Vancouver Coastal Health Authority

MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

ADULTS, AGE 19 AND ABOVE

IDENTIFICATION LABEL

A **I anticipate CPR to be of clear benefit and medically appropriate for the patient in the event of a medical crisis. I have not discussed this with the patient/SDM:**

☐ **Attempt CPR and refer to Critical Care -** _____ _____
Responsible Provider Signature Date

B **I have had a discussion with patient and / or substitute decision maker:**

Patient/Resident: ☐ is at this time capable to make own medical decisions

☐ is NOT currently capable to make own medical decisions

Patient / Resident / Substitute Decision Maker (SDM) consulted in development of Order / advised of Order:

_____
Printed name Date

☐ Patient / Resident ☐ TSDM
☐ Representative ☐ Personal Guardian
☐ Other (explain below) ☐ None (explain below)
Explain:

☐ Client / SDM disagrees with Order

_____
Optional space for signature of Client or SDM aware of Order, intended for use in residential care. Order valid with or without signature.

☐ **Attempt Cardiopulmonary Resuscitation (CPR)**

In the event of acute medical event, maximum therapeutic effort.

☐ **Do Not Attempt Cardiopulmonary Resuscitation (DNACPR: No chest compressions or other direct means of restarting the heart)**

IN THE EVENT OF SERIOUS ACUTE MEDICAL EVENT:

☐ **Option 1 (M1)*** No CPR. Supportive care, symptom management, and comfort measures. Allow natural death.

☐ **Option 2 (M2)** No CPR. Option 1 (M1) plus therapeutic measures and medications to manage acute conditions within the current setting. If in residential care or hospice, transfer to acute care will not occur except in special circumstances (eg fracture).

☐ **Option 3 (M3)** No CPR. Option 2 (M2) plus admission to an acute care hospital (if not already admitted) for medical/surgical treatment as indicated. No referral to Critical Care.

☐ **Option 4 (C1)** No CPR. Maximum therapeutic effort as in Option 3 (M3) including referral to Critical Care but **not including** intubation and ventilation.

☐ **Option 5 (C2)** No CPR. Maximum therapeutic effort as in Option 4 (C1) including referral to Critical Care and **including** intubation and ventilation.

Specific comments on Order / Goals of Care to aid interpretation:

DNACPR as detailed on this MOST will automatically be suspended for surgery and other procedures involving anesthesia or procedural sedation and treatment will be provided at the discretion of the Most Responsible Provider, unless specific direction is provided below:

_____
Provider detailing circumstances of suspension of DNACPR / MOST

SUPPORTING DOCUMENTATION: *Ask each patient / family if patient has expressed or documented wishes about future care*

☐ Previous DNACPR / MOST ☐ Provincial No CPR	☐ VCH ACP Record ☐ Advance Directive	☐ Representation Agreement ☐ *Section 9* ☐ *Section 7*	☐ Other:

This MOST Order first documented	_____ Date (dd/mm/yr)	Print Name:	**Signature,** **Most Responsible Provider**
	_____ College #	Contact #:	
MOST Order Reviewed - no change **If changed, prepare new MOST form and strike through this one**	_____ Date (dd/mm/yr)	Print Name:	**Signature,** **Most Responsible Provider**

***** M1-C2 codes reflect codes used in Fraser and other health authorities

ALL NEW ORDERS MUST BE FLAGGED
PLACE AT FRONT OF PATIENT / RESIDENT'S CHART
Guidelines for Medical Orders for Scope of Treatment

1. The Most Responsible Provider (MRP) ensures that a Medical Order for Scope of Treatment is documented and placed within the green plastic sleeve early in a patient's (including resident's) course of care and/or treatment:
    a) Patients for whom the default expectation of "Attempt CPR including Referral to Critical Care Intervention" is clinically appropriate, the MRP may document the Order based on his/her own determination without consultation with the patient or Decision Maker, completing only section A.
    b) In any other circumstance, the MRP completes section B – having confirmed the Order with the capable patient or the authorized Substitute Decision Maker of an incapable patient, or documents an explanation of the situation

    In the event of dispute in reaching a Medical Order for Scope of Treatment decision, the patient (or SDM) is to be made aware of available dispute resolution resources (see Client Relations and Risk Management Bulletin ***"Resolution of disputes about expectations for care not considered beneficial"*** (www.vcha.ca)).

2. Medical Orders for Scope of Treatment may, in the exceptional case, be written by the MRP without the agreement of the patient/Substitute Decision Maker, only after the patient/Substitute Decision Maker has been
    a) advised of and consulted in the development of the Orders
    b) informed of the content of the Medical Orders for Scope of Treatment, and
    c) if there is a challenge of the MOST, the MRP has followed the Dispute Resolution Process (see 2.3) which, in summary directs the MRP to:
        i. communicate sensitively and respectfully to address the concerns of the patient/Substitute Decision Maker
        ii. consider the request for care not initially offered
        iii. make arrangements for a second opinion (and, if necessary, additional opinions) which will either confirm or revise the initial offer
        iv. advise the patient/representative of the decision of care offered and the options available, advising Risk Management immediately if the dispute is not resolvable and/or if Court intervention may be sought by the patient/Substitute Decision Maker
        v. Document on the health care record the discussions about MOST held with the patient/ Substitute Decision Maker

Note: Resources to assist in resolution of disputes include Client Relations and Risk Management staff, Ethics Consultants, Spiritual Care and/or Palliative Care

3. On discharge or transfer, a copy of the Medical Order for Scope of Treatment is to be made and provided with the patient for the information of providers at the destination care setting, and / or for the patient to discuss with their primary care provider.

4. When a Medical Order for Scope of Treatment is changed from one previously documented, a new Medical Order for Scope of Treatment is completed and a single strikethrough is made on the outdated form which is to be retained in the patient's chart.

5. The Medical Order for Scope of Treatment is direction to the care team in the current admission of care, serves as an 'order in transfer' for subsequent care providers, and is to be relied upon unless there is some indication that it is clearly outdated and inappropriate.

Definitions:
CPR: Cardiopulmonary resuscitation refers to chest compressions or other direct means of restarting the heart.

Previously expressed wishes, Advance Directives, and other Advance Care Planning documents:

- Providers ask each patient / family if patient has expressed or documented wishes about future care.
- When available, copies of any documentation regarding patient's/resident's wishes are to be stored with this form (Advance Directive completed "My Voice" document, verbally expressed wishes, documentation from the community or previous facility, etc).
- Irrespective of prior documentation, a Medical Orders for Scope of Treatment form must be completed.

Vancouver Coastal Health Authority

ADVANCE CARE PLANNING (ACP) RECORD

For use by all members of the health care team

PCIS LABEL

Guidelines for Use:

1. This form is for use by all members of the health care team (e.g. nurses, social workers, spiritual care, physicians) as a written communication tool to record information relevant to advance care planning. This could include: conversations about the patient's medical condition, goals, values, DNACPR status or MOST and Goals of Care, withholding / withdrawing support, comfort care.
2. Discussions with patient, family and/or substitute decision maker are documented, along with the subsequent action taken (e.g. Physician notified, or 'My Voice' workbook introduced).
3. This form is placed in the green sleeve (green page protector) and with other advance care planning documents. All Advance Care Planning records are to remain in the green sleeve, and are to be reviewed to confirm the wishes are the most current capable wishes at each admission with changes in health status, or more frequently as determined by the program.
4. MOST form, other documentation regarding DNACPR status, or other Goals of Care MUST be reviewed promptly at each admission.

Advance care planning conversations with patient, family or substitute decision maker				
Date	**Brief summary of ACP discussion/focus**	**Action**	**Staff Name** (first name last initial)	**Discipline**

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