END-OF-LIFE SERIES · PART 2

Where the Decision Gets Lost

Advance Directives, POLST, and DNR Orders

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Most code status cases don't start with a patient who never made a decision. They start with a patient who made a clear one, signed it, and then watched it get lost somewhere between the nursing home, the ambulance, and the hospital.

This week's episode is part two of our end-of-life series, and it's about the paperwork: advance directives, POLST forms, and DNR orders. People mix these up all the time, clinicians included, so here's the short version.

THREE DOCUMENTS, OFTEN CONFUSED

An advance directive is an instruction, not an order. A living will or a health care proxy tells people what the patient wants or who speaks for them, but a nurse or paramedic can't act on a living will sitting in a drawer. Someone has to turn it into a medical order.

A DNR is that order for one thing only: don't start CPR. It doesn't mean don't treat. A patient with a DNR can still want antibiotics, a hospital transfer, and good pain control. When a DNR gets read as "do nothing," patients die of things that were treatable, and that side of the problem gets far less attention than it should.

A POLST goes further. It covers CPR, the overall level of treatment, and often feeding tubes, and it's built to travel with the patient. The newest valid POLST replaces any older one, which matters when you find two or three different versions of a patient's wishes in the same chart. And it's only valid in a state that has adopted that form.

WHERE IT BREAKS

The pattern we see most often is a transition failure. The POLST isn't in the transfer packet, the hospital defaults to full code, the readmission orders come back to the facility as full code, and

the electronic banner changes. The paper POLST is still in a binder at the nurses' station, but nobody looks at the binder at 3 a.m. They look at the screen.

WHAT WE REQUEST

When we review one of these cases, we gather every directive and POLST version with dates and signatures, pull the facility's code status policy, and then ask for the audit trail showing every change to the code status order. Add the code record, the EMS run sheet (paramedics often document whether a DNR was shown to them), and the facility's survey history for resident rights deficiencies.

Check both directions, too. Was a refusal ignored, or was a refusal assumed or stretched beyond what the patient actually chose?

Episode 78 of Lexcura Clinical Insights walks through a full example. Next week we look at what happens when there's no document at all and the family can't agree.

This newsletter is for education only and isn't medical or legal advice.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a case that turns on what the medical record really shows, we'd welcome the conversation.

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