



MEDICAL ORDERS FOR LIFE SUSTAINING TREATMENT (MOLST)

1.0 Introduction:

In 1987, the DNR Law was enacted in the State of New York in response to a recognized need to legalize and codify DNR Orders. Thereafter, the Health Care Proxy Law was passed which took precedence over any conflicting provisions in the DNR Law and finally, the Family Health Care Decisions Act (FHCDA) was passed, effective June 1, 2010, which essentially subsumed the DNR Law by creating Surrogates to make health care decisions including DNR.

Please note that maximal therapeutic effort is compatible with DNR orders that every patient is to be resuscitated in the absence of a DNR order. Also be aware of the availability of an Ethics Consult and an Ethics Review Committee for those instances where differences of opinion occur.

Consent to the writing of a DNR order does not constitute consent to withhold or withdraw medical treatment other than CPR. Furthermore, a DNR order does not preclude an individual from requesting certain resuscitative interventions, including, but not limited to Heimlick maneuver, medication for arrhythmias, and intubation for respiratory distress.

2.0 MOLST: Medical Orders for Life Sustaining Treatment is a portable document designed to help health care professionals honor the treatment wishes of their patients. The MOLST is a set of physician's orders and does not replace existing advance directives, but summarizes the patient's wishes. The MOLST form was revised, effective June, 2010, consistent with the FHCDA.

3.0 Definitions:

3.1 *Adult* – Any person who is eighteen years of age or older, or who is under the age of eighteen but is the parent of a child or has married.

3.2 *Attending Physician* – The physician selected by or assigned to a patient who has primary responsibility for the treatment and care of the patient. Where more than one physician shares responsibility, or where a physician is acting on the attending physician's behalf, any such physician may serve as the attending physician for purposes of this policy.

3.3 *Capacity* – The ability to understand and appreciate the nature and consequences of DNR/MOLST orders, including the benefits and disadvantages of such an order, and to reach an informed decision regarding DNR/MOLST order. Every adult patient is presumed to have capacity unless there has been a determination of lack of capacity. If a determination has been made of lack of capacity, the Health Care Proxy or Surrogate Decision-Maker under FHCDA and the patient (if there is any indication of their ability to comprehend information) shall be promptly notified.

3.4 *Cardiopulmonary Resuscitation (CPR)* – Measures to restore cardiac function and/or to support ventilation in the event of a cardiac or respiratory arrest.

3.5 *Close Friend* – Any person eighteen years of age or older who is a close friend of the patient, or a relative of the patient (other than a spouse, adult child, parent, brother, or sister), who has maintained such regular

contact with the patient as to be familiar with the patient's activities, health, and religious or moral beliefs, and who presents a signed statement to that effect to the attending physician.

3.6 *Concurring Determination* – An initial determination that a patient lacks decision-making capacity shall be subject to a concurring determination, and documented in the patient record. A health or social services practitioner (Section 3.12) employed by or formally affiliated with the facility must independently determine whether an adult patient lacks decision-making capacity if the surgeon's decision concerns the withdrawal or withholding of life-sustaining treatment. If the patient lacks capacity because of a mental illness as defined by OMH (this does not include dementia), the concurring physician must be board certified or board eligible in psychiatry. If the patient lacks capacity because of developmental disability, the concurring opinion must be rendered by a physician or psychologist with special experience or training in the field of developmental disabilities approved by the Commissioner of Mental Retardation and Developmental Disabilities.

3.7 *Developmental Disability* – A disability of a patient attributable to mental retardation, cerebral palsy, neurological impairment of autism, or other similar condition which constitutes a substantial handicap to the patient's ability to function normally in society as defined in subdivision twenty-two of section 1.03 of the mental hygiene law.

3.8 *Domestic Partner* means a person who with respect to another person:

- Is formally a party in a domestic partnership or similar relationship with the other person recognized by the law of the United States or any state or foreign jurisdiction. OR
- Is formally recognized as a beneficiary or covered person under the other person's employment benefits or health insurance. OR
- Is dependent or mutually interdependent on the other person for support.

3.9 *Do Not Intubate (DNI) order* – An advance directive that precludes the placement of an endotracheal (orotracheal or nasotracheal) tube or tracheostomy tube. A DNI order does not preclude the use of CPAP or BiPAP.

3.10 *Ethics Review Committee* is an interdisciplinary committee, whose members are determined by hospital Administration and in consultation with the Ethics committee to respond to the following situations:

1. Hospital or attending physician objects to surrogate's decision to withdraw/withhold artificial hydration/nutrition.
2. To resolve a dispute among persons involved in a case NOT resolved by other discussions (this can include an ethics consult) and
3. Emancipated minor request to withdraw/withhold life sustaining treatment.

The Ethics Review Committee will follow procedures as outlined in the FHCDA when convened to provide advice, make recommendation about proposed health care or provide assistance in resolving disputes.

3.11 *Health Care Agent (HCA)* means a health care agent designated by an adult and pursuant to article twenty-nine CC PHL. A proxy/surrogate (who may be a family member or other individual) must be designated by the patient while the patient had capacity, either:

- (1) In writing, dated, and signed in the presence of two witnesses who shall sign the designation,
OR
- (2) Orally in the presence of two witnesses.

The HCA has the same rights and duties of an adult with capacity.

- 3.12 *Health or social service practitioner* means a registered professional nurse, nurse practitioner, physician, physician assistant, psychologist or licensed clinical social worker, licensed or certified pursuant to the education law acting within his or her scope of practice. This includes hospital medical staff and licensed house staff.
- 3.13 “*Life-sustaining treatment*” (*LST*) means any medical treatment or procedure without which the patient will die within a relatively short time as determined by an attending physician to a reasonable degree of medical certainty. CPR is presumed to be a LST.
- 3.14 *Mental Illness* – An affliction manifested by a disorder or disturbance in behavior, feeling, thinking or judgment to such an extent that the patient requires care, treatment, and rehabilitation. This means a mental illness defined in subdivision twenty of section 1.03 of the mental hygiene law, and does not include dementia, such as Alzheimer’s disease, or other disorders related to dementia.
- 3.15 *Minor* means any person who is not an adult. If the minor has decision-making capacity as determined by the attending physician in consultation with the minor’s parent or guardian an order to withhold/withdraw LST cannot be implemented without the minor’s consent.
- 3.16 *Order Not to Resuscitate (DNR Order)* – An order not to attempt CPR in the event of a cardiac or respiratory arrest.
- 3.17 *MOLST* – Medical Orders for Life Sustaining Treatment is a *physician’s order sheet*, based on the patient’s current medical condition and wishes addressing issues related to Do-Not-Resuscitate (DNR), Do-Not-Intubate (DNI) and other Life-Sustaining Treatment (LST).
- 3.18 *Previously Consented* – A consent to a DNR/MOLST order by a patient prior to losing capacity which was given in a manner consistent with this policy.
- 3.19 *Surrogate* – A person selected to make decisions regarding health care decisions on behalf of a patient only in the absence of a health care proxy. In order of priority listed, the following individuals, who must be reasonably available, willing, and competent to make a decision regarding health care may serve as a surrogate.
- Health care agent;
 - Guardian, authorized by article 81 of the Mental Hygiene Law;
 - A spouse or domestic partner;
 - A son or daughter, aged 18 or older;
 - A parent;
 - A sibling, aged 18 or older; or
 - A close friend (See Section 3.5)
- (If no appropriate surrogate decision-maker is available go to checklist #4)

Surrogates may authorize to withhold or withdraw treatment only if the treatment would be an extraordinary burden to the patient and the attending physician determines that to a reasonable degree of medical certainty with independent concurrence of another physician:

- The patient has an illness or injury expected to cause death within 6 months whether or not treatment is provided, OR
- The patient is permanently unconscious, OR
- The provision of treatment would involve such pain, suffering or other burden that it would reasonably be deemed inhumane or extraordinarily burdensome under the circumstances and the patient has an irreversible or incurable condition as determined by the attending physician with independent concurrence by another physician.

3.20 *Health Care Agent (HCA)* – An HCA has the same rights and duties of an adult with capacity. If the principal’s wishes regarding artificial nutrition/hydration (AHN) are not reasonably known or cannot be ascertained, the HCA shall not have the authority to make those decisions regarding AHN.

3.21 *Witness* – Any individual aged eighteen or over.

3.22 *Verbal Consent* – If verbal consent is given for a DNR/DNI by a patient with capacity, Health Care Agent, or the Public Health Law Surrogate, the form must be witnessed by 2 individuals, one of whom can be the attending physician (See Section 3.2).

4.0 Documentation and Implementation of MOLST

4.1 MOLST: (Medical Orders for Life-Sustaining Treatment DOH-5003 6/10/Lawson Form #11004. This is a Physician’s order sheet. It is based on the patient’s current medical condition and wishes. It summarizes advance directives including resuscitation status as well as other orders for LST. The MOLST form also serves as a Non-Hospital DNR and DNI order in New York State.

4.2 The following checklists will serve to meet legal requirements and serve as documentation in the medical record.

Documentation for health care decisions

- **Checklist #1 Adult patients with medical decision-making capacity (form #13231):**
http://intranet/network2000/mrforms/pdf_forms/13231.PDF
- **Checklist #2 Adult patients without medical decision-making capacity who have a health care proxy (form #13232):** http://intranet/network2000/mrforms/pdf_forms/13232.PDF
- **Checklist #3 Adult patients without medical decision-making capacity who do not have a health care proxy, and decision-maker is Public Health Law Surrogate (form #13233):**
http://intranet/network2000/mrforms/pdf_forms/13233.PDF
- **Checklist #4 Adult patients without medical decision-making capacity who do not have a health care proxy or a Public Health Law Surrogate (form #13234):**
http://intranet/network2000/mrforms/pdf_forms/13234.PDF
- **Checklist #5 Adult patients without medical decision-making capacity who do not have a health care proxy, and MOLST form is being completed in the community (form #13235):**
http://intranet/network2000/mrforms/pdf_forms/13235.PDF

Place MOLST and checklist in AHD section of the Medical Record.

4.3 If checklist #4 is selected, the Vice President of Medical Affairs will select the concurring physician. An Ethics consult will be required.

4.4 Verbal Orders – If a health practitioner, acting in place of attending physician, has a conversation regarding AHD, they will complete the appropriate checklist and obtain a verbal order from the attending physician. The verbal order will be documented on the **MOLST form in Section C on PRINT physician name line with VO and print the physician’s name and date/time**. The health practitioner will print their name as one of the witnesses in Section B. Attending physician must sign within 24 hours on MOLST form.

4.5 Waiver of Do Not Resuscitate Order For Procedures (form #13610):
http://intranet/network2000/mrforms/pdf_forms/13610.pdf The DNR order is not automatically waived when a patient with a DNR order goes to surgery, dialysis, or any other procedure. With informed consent, after discussion with the patient or his/her proxy/surrogate (if the patient does not have capacity) an attending physician must document on the Waiver of DNR for Procedure form the waiver of the DNR order

during the perioperative/periprocedure period. The perioperative/periprocedure period is defined as that period from the time the patient leaves his/her room until he/she returns to the room after surgery.

With respect to patients at ambulatory surgery centers, the perioperative/periprocedure period is defined as that period from the time the patient leaves the preoperative/preprocedure area until he/she arrives at the Phase II recovery area.

5.0 Review of DNR/MOLST Orders:

- 5.1 The attending physicians must review the DNR/MOLST order of acute level inpatients in light of the patient's condition at least every 7 days (or more often if there is a significant change in the patient's status) and document such review on the DNR/MOLST order sheet (Section F). If not reviewed in 7 days, the DNR is still in effect. For Alternate Level of Care patients, the review of the DNR/MOLST order must be at least once every 60 days or sooner if warranted by a change in the patient's condition.
- 5.2 In the community, a Non-hospital order not to resuscitate shall be reviewed for appropriateness by the attending physician each time he/she examines the patient but at least every 90 days. Failure to comply with this review shall NOT render the non hospital DNR ineffective.

6.0 Rescinding/Revocation of DNR Orders:

- 6.1 A patient may revoke his consent to DNR/MOLST orders at any time by an oral or written declaration made to a physician or member of the nursing staff, or by any act evidencing intent to revoke consent.
- 6.2 When a patient, HCA/surrogate, or a parent or legal guardian in the case of a minor, informs a member of the health-care team that he/she wants the DNR/MOLST orders rescinded, the RN will notify the physician of the decision immediately. The DNR/MOLST orders are rescinded at the time any member of the care team is notified. The attending physician must amend Section F indicating either 'form voided, new form completed' or 'form voided, no new form'. If form VOIDED, VOID must be written across all sections of the MOLST form and dated and initialed by health care practitioner. Attach a patient sticker to the first page so that Medical Records will know which account to apply it to. If a new MOLST is completed, the VOIDED MOLST can be send down with the discharged charts of the day. Do not send inner-office mail.
- 6.3 In cases in which a DNR order has been written for patient who lacks capacity, if the attending physician determines that the patient no longer has a condition that would allow for a DNR order, or the patient has gained or regained capacity, then the attending physician shall document this in the patient's medical record. Void the DNR order and notify all hospital staff responsible. If the newly capable patient requests a DNR status, a new MOLST form should be completed.

7.0 Ethics Review Committee

- 7.1 The Law provides that each institution must identify a system for reviewing disagreements relating to LST (See Section 3.13). Persons wishing to refer matters to the ethics review committee should call Administration and request an ethics consult. The ethics consult committee will attempt to resolve the dispute. If this is not possible, the case will be referred to the Ethics Review Committee (See Section 3.10).

8.0 Patients Transferred from Mental Hygiene Facilities:

- 8.1 Whenever a patient has been transferred to the hospital from a facility licensed by the Office of Mental Health or by the Office of Mental Retardation and Developmental Disabilities, any notice required by the Policy or the Documentation Sheets shall also be given to the Director of the sending facility. If the Director objects to the DNR/MOLST order, an Ethics consult is recommended. If no resolution of the conflict, the matter shall be referred to the ethics review committee.

9.0 Inter-Institutional Transfers:

- 9.1 When a patient is transferred and a valid DNR/MOLST order was signed in the transferring facility, the DNR/MOLST order remains in effect in the receiving facility until the attending physician examines the patient. This examination should occur as soon as possible but no longer than 24 hours after admission. Once the patient is examined, the physician must renew, modify or void the DNR/MOLST order. An order may be renewed by signing Section F without further documentation or checklist completion. The original or a copy of the valid DNR/MOLST order and other AHD from the transferring facility must be placed in the medical record.
- 9.2 When a patient is transferred from another facility and a DNR order has been signed using forms other than the DNR/MOLST forms, the attending physician at the receiving facility will need to review the DNR order and attach it to the DNR/MOLST form and document on the MOLST form it has been reviewed and sign and date it in section F. The checklist does not need to be completed.

10.0 Non-hospital DNR Orders:

- 10.1 The MOLST form is the Non-hospital DNR/DNI order recognized throughout New York State.
- From a proxy-designated health care agent, orally, to the attending physician alone even though two witnesses are recommended
- 10.2 For a patient not in a hospital, the attending physician is defined as the one who has primary responsibility for the care and treatment of the patient. If this responsibility is shared by more than one physician, any of the physicians can obtain the consent.
- 10.3 Consent in the community may be obtained:
- From the patient, in writing, dated, and signed in the presence of at least one witness eighteen years of age or older even though two witnesses are recommended; or
 - From the patient, orally, to the attending physician alone; even though two witnesses are recommended

11.0 DNR/MOLST order completion in-hospital patient

- 11.1 If the patient brings a copy of the MOLST form on admission, the document needs to be reviewed within 24 hours and section F needs to be updated.
- 11.2 If the patient has a MOLST form but did not bring it to the hospital, it can be printed by health information management at the request of the nurse and/or upon review of admission by health information management and fax a copy to the unit. The appropriateness of the order must be reviewed within 24 hours and Section F must be signed and dated. This copy is a legal and binding document.
- 11.3 If the patient had a MOLST form filled out on a previous admission and now does not have capacity, the original MOLST is still applicable. The Health Care Agent or surrogate must be notified of the order within 24 hours and this discussion should be documented within the chart, and section F must be filled out. A new MOLST form or checklist does not need to be completed.
- 11.4 If additions are made to previous MOLST form, document in section E with name, date and time.
- 11.5 If a patient requests a DNR order and they do not have supporting documentation, the nurse will immediately notify the physician/clinical affiliate and document in the computer under the notification tab (See Section 4.3)

11.6 If a patient in the community has a Non-Hospital Do Not Resuscitate Order form, the physician may transcribe that order onto the MOLST form upon review of the form with the patient and the patient's decision-maker, if any. Once the physician has signed the MOLST, the separate non-hospital form should stay as part of the patient's medical record in the physician's office or hospital record but need not remain as part of the MOLST.

12.0 Discharge:

12.1 When a patient is discharged, the unit secretary will copy the MOLST form and place it in the AHD section of the medical record. The patient will retain the Bright Pink original.

12.2 The secretary from each unit will fax on discharge to the Primary Care Provider the MOLST form with the discharge instruction information.

12.3 If pink (original) form is sent to health information management at discharge, it will be mailed to the patient's address or to the facility the patient was discharged to.



A Higher Level of Care

POLICY/PROCEDURE/FORMS TRACKING FILE

Title: Medical Orders for Life Sustaining Treatment (MOLST)	
Document Owner: Mary Rose Kott	Department:
Reviewed by the following:	
Dr. Robert Friedman	Date: 4/03 5/05 12/05 2/06
Executive Committee of the Medical Staff	Date: 2/06
Hospital Policy	Date: 4/06
NRED	Date: 3/06
Dr. Ehrich	Date: 11/08
Don Nichols	Date: 9/08 5/10 7/10 10/10
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Ethics Committee	Date: 9/10
Administrative Approval:	
<p>Sandra Sulik, M.D. Vice President for Medical Affairs</p> <p>AnneMarie W. Czyz, RN, MS Chief Nursing Officer and Vice President for Clinical Services</p>	
Education:	
<input checked="" type="checkbox"/> Monthly policy/procedure update	Dates: 12/10
<input type="checkbox"/> Lecture	Dates:
<input type="checkbox"/> Poster	Dates:
<input type="checkbox"/> Online Inservice	Dates:
<input type="checkbox"/> Other	Dates:
<p>2/06, 3/06, 4/06 Core presentation. All Medical and Nursing Staff Educated during the months of March and April 2006</p> <p>4/06 On line In-service and Core Presentation</p> <p>11/08 Core Presentation</p> <p>11/09 Core Presentation</p> <p>7/09 Core Presentation</p> <p>10/10 All nursing education during month of October</p> <p>10/10, 11/10 On line inservice</p> <p>11/10 Medical staff education</p>	

Revisions: 5/06 All terminology and forms revised to reflect community standard 12/05 If a patient presents without their pink copy, but we have a DNR on file, it may be used. The physician will need to review it. 5/06 Revised Form, Replaces Non-Hospital DNR for Monroe & Onondaga Counties. Do Not Intubate has been moved to section E 12/08 Revised to reflect changes in NYS Law 7/09 12.4 added statement "The physician/clinical affiliate will be immediately notified if a patient verbalizes a desire to be a DNR, and no documentation is in the patient record." 12/10 Editorial Clarification	
List References: R = Research L = Literature N = National Guidelines E = Expert Opinion 5/06 N NYS and Federal Law Patient Determination Act 7/08 NYS –PHL § 2977 (3) Signed Governor Patterson 7/8/08 6/10 Family Health Care Decision Act Article 29-CC	
Original Date: 4/88	Reviewed/Revision Dates: 9/89 11/90 9/91 1/92 5/93 7/93 10/93 12/95 10/96 8/98 12/00 3/01 4/03 5/05 12/05 5/06 12/08 7/09 12/10