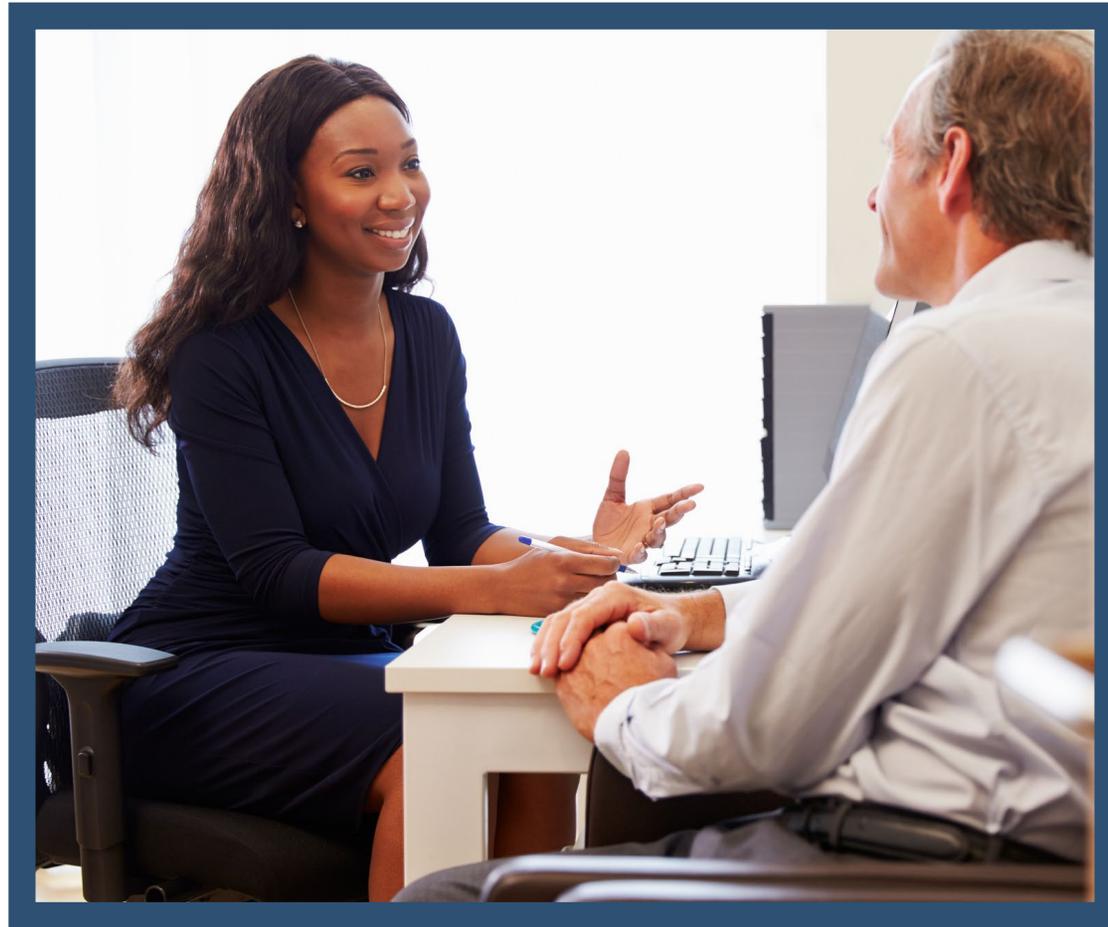


POLST

Conversation Guide



POLST Introduction

The Provider Orders for Life Sustaining Treatment (POLST) was developed to improve the quality of patient care by creating a system to elicit patients' preferences regarding medical treatment, and communicate and honor those preferences by creating portable medical orders. Only patients with serious illnesses, frailty or those who are healthy and wish to limit certain medical interventions should have a POLST form.

A key component of the POLST system is thoughtful conversations between health care professionals and patients (and/or surrogates) to determine what treatments patients do and do not want based on their personal values and current state of health. In these conversations, patients/surrogates are informed of treatment options and, if they wish, their health care professional will complete a POLST form based on the patient's expressed treatment preferences. The completed POLST form is a standing medical order for emergency medical care.

The goal of this POLST Conversation Guide is to help prepare health care professionals to conduct these thoughtful conversations.

Definitions:

- **Goals of Care Conversation (GoCC):** A discussion between a health care team member and a high-risk patient (or surrogate) that helps identify the patient's values, health care goals and decisions about life-sustaining treatments and other care.
- **Life-Sustaining Treatment (LST):** A medical treatment that is administered in an attempt to prolong the life of a patient who would be expected to die soon without the treatment.

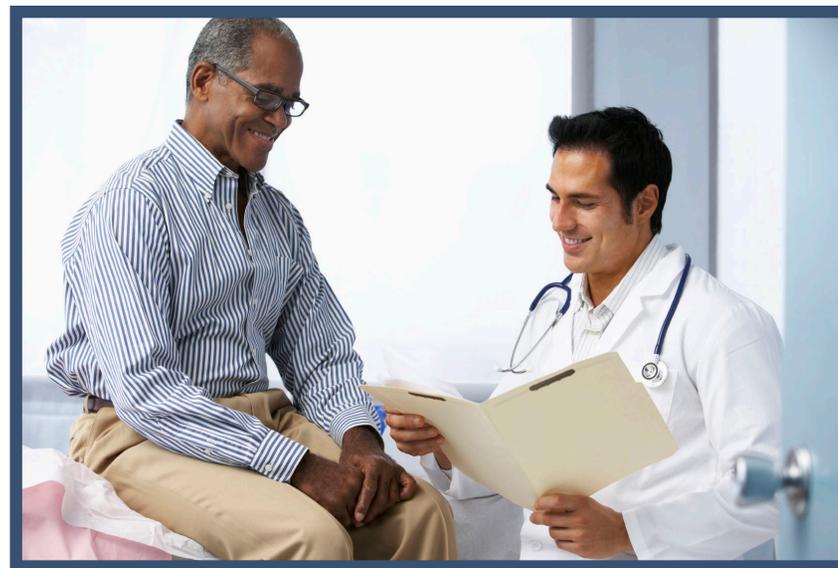
Examples:

- Cardiopulmonary resuscitation (CPR)
- Mechanical ventilation
- Feeding tubes
- Dialysis

Discussion Steps and Tips for Goals of Care Conversations (GoCC)

CAPTURES — A Map for GoCCs about Life-Sustaining Treatment:

- Capacity
- Authorized Surrogate and Advance Directives
- Perception of Illness and Prognosis
- Target Patient's Values and Goals
- Understanding Treatment Options
- Recommendations
- Exploration of Challenges and Empathic Responses
- Summary



Discussion Steps and Tips

Does a patient with a POLST need an advance directive? Yes.

CAPTURES: Capacity

- Health Care Decision Making Capacity = A clinical judgment about a patient's ability to make a particular health care decision at a particular point in time.
- Ensure the patient can make decisions about life-sustaining treatment (LST). Capacity to make decisions about LST can be assessed throughout the LST goals of care conversation.
- A patient is considered to have health care decision-making capacity when they can do ALL of the following:
 1. Understand the nature, extent or probable consequences of health status and health care alternatives
 2. Make a rational evaluation of the burdens, risks, benefits and alternatives of accepting or rejecting health care
 3. Communicate a decision

Advance Directive	POLST
For anyone 18 and older	For persons with serious illness and/or limited life expectancy at any age and/or someone who wants limits to life-sustaining interventions
Can be completed by the patient only (not their surrogate)	Can be completed by the patient or their surrogate with a licensed health professional
Instructions for future treatment	Medical orders for current treatment
Can appoint a health care agent	Only legal mechanism for a Utahn to have a do not resuscitate (DNR) order outside of a licensed health care facility
Does not guide emergency medical personnel	Can guide actions by emergency medical personnel



CAPTURES: Authorized Surrogate, Advance Directives

- Begin with an introduction of the conversation and give an overview of what you will discuss.
- Verify whom the patient has authorized to speak for them if they lose health care decision-making capacity.
- Ask the patient to complete a Durable Power of Attorney for Health Care to name a health care agent (if not done previously or the patient wishes to change surrogate).
- Ask for permission to proceed with the conversation.
- If a GoCC is warranted and the patient lacks decision-making capacity, the conversation can be conducted with the patient's surrogate. Decisions should be based on the patient's values, goals and preferences.

The Utah Surrogate Hierarchy:

1. A health care agent appointed by the adult.
2. Legal or special guardian appointed by a court of law.
3. Next of kin, 18+ years of age, in the following order of priority: spouse, child(ren), parent(s), sibling(s), grandchild(ren), grandparent(s).
4. An adult who has exhibited special care and concern for the patient and knows the patient and the patient's personal values.

CAPTURES: Authorized Surrogate, Advance Directives

Introduce the conversation:

- It's important for me to understand what matters most to you as we look ahead and make plans for your care. This can help me make sure you get the care that matches your goals.
- Can we spend a little time talking about this?
- Have you thought about the person you would want to speak for you if you were ever unable to make health care decisions for yourself?
- Have you completed an advance directive to name this person as your health care agent?

If the patient has not completed an advance directive:

- If you haven't completed an advance directive naming a health care agent, [next of kin at the top of the Utah surrogate hierarchy] will be your official decision maker if you are unable to make health care decisions for yourself.
- If you don't want your [next of kin] to make health care decisions for you, you need to fill out an advance directive to name someone else. Would you like [our social worker] to help you with that?

Discussion Steps and Tips

CAPTURES: Perception of Illness and Prognosis

- Patients cannot make informed decisions about goals and treatments when they don't know what to expect with their illness.
- If the patient is not aware of their prognosis, discuss prognosis with them and allow them time to adjust to the news.
- If discussing prognosis is out of your scope of practice, you can explore the patient's perceptions and refer to the appropriate medical team member for this discussion.
- If the patient has a different perception of their illness or prognosis, the medical team should spend time re-framing the prognosis. The message is the patient has an illness that could get worse in the coming days, weeks or months, and it is important to think about the future.
 - Most patients will have an emotional response to hearing the reframe. This is normal.
 - The emotional response may sound like a factual question:
 - Isn't there something else you can do?
 - Are you sure we've looked into everything?
 - Respond to these questions with empathic statements (see pages 10-11 for examples of empathic responses).
- Allow the patient time to adjust to the serious news before proceeding with decisions, especially about LST.
- Ask permission before moving on.
- If the clinical situation is NON-URGENT and the patient does not want to discuss the topic, set up a future appointment to continue this conversation.
- If the clinical situation is URGENT and the patient does not want to discuss the topic, ask permission to continue the conversation with the patient's surrogate.

Words that Work

CAPTURES: Perception of Illness and Prognosis

Ask about perceptions of illness and prognosis:

- I have reviewed your chart and it would help me if you shared what your doctors have told you about your [name medical condition]?
- Tell me what you think the future might look like with your [medical condition].

Reframe - if the patient has a different perception of their illness or prognosis:

- Given where you are in your illness, it seems like a good time to talk about where to go from here.
- We're in a different place than we were [x] months ago.

Respond with empathy:

- I can see that you are really concerned.
- I get a sense this is not what you were expecting to hear today.
- See pages 10-11 for more examples of empathic responses.

Ask permission before moving on:

- Is it OK for us to talk about what this means?

If the clinical situation is NON-URGENT and the patient does not want to discuss the topic after exploring their hesitations and worries:

- This topic deserves time and attention. We don't need to make decisions today. Let's set up a time to talk again when you are ready. In the meantime, here is some material that you may like to review.

If the clinical situation is URGENT and the patient does not want to discuss the topic after exploring their hesitations and worries:

- This is hard to talk about but it's also very important we understand your wishes. If you do not want to discuss this, would it be OK if we ask your [authorized surrogate] to help make decisions since we need to decide right away?

Discussion Steps and Tips

CAPTURES: Target Patient's Values and Goals

- You must know the patient's goals and values before creating a plan with them.
- How do you know what's important to the patient? Ask.
- If asked correctly, the question makes sense and isn't scary.
- The patient's values and priorities will help determine which treatment plan is right for the patient.
- No one wants LSTs; they are willing to undergo them to reach their goals.
- Patient goals are the **destination** and treatments are the **route** to get them there.

Words that Work

CAPTURES: Target Patient's Values and Goals

- Given this situation, what matters the most to you? What else?
- If it turns out that time is limited, what things would you want to do? What else?
- As you think about the future, what are you worried about? What else?
- Are there any medical treatments you would want to avoid? What else?

Discussion Steps and Tips

CAPTURES: Understanding Treatment Options

- Asking patients if they would or wouldn't want an LST without assessing their understanding of the intervention, determining their readiness to have the discussion and discussing whether it supports their goals can lead to poorly informed decisions.
- Ask an open ended question such as, "Can you tell me what you've heard about CPR?" Rather than saying, "Would you want CPR?"
 - This allows you to determine the patients' readiness to continue the conversation.
 - Allows you to assess the patients' understanding of the LST and fill in knowledge gaps.

Words that Work

CAPTURES: Understanding Treatment Options

Introduce the treatment and assess understanding:

- As I mentioned, I want to be sure you get the care that helps you achieve what matters most to you.
- It's helpful to know in advance whether you would or wouldn't want certain procedures.
- One of these procedures is CPR.
- Has anyone talked to you about CPR or have you seen it on TV?
- Can you tell me what you've heard about CPR?

CAPTURES: Understanding Treatment Options

- If the patient has an understanding of the LST go directly to recommendation (see page 7).
- If the patient does not have a basic understanding of the LST, provide information desired by the patient to fill in the gaps.
 - Be clear and direct.
 - Avoid medical jargon.
 - Give one or two pieces of information at a time, then stop and wait for the patient to respond.
 - Assess the type (if any) of additional information the patient wants.
- If the patient wants outcome data:
 - Discuss probable outcomes instead of presenting them as certain.
 - Explain that outcomes are for “people with health problems like yours” as we cannot predict exactly how the patient will respond to the procedure.
 - If the patient is interested in numbers avoid using percentages as many patients do not understand them.
 - Explain outcomes as # out of 100 that survive and # out of 100 that die. It is helpful to patients to have data presented both ways.
 - Explain that numbers are averages and if needed, customize the probable outcome by using terms such as much lower, lower, about the same, higher, much higher, etc.
- Whenever possible link outcomes to the patient’s goals.

CAPTURES: Understanding Treatment Options

Basic description (if needed):

- CPR can be used when a person’s heart and breathing stop. CPR involves forcefully pushing on the chest, and can also include shocking the heart and putting a tube down the throat to try and get the heart and breathing to start again.

Assess the type (if any) of additional information the patient wants:

- Some people like to know the chances of surviving after CPR, or what life might be like afterward, others might have spiritual questions.
- Is there any information I can share that would be helpful to you?

Provide any information desired by the patient. Examples include:

1. General Survival Outcomes:

Most adults who receive CPR don’t survive. Young and otherwise healthy people have better chances of surviving, and people with serious health problems have lower chances.

2. Specific Survival Statistics:

If 100 people in the hospital received CPR, only about 17 would survive to leave the hospital.* That means 83 out of 100 people would die.* These are averages. Unfortunately, for people with health problems like yours, the chances of survival are [much lower].*

3. CPR Outcome Related to the Patient’s Stated Goals:**

I’m concerned that CPR won’t help you live the life you want. There’s a high risk of broken ribs that would cause pain, and a [large chance]* you would need more help and wouldn’t be able to live at home. After CPR, you might need the support of breathing machines to keep you alive.* That sounds like what you said you want to avoid.

*customize per patient risk (refer to CPR Outcomes Tip Sheet)

**customize to patient’s goals using their words.

CAPTURES: Recommendations

- Making a recommendation about an LST can be a very effective way to unite the patient's values and goals with treatment options.
- Ask permission before making a recommendation since some patients may prefer to let you know their thoughts.
- Recommend treatments that may help meet the patient's goals.
 - Focus on what can be achieved.
 - Focus on what might be possible.
 - Discuss what you will not do because it will not meet the goal.
- When making a recommendation, repeat the patient's goals using their own words.
- After making a recommendation, ask if it makes sense given the patient's goals.
- For medical trainees and some clinicians, it may not be possible to immediately formulate a recommendation.
 - Elicit the patient's values and goals, inform your team what is important to the patient and return with recommendations from the team.

CAPTURES: Recommendations

Ask permission to make a recommendation:

- Would it be OK if I make a recommendation about CPR based on what you said matters to you?

Link recommendations to the patient's goals. First, start by discussing what you will do based on the patient's goals:

- You mentioned it's important for you to [be independent at home with your family].* Based on what you've said, it sounds like we should focus on [managing your pain so you can be as independent as possible and comfortable at home].*

Next, discuss what you recommend against based on the patient's goals:

- From what you've said, it sounds like if you get a lot sicker and your heart stops, it would not make sense to do CPR.* If that happens, you will likely not get off breathing machines, and even if you do, you would be a lot more dependent. I worry CPR would prolong the dying process instead of giving you more meaningful time. Since that sounds like what you said you want to avoid, I recommend against CPR for you.

**customize to patient's goals using their words*

CAPTURES: Exploration of Challenges and Empathic Responses

- If a decision about LST appears inconsistent with the patient's goals or the patient is hesitant to make decisions empathize and explore the reasons why.
- Remember these conversations can be emotional.
- Clinicians must attend to emotion BEFORE moving on to anything else.
- Emotional responses often sound like a factual question.
- Do not respond to feelings with facts; respond with empathy (see pages 10-11 for examples of empathic responses).
 - "NURSE" statements
 - "I WISH" statements
- If the clinical situation is NON-URGENT and the patient does not want to discuss the topic, set up a future appointment to continue this conversation.
- If the clinical situation is URGENT and the patient does not want to discuss the topic, ask permission to continue the conversation with the patient's surrogate.

CAPTURES: Exploration of Challenges and Empathic Responses

Explore choices that conflict with goals:

- Tell me more about what you are hoping for with CPR.
- Is there a situation you could imagine when you [would/would not] want CPR?

Explore hesitations to make decisions:

- Can you tell me what worries you about talking about CPR?

If the clinical situation is NON-URGENT and the patient does not want to discuss the topic after exploring their hesitations and worries:

- This topic deserves time and attention. We don't need to make decisions today. Let's set up a time to talk again when you are ready. In the meantime, here is some material that you may like to review.

If the clinical situation is URGENT and the patient does not want to discuss the topic after exploring their hesitations and worries:

- It is hard to talk about this and it's also very important so we understand your wishes. If you do not want to discuss this, would it be OK if we ask your [authorized surrogate] to help make decisions since we need to make decisions right away?



Discussion Steps and Tips

CAPTURES: Summary

- To ensure shared understanding, summarize the plan and ask the patient to confirm.
- Repeat what the patient has just told you; this communicates that you have listened.
- Identify next steps.

Discussion Steps and Tips

Review and Verify Preferences at a Later Date

- With changes in condition you may need to review and verify the patient's preferences with the patient or their surrogate.
- Your recommendation may not have changed and you may want to review and verify the orders without casting doubt on decisions.
- The clinical situation may have changed and you may need to re-conduct the conversation by reframing perception.

Words that Work

CAPTURES: Summary

- At this point, you would want an attempt at CPR if your heart and breathing stop. If [state limitations verbalized by the patient] you wouldn't want CPR. Do I have that right?
- Thanks for helping me understand what you want. Your [surrogate] should know about these decisions, since you choose [him/her] to communicate your decisions if you can't speak for your self.
- Thank you for taking the time to have this important conversation with me.

Words that Work

Review and Verify Preferences at a Later Date

No changes to recommendations:

- During your mother's clinic visit with Dr. Jones, she said spending time with family and being as independent as possible was important to her.
- She wanted medical orders written to avoid being placed on a breathing machine and to avoid CPR.
- We plan to honor her wishes. Is there any additional information you can share to help us respect her decisions?

Changes to recommendations:

- The last time you were in the hospital you said you wanted to live as long as possible if you could take care of yourself at home.
- You chose CPR as long as there was a chance you could live at home, recognize family and make your own decisions.
- I think we are in a different place now. [brief pause] I worry CPR will no longer meet your goals.
- [Pause and respond to emotion with empathy.] See pgs. 10-11
- Can we spend some time talking about what's most important to you now and where we should go from here?

Examples of Empathic Responses

Naming	Understanding	Respecting	Supporting	Exploring	"I Wish"
This must be . . . <ul style="list-style-type: none"> • Frustrating • Overwhelming • Scary • Difficult • Challenging • Hard 	What you just said really helps me understand the situation better.	I really admire your <ul style="list-style-type: none"> • Faith • Strength • Commitment to your family • Thoughtfulness • Love for your family 	We will do our very best to make sure you have what you need.	Could you say more about what you mean when you say . . . <ul style="list-style-type: none"> • I don't want to give up • I am hoping for a miracle 	I wish we had a treatment that would cure you [make your illness go away]. *[Remember we do have palliative treatments to offer the patient]
I'm wondering if you are feeling . . . <ul style="list-style-type: none"> • Sad • Scared • Anxious • Nervous • Angry 	This really helps me better understand what you are thinking.	You (or your dad, mom, child, spouse) are/is such a strong person and have/has been through so much.	Our team is here to help you with this.	Help me understand more about . . .	I wish I had better news.
It sounds like you may be feeling . . .	I can see how important this is to you.	I can really see how [strong, dedicated, loving, caring, etc.] you are.	We will work hard to get you the support that you need.	Can you say more about that?	I wish the situation were different.
In this situation some people might feel . . .	Dealing with this illness has been such a big part of your life and taken so much energy.	You are such a [strong, caring, dedicated] person.	We are committed to help you in any way we can.	Tell me more about what [a miracle, fighting, not giving up, etc.] might look like for you?	I wish that for you too. [In response to what a patient or family members wishes, such as a miracle]
I can see how dealing with this might be . . . <ul style="list-style-type: none"> • Hard on you • Frustrating • Challenging • Scary 		I'm really impressed by all that you've done to manage your illness [help your loved one deal with their illness].	We will be here for you.		I wish we weren't in this spot right now.

Examples of Empathic Responses to Challenging Questions

God's going to bring me a miracle:

- I hope that for you too. (**Remember - no buts!**) (**SUPPORTING**)
- I really admire and respect your faith. (**RESPECTING**)
- Having faith is very important. (**RESPECTING**)
- Can you share with me what a miracle might look like for you? (**EXPLORING**)

Are you telling me my dad is dying?

NOTE: These responses will affirm the question emphatically – so do not use them if the patient is not dying.

- I wish I had better news.
- This must be such a shock for you. (**NAMING**)
- I can't even imagine how difficult this must be. (**UNDERSTANDING**)

Are you saying there is nothing more you can do?

- It sounds like you might be feeling ... (**NAMING/EXPLORING**)
 - Alone
 - Scared
 - Frustrated
 - Etc.
- I wish we had a treatment that would cure you. Our team is here to help you through this. (**Remember - no buts!**) (**SUPPORTING**)
- I can't even imagine how (**NAME EMOTION**) this must be. (**NAMING**)

How much time do I have left?

NOTE: This question may mean many things – they are scared, they want to know so they can plan, they are suffering, etc. Exploring what they want to know can be very helpful.

- That is a great question. I am going to answer it the best that I can. Can you tell me what you are worried about? (**EXPLORING**)
- That is a great question. I am going to answer it the best that I can. Can you tell me what information would be most helpful to you? (**EXPLORING**)

Are you giving up on me?

- I wish we had more curative treatments to offer. Our team is committed to help you in every way we can. (**Remember - no buts!**) (**SUPPORTING**)
- We will be here for you. (**SUPPORTING**)
- It sounds like you might be feeling ... (**NAMING/EXPLORING**)
 - Alone
 - Scared
 - Etc.
- We will work hard to get you the support that you need. (**SUPPORTING**)

My dad is a fighter!

- He is. He is such a strong person and he has been through so much. (**Remember - no buts!**) (**RESPECTING**)
- I admire that so much about him. (**RESPECTING**)
- I really admire how much you care about your dad. (**RESPECTING**)
- It must be (**NAME EMOTION**) to see him so sick. (**NAMING**)
- Tell me more about your dad and what matters most to him. (**EXPLORING**)

CPR Outcomes

Most patients get information about CPR from TV. Depictions of CPR on TV create overly-optimistic impressions about CPR's effectiveness. A study¹ reviewing outcomes after CPR as portrayed on *ER*, *Chicago Hope*, & *Rescue 911* found the following across 60 episodes of CPR:

- 77% of patients resuscitated on these TV shows survived the immediate arrest;
- Most cases implied long term survival; and
- Only one survivor incurred any obvious disability after CPR.

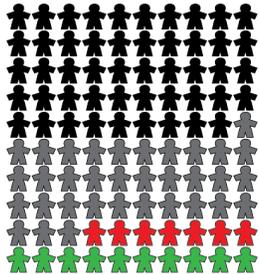
Real-life outcomes are not as positive.

Among adults who received CPR in the hospital^{2,3}:

- 56% died during resuscitation
- 27% died before hospital discharge
- 17% survived to discharge

Among patients 65 and older who received CPR in the hospital⁴:

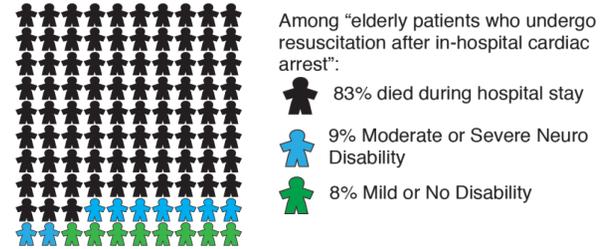
- 49% died during resuscitation (black figures, below)
- 34% died before hospital discharge (gray figures)
- 17% survived to discharge (red and green figures)
- 10% were alive one year after discharge (green figures)



Source of images:
<http://www.geripal.org/2013/09/outcomes-of-in-hospital-cpr-not-as-rosy.html>

Keep in mind that these numbers are averages. Survival rates after CPR are lower for some patient groups, higher for other.

This figure illustrates the risk of experiencing cognitive disability after CPR for patients age 65+.



Among those who survived after CPR and had good cognitive performance before their arrest, most (86%) had good cognitive performance after CPR; some (14%) had at least moderate cognitive impairment.²

There is also a risk of not being able to return home, or being unable to care for oneself after surviving CPR. In a recent large study, 83% died during CPR or prior to discharge, 9% were discharged to an inpatient facility, 7% were discharged home, and 1% were discharged to hospice.⁴

¹ Diem SJ, Lantos JD, Tulsy JA. Cardiopulmonary resuscitation on television: Miracles and misinformation. *N Eng J Med* 1996;334: 1578-82.

² Peberdy MA, Kaye W, Ornato JP, Larkin GL, Nadkarni V, Mancini ME, Berg RA, Nichol G, Lane-Trullt T. Cardiopulmonary resuscitation of adults in the hospital: a report of 14720 cardiac arrests from the National Registry of Cardiopulmonary Resuscitation. *Resuscitation* 2003;58:297-308.

1. Conversation Introduction

I was hoping we could talk about your health and what matters to you, and about the kind of medical care you would or wouldn't want in the future. This can help me make sure you get the care that matches your wishes. Can we spend some time talking about this now?

2. Authorized Surrogate and Advance Directive

- Have you thought about the person you would want to speak for you if you were ever unable to make health care decisions for yourself?
- Have you completed an advance directive to name this person as your health care agent?

If the patient has not completed an advance directive:

- Since you haven't completed an advance directive naming a health care agent, [next of kin at top of federal (for VA) or state surrogate hierarchy] would be your official decision maker, if you were unable to make health care decisions for yourself.
- If you don't want [next of kin at top of federal (for VA) or state surrogate hierarchy] to make health care decisions for you, you need to name someone else in an advance directive. Would you like our [social worker] to help you with that?



3. Perception of Illness and Prognosis

- I've reviewed your chart and it would help me if you shared what your doctors have told you about your [name medical condition].
- Tell me what you think the future might look like with your [medical condition].
- Given where you are in your illness, it seems like a good time to talk about where to go from here.

If the patient has a different perception of their illness or prognosis – reframe:

- We're in a different place than we were [x] months ago.

Respond to emotion with empathetic responses [see Empathetic Responses Tip Sheet]

- I get a sense that this is not what you were expecting to hear today. I wish I had better news.

Ask permission before moving on:

- Is it OK for us to talk about what this means?

Do not move on with the conversation until the patient has time to adjust to upsetting news.

4. Targeting Values and Goals of Care

- Given this situation, what matters the most to you? What else is important?
- If it turns out that time is limited, what things would you want to do? What else?
- As you think about the future, what are you worried about? What else?
- Are there any medical treatments you would want to avoid? What else?

5. Understanding of Life-Sustaining Treatments (CPR Example)

Introduce the life-sustaining treatment and assess understanding:

- As I mentioned, I want to be sure you get the care that helps achieve what matters most to you. It's helpful to know in advance whether you would or wouldn't want certain treatments or procedures. One of those treatments is CPR. Can you tell me what you've heard about it?

Whenever possible, go directly to recommendation. *IF NEEDED*, provided desired information about CPR

Basic description (if needed):

- CPR can be used when a person's heart and breathing stop. CPR involves forcefully pushing on the chest, and can also include shocking the heart and putting a tube down the throat to try to get the heart and breathing to start again.

Assess the type (if any) of additional information the patient wants:

- Some people like to know the chances of surviving after CPR, or what life might be like afterward, others have spiritual questions related to these decisions. Some people don't want more information. What about you?

Provide any information desired by the patient (if no information desired go to recommendation).

1. Example General Survival Outcomes:

Most adults who receive CPR don't survive. Young and otherwise healthy people have better chances of surviving, and people with serious health problems have lower chances.

2. Example Specific Survival Statistics:

If 100 people in the hospital receive d CPR, only about 17 would survive to leave the hospital**. That means 83 out of 100 people would die**. These are averages. Unfortunately, for people with health problems like yours, the chances of survival are [much lower]**.

3. Example CPR Outcomes Related to the Patient's Stated Goals*:

I'm concerned that CPR won't help you live the life you want. There's a high risk of broken ribs that would cause pain, and a [large chance]** you'd need more help and wouldn't be able to live at home. After CPR, you might need the support of breathing machines to keep you alive.** That sounds like what you said you want to avoid.

**customize to patient's goals using their words*

***customize per patient risk (refer to CPR Outcomes Tip Sheet)*

6. Recommendation (CPR example)

Ask permission to make a recommendation:

- Can I make a recommendation about CPR based on what you said matters to you?

First, always start by discussing what you will do based on the patient's goals*:

- Example: You mentioned it's important for you to [be independent at home with your family].* Based on what you've said, it sounds like we should focus on [managing your pain so that you can be as independent as possible and comfortable at home].*

Next, discuss what you recommend against based on the patient's goals*:

- Example: From what you've said, it sounds like if you get a lot sicker and your heart stops, it would not make sense to do CPR. If that happens, you will likely not get off breathing machines, and even if you do, you would be a lot more dependent. I worry CPR would prolong the dying process instead of giving you more meaningful time. Since that sounds like what you said you want to avoid, I recommend against CPR for you.

**customize to patient's goals using their words*

7. Exploring Inconsistencies Between Goals and Choices (CPR example)

- I worry CPR won't help you live the life you want. Can you tell me what you are hoping for with CPR?
- Can you think of a situation when you wouldn't want CPR?

8. Summary of Plan

- Summarize what the patient has chosen and ensure the patient agrees.

This conversation guide is adapted from materials developed by the National Center for Ethics in Health Care, Department of Veterans Affairs, 2018

Created by: Shaida Talebreza, MD and Paige Hoffman

Updated: 4/25/18

Sources

- Goals of Care Conversations Training, Department of Veterans Affairs. <http://www.ethics.va.gov/goalsofcaretraining.asp>
- Palliative Care Fast Facts and Concepts (originally published by the End-of-Life/Palliative Education Resource Center, Medical College of Wisconsin), Palliative Care Network of Wisconsin. <http://www.mypcnow.org/#!fast-facts/c6xb>
- VitalTalk. <http://www.vitaltalk.org>
- POLST. Retrieved from: <http://www.polst.org/about-the-national-polst-paradigm/what-is-polst/>

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