AH4000 - MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) AND ADVANCE CARE PLANNING (ACP)

POLICY APPROVED BY SET IN SEPTEMBER 2014, POLICY COMES INTO EFFECT AS OF JUNE 1, 2015

1.0 PURPOSE

Ensure patient's wishes and/or instructions are acknowledged and respected regarding his/her healthcare and end of life care.

Provide a standardized framework and documentation process for conversations regarding Advance Care Planning.

Standardize the Most Responsible Physician (MRP) orders regarding resuscitation status (code status) and scope of health care treatment decisions.

Articulate and manage expectations of one or more of the four goals of medical treatment:

(a) prevention of disease; (b) curative; (c) disease management; and, (d) palliative/comfort care.

2.0 DEFINITIONS

See Appendix A

3.0 POLICY

3.1 Scope

This policy applies to adults (19 years of age or older) where clinically relevant and appropriate.

It ***does not*** apply to children or to the psychiatric treatment of patients who are involuntarily detained under the *Mental Health Act.* However, it ***does*** apply to the non-psychiatric treatment of involuntary patients.

3.2 Medical Orders for Scope of Treatment (MOST)

1. Medical Orders for Scope of Treatment (MOST) encompass six designations that provide direction on: Resuscitation Status (code status); Critical Care Interventions; and, Medical Interventions. The orders are determined by the Most Responsible Physician (MRP). See Appendix B for a sample of designation orders on the *MOST* form.

a. A **designation** indicating decisions regarding **Resuscitation Status (code status):**

C0:	Do Not Resuscitate (DNR)	No Cardiopulmonary Resuscitation (CPR), Intubation or Defibrillation
C1:	Intubation only	No Cardiopulmonary Resuscitation (CPR) or Defibrillation
C2:	Attempt Cardiopulmonary Resuscitation (CPR)	Intubation and/or Defibrillation

b. A **designation** indicating decisions regarding scope of **Critical Care Interventions:**

C0	Critical Care Interventions excluding CPR; Intubation; Defibrillation
C1:	Critical Care Interventions including Intubation, but no CPR or Defibrillation
C2:	Critical Care Interventions including CPR, Intubation, and/or Defibrillation

c. A **designation** indicating decisions regarding scope of **Medical Interventions** (excluding Critical Care Interventions & Resuscitation):

M1:	Supportive Care, Symptom Management, and Comfort Measures only. Allow a natural death
M2:	Medical Treatments within current location of care. Transfer to higher level of care only when cure or control of symptoms of illness cannot be met in current location, exclusive of Resuscitation or Critical Care Interventions. Allow a natural death
M3:	Full Medical Treatments for cure or control of symptoms of illness; exclusive of Resuscitation or Critical Care Interventions.

d. Additional instructions regarding **Specific Interventions**, as appropriate can be noted, but further details would be found on the relevant *Patient Consent Record*.

2. The MOST policy applies in all applicable Interior Health programs and care settings therefore all physicians, nurse practitioners (NP) and staff, contracted service providers, students, and other persons acting on behalf of Interior Health except as noted in scope statement (3.1) are obligated to follow this policy. The *MOST* form is recognized and honored by the British Columbia Ambulance Service (BCAS).

3. The *MOST* form is completed as an outcome of ACP conversations with a patient capable of providing consent to health care; or, if the patient is no longer capable, by reviewing his/her Advance Directive (AD) available and specific to the health care treatment being proposed; or finally, in absence of obtaining consent from the capable patient or AD, by approaching his/her Substitute Decision Maker (SDM) for substitute consent. The ACP conversations should be documented.

4. The MOST designation must be written by a MRP clarifying degree of health care interventions and treatments to be provided. The current *MOST* form should be filed in the *Patient Health Record*. A new *MOST* form needs to be completed if there is a change or addition to the previous MOST designation. A previous *MOST* form should be voided by putting a line through the form; as well, indicate date the form was voided with the signature of the person who voided the form and file as a component of the *Patient Health Record*.

5. As long as the patient is capable of providing consent, consent will always be sought from the patient directly. The patient's previous *MOST* form, in this situation, would be referenced to reaffirm prior decisions around goals of care and scope of treatment (IH Policy AL0100 Consent - Adults). If a patient has refused consent to health care treatment (referred to as 'consent refusal'), a health care provider must stop or withdraw treatment as per the Health Care (Consent) and Care Facility (Admission) Act (HCCCFAA).

6. The MRP is ultimately responsible for discussion and documentation of the *MOST* form. This includes documentation of the process by which the MOST designation was determined. Reasonable efforts should be made to identify, obtain and understand prior written instructions or wishes in whatever form they exist and to place them in the *Patient Health Record*.

7. Another physician providing care may complete a *MOST* document provided the situation has been discussed with the MRP, and the physician is prepared to complete the required documentation as described in this policy.

8. In unusual circumstances, a telephone order may be accepted for a MOST designation by a registered nurse, registered psychiatric nurse or licensed practical nurse from the attending MRP. The MOST designation would then be written by the nurse as a MRP order. As soon as possible, the *MOST* form would be completed and signed by the MRP and placed in the *Patient Health Record*.

9. A *MOST* designation form remains valid for 12 months from the date signed, at which point, a review is required.

    - If the review indicates that changes are necessary, a new *MOST* form would need to be completed.
    - If no changes are required to the current *MOST* form, the original form can be re-validated by the MRP by signing and dating it.
    - If the original form is not available, a new form must be completed.
    - Where no review has taken place within the 12 month time frame, it must be done as soon as possible and this same process applies.

10. An existing *MOST* form is valid within the 12 month time frame, providing the MRP is satisfied that the document is current and valid, and there is no indication the capable adult or the SDM's instructions have changed.

11. A *MOST* form will be initiated or reviewed in the context of significant changes in the patient's condition or circumstances relevant to the *MOST*. Review of the patient's plan of care should also be done to ensure it remains current.

12. Review of the *MOST* is the responsibility of the MRP, in conjunction with the health care team, and the capable patient; or, if the patient is no longer capable, through written instructions in his/her AD; or finally, with substitute consent from the SDM.

13. An existing *MOST* will be reviewed by a patient's MRP within the following time frames:

    a) Acute Care Facility – twenty-four (24) hours after admission and prior to discharge;

    b) Residential Care – sixty (60) days after admission and at least every twelve (12) months;

    c) Renal Program – ninety (90) days and at least every twelve (12) months

    d) Assisted Living, Home Health, Primary Care and clinic settings – at least every twelve (12) months; or

    e) Hospice – prior to admission.

14. If a patient is transferred from an institution outside of Interior Health with a *MOST* or provincially recognized orders, such as the Provincial No Cardiopulmonary Resuscitation (*BC No CPR form*), it remains in place until it is reviewed by the receiving MRP. The receiving MRP ensures a new *MOST* is written within the time frames noted in 3.4 (13). The new *MOST* (and additional documents transferred with the patient) will be placed at the front of the *Patient Health Record* and becomes part of the permanent health record.

15. The patient or SDM should be offered a copy of the *MOST* form and encouraged to keep a copy at home and have available for HCP visits, Emergency Department visits and/or admissions to hospital.

3.3 Advance Care Planning

1. Interior Health supports health care providers (HCP) to engage in advance care planning conversations with patients, and their families or substitute decision makers (SDM) in all settings of care.

2. Advance care planning is a process that may involve inter professional collaboration early in a patient's course of care and/or treatment with the capable patient or, if no longer capable, with the SDM to encompass discussions regarding:

    a. Understanding what is important to the patient.

b. Provision and clarification of medical information about disease progression, prognosis, & treatment options to clarify goals of care and consent decisions.

c. Information about personal planning options and scope of authority of these options/resources as described in the Health Care (Consent) and Care Facility (Admission) Act and Representation Agreement Act or the Patient's Property Act.

3. Any known consent refusal in an Advance Directive (AD) must be followed by HCPs. Consent for specific treatment in an AD may be followed depending on the health assessment at the time a specific treatment is being proposed by the health care provider. A valid AD will meet legislative requirements set in the Health Care (Consent) and Care Facility (Admission) Act.

4. Patients and SDMs are responsible to notify the most responsible HCP if an Advance Care Plan includes an AD, and/or Representation Agreement. HCPs must review these written documents to determine scope of authority authorized and/or any specific instructions or wishes.

3.4 Emergency Health Care Interventions and Decisions Regarding Resuscitation

1. CPR is an intervention that has the highest chance for success in patients whose cardiac arrest is due to a known/witnessed acute cardiac arrhythmia.

2. When a cardiac arrest is un-witnessed and vital signs and agonal movements such as spontaneous respiration or swallowing are absent, there is no indication for resuscitation. However, trained staff may initiate CPR at their discretion and/or call 911 or Code Blue depending on the setting.

3. When a cardiac arrest is witnessed in the absence of a completed *MOST form*, CPR will be initiated and appropriate orders clarified as soon as possible. In community settings where resuscitation status has not been clarified by the MRP or there is no *MOST* form or *BC No CPR Order* in place, 911 should be called.

4. A physician assessment regarding benefit of CPR based on best clinical judgment should form the basis of recommendations to the patient and/or substitute decision maker (SDM) regarding code status and a MOST designation (Appendix B).

5. In an emergency situation where a patient is at or near the end of an irreversible disease process or dying from an acute disease process known to be unresponsive to CPR and there would be no benefit from such interventions, a physician is not obligated to offer non-beneficial treatment. Using best clinical judgment, the physician will initiate a clinically appropriate course of treatment and plan of care.

6. A MOST designation may be revised by the MRP based on his/her health assessment, unless contrary to a known consent refusal in the patient's Advance Directive.

7. Where consent is in place for organ donation, life support interventions may be continued to allow for optimal viability of the organs for potential donation even after the pronouncement of neurologic death. In cases of organ donation after cardio-circulatory death, life sustaining interventions may be continued to allow for work up

of the potential donor organs to be adequately completed and to allow timely retrieval from the surgical procurement team.

3.5 Communication Issues and Dispute Resolution

1. Standardized MOST practices and processes across IH will enhance engagement with patients as full partners in their care, and support transitions across health service area with clear, concise and effective planning regarding goals of care and treatment choices.
2. Should dispute occur between partners regarding a MOST designation, efforts should be made to resolve concerns as informally as possible. HCPs can refer to the clinical ethics decision support tools for guidance on an approach to articulate and resolve concerns.
3. When goals or preferences for care come into conflict, additional support should be sought. The MRP may seek second opinions from other HCPs with knowledge and skills relevant to the circumstances of the patient's condition.
4. A clinical ethics consultation may be requested to provide support and guidance in resolving ethical dilemmas that could arise in specific situations.
5. If appropriate avenues of decision support and dispute resolution have been explored, including second opinion review and consultation and disagreement persists the MRP may:
    - **if the proposed treatment being disputed has not been started**, based on his/her best clinical and professional judgment, write a MOST designation and inform the patient and/or substitute decision maker; or
    - **if the disputed treatment has been started,** a *MOST* form cannot be written without consent or substitute consent if the MOST designation would result in a withdrawal of the disputed treatment and withdrawal ties in to palliative care.
6. Programs will follow dispute resolution processes established. This typically involves Managers, Directors, Program Medical Directors/Department Heads and escalation within the program structure as appropriate. The patient and SDM should be made aware of dispute resolution resources (IH Policy: AK0100-Client Complaint Management).
7. Risk Management should be contacted with legal issues including the threat of litigation. Consultation for guidance on capability issues, abuse a/or neglect may also be required by professionals, such as the Clinical Specialist in Adult Abuse and Neglect.

4.0 PROCEDURES

Refer to Form # 829641 (under development). See sample in Appendix B and Appendix C

5.0 REFERENCES

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APPENDIX A: DEFINITIONS

Adult: In British Columbia, refers to a person 19 years of age or older.

Advance Care Plan (ACP): A summary of a capable adult's wishes or instructions to guide a substitute decision maker if that person is asked by a physician or other health care provider to make a health care treatment decision on behalf of the adult. This summary may include written documents such as an Advance Directive and/or Representation Agreement.

Advance Care Planning: The process of a capable adult talking over their beliefs, values, and wishes about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions. (*MoH My Voice Expressing My Wishes for Future Health Care Treatment Advance Care Planning Guide*)

Advance Directive (AD): A written instruction, completed when adult remains capable, that provide instructions directly to the health care provider about the healthcare treatment the adult consents to, or refuses. It is effective when the capable adult becomes incapable and only applies to the health care conditions and treatments noted in the AD. An AD that meets the requirements per the HCCCFAA, outranks everyone except the capable adult.

Capable Adult: All adults are presumed to be capable of making health care decisions until there is clear evidence that the adult is incapable of making a clear decision. In deciding incapability, decision must be based on whether the adult demonstrates that he or she:

- Understands the information being given about health condition
- Understands the nature of the proposed health care
- Understands the information provided applies to him/her

Cardiac Defibrillation: Administration of an electric shock delivered through a device on the exterior of the chest wall to normalize the rhythm of the heart or restore it.

Comfort Care: Refers to medical care for symptom control, psychological and spiritual support with a palliative approach to care.

Committee of Person (also called Personal Guardian): Person appointed by the court under *Patients Property Act* to be the Personal Guardian of an adult. The powers of a Committee of Person, though extensive, can be limited by restrictions imposed in the court order.

CPR (Cardio-Pulmonary Resuscitation): Defined as the manual application of chest compressions and ventilation.

Critical Care Interventions: Interventions that require advanced monitoring and higher levels of care.

Health Care Provider:	Professional licensed, certified, or registered to provide health care under the Health Care Professions Act and Social Workers Act.
Health Care Treatment:	Anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health care purpose and may be a series of similar treatments or care given over time or a plan for a variety of care purposes for up to one year.
Intubation:	The insertion of an endotracheal tube to assist with breathing.
Life Prolonging Medical Interventions:	Health care treatments like tube feedings, ventilators, kidney dialysis, medications, and cardiopulmonary resuscitation. The Intensive Care Unit (ICU) typically is a location where such interventions are provided in an attempt to restore normal physiology, however, not exclusively. These interventions are considered 'Medically Appropriate Care' when the goal of care is to continue or prolong life.
Medically Appropriate Care:	Health care treatment offered by a health care provider that is consistent with the patient's condition and goals of care, based on the health care provider's health assessment.
Non-beneficial Medical Treatments:	Treatments where, in the best clinical judgment of a physician there is no clinical benefit or reasonable hope of recovery or improvement.
Nurse Practitioner:	Registered nurse who has met the requirements of the profession to be registered and to use the title of nurse practitioner. They provide expanded nursing services including diagnosing, prescribing, ordering tests and managing common acute illnesses and chronic conditions.
Patient:	Refers to a patient, client, or resident.
Plan of Care:	An inter-professional documentation tool that outlines the care for the patient, and reflects his/her needs and goals which all health care team members need to consider in their interactions with the patient.
Public Guardian and Trustee:	A corporation established under the Public Guardian and Trustee Act with a mandate to serve: children and youth under the age of 19 by protecting their legal and financial interests; adults who require assistance in decision making through protection of their legal rights, financial interests and personal care interests; and heirs and beneficiaries of deceased persons when there is no one willing or able to administer their estates, the estates of missing persons, and the beneficiaries of personal trusts.
Representation Agreement (RA):	The document in which a capable adult names their representative to make health care treatment decisions and other decisions on his/her own behalf when incapable. Scope of authority is dependent on the type of agreement as well as the scope of decisions laid out by the capable adult. There are two types of Representation Agreements, Section 7 RA and Section 9 RA.

Representative:	A person 19 years or older who is named by a capable adult, in a Representation Agreement appointed to make health care treatment decisions and other decisions on his/her behalf when no longer capable of providing consent decisions.
Substitute Decision Maker (SDM):	A capable person with authority to make health care treatment decisions on behalf of an incapable adult. There are three types of substitute decision makers: Committee of Person/Personal Guardian; Representative; and Temporary Substitute Decision Maker (TSDM).
Temporary Substitute Decision-Maker (TSDM):	A capable adult chosen by the health care provider who is qualified, willing and available to make health care treatment decisions on behalf of the incapable adult when substitute consent is needed. The HCP must select a TSDM from the list of eligible people to be appointed in the Health Care Consent and Care Facility Admission Act in the order given. TSDM appointment is time limited and applies only to the specific health issue at hand. A TSDM is not authorized to make health care treatment decisions in advance of a proposed treatment being offered by the MRP. The Health Care Providers' Guide to Consent to Health Care lists in ranked order individuals who could be chosen by the HCP as a TSDM
Un-witnessed Arrests:	An arrest is considered un-witnessed when the patient is found with no vital signs, unresponsive pupils, no spontaneous attempts at respiration and no other agonal movements (for example attempts to swallow), and where there are no clues of any kind to indicate when the actual cessation of consciousness occurred

APPENDIX B – MOST Designation Order Form (# 829641)

Insert sample of the form and link to form on InsideNet (currently under development)

APPENDIX C: SUMMARY OF PROCESS TO DETERMINE MOST DESIGNATION

(# Reverse side of Form # 829641)