Implementation of Medical Orders for Life-Sustaining Treatment

Janette N. Evans, RN, MS, ANP-C, Lisa S. Ball, PhD, RN, FNP-BC, and Camille P. Wicher, PhD, Esq., MSN, RN

**Background:** When an outpatient in a northeastern cancer institute requested a Medical Orders for Life-Sustaining Treatment (MOLST) form, the state’s approved resuscitation form in all settings, none were available. A project was undertaken to institute MOLST forms into policy and routine practice. Research supports early discussions of end-of-life care in patients with cancer and the use of MOLST as an effective tool.

**Objectives:** The purpose of this article is to discuss the initiation and facilitation of MOLST implementation into practice and policy at a cancer institute.

**Methods:** Introducing, overcoming resistance to, piloting, and adopting MOLST in an oncology setting is reported and explained based on the three stages of Lewin’s Theory of Planned Change: unfreezing, moving, and refreezing.

**Findings:** A small pilot of MOLST with palliative care providers demonstrated the feasibility and suitability of using MOLST in the oncology setting. MOLST was adopted into policy and routine practice at the cancer institute.

**Background**

Speaking to patients about EOL care and life-sustaining treatment is difficult in any patient population, but, in the presence of cancer, this conversation becomes even more challenging. Discussing EOL care has not historically been common practice in cancer care, even when patients have advanced disease. Early discussions are particularly important in this setting because the treatment itself may cause further illness (Ozanne, Partridge, Moy, Ellis, & Sepucha, 2009). Most patients with cancer want medical professionals to include them in the decision-making process (Miccinesi, Bianchi, Brunelli, & Borreani, 2012), but very few actually discuss advance directives with their providers (Dow et al., 2010). In addition, initial discussions about EOL care are best approached when patients are stable, but most are initiated after patients have been admitted to the hospital and when their health may be unstable (Bernacki & Block, 2014).

The proper use of advance directives and early EOL discussions can benefit patients and their loved ones. In a study focused on patients with advanced cancer, 125 (39%) of 322 patients who had discussed EOL care with their physician were more likely to receive care that aligned with their wishes than patients who did not (Mack, Weeks, Wright, Block, & Prigerson, 2010). Families also experienced less anxiety, depression, and stress related to a patient’s death when an advance directive was in place (Mahon, 2011). Appropriate communication can prevent patients from receiving unwanted aggressive medical care close to death and allow for a better quality of life for
patients and family members (Boyd, Merkh, Rutledge, & Randall, 2011).

Despite existing for a half-century, traditional advance directives, such as living wills and healthcare proxies, fall short of fulfilling the needs of patients. The concept of advance directives was introduced in the late 1960s, allowing patients to document their wishes in a "living will," and the concept has continued to evolve (Sabatino, 2010). In 1990, the Patient Self-Determination Act was passed, mandating that healthcare facilities receiving Centers for Medicare and Medicaid Services funding inform patients on admission about advance healthcare directives (Cohen & Nirenberg, 2011; Nevidjon & Mayer, 2012). However, as was reported to Congress in 2008, advance directives fail to consistently ensure that patients' wishes are fulfilled (U.S. Department of Health and Human Services, 2008). This disparity may be attributable to complex language being used in the forms, patients' goals changing over time without revisions being made to their advance directives, and healthcare agents having a poor understanding of patients' wishes (Hickman, Sabatino, Moss, & Nester, 2008).

One form for advance directives, the Physician Orders for Life-Sustaining Treatment (POLST), was developed in Oregon during the late 1990s to address those gaps found with traditional advance directives (Hickman et al., 2008; Richardson, Fromme, Zive, Fu, & Newgard, 2014). POLST can be used in conjunction with advance directives or alone (Bomba, Kemp, & Black, 2012). These are actionable and legal orders completed with patients in advance of health crises, rather than instructions that need to be translated into an order when patients become gravely ill (Bomba et al., 2012). Evidence from a decade of research has further supported POLST's accuracy in communicating chronically ill patients' wishes at EOL (Bomba, Morrissey, & Leven, 2011). Educational resources are listed in Figure 1.

Since its inception, the POLST paradigm has been implemented in most states with at least 14 different names, including MOLST (Nogler, 2014; Pope & Hexum, 2012). The number of states with a POLST program continues to grow. At this time, endorsed programs exist in 17 states and developing programs in 28 states. The only states that have not initiated some sort of POLST program are Alabama, Alaska, Arkansas, Nebraska, and South Dakota (POLST: Physician Orders for Life Sustaining Treatment Paradigm, 2015). The National POLST Paradigm Task Force (NPPTF) was developed in 2004 to ensure consistent quality among programs because they differ to fit each state's specific medical, cultural, and legal needs (POLST: Physician Orders for Life Sustaining Treatment Paradigm, 2015). The universal concept of these forms is to clearly define EOL care wishes in a legal and universally recognized actionable physician order (Nogler, 2014).

The POLST program adopted at the Roswell Park Cancer Institute in Buffalo, New York, is approved by the New York State Department of Health in all healthcare settings across the state. The form used is a MOLST form and is intended for patients with a limited life expectancy. However, this form can be completed with anyone who wants to specify his or her wishes (Bomba et al., 2011; Schmidt, Zive, Fromme, Cook, & Tolle, 2014). MOLST is an unbiased tool that clearly defines a patient's requests in a medical order; in addition, it is universally recognized by healthcare professionals, including first responders (Bomba et al., 2011; Hickman et al., 2010). The situations specifically addressed on the form are resuscitation status, intubation and mechanical ventilation, antibiotics, artificial nutrition and hydration, transportation to the hospital, and intensive care unit care (Bomba et al., 2011). The National Quality Forum (2006) reported that the MOLST and similar forms are more often adhered to by medical professionals and communicate a patient's preferences for EOL care more accurately than other types of advance directives.

Lewin's (1947) three-stage change theory has been used extensively to guide planned practice change. The unfreezing stage consists of recognizing what change is needed and challenging the current thought process or behavior (Lewin, 1947); for the current article, this stage involved developing a rapport with stakeholders and helping them to realize the benefits of implementing MOLST into policy and practice. During the moving stage, a detailed plan was created, and key stakeholders were engaged to pilot the proposed change, which was suggested by Shirey (2013) who has discussed practical strategies for nurses wishing to facilitate organizational change. Refreezing occurred when MOLST was adopted into practice at the cancer institute; during this stage, providing positive feedback, recognition, and encouragement is critical because individuals are vulnerable to lapsing into the previous behavior (Lewin, 1947; Shirey, 2013; Stichler, 2011).

Unfreezing Stage

Upon learning that MOLST forms were not available at the cancer institute, research was compiled to support the use of MOLST. A meeting was then scheduled by the investigator—one of the current authors—with the cancer institute's vice president of medical ethics and research subject protection and the vice president for risk management and corporate compliance, as well as social work representatives and the palliative care team. This meeting was called to propose the introduction of MOLST forms into the institute and identify approaches for implementation.

The parties present at the proposal meeting had varying opinions on the appropriateness of initiation of MOLST forms at the institute. The vice president for risk management and corporate compliance stated that MOLST had been explored several years prior but was abandoned when resistance was encountered from physicians at the institute. One physician from the palliative care team questioned whether the form was
suitable for the setting. A social worker present wondered about the extensiveness of the form and how long it would take to complete; she felt this was not a feasible task for the providers. A physician, nurse practitioner, and nurse who had prior experience with the form supported initiating MOLST into practice at the institute. They provided real-life situations where MOLST would have been more effective than the do-not-resuscitate (DNR) forms available at the institute, such as regarding issues like intubation and tube feeding. The vice president of medical ethics and research subject protection believed that the form could be introduced but stressed that it should not be the sole format for advance directives at the facility. The meeting concluded with a cooperative decision to pilot MOLST with the palliative care team—which included two clinical nurse specialists, two nurse practitioners, and two physicians—in their outpatient clinic and with the inpatients who had palliative care consults. The fit and ease of use of MOLST at the institute was to be pilot tested to provide evidence regarding feasibility of the MOLST for widespread use at the institute.

Moving Stage

A plan was put in place to pilot the MOLST forms. A means for obtaining mass numbers of MOLST forms was set in place with the institute’s print shop, including ordering fluorescent pink cardstock and uploading a digital copy of the form into the internal print shop ordering system, so that the form could be printed at the institute. MOLST and POLST forms are printed on bright pink cardstock to facilitate identification by medical personnel in emergency situations. In addition, MOLST forms and information booklets were ordered from the state’s department of health and provided to the palliative care team to use until the capability to print was finalized.

Although the palliative care providers had an understanding of how to appropriately fill out the MOLST form from prior experiences, this was reinforced with additional education by the investigator and palliative care team. This review included a checklist and other information from the state’s department of health, such as the legal processes related to MOLST (e.g., who can make decisions about a patient’s status, who may complete the details of the patient’s wishes, what sections must be completed, how the MOLST form is appropriately witnessed, what providers may sign the orders). During a three-month period, the palliative care team used the form in the outpatient clinic and on the inpatient units.

The palliative care team members also provided anecdotal evidence and completed an informal survey regarding ease of use of the MOLST form, its suitability for the institute, and how its implementation might be easily facilitated into practice there. Overall, team members described a positive experience using the MOLST form at the institute and unanimously agreed that the form worked well in this setting and that it was “easier to use this form since it is what is used in most facilities” throughout the state and across the country. They felt that, although the form initially seemed cumbersome to complete, the more they used it, the easier the form became to fill out. The two areas that patients addressed most often were resuscitation status and intubation. Being able to specify whether a patient wished to be intubated turned out to be particularly useful because this was not addressed in the existing DNR order. The other life-sustaining measures listed on the MOLST form were discussed with the patient when appropriate. Addressing the use of IV fluids and feeding tubes is decided on a case-by-case basis, and, if decisions exist that a patient is not prepared to make or that a provider does not feel is necessary to address at that time, a partially completed form is acceptable. Documentation of DNR or do-not-intubate status is all that is traditionally done, and the form itself would have to be reviewed if and when the other issues need to be addressed. Legally, the form cannot be edited, so if a patient wishes to revise his or her decisions, a new form would need to be completed. With implementation of MOLST forms at this cancer institute, providers verbalized that they appreciated the ability of the form to serve as a clear communication with other healthcare professionals. The consensus was that educating the cancer institute’s staff would be the best way to facilitate the implementation of MOLST throughout the institute. One of the providers also suggested the use of MOLST champions on each floor.

Following the three-month pilot project with the palliative care team, feedback was sought from nurse managers and supervisors regarding implementation of MOLST throughout the cancer institute’s various inpatient and outpatient settings. Two of the nurse managers had had positive experiences with MOLST; one of them even claimed that the form “saved” the nursing staff while dealing with a difficult critically ill patient who was having trouble making decisions about life-sustaining treatments. Unfortunately, no definitive way to indicate that a MOLST form had been completed was established during this implementation project; as a result, the number of forms completed is unclear. However, this limitation was later recognized, and MOLST information was added to patients’ electronic medical record so that these numbers could be easily tracked in the future.

Additional meetings with the investigator, palliative care team, and vice president of medical ethics and research subject protection ensued to discuss facilitation of MOLST across the institute. The vice president of medical ethics and research subject protection was agreeable and took materials to present to the Council of Chairs, consisting of the head physicians at the institute. A decision was made to include the form in new patient packets at the institute so that patients could be familiar with MOLST when providers approached the subject with them.

Refreezing Stage

The vice president of medical ethics and research subject protection and her staff added MOLST to the existing DNR orders, advance directives, and family health decision policy as an available advance directive form. The MOLST forms were available only in paper form. An electronic version is available in New York and was proposed to the providers, but they felt it would be overwhelming and confusing to simultaneously introduce paper and electronic versions. In the following weeks, MOLST forms were introduced and disseminated across the cancer institute’s settings, and education was provided to physicians, RNs, and other healthcare professionals during grand rounds and staff meetings. The senior patient education facilitator was charged with placing the MOLST forms in the new patient packets and adding information regarding MOLST
to the patient education booklets about advance directives. At discharge, MOLST forms were copied in their entirety and placed in the electronic medical record, and the original forms were sent home with patients. Patients also were instructed to position the form on their refrigerator because that location is where emergency medical service employees are instructed to look for it. In addition, patients were told to bring the form with them to their other providers to record its instructions.

A plan was developed to create online and face-to-face inservices for the nursing staff; these were to involve reviewing the updated policy, reading material about the proper use of the MOLST form, and providing a link to the state department of health’s website. The investigator formally introduced the project during a meeting with the cancer institute’s nursing management, as well as addressed any questions about moving forward with a hospital-wide implementation.

Discussion

This MOLST implementation project adds a small-scale example to the scarce but needed body of knowledge in this area. Despite concern related to the suitability of MOLST in a cancer institute, MOLST was feasible, theoretically and practically, in this setting. Additional research related to implementation of MOLST across various settings is warranted. Examining MOLST compared to other forms of advance directives is also necessary to generate evidence to support best practices. The specificity of the form has been found to improve care by allowing the providers and nurses to deliver care directed by patients.

EOL care in cancer settings is a difficult subject to broach. A gap exists in the literature concerning early discussions of EOL and palliative care in cancer settings. The effects of integrating MOLST into discussions of EOL care should be examined to determine if and to what degree MOLST facilitates these conversations and the resulting decisions. Complications can arise from cancer treatment, causing patients to urgently make EOL decisions. Patients may need to seek care from providers who do not know them or their wishes in an EOL situation. MOLST has been adapted in most states across the United States, and it allows for clear communication across multiple settings, including the home, when patients face EOL decision making. Having a MOLST form may reduce stress for patients and families. This has not clearly been researched in the cancer setting, but findings from the current implementation project demonstrate that providers realized and appreciated the benefits of MOLST form has been found to improve care by allowing the providers and nurses to deliver care directed by patients.

Implications for Nursing and Conclusion

Overall, the current project demonstrated that providers quickly became comfortable with and appreciated using MOLST with their patients. Initial concerns included the cumbersome nature of the form, and because this project was small, this facet was only limitedly explored. A large-scale study of providers that explores the ease or difficulty using the MOLST form could provide data to improve the experience for future providers new to MOLST.

As a result of MOLST and POLST not being nationwide initiatives, a change agent from each state must take on the responsibility of developing a program. Assistance is available through the NPPTF, but this is a large undertaking. Continued exposure and understanding in the medical community through varied publication may develop more interest in the states that lack such a program. In this age of readily available information, members of the public should easily be able to discover what is available in their respective state and inquire when gaps exist from state to state.

Advocating for change to benefit patients is the responsibility of any nurse who recognizes a gap in practice. The process of change can be tumultuous, but the promise of improved practice is necessary to advance healthcare delivery. The use of Lewin’s change theory can aid in changing practice in this area.

Because MOLST was New York’s approved universal resuscitation form, the initial assumption was that it would be readily accepted by the cancer institute. Realizing that more challenges existed than first expected, and before MOLST could be accepted across the cancer institute, momentum had to be built and support gained from key stakeholders. Dedicating time to presenting the benefits of MOLST to physicians, nurses, social workers, and members of nursing and medical management proved to provide additional support for MOLST, benefiting the patient population of this institute. In addition, being available for continuing discussion and exploration of questions that arose maintained momentum throughout the project. Also, as the participants who used MOLST presented positive feedback, more support was gained. The ability to share experiences from trusted institute providers and staff reinforced the necessity of using MOLST to key stakeholders. Recognizing that having a completed MOLST form was able to improve the delivery of care for patients was vital to MOLST being added to the institute’s policy.

Exploring all aspects of implementing a proposed change is needed to find where gaining support is most important, as well as the most appropriate strategy to alter the current practice. Implementation of MOLST in a cancer institute demonstrated how even a small project can be used to ease resistant forces and ultimately allow a major change to occur. This project concluded with the institute having the ability to use the MOLST form to document patients’ EOL wishes where, previously, the form was not available for use. Allowing patients to actively participate in their EOL decisions can give them back power in a seemingly powerless situation. Providers hold the responsibility of giving patients the education and time necessary to make these difficult decisions—an endeavor that should become commonplace across the nation, particularly in cancer care.

Implications for Practice

- Increase communication between the patient and providers regarding the patient’s end-of-life care wishes in advance.
- Reduce stress for patients, families, and providers in emergent situations.
- Identify providers and patients who require more education regarding end-of-life care and the decision-making process.
References


