island health

Advance Care Planning:
making the MOST of CONVERSATIONS

Medical Orders for Scope of Treatment (MOST)

PART 1: RESUSCITATION STATUS and MEDICAL TREATMENTS	
Check **ONE** designation.	CPR is provided in accordance with the MOST policy and **only with C2 designation**
☐ **M1**	**Supportive care, symptom management and comfort measures only**. **Allow a natural death**. *Transfer to higher level of care only if patient's **comfort needs** cannot be met in current location.*
☐ **M2**	**Medical treatments within current location of care, <u>excluding critical care interventions</u>.** *Transfer to higher level of care only if patient's **comfort needs** cannot be met in current location.*
☐ **M3**	**Medical treatments including transfer to higher level of care, <u>excluding critical care interventions</u>.** *Transfer to a higher level of care only if patient's **medical treatment needs** cannot be met in current location.*
☐ **C0**	**Critical Care Interventions, <u>excluding</u> CPR and intubation.** *Patient is accepting of any intervention from which they may benefit, excluding CPR and intubation.*
☐ **C1**	**Critical Care Interventions, <u>excluding</u> CPR but including intubation.** *Patient is accepting of any intervention from which they may benefit, excluding CPR.*
☐ **C2**	**Critical Care Interventions, <u>including</u> CPR and intubation.** *Patient is accepting of any intervention from which they may benefit.*

PART 2: ADDITIONAL DIRECTIONS/COMMENTS related to MOST (optional)

PART 3: SUPPORTING DOCUMENTATION (check all documents reviewed)			
☐ Previous MOST	☐ Written expression of wishes	☐ Advance Directive	☐ Rep 9 agreement
☐ No CPR Form (BC)	☐ Health care provider documentation	☐ Other_____	

PART 4: MOST entered following a CONVERSATION with (check at least one)	
☐ Capable Patient	☐ Personal Guardian (Committee) Name _____
☐ Representative Name _____	☐ Temporary Substitute Decision Maker Name _____
☐ Incapable Patient/Substitute Decision Maker unavailable	

PART 5: SIGNATURE OF PHYSICIAN or NURSE PRACTITIONER	
I have considered the available documents noted in Part 3 and discussed the benefits, consequences and preferences of the MOST designation with the individual(s) indicated in Part 4.	
Name (please print)	Signature
Date (yyyy/mm/dd) Time	Location of patient

A MOST does not replace the consent to care and treatment process.

Community PCPs, please fax form to 250-740-2687 to be entered in the Island Health Cerner EHR system.

MOST decision Support tools

MOST is completed as a result of an Advance Care Planning (ACP) and Goals of Care conversations. Consider using the Conversation Guide for ACP and Goals of Care below:

Conversation Guide for ACP & Goals of Care:

Keep in mind that ACP is an ongoing process and may take several conversations over time

Questions you can consider asking:

- What do you understand about your illness?
- How much information would you like about what to expect with your illness?
  Tip: Some people like to know about how much time they have, others like to know about what to expect, others like both
  Offer to provide your view of prognosis and possible trajectory, tailored to information preferences
- Have you talked with anyone about your health goals or preferences? Do you have an advance care plan? Do you know what I mean by an advance care plan?
  - ➤ If yes: discuss details.
  - ➤ If no: then ask, "If medical decisions need to be made about your care and you are unable to speak for yourself, who would you want me to speak to about your wishes?"
- If your health situation worsens, what are your most important goals of care?
- What are your fears or worries about the future?
- Do you have the information you need to make decisions about the kinds of procedures you do or do not want if you become very sick?
- How much do your loved ones know about your wishes and goals of care? Tip: Suggest bring a family member or friend next visit.

REFLECT

- **Prognosis:** Did I talk about his/her prognosis?
- **Preferences:** Did I ask about preferences for future health care?
- **Goals**: Did I ask about their goals and/or values? What does he/she want to do with the time that is left?
- **Substitute Decision Maker (SDM):** Do I know whom to contact if the adult cannot communicate their wishes? Or did I include the SDM if the adult cannot speak for themselves?
- **Documentation:** Did I document all of the above?

	CPR	Intubation	Critical Care Interventions	Site Transfer	Treat Reversible Condition	Symptom Control
Code Status and MOST Designations						
M1	NO	NO	NO	NO*	NO	Y
M2	NO	NO	NO	NO*	Y	Y
M3	NO	NO	NO	Y	Y	Y
C0	NO	NO	Y	Y	Y	Y
C1	NO	Y	Y	Y	Y	Y
C2	Y	Y	Y	Y	Y	Y

*Unless comfort measures cannot be met in current location