# Carroll County Department of Fire & EMS

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| **Standard Operating Procedure: 3.47** | **Effective Date: July 10, 2024** |
| **Subject: Handling of MOLST / DNR Patients** | **Section: Emergency Medical Services** |
| **Authorized: Eric Zaney, Assistant Chief of EMS** | **Revision Date: N/A** |

## I. PURPOSE

The Carroll County Department of Fire and EMS (CCDFEMS) recognizes the need to provide clarification regarding how emergency service personnel care for patients presenting with an active MOLST / DNR designation. This policy serves as jurisdictional supplement and does not supersede the Maryland Medical Protocols for Emergency Medical Services.

## II. APPLICABILITY

This policy applies to Carroll County Department of Fire and EMS career and volunteer personnel.

## III. DEFINITIONS

MOLST: Medical order for life-sustaining treatment. A form or acceptable EMS Do Not Resuscitate (DNR) order.

Attempt CPR: If cardiac or respiratory arrest occurs perform CPR, artificial Ventilation and all medical efforts that are indicated during arrest to restore or stabilize cardiopulmonary function.

DNR: A Do Not Resuscitate order is a legal document ordering the withholding of CPR and other life-sustaining measures in the event of cardiopulmonary arrest.

## IV. PROCEDURES

A. Acceptable Orders
   1. Maryland MOLST Form - May be an original, copy, or electronic format for patient care decisions, however, sending facility must provide paper copy to EMS prior to patient transport.
   2. Maryland EMS/DNR Form - There is no expiration on older versions of DNR forms.
   3. Medic Alert DNR Bracelet or Necklace
   4. Out-of-state EMS/DNR Form
   5. Oral DNR Order from EMS System Medical Consultation
   6. Oral DNR Order from an on-site physician, physician assistant, or nurse practitioner

B. Unacceptable DNR Orders
   1. Advanced directives (without a MOLST or DNR Order) or other oral or written requests shall not be honored by EMS without EMS System Medical Consultation.

C. MOLST A-1 Patients – Maximal Restorative Efforts
   1. Prior to respiratory or cardiac arrest: the Option A-1 patient shall receive the full scope of interventions permissible under The Maryland Medical Protocols for Emergency Medical Services, including intubation, CPAP/BiPAP, cardiac pacing, IVs, and medications in attempt to forestall cardiac or respiratory arrest.
   2. If respiratory or cardiac arrest occurs do not initiate CPR or any resuscitative efforts. Withhold or withdraw resuscitative efforts if they were already in progress prior to discovery of the MOLST or EMS/DNR Order.

D. MOLST A-2 – Comprehensive Efforts
   1. Prior to respiratory or cardiac arrest: the option A-2 patient shall receive the full scope of interventions permissible under the Maryland Medical Protocols for Emergency Medical Services, excluding intubation. Prior to respiratory or cardiac arrest: same as option A-1, except no intubation is permitted. If respiratory or cardiac arrest occurs: no CPR, same as option A-1.
   2. If respiratory or cardiac arrest occurs do not initiate CPR or any resuscitative efforts. Withhold or withdraw resuscitative efforts if they were already in progress prior to discovery of the MOLST or EMS/DNR Order.

E. MOLST B – Palliative and Supportive Care
   1. Prior to respiratory or cardiac arrest, provide supportive treatment. MOLST B order does not equate to no care, or even BLS care only. If the patient is conscious and capable of making medical decisions,

they shall be included in decisions regarding their medical care. Please document the patient's preference and intervention performed/medication given in the PCR.

i. Respiratory: Open and maintain airway using chin lift, jaw thrust, finger sweep, nasopharyngeal or oropharyngeal airway, Heimlich maneuver, or laryngoscopy with Magill forceps for suspected airway obstruction, but no intubation, cricothyroidotomy, or tracheostomy.
ii. Oxygen: may provide passive oxygen via nasal cannula or non-rebreather mask, but no positive pressure oxygen via BVM, demand valve, CPAP or ventilator.
iii. Blood glucose monitoring: Testing shall not be obtained.
iv. Non-invasive monitoring: The use of both 4 and 12 lead ECGs are permitted at the discretion of the clinician, however, if abnormalities are identified they cannot be treated without explicit permission from the patient or under orders from medical consult.
v. Pulse oximetry / Capnography: May be used.
vi. Bleeding control: Hemostatic gauze may be utilized to control active bleeding. Standard treatment such as direct pressure and tourniquets are permissible. No IV therapies such as TXA and blood should be initiated.
vii. Fracture management: Immobilize with appropriate devices to minimize pain.
viii. Medication management: Patients with significant pain or pain with prolonged transport times should be treated in accordance with the pain management protocol. Pain medications should be delivered via the least invasive route (i.e. intranasal, PO and ODT), however, an IV may be initiated to deliver pain medications at the discretion of the clinician. Clinicians may also allow the patient, family, or other healthcare clinicians to administer the patient's prescribed medications. The use of any pain management medication must be well documented in the patients PCR. Patients with patient-controlled analgesia (PCA) systems should have these systems maintained and monitored during transport. Patients experiencing severe nausea and vomiting may receive anti-emetic medications via oral, ODT, IM or IV routes.
ix. Ventilator patients: If the patient is found on an outpatient ventilator and is not in cardiac arrest, maintain ventilator support during transport to the hospital. If the patient is found on an outpatient ventilator and in cardiac arrest, contact online medical direction before disconnecting the ventilator.
x. Suction: May be performed as necessary.
xi. Position for comfort.
xii. Existing IV lines: Shall be maintained in place.

xiii. Transport: Upon request of the patient, family or caregivers, EMS clinicians may transport MOLST-B EMS/DNR patients to a specified inpatient hospice facility for pain control, symptom management or respite care (in lieu of transport to a hospital-based emergency department). This requires communication with the patient's hospice coordinator and the accepting facility. This cannot be performed through EMRC and should be done via telephone. EMS clinicians must notify and confirm acceptance from the hospice facility prior to transport. The clinician shall document the hospice facility, the accepting personnel name and title, time, and method of contact and pertinent times within the patients PCR.

MOLST-B patients meeting the trauma activation criteria are ineligible for medevac per the Maryland Medical Protocols for Emergency Medical Services. Clinicians should perform a dual consultation between the most appropriate receiving facility and the closest facility for destination guidance.

If a MOLST-B patient meets Stroke, STEMI, or Sepsis alert criteria based on history, physical exam findings or vital sign assessment, appropriate hospital notifications shall be made. This notification shall include information that the patient is a MOLST-B and any interventions performed / medications given or withheld. Clinicians should document any additional orders given the name of the physician giving the orders, and if they were fulfilled. This information shall be included in the PCR.

F. Revocation of DNR orders

1. EMS/DNR Order may be revoked at any time by:

i. Physical cancellation or destruction of all EMS/DNR Order devices.

ii. A verbal statement by the patient made directly to EMS clinicians requesting resuscitation or palliative care only. In this case, EMS/DNR devices do not need to be destroyed. EMS clinicians must thoroughly document the revocation. A verbal revocation by the patient is only good for the current response for which it was issued.

iii. An authorized decision-maker, other than the patient, cannot revoke an EMS/DNR Order verbally. Decision-makers with the authority to revoke an EMS/DNR Order must either void or withhold all EMS/DNR Order devices if they wish resuscitation for the patient. If there is any confusion, the EMS clinician should consult a Base Station

G. Documentation

1. A copy of the MOLST or other acceptable EMS/DNR Order must be transported with the patient to the emergency department or inpatient hospice facility.
2. MOLST or EMS/DNR order status must be documented in the patient care report.
3. An oral DNR Order from EMS System Medical Consultation is acceptable if a MOLST or DNR form is not present. Obtain medical consultation if the MOLST or DNR form instructions are unclear, or the form is unreadable.

H. Non-Transports

1. Non-transported EMS/DNR Patients - Follow local operational procedures for handling deceased patients.
2. Do not remove DNR or Medical Alert Bracelets or Necklaces from the patient; leave the original MOLST or EMS/DNR Order with the patient.
3. Law enforcement or medical examiner's office need to be notified only in the case of sudden or unanticipated death that occurs:
   i. By violence
   ii. By suicide
   iii. As the result of an accident
   iv. Suddenly, if the deceased was in apparent good health
   v. In any suspicious or unusual manner

## IV. RECISION

This Standard Operating Procedure rescinds all directives regarding Handling of MOLST / DNR Patients or similar content previously issued for personnel of the Carroll County Department of Fire & EMS.