island health

Advance Care Planning:
making the **MOST** of **CONVERSATIONS**

Medical Orders for Scope of Treatment (MOST)

PART 1- RESUSCITATION STATUS & MEDICAL TREATMENTS Most Responsible Physician (MRP) to initial only **ONE** designation. Note: CPR is provided in accordance with the MOST policy	
____**M1**	**Supportive care, symptom management and comfort measures only**. *Care is for physical, psychological and spiritual preparation for an expected or imminent death. Do not transfer to higher level of care unless to address comfort measures that cannot be met in current location. Allow a natural death.*
____**M2**	**Medical treatments within current location of care, *excluding* critical care interventions, CPR and intubation.** *Transfer to higher level of care only if patient's medical treatment needs cannot be met in current location.* *Goals of care and interventions are for cure or control of symptoms of illness. No critical care interventions.*
____**M3**	**Medical treatments including transfer to higher level of care, *excluding* critical care interventions, CPR, and intubation.** *Medical treatments are for cure or control of symptoms of illness. Transfer to a higher level of care may occur if required for diagnostics and treatment.*
____**C0**	**Critical Care Interventions, *excluding* CPR and intubation.** *Patient is expected to benefit from and is accepting of any appropriate investigations and interventions that can be offered **excluding CPR, and intubation.***
____**C1**	**Critical Care Interventions, *excluding* CPR but *including* intubation.** *Patient is expected to benefit from and is accepting of any appropriate investigations and interventions that can be offered **excluding CPR**.*
____**C2**	**Appropriate Critical Care Interventions, *including* CPR, and intubation.** *Patient is expected to benefit from and is accepting of investigations and interventions that can be offered.*

PART 2- Additional direction(s) related to MOST (OPTIONAL)

PART 3- SUPPORTING DOCUMENTATION *(* check all documents reviewed)

☐ Previous MOST Order ☐ Written expression of wishes ☐ Advance Directive ☐ Rep 9 agreement
☐ No CPR Form (BC) ☐ Health care provider documentation ☐Other:_____

PART 4- MOST order entered following a CONVERSATION with (check all that apply)

☐ Capable Patient ☐ Personal Guardian (Committee) Name:_____
☐ Representative Name:_____ ☐ Temporary Substitute Decision Maker(TSDM) Name:_____
☐ Patient incapable/TSDM unavailable ☐Consultation with other health care provider(s)

SIGNATURE OF ORDERING PHYSICIAN

As the patient's ordering Physician I have considered the available documents noted in Part 3 and discussed the benefits and consequences and preferences of the above Order with the indicated individual(s) in Part 4.

Name of MRP (please print)	Signature
Date (dd/mm/yyyy) Time	Location of patient

REVALIDATION OF THE MOST

☐ MOST order revalidation (No Change) Signature:	Date (dd/mm/yyyy)
☐ MOST order revalidation (Update) Prepare new MOST form, and strike through this one	Date (dd/mm/yyyy)

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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?

Code Status and MOST Designations

	CPR	Intubation	Critical Care Interventions	Site Transfer	Treat Reversible Condition	Symptom Control
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

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