State of Delaware

Pre-Hospital Advanced Care Directive Regulations (PACD)

vs.

Medical Orders for Life-Sustaining Treatment (MOLST)

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Office of Emergency Medical Services

What is a PACD?

A Pre-Hospital Advanced Care Directive (PACD) allows terminally ill patients, upon discussion with their primary physician, the right to elect to either receive full, limited, or no resuscitative efforts by EMS field responders.

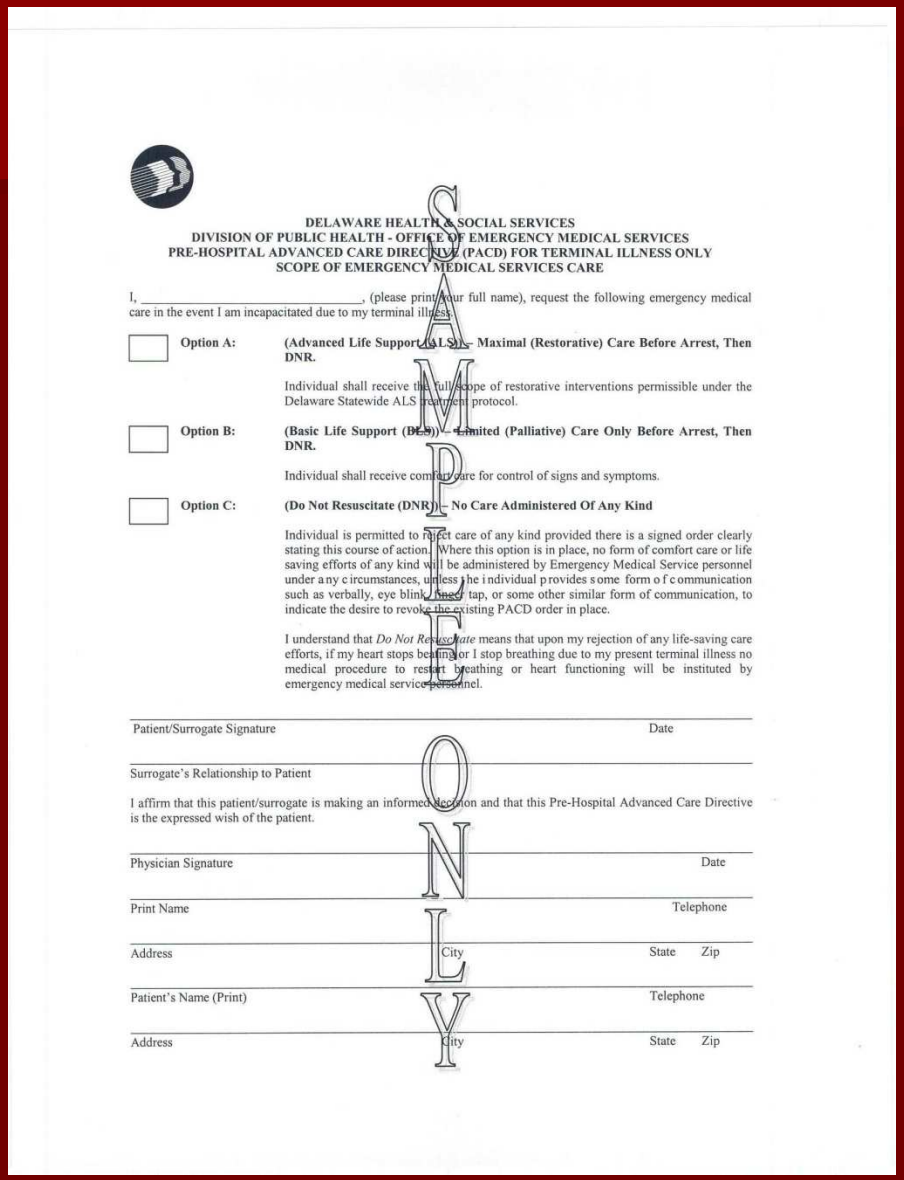
What is a MOLST?

A Medical Order for Life Sustaining Treatment (MOLST) form is an actionable medical order form covering options for Cardiopulmonary Resuscitation (CPR) and other life-sustaining treatments.

What are the differences between a PACD form and a MOLST form?

- A MOLST form is an updated version of the PACD form
- PACD loses authority when a patient changes locations; it is strictly pre-hospital
- MOLST form does not expire, it is valid across the continuum of care in all health care settings

PACD Form



DELAWARE HEALTH & SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH - OFFICE OF EMERGENCY MEDICAL SERVICES
PRE-HOSPITAL ADVANCED CARE DIRECTIVE (PACD) FOR TERMINAL ILLNESS ONLY
SCOPE OF EMERGENCY MEDICAL SERVICES CARE

I, _____, (please print your full name), request the following emergency medical care in the event I am incapacitated due to my terminal illness:

☐ **Option A:** **(Advanced Life Support (ALS)) – Maximal (Restorative) Care Before Arrest, Then DNR.**

Individual shall receive the full scope of restorative interventions permissible under the Delaware Statewide ALS treatment protocol.

☐ **Option B:** **(Basic Life Support (BLS)) – Limited (Palliative) Care Only Before Arrest, Then DNR.**

Individual shall receive comfort care for control of signs and symptoms.

☐ **Option C:** **(Do Not Resuscitate (DNR)) – No Care Administered Of Any Kind**

Individual is permitted to reject care of any kind provided there is a signed order clearly stating this course of action. Where this option is in place, no form of comfort care or life saving efforts of any kind will be administered by Emergency Medical Service personnel under any circumstances, unless the individual provides some form of communication such as verbally, eye blink, knee tap, or some other similar form of communication, to indicate the desire to revoke the existing PACD order in place.

I understand that *Do Not Resuscitate* means that upon my rejection of any life-saving care efforts, if my heart stops beating or I stop breathing due to my present terminal illness no medical procedure to restart breathing or heart functioning will be instituted by emergency medical service personnel.

Patient/Surrogate Signature Date

Surrogate's Relationship to Patient

I affirm that this patient/surrogate is making an informed decision and that this Pre-Hospital Advanced Care Directive is the expressed wish of the patient.

Physician Signature Date

Print Name Telephone

Address City State Zip

Patient's Name (Print) Telephone

Address City State Zip

As is cited in Section 2513(b) of the *Death with Dignity Act (Code of Delaware)*, and in the Pre-Hospital Advanced Care Directive Regulations Section 7.0; willful concealment, destruction, falsification or forging of an advance directive, without the individual's or authorized decision maker's consent, is a class C felony.

Record Keeping Instructions:

The original live-signature copy of this document is to be kept with the patient's permanent medical records/files at the facility providing the primary care for the patient; i.e., health care provider (physician's office), Hospital, Nursing Home, or other health care provider facility.

A copy of this document is to be kept with the patient either at the patient's home, or the health care facility where the patient is admitted and receiving medical care/treatment.

Patient PACD Card Instructions:

Once the information has been completed below, punch card out on the perforated lines, fold in half, and carry on your person at all times (wallet, purse, etc.). Present this card, along with the copy of your signed PACD form, to emergency medical personnel upon their response/ arrival.

Front of Card

Delaware Health & Social Services
Division of Public Health
Pre-Hospital Advanced Care Directive (PACD)
Wallet Identification Card

This PACD wallet identification card has been issued to the recipient listed below.

Patient Name **Date**

Patient Signature **[Option #]**

Back of Card

An official State of Delaware PACD Form signed by the patient's physician and the patient/surrogate must be presented to EMS personnel along with this wallet identification card at the time of emergency response for this wallet identification card to be valid and honored.

Physician Name **Date**

Physician Signature

MOLST Form

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

STATE OF DELAWARE MOLST FORM

HIPAA PERMITS DISCLOSURE OF MOLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

MEDICAL ORDERS for life-sustaining treatment (MOLST)

FIRST follow these orders, THEN contact physician. This is a medical order sheet based on the person's current medical condition and wishes. Any section not complete implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name/First Name/Middle Initial	__/__/__ date of birth	___ ___ ___ ___ Last 4 SSN #	M☐ F☐ Gender

A Check One Box Only

Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing.*

☐ Attempt Resuscitation (CPR) ☐ Do Not Attempt Resuscitation (DNR/No CPR)

*When person is **not** in cardiopulmonary arrest, follow orders in **B**, **C**, and **D**.

B Check One Box Only

Medical Interventions: Person has a pulse and/or is breathing.

☐ **COMFORT MEASURES ONLY.** Use medications by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, oral suctioning, and manual treatment of airway obstruction as needed for comfort. ***Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.***

☐ **LIMITED ADDITIONAL INTERVENTIONS.** Includes care described above. Use medical treatment, IV fluids, and cardiac monitor as indicated. Do not use intubation or mechanical ventilation. May use less invasive airway support (e.g. CPAP, BiPAP). ***Transfer** to hospital if indicated. Avoid intensive care.*

☐ **FULL TREATMENT.** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer** to hospital if indicated. Includes intensive care.*

Additional Orders: (e.g. dialysis, etc.) _____

C Check One Box Only

ANTIBIOTICS:

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics if infection occurs, with comfort as goal.

☐ Use antibiotics if life can be prolonged.

Additional Orders:

D Check One Box Only

ARTIFICIALLY ADMINISTERED NUTRITION:

Always offer food and liquids by mouth, if feasible.

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

(Goal): _____

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

E

SUMMARY OF MEDICAL CONDITION/GOALS:

F

SIGNATURES: Preferences have been expressed to the health care provider whose signature is found below. This document reflects those preferences. If signed by a surrogate, preferences must reflect patient's wishes as best understood by the surrogate.

Discussed with:

☐ Patient ☐ Parent of Minor
☐ Legal Guardian ☐ Next-of-Kin
☐ Health Care Agent

PRINT – Physician/APN/PA Name Phone #

Physician/APN/PA Signature (mandatory) Date

Physician Co-Signature if PA Signs Above (mandatory) Date

Patient or Legal Surrogate Signature/Relationship (mandatory) Date

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED.

Use of original form is strongly encouraged. Photocopies and FAXes of signed MOLST forms are legal and valid.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

STATE OF DELAWARE MOLST FORM

HIPAA PERMITS DISCLOSURE OF MOLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY.

Other Contact Information (Please Print)

Name of Guardian, Surrogate, or Other Contact Person	Relationship	Phone Number

Person has: ☐ Health Care Directive (living will) ☐ Power of Attorney for Health Care (POA-HC)

Encourage all advance care planning documents to accompany MOLST

Directions for Health Care Professionals

Completing MOLST

- MOLST must be completed by a health care professional, based on patient preferences and medical indications.
- MOLST should reflect person's current preferences and medical indications. Encourage completion of advance directive.
- MOLST must be signed by a Physician/APN/or PA with Physician co-signature to be valid. Verbal orders are acceptable with follow-up signature by Physician/APN/or PA with physician co-signature in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and FAXes of signed MOLST form are legal and valid.

Using MOLST

Any incomplete section of MOLST implies full treatment for that section.

SECTION A:

- No defibrillator (including AED's) should be used on a person who has chosen "Do Not Attempt Resuscitation."

SECTION B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g. treatment of a hip fracture).
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment."

SECTION D:

- Oral fluids and nutrition must always be offered if medically feasible.
- A person with capacity or the surrogate of a person without capacity can void the form and request alternative treatment.

Reviewing MOLST

This MOLST should be reviewed periodically whenever:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

To void this form, draw a line through "Medical Orders" and write "VOID" in large letters. Any changes require a new MOLST.

Review of this MOLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided and New Form Completed
Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided and New Form Completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED.

Use of original form is strongly encouraged. Photocopies and FAXes of signed MOLST forms are legal and valid.

Revised June 2011

MOLST orders are based on:

- An individual's wishes and goals
- Current medical situation and prognosis
- Potential treatment options
- Determination of medical ineffectiveness

What Are Our Responsibilities?

- **Primary Care Physicians**
  - Explaining the form to their terminally ill patients
  - Explaining the options of care
  - Helping the patient select the option they desire
  - Helping the patient fill out the form
  - Keeping a copy of the form in the patient's medical records.
- **EMS Field Responders**
  - Locating the signed form
  - Determining its validity
  - Adhering to the option of care chosen

Section A: Cardiopulmonary Resuscitation (CPR)*

*Person has no pulse and is not breathing

Choose One:

- Attempt Resuscitation (CPR)
- Do Not Attempt Resuscitation (DNR/No CPR)

When patient is not in cardiopulmonary arrest, follow orders in B, C and D.

Section B: Medical Interventions*

*Person has a pulse and/or is breathing

Choose One:

- Comfort Measures Only
- Limited Additional Interventions
- Full Treatment

Section C: Antibiotics

Choose One:

- No Antibiotics. Use other measures to relieve symptoms
- Determine use or limitation of antibiotics if infection occurs, with comfort as goal.
- Use antibiotics if life can be prolonged.

Section D: Artificially Administered Nutrition

Choose One:

(Always offer food and liquid by mouth, if feasible)

- No artificial nutrition by tube.
- Defined trial period of artificial nutrition by tube.
- Long-term artificial nutrition by tube.

Section E: Summary of Medical Conditions/Goals:

- Indicate additional preferences for other life-sustaining treatments.

Section F: Signatures

- Who may sign the Delaware MOLST?
  - Any physician, physician assistant or advanced practice nurse.
  - The Delaware MOLST form is not valid without one of the above signatures.

When are Delaware MOLST orders reviewed?

- When the patient is transferred from one care setting or care level to another.
- When there is a substantial change in the patients health status.
- When the patient changes their treatment preferences.

How are MOLST orders revised?

- Void the existing MOLST form and complete a new MOLST form to reflect the current orders.

How is a MOLST form voided?

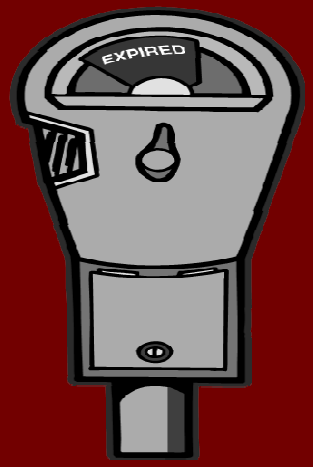
- Draw a single diagonal line across the page
- Write “Void” in large letters and
- Have the physician, physician assistant or advanced practice nurse sign and date below the line
- Keep the form in the patient’s active or archived medical record

Is a copy of a MOLST form a valid order?

- Photocopies and Faxes of the signed MOLST form are legal and valid.

Do DE MOLST orders expire?

- Delaware MOLST orders do not expire.



Will older versions of the PACD form still be valid?

- All previous versions of the PACD form are still valid.
- Older PACD forms are to be updated to the Delaware MOLST form when the orders are reviewed.

What if the form is not complete?

- Provide full EMS care.
- Contact medical control if further guidance is needed.