| TOOL 2-6 | ***Sample*** MOLST Policy for Acute Care Hospitals[1] |  |
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*Caution – It is not advisable to use MOLST policy written for other institutions, especially policies from out of state. Each institution needs to develop its own MOLST policy as appropriate within the context of state, local and institutional clinical practice.*

**PURPOSE**

The purpose of this policy is to define a process for general acute care hospitals to follow when a patient presents with a MOLST form. This policy also outlines procedures regarding the completion of a MOLST form by a clinician and patient, and necessary steps for re-discussing or revising a MOLST form.

**PREAMBLE**

The Medical Orders for Life-Sustaining Treatment (MOLST) form should be executed as one possible outcome of the health care planning process and broader advance care planning conversations. The MOLST form is a medical order form that converts an individual's preferences regarding life-sustaining treatment into Medical Orders. It is designed as a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining treatments across health care settings. It is designed to be a portable, valid and immediately actionable medical order that is consistent with the patient's preferences and current medical condition, which shall be honored across treatment settings.

The MOLST form:

- Is a standardized form that is clearly identifiable[2];
- Is used voluntarily and can be revised or revoked at any time;
- Is recognized as a valid medical order;
- Is recognized and honored across treatment settings;
- Is an expansion of the Massachusetts Comfort Care/Do Not Resuscitate verification protocol, although MOLST is more comprehensive in that it addresses preferences to receive or not receive other life-sustaining treatment in addition to resuscitation; and,
- Should be made available for suitable patients who wish to execute a MOLST form while they are in the general acute care hospital.

A clinician is not required to initiate the MOLST process and form, but is encouraged to treat a patient in accordance with his or her MOLST form instructions. As outlined in the following procedures, the clinician will review the MOLST and incorporate the content of the MOLST into the patient's care and treatment plan. This does not apply if the MOLST requires medically ineffective health care or health care contrary to generally accepted health care standards.[3]

A legally recognized health care agent or guardian[4] may execute, revise or revoke the MOLST form for a patient to the extent permitted by Massachusetts law. This policy does not address the criteria or process for determining or



[1] *(Additional sample policies can be found at www.ohsu.edu/polst/resources/policy.htm and at www.compassionandsupport.org/index.php/for_professionals/molst_training_center/implementation_resources)*

[2] The official MOLST form for Massachusetts can be seen at: *www.molst-ma.org. A photocopy of the form is also valid.*

[3] A clinician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care agent, issue a new order consistent with the most current information available about the individual's health status and goals of care.

[4] "Legally recognized health care agent" is the person's designated healthcare agent as assigned by a Massachusetts health care proxy form. A guardian can sign to the extent permitted by Massachusetts law. Consult legal counsel with questions about a guardian's authority.

appointing a legally recognized health care agent, nor does it address the criteria or process for determining decision-making capacity[5]. Legal counsel should be consulted with questions about a health care agent's or guardian's authority.

While a health care provider such as a nurse or social worker may explain a MOLST form to the patient and/or the patient's legally recognized health care decision maker, an attending clinician[6] is responsible for discussing the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent.

Once the MOLST form is completed, it must be signed by the patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, AND the attending clinician.

The MOLST form is intended for the voluntary use of patients approaching the end of life due to a serious medical condition, including but not limited to: chronic progressive disease (including dementia); life-threatening illness or injury; medical frailty; or any patient whose doctor would consider discussing DNR status with them or who would not be surprised if the patient died during the next year. Completion of a MOLST form should reflect a prior process of careful shared decision-making by the patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, in consultation with the clinician about the patient's current medical condition, prognoses, values and goals of care.

**GENERAL ACUTE CARE HOSPITAL SAMPLE PROCEDURES**

**I. Patient in Emergency Department with a Completed MOLST Form**

1. During the initial patient assessment, document the existence of the MOLST form[7] and confirm with the patient, if possible, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, that the MOLST form in hand has not been voided or superseded by a subsequent MOLST form.

2. A nurse or designated staff member will communicate to the emergency department clinician caring for the patient the existence of the MOLST.[8]

3. MOLST orders will be honored by health care providers as a valid medical order until the emergency department clinician reviews the MOLST form and incorporates the content of the MOLST into the care and treatment plan of the patient, as appropriate.[9] The clinician should document his/her review of the MOLST in the medical record.

4. If the emergency department clinician, upon review of the MOLST and evaluation of the patient, determines that a new order is indicated, he/she shall review the proposed changes with the patient and/or legally recognized health care agent, and issue a new order consistent with the most current information available about the patient's health status, medical condition, treatment preferences and goals of care. The clinician should document the reasons for any deviation from the MOLST in the medical record.

5. Discussions with the patient and/or the patient's legally recognized health care agent regarding the MOLST and related treatment decisions should be documented in the medical record.

6. Copy the MOLST form for the medical record and/or scan into the electronic medical record.



[5] Hospitals should refer to Commonwealth law and/or their own legal department regarding determination of decision-making capacity, and of a legally recognized health care agent.
[6] "Clinician" means a licensed physician, nurse practitioner or physician assistant.
[7] Hospitals should designate by policy the specific staff responsible for this action.
[8] Hospitals should designate by policy the specific staff responsible for this action.
[9] A clinician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care agent, issue a new order consistent with the most current information available about the individual's health status and goals of care.

7. Place appropriate hospital patient information label (e.g. addressograph) on the copy of the MOLST form where indicated (in the upper right corner of the front page of the form) and write "COPY" on the form and the date copied.

8. Place the current original MOLST form in the appropriate and prominent section of the patient's medical record.[10] The date and time the order is placed in the medical record must be documented.

9. If the patient is discharged from the Emergency Department, *return the current original MOLST form to the patient* and document such action.

10. If the patient is admitted to an inpatient unit, send the *current original* MOLST with the patient to the inpatient unit.

**II. Patient Admitted with a Completed MOLST Form**

1. During the initial patient assessment, document the existence of the MOLST form[11], and confirm with the patient, if possible, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, that the MOLST form in hand has not been voided or superseded by a subsequent MOLST form.

2. A nurse, social worker or other designated staff member will communicate to the admitting clinician caring for the patient the existence of the MOLST[12].

3. MOLST orders will be followed by health care providers as a valid medical order until the admitting clinician reviews the MOLST form and incorporates the content of the MOLST into the care and treatment plan of the patient, as appropriate[13]. The clinician should document his/her review of the MOLST in the medical record.

4. If the admitting clinician, upon review of the MOLST and evaluation of the patient, determines that a new order is indicated, he/she shall review the proposed changes with the patient and/or legally recognized health care agent, and issue a new order consistent with the most current information available about the patient's health status, medical condition, treatment preferences and goals of care. The clinician should document the reasons for any deviation from the MOLST in the medical record.

5. Discussions with the patient and/or the patient's legally recognized health care agent regarding the MOLST and related treatment decisions should be documented in the medical record.

6. Copy the MOLST form for the medical record and/or scan into the electronic medical record.

7. Place appropriate hospital patient information label (e.g. addressograph) on the copy of the MOLST form in the "Office Use Only" box and write "COPY" on the form and the date copied.

8. Place the current original MOLST form in the appropriate and prominent section of the patient's chart[14]. The date and time the order is placed in the medical record must be documented.

9. Because the current original MOLST is the patient's personal property, ensure its return to the patient, or legally recognized health care agent, upon discharge or transfer[15].



[10] Hospitals may choose an alternative process that differs in the basic principle of whether the original MOLST should be included in the medical record or treated as "personal property" and secured by another mechanism. For example, "Place the copy of the MOLST form in the front of the patient's chart and keep original with the patient's other personal property."
[11] Hospitals should designate by policy the specific staff responsible for this action.
[12] Hospital should designate by policy the specific staff responsible for this action.
[13] A clinician may conduct an evaluation of the individual and, if possible, in consultation with the individual, or the individual's legally recognized health care agent, issue a new order consistent with the most current information available about the individual's health status and goals of care.
[14] Hospitals should designate by policy the specific staff responsible for this action.
[15] Hospitals should designate by policy the specific staff responsible for this action.

10. At discharge, send the most current original MOLST with patient during any transfers to another health care facility or to home. Document in the medical record that the MOLST was sent with the patient at the time of discharge.

**III. Completing a MOLST Form with the Patient**

1. If the patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, wishes to complete a MOLST form, the patient's clinician should be contacted. The clinician should discuss the patient's medical condition, prognosis and treatment options with the patient or the legally recognized health care agent. The discussion should include information or statements the patient has made regarding his/her values and goals for end of life care and treatments. The benefits, burdens, efficacy and appropriateness of treatment and medical interventions should be discussed by the clinician with the patient and/or the patient's legally recognized health care agent.

2. A health care provider such as a nurse or social worker can explain the MOLST form to the patient and/or the patient's legally recognized health care agent, however, the clinician is responsible for discussing treatment options with the patient or the patient's legally recognized health care agent and for co-signing the MOLST form with the patient or the legally recognized health care agent.

3. The above-described discussions should be documented in the medical record, and dated and timed.

4. The MOLST form is to be completed based on the patient's expressed treatment preferences and current medical condition. If the patient lacks decision-making capacity and the MOLST form is completed with the patient's legally recognized health care agent, it must be consistent with the known desires of and in the best interest of the patient.

5. In order to be valid, the MOLST must be signed by a clinician and by the patient, or if the patient lacks decision-making capacity the legally recognized health care agent.

6. Follow the instructions above for copying the MOLST form and putting it in the medical record.

7. Because the current original MOLST is the patient's personal property, ensure its return to the patient, or legally recognized health care agent, upon discharge or transfer[16].

8. If patient will not be transferred or discharged for a period of time, place the completed current original MOLST in the appropriate and prominent section of the chart. Indicate that the patient has a MOLST on the Discharge Summary Form/Discharge Checklist. The current original MOLST will be sent with patient at time of discharge.

**IV. Reviewing/Revising a MOLST Form**

1. Discussions about revising or revoking the MOLST should be documented in the medical record, and dated and timed. This documentation should include the essence of the conversation and the parties involved in the discussion.

2. At any time the attending clinician and patient, or if the patient lacks decision-making capacity the patient's legally recognized health care agent, together, may review or revise the MOLST consistent with the patient's most recently expressed wishes. In the case of a patient who lacks decision-making capacity, the attending clinician and the patient's legally recognized health care agent may revise the MOLST, as long as it is consistent with the known desires of and in the best interest of the patient.

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[16] Hospitals should designate by policy the specific staff responsible for this action.

3. During the acute care admission, care conferences and/or discharge planning, the attending clinician should review the MOLST when there is change in the patient's health status, medical condition or when the patient's treatment preferences change.

4. If the current MOLST is no longer valid due to a patient changing his/her treatment preferences, or if a change in the patient's health status or medical condition warrant a change in the MOLST, the MOLST can be voided. To void MOLST, write "VOID" in large letters on both sides of the form. Sign and date this line.

5. If a new MOLST is completed, a copy of the original MOLST marked "VOID" (that is signed and dated) should be kept in the medical record directly behind the current MOLST.

**V. Conflict Resolution**

If the MOLST conflicts with the patient's previously-expressed health care instructions, then, to the extent of the conflict, the most recent expression of the patient's wishes govern.

If there are any conflicts or ethical concerns about the MOLST orders, appropriate hospital resources – e.g., ethics committees, care conference, legal, risk management or other administrative and medical staff resources – may be utilized to address the conflict.

During conflict resolution, consideration should always be given to: a) the attending clinician's assessment of the patient's current health status and the medical indications for care or treatment; b) the determination by the clinician as to whether the care or treatment specified by MOLST is medically ineffective, non-beneficial, or contrary to generally accepted health care standards; and c) the patient's most recently expressed preferences for treatment and the patient's treatment goals.