MOLST Implementation in Nursing Homes: A Close-up View of MOLST-related Interactions and Activities

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Purpose of POLST/MOLST

-- Physician’s/Medical Order for Life-Sustaining Treatments --

▸ Standardized medical order form for use by clinicians caring for patients with serious advancing illnesses.
▸ Meant for patients nearing end of life; not designed for people who don’t have expectation of limited life expectancy.
▸ Used to document, communicate, and honor life-sustaining treatment preferences of patients with advanced illness across care settings.
▸ Completed form must be signed by patient (or healthcare proxy) and patient’s clinician (physician, nurse practitioner, or physician assistant).
▸ Form should be filled out and signed after in-depth conversation between patient and clinician signer.
Massachusetts developed its own version of the MOLST (MA MOLST – www.molst-ma.org).


Evaluation of MOLST expansion found evidence of implementation initiatives, but also demonstrated inconsistent MOLST-related activity across agencies (Gurewich & Posner 2014).

To date, little insight into how implementation of MOLST works “on the ground” as part of daily routine in healthcare settings.
Our Study: Close-up View of MOLST-related Interactions and Activities

- How is the MOLST implemented in nursing homes?
- Who is involved in the MOLST process?
- What do conversations about the MOLST look like?
- What types of interactions seem to be more or less effective?
- What about the MOLST is positive or helpful?
- What about using the MOLST is challenging?
- What would make it easier?
Approach

- Qualitative study design to allow for in-depth exploration.
- Selected two nursing homes that varied regarding hospice utilization to consider if “culture of care setting” matters.
- Sought to speak with different staff involved in MOLST implementation at these sites.
- Data collection primarily with interviews; open interviewing style.
- Interviews conducted by Co-PI and RA; audiotaped and transcribed.
- Review of transcripts in progress.
# Who We Talked To

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<thead>
<tr>
<th>Role</th>
<th>Site 1</th>
<th>Site 2</th>
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<tr>
<td>Unit Manager</td>
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<tr>
<td>Floor Nurse</td>
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<td>Nurse Educator</td>
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<tr>
<td>Manager of Clinical Operations</td>
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<tr>
<td>Director of Social Services</td>
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<td><strong>Total N</strong></td>
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Preliminary Findings
MOLST Benefits

- Helpful guidance for staff
- Guidance and relief for families
- Legal protection for staff
- Keeper of patient’s rights
- Helpful for initiating conversations

I: Has the MOLST changed anything?
P: No, Made it easier? No.
I: Made it harder?
P: No, maybe clearer. Not easier.
I: Do you find it a useful form?
P: No, not really. Do you? It's confusing.
MOLST Challenges: Discrepancy Between MOLST Protocol and Practice

- Completing MOLST with all patients, not just those nearing end of life.

When they first came out with the MOLST, it was meant to address end of life care. It was meant to be for someone who has a terminal illness, and what would you want your wishes to be. A 42 year old patient who comes in had a knee replacement, and they do that MOLST, he has no concept of a feeding tube, say, or intubation. I'm healthy, I just went through surgery, I did well, I'm here for 7 days and then I'm going home. So, if it were done when someone is facing a terminal illness, I think it's more appropriate.

- Admitting nurse tasked with MOLST conversation, physician signs.

It's the nurse. But it's not within the nurse scope of practice. This has been an ongoing issue. It's actually the doctor's job to do the MOLST, and it ends up falling on nurses. So a lot of times, I'll try to bring in, if there is a doctor, I try to bring him in with me. Because, I find that it's better, they have more of the answers. They can explain it in better terminology.
MOLST Challenges: Procedural Difficulties

- Timing of full MOLST completion during admission.
  
  My biggest thing with this is CPR should be separate, everything else can be discussed later. That's my biggest take on this. Resident comes into a building, let's talk about CPR. I don't need to talk to you about a feeding tube, right?

- Getting the MOLST signed; unsigned MOLST means full code.
  
  It's not an order till a doctor signs it. So a doctor could be here on a Friday, this person comes in Friday night for end of life care, they were DNR in the hospital, in lieu of an order, they're full code. If the doctor has not signed an order for DNR, that person's a full code. The doctor's not coming back in to the building until Monday. So you have someone coming in, end of life, Friday night, and we're gonna say they're a full code until the doctor signs the orders.
MOLST Challenges: Difficulties With Form/Language/Categories

- Misguiding language
  
  Do Not Resuscitate sounds like you're not going to do anything. I think the terminology doesn't ... it could be better. “Allow Natural Death” would be better, say we want to allow natural death. Just because you're not going to resuscitate somebody doesn't mean you're not going to do anything.

- Confusing language
  
  I really have trouble with this Transfer to Hospital ... because it says unless needed for comfort. That's why I have them sign Transfer to Hospital because ... laying on the floor with a broken hip is not comfort. But it says, do not transfer to the hospital unless needed for comfort. I don't understand it. I really don't understand it. And that's why I ask them, if you were to fall on the floor and break a hip, would you want to be transferred to the hospital or do you just want me to let you lay there, in pain?

- Conflicting language
  
  We have some people who say, I want to be resuscitated but I don't want to be intubated. You can't have anybody resuscitated without intubating … it doesn't explain the fact that it's virtually impossible to adequately do resuscitation without intubation. So I think the wording can be better there.
Initial Reflections

- Important to reconsider who the MOLST is completed with, at what point, and who should be handling it.
- Features of MOLST perceived as confusing/misleading need attention.
- MOLST challenges may be exacerbating already difficult interactions with patients and family about end of life care.
- Need more consistency and transferability across care settings.

I: Is there anything we’ve missed?
P: I don't think so. Everybody's like, Oh I hope they can change things for us. I hope so too.
I: What change would you like to see?
P: Just to make the process easier. This is a mandate. Just because we follow it, how come no one else has to follow it?
I: That's one of the key things we're learned here. That you're not getting a lot of help from the surrounding hospitals?
P: Or any back-up through the people who threw it at us...