MOLST LTC Cases Answer Key

Case 1

Slide 1

- 84 year-old woman admitted from the hospital following a CHF exacerbation
- MOLST completed in the hospital
- Photocopied MOLST (on white paper) is sent with resident to the Nursing Home

Slide 2

- **Is this advance directive documentation valid?**
  - ➢ Yes. Use of the original form is strongly encouraged. Photocopies and FAXes of signed MOLST are legal and valid.
- **Does the MOLST need to be completed again?**
  - ➢ No. However, MOLST orders should be reviewed and renewed as the resident is being transferred from one care setting to another.
- **What policies and procedures could address this situation?**
  - ➢ Policies and procedures should indicate that while use of the original form is strongly encouraged, photocopies and FAXes of signed MOLST are legal and valid.
  - ➢ Providing feedback to the hospital can assist with training and help ensure the original form travels with the patient and appropriate copies are retained by the hospital.
- **How do you provide feedback to the hospital?**
  - ➢ Call the hospital. Request that the original MOLST be sent to the nursing home. Indicate that a copy can be made to be kept at the hospital. Using pulsar pink paper retains the pinkness of the form and makes the form easily recognizable in an emergency.

Case 2

Slide 1

- 79 year old man with dementia, lacking decision-making capacity for advance care planning.
- He has prior DNR completed from admission 4 years ago to the facility.
- Nursing Home has now adopted the MOLST and appropriate policies.

Slide 2

- **How do you "transition" this resident to the new MOLST?**
  - ➢ Attach the prior DNR form from 4 years ago, along with the documentation of capacity, to the MOLST form.
- **Is his prior advance directive still valid?**
  - ➢ Yes. Converting to the MOLST does not negate the decision he made while he had capacity.
- **What does the health care proxy need to do?**
  - ➢ The Health Care Agent designated in the Health Care Proxy can make decisions regarding orders for other life-sustaining treatment and future hospitalizations, as outlined on MOLST. Decisions made by the Agent regarding artificial hydration and nutrition must be based on reasonable knowledge of the patient's wishes.
- **What about the non-Hospital DNR?**
  - ➢ If the patient resides in Monroe or Onandaga counties, a completed, signed MOLST form can replace the New York State Out-of-Hospital DNR form.
  - ➢ If the patient lives outside of Monroe and Onondaga counties, the New York State Out-of-hospital DNR form must be completed in addition to the MOLST.

MOLST LTC Cases Answer Key

Case 3

Slide 1

- 72 year old woman sustained a fall in the nursing home and has a probable right hip fracture.
- EMS arrives for transport to the hospital emergency department.
- She has an original copy of the pink MOLST in the medical record.

Slide 2

- **What needs to be done prior to the arrival of EMS and transport by ambulance?**
  - ➢ After completing the patient assessment, the patient is prepared for transport to the emergency department. Included in this process is the transfer of pertinent information, including the actionable medical orders contained on the MOLST form.
- **Do you send the original MOLST or a photocopy with the resident?**
  - ➢ Yes, send the original MOLST form and keep a photocopy for the chart.
- **If a copy is sent, how do you maintain the “pinkness” of the form?**
  - ➢ The nursing home makes a copy of the MOLST form on pulsar pink paper that is to be kept in the nursing home medical record.
- **What other documentation should be sent to the hospital?**
  - ➢ In terms of advance directives, a copy of the Health Care Proxy, the Living Will and any additional documentation of patient-centered conversations and preferences as well as assessment of patient capacity should be sent as well.

Case 4

Slide 1

- 79 year old male with multiple problems admitted to SNF
  - ➢ Health care proxy preferences, 2004: full code, wants tube feedings if necessary
- Multiple hospitalizations ensue in 2004
- Readmitted to the nursing home in late 2004
  - ➢ SW visits a few days after readmission; new health care proxy created and placed in the resident’s medical record
  - ➢ ”I have made my wishes known to my agent and I hereby authorize her to consent to withdrawal or withholding of artificial nutrition and hydration under circumstances known to her.”
  - ➢ Resident grants DNR status; hospitalize if condition warrants

Slide 2

- Medical record documentation
  - ➢ The day following the new health care proxy, the resident was examined by the Nurse Practitioner and his mini-mental exam score was 4.
  - ➢ Two days later, he was seen by the Attending Physician; no note was entered in the medical record but his code status was changed to DNR.
  - ➢ Further hospitalizations ensued and nothing was changed.

Slide 3

- July 2005 patient had a cardio-respiratory arrest.
  - ➢ Confusion arose as to what his code status was.
  - ➢ During CPR, attempts to reach the health care agent were unsuccessful.
  - ➢ Another member of his family said to continue CPR and send to the hospital.
- The patient was admitted to the ICU, intubated, and died the next day.
- A MOLST form had not been filled out.

MOLST LTC Cases Answer Key

Slide 4

- **What went right with the case?**
  - Health care proxy preferences were discussed at the time of admission. Unfortunately, capacity assessment is not documented.
- **What went wrong with the case?**
  - Capacity assessment was neither documented when he was first admitted in 2004 nor when he was readmitted in late 2004.
  - No goals for care documented throughout.
  - The results of his mini-mental status exam were noted by the NP but his ability to complete a Health Care Proxy was not addressed.
  - Capacity assessment was not addressed by his Attending Physician in light of the SW and NP notes. DNR order issued.
  - No discussion with family is documented in late 2004.
  - No further discussions are documented despite further hospitalizations.
- **When could/should a MOLST form have been filled out?**
  - A MOLST form could/should have been completed at the time of his initial SNF admission and reviewed and renewed at the time of transfer from one care setting to another and when there has been a substantial change in the resident's status.
- **What should have been done if this were your patient? Your relative?**
  - A MOLST form would have been completed at the time of his initial SNF admission and reviewed and renewed at the time of transfer from one care setting to another and when there has been a substantial change in the resident's status.
- **Did the SW, NP, Attending Physician err?**
  - All members of the team erred.
  - No apparent communication among health care team or with patient/family unit.
  - Capacity assessment was neither documented when he was first admitted in 2004 nor when he was readmitted in late 2004.

Case 5

Slide 1

- 89 year old woman with very advanced dementia, fully dependent in all aspects of care including feeding
- Admitted with aspiration pneumonia
- Although she is awake, she doesn't seem aware of much around her, even her husband who spends most of the day with her
- Rarely speaks a few words that may or may not make sense
- Has Health Care Proxy, DNR, no MOLST

Slide 2

- In the hospital, presently
  - very hard to feed
  - does not seem to want to eat
  - pockets her food, slow to swallow, sometimes coughs during feeding
- At nursing home, past 6 months
  - feeding pattern same for almost 6 months
  - always has a cough
  - fevers come and go sometimes
  - lost weight: now about 100lbs, down 30 lbs in 3 years

MOLST LTC Cases Answer Key

Slide 3

- Respiratory distress and fever have resolved
- Swallowing evaluation/study ordered
- Nurse contacts MD to meet with husband because the speech therapist state his wife needs a feeding tube
- Husband, her Agent is very worried
- When she had capacity, she wanted “No Heroics” to prolong her dying
- **How would you complete MOLST?**
  - Use the 8-Step MOLST Protocol, available on www.compassionandsupport.org, to guide the discussion.
  - Help husband to respect her wish for “no heroics” to prolong her dying.
  - Share medical evidence to ensure informed medical-decision making. Discuss benefits/burdens and review poor outcomes of artificial nutrition given clinical status.
  - The Agent can make any medical care decision the patient can make, including DNR. Decisions made by the Agent regarding artificial hydration and nutrition must be based on reasonable knowledge of the patient’s wishes.

Case 6

Slide 1

- 75 year old white female with idiopathic pulmonary fibrosis and severe osteoporosis
- On hospice in long term care facility
- Completed MOLST: DNR, DNI, no tube feedings, no IV fluids, comfort measures only
- She falls and breaks her hip
- **Should EMS be called?**
  - Yes. Comfort care needs cannot be met in her current location. Hospice care does not preclude treatment for a fractured hip.
- **If EMS is called, what should be plan of care?**
  - Transport to the hospital as comfort care needs cannot be met in current location.
  - A patient on hospice who sustains a hip fracture can undergo appropriate treatment, including surgical repair, which can provide palliation of pain.

Case 7

Slide 1

- 80 year old retired businessman, former athlete, currently resides in SNF
- 25-year history of Parkinson’s Disease
- 10-year history of associated dementia
- Host of other medical problems
- Dependent in all ADL’s
- Rarely “recognizes” his wife but does not recognize other family
- 2 years ago, he was moved from a private to semi-private room and became delirious; delirium lasted several months.

Slide 2

- Health Care Proxy and Living Will completed while he had decision-making capacity
- Wife is his named Agent and she has decision-making capacity
- Nursing staff at SNF discussed DNR
- Wife recognizes that this would be her husband’s wish but she is conflicted, as is son
- Daughter believes her father’s wishes should be honored regardless of personal feelings.
- Family meeting arranged

MOLST LTC Cases Answer Key

Slide 3

- Patient develops fever and is sent to ED before family meeting occurs
- **What would be the best way to initiate conversation with family re DNR?**
  - Use the 8-Step MOLST Protocol, available on www.compassionandsupport.org, to guide discussion.
- **When is best time to initiate conversation re DNR? Is it best in SNF before transfer, in ED or on hospital floor?**
  - While the best time for conversations is before an acute crisis, this time has passed. Assessment and treatment should not be delayed. If the patient has a substantial change in health status requiring transfer and the appropriate people are not immediately available, discussions should occur after the patient is transferred, assessed and treatment initiated.
  - When the patient is transferred, the nursing home staff should communicate the underlying family conflict regarding DNR to the hospital staff.
- **Under these circumstances, do you recommend a DNR order, or should you leave it fully up to the proxy to decide?**
  - Base conversations on patient goals. Allow the patient's goals to guide interventions.
  - Share medical evidence to ensure informed medical-decision making. Help family to understand poor outcomes of CPR given clinical status.
  - Be sure family understands that Do Not Resuscitate (DNR) *does not mean Do Not Treat (DNT)*.
  - The Agent can make any medical care decision the patient can make, including DNR. Decisions made by the Agent regarding artificial hydration and nutrition must be based on reasonable knowledge of the patient's wishes.

Slide 4

- **Are there other decisions triggered by MOLST that should be addressed with this family?**
  - Using Section E of the MOLST form, discussion should focus on other potential life-sustaining treatment, given the underlying multiple co-morbidities and current acute illness.
- **Do the legal standards of proof vary between decisions?**
  - In accordance with New York State Law, since the patient lacks capacity, capacity determination and the MOLST "Supplemental" Documentation Form for Adults must be completed.
  - Since the patient executed a Health Care Proxy while he had capacity and since his wife (his named Agent) has capacity, his wife is able to make all decisions on his behalf.
  - In terms of the DNR decision, his wife as Agent can base the decision on known patient wishes. The decision is not contingent on physician determination of lack of utility for cardiopulmonary resuscitation.
- **How would you have proceeded if there was not a named Agent?**
  - In accordance with New York State Law, since the patient lacks capacity, capacity determination and the MOLST "Supplemental" Documentation Form for Adults must be completed.
  - ***DNR**:*
    - If there is no Health Care Proxy and no named Agent, surrogate selection for DNR decisions is based on hierarchy established by New York State Law. See Step 4 on the "Supplemental" Documentation Form for Adults to select the appropriate surrogate, as listed in the order of priority.
    - The decision is contingent on physician determination of lack of utility for cardiopulmonary resuscitation. See Step 3 on the "Supplemental" Documentation Form for Adults.

MOLST LTC Cases Answer Key

- ***Life-Sustaining Treatments:***
  - For incapacitated patients without a Health Care Agent, clear and convincing evidence must exist, in the form of a living will or repeated oral expression, as per In the Matter of Westchester County Medical Center, on behalf of Mary O'Connor, p. 8:
    - *"The ideal situation is one in which the patient's wishes were expressed in some form of a writing, perhaps a "living will," while he or she was still competent. The existence of the writing suggests the seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks."*
    - *"Of course, a requirement of a written expression in every case would be unrealistic. Further, it would unfairly penalize those who lack the skill to place their feelings in writing. For that reason, we must always remain open to applications such as this, which are based upon the repeated oral expressions of the patient."*