VA LIFE-SUSTAINING TREATMENT DECISIONS INITIATIVE

Guide for Residents
VA Life-Sustaining Treatment Decisions Initiative

National quality improvement initiative to promote personalized, proactive, patient-driven care for Veterans with serious illness

Desired outcomes:
The values, goals, and life-sustaining treatment decisions of Veterans with serious illness are proactively elicited, documented, and honored.
The Life-Sustaining Treatment Initiative (LSTI) Note

➢ This does NOT replace the VA Advance Directive documentation (which consists of Health Care Proxy + Living Will)

➢ This **DOES** replace the DNR note/order. Starting 01/08/18 the DNR note has been discontinued.

➢ What’s different about the LSTI?
  ➢ This note + order set does not expire (unlike the previous DNR order).
  ➢ Think of this note like a MOLST form but electronic within the VA system. It can be completed inpatient and outpatient.
    ➢ You will still have to complete any paper documentation as required previously—ie MOLST, POLST, etc
  ➢ This note allows you to place other orders that address life-sustaining treatments or goals of care. For example, mechanical ventilation, artificial nutrition, escalation of care, etc.
Roles of the Resident and Attending

- **Resident:**
  - Write the note
  - Designate a cosigner
    - In the note, mention the “supervising practitioner” (attending who will cosign)
  - Sign off on the orders triggered by the note

- **Attending:**
  - Cosign the note if in agreement with the note.
  - If he/she does not concur with the note, then it still must be cosigned by the attending but with an addendum AND new LST orders must be placed.
    - The updates can either be mentioned in the addendum or a new note can be placed
➢ Patient’s capacity to make decisions about life-sustaining treatments*

➢ Surrogate information

➢ Whether documents reflecting patient’s wishes (e.g., advance directives, state-authorized portable orders) were available and reviewed

➢ Patient’s (or surrogate’s) understanding of medical condition/prognosis

➢ Goals of care*

➢ Plan for use life-sustaining treatments
  ➢ In the event of cardiopulmonary arrest* (CPR)
  ➢ In circumstances other than cardiopulmonary arrest (e.g., mechanical ventilation, feeding tubes, transfers to hospital/ICU)

➢ Participants in the conversation

➢ Consent for plan*
How to access the note?

Using the notes tab, generate a new note and enter “Life-Sustaining Treatment”: 
There are 8 components to this. However, they are not all required to complete the note.

The more you become familiar with the note, the easier it will become to complete it.

Though it may appear “cumbersome,” it is straightforward and allows you to document your conversation with the patient appropriately.
Required Question #1: Decision-Making Capacity

Clicking on this will always expand to reveal more information and definitions related to the question and what it is asking, and provide definitions. So for this example, it will define what capacity entails and what to do if the patient does not have capacity.

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**LIFE-SUSTAINING TREATMENT**

*1. Does the patient have capacity to make decisions about life-sustaining treatments?*

☐ HELP ME understand decision-making capacity.

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**1. Decision-Making Capacity**

☐ The patient has capacity to make decisions about life-sustaining treatments.

☐ The patient lacks capacity to make decisions about life-sustaining treatments and has a surrogate.

☐ The patient lacks capacity to make decisions about life-sustaining treatments and has no surrogate.
2. Who is the person authorized under VA policy to make decisions for the patient if/when the patient loses decision-making capacity?

- [ ] HELP ME identify the authorized surrogate.

- [ ] Authorized surrogate if/when the patient loses decision-making capacity:
  - [ ] Must select one:
  - [ ] Name(s):
  - [ ] Contact Information:

- [ ] The patient has no surrogate authorized to make health care decisions if/when the patient loses decision-making capacity.

3. Have you reviewed available documents that reflect the patient’s wishes regarding life-sustaining treatments? Examples: advance directives, state-authorized portable orders (e.g., POLST, MOST), Life-Sustaining Treatment notes/orders.

- [ ] HELP ME decide which documents I must review, and when to review them with the patient (or surrogate).

- [ ] No advance directive, state-authorized portable orders (e.g., POLST, MOST), or Life-Sustaining Treatment notes/orders were available in the record or presented by the patient (or surrogate).

- [ ] I reviewed with the patient (or surrogate) all active advance directive(s), state-authorized portable orders (e.g., POLST, MOST), and/or Life-Sustaining Treatment notes/orders available in the record and/or presented by the patient (or surrogate).

4. Does the patient (or surrogate) have sufficient understanding of the patient’s medical condition to make informed decisions about life-sustaining treatments?

- [ ] HELP ME decide what to do if the patient (or surrogate) does not have sufficient understanding of the patient’s condition to make informed decisions about life-sustaining treatments.

- [ ] Yes. The patient’s (or surrogate’s) understanding is consistent with the medical facts.

- [ ] Other: (e.g., the patient lacks decision-making capacity and has no surrogate)
Required Question #5: What are the goals?

Checking off this box will allow you to freetext the conversation you’ve had.

*5. What are the patient's goals of care? (Select all that apply. Do not attempt to rank the goals of care here – see HELP box for additional information.)

- Patient's goals in their own words, or as stated by the surrogate(s):
  - * This is the option if you want to freetext your conversation

- To be cured of:
- To prolong life
- To improve or maintain function, independence, quality of life
- To be comfortable
- To obtain support for family/caregiver
- To achieve life goals, including:
Required Question #6: LST Orders

Answering this question generates the order set that will automatically place orders. *Note: It does not generate a “Full Code” order.

6. What is the current plan for use of life-sustaining treatments?

- FULL SCOPE OF TREATMENT in circumstances OTHER than cardiopulmonary arrest.
- Limit life-sustaining treatment (e.g., mechanical ventilation, artificial nutrition) as specified in circumstances OTHER than cardiopulmonary arrest.
- No life-sustaining treatment in circumstances OTHER than cardiopulmonary arrest.

*CARDIOPULMONARY RESUSCITATION
- Full code: Attempt CPR.
- DNR: Do not attempt CPR.
- DNR with exception: ONLY attempt CPR during the following procedure: *

Expanding this will allow you to create orders for other treatments or management plan—ventilation, artificial hydration, etc. See next slide.
Required Question #6: LST Orders

6. What is the current plan for use of life-sustaining treatments?

- FULL SCOPE OF TREATMENT in circumstances OTHER than cardiopulmonary arrest.
- Limit life-sustaining treatment (e.g., mechanical ventilation, artificial nutrition) as specified in circumstances OTHER than cardiopulmonary arrest:
  - Artificial Nutrition
  - Artificial Hydration
  - Mechanical Ventilation
    - Mechanical Ventilation
      - No invasive mechanical ventilation (e.g., endotracheal or tracheostomy tube)
      - No non-invasive mechanical ventilation (e.g., CPAP, BiPAP)
      - Limit mechanical ventilation as follows:
  - Transfers between Levels of Care
  - Limit other life-sustaining treatment as follows (e.g., blood products, dialysis):
- No life-sustaining treatment in circumstances OTHER than cardiopulmonary arrest.

*CARDIOPULMONARY RESUSCITATION
- Full code: Attempt CPR.
- DNR: Do not attempt CPR.
- DNR with exception: ONLY attempt CPR during the following procedure: *

Expanding “Limit life-sustaining treatment” will reveal this orders.
7. Who participated in this discussion?

☐ (Strongly recommended) Document participants and other relevant information:

*8. Who has given oral informed consent for the life-sustaining treatment plan outlined above?

☐ HELP ME understand informed consent for life-sustaining treatment plans, and how this differs from informed consent for initiating or discontinuing specific life-sustaining treatment.

*9. Informed Consent

☐ The PATIENT has given oral informed consent for the life-sustaining treatment plan.

☐ The SURROGATE(S) has/have given oral informed consent for the life-sustaining treatment plan. Name of surrogate(s) providing consent:

☐ The patient lacks decision-making capacity and has no surrogate.
Although there is no asterisk—this portion is required. The supervising practitioner is the attending you’ve designated to cosign this document.

Please do not forget to check off this box!

Once complete, hit “Finish” on the template.
Once you click “Finish,” these windows appear:

This window allows you to enter more orders regarding LST but it is not needed if you’ve already designated the orders you wanted through the template.

If you do add extra orders, please make sure it’s documented in the note.

You can bypass this part by clicking “Done” at the top right corner of the window.
Final Steps

- The note is now generated, which you can sign.

- Then entering the order tab will reveal your orders, which you must sign.
  - Note: there will be no orders if your patient is Full Code and you did not click on any other LST measures in question #6.

- Remember the attending does not need to put in any orders, they simply need to co-sign your note.

<table>
<thead>
<tr>
<th>Service</th>
<th>Order</th>
<th>Start / Stop</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life-Sustaining Treatment</td>
<td>&gt;&gt; DNR: Do not attempt CPR in the event of cardiopulmonary arrest <em>UNSIGNED</em></td>
<td>Start: no</td>
<td>Wazed.Bushra</td>
</tr>
<tr>
<td></td>
<td>&gt;&gt; No invasive mechanical ventilation (e.g., endotracheal or tracheostomy tube) in circumstances other than cardiopulmonary arrest <em>UNSIGNED</em></td>
<td>Start: N</td>
<td>Wazed.Bushra</td>
</tr>
</tbody>
</table>
Once co-signed by attending, the note appears as a posting:

- Accessible from the CPRS Cover Sheet
- Does not have to be re-written on each admission if there are no changes to patient’s goals or preferences
- You can view the entire note through this