN and one monitor technician for each 12-h shift.

Problem description

The RNs at Sharp Grossmont Hospital had not received POLST form training. Although the POLST form was included in the transfer documentation with a patient from a SNF, the RNs in the hospital did not know what to do because they were not familiar with the information provided on the form. For example, they did not know which orders to follow when there was a discrepancy between the resuscitation order on the POLST form and the order from the admitting physician. Additionally, the PCU RNs often suggested physicians order palliative team consults so the PCU RNs did not have to discuss end-of-life care with the patients or their family. Workplace education on advanced directives has been shown to increase RNs' knowledge and facilitate positive experiences in end-of-life care.[17] Vo et al[18] compared health care providers' characteristics between SNFs with high and low POLST form completion rates. In SNFs with higher POLST form completion rates, the health care providers had higher knowledge about the POLST form and were able to use this form more successfully. Therefore, this evidenced-based practice project focused on answering the question: among the RNs in the PCU, does implementing a formal evidence-based practice POLST program compared to current practice increase RNs' knowledge and comfort level using the POLST form?

Methods

Project design and sample

This evidence-based descriptive project evaluated RNs' usage, knowledge and comfort level using the POLST form pre- and post-education. The POLST form education was mandatory. Participation in the pre- and post-education surveys was voluntary. After receiving approval from the Institutional Review Board, volunteers were solicited to participate in the online survey via email and posted flyers in each unit. The email and flyers included a description of the project and a link to the survey. All 105 RNs employed and not on leave in both PCUs were sent the email. Participants consented to participate by completing the survey. No identification information was collected from RNs in the online survey. There was no match in the participants pre- and post-survey.

Intervention

The education was delivered at a mandatory staff meeting and included a 12 min "POLST at Work in California" video from the California POLST website (http://capolst.org/polst-for-patients-loved-ones/), followed by a 20 min slide presentation and discussion. The video focused on providing knowledge about the purpose of the POLST form, the basic concepts of the POLST form, the medical interventions listed in California's POLST form, and an example about how the POLST form travels with the patient in the health care system so the patient's wishes are honored by all health care providers. The slide presentation concentrated on the differences between the POLST form and an advanced directive, example dialogues discussing each section of the POLST form, and a scenario of a patient admitted to the hospital with a POLST form.

To assist those who were not able to attend the staff meeting and to reinforce the education to those who attended the staff meeting, the link of the video was emailed to all PCU RNs via the hospital's internal email system. An educational poster board with the information in the video and slide presentation was reviewed with individual RNs who missed the staff meeting. Additionally, the poster board was displayed in each unit for the PCU RNs to review for one month after the staff meeting.