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Decision Support Tool
Advance Care Planning and Medical Order for Scope of Treatment

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Purpose

The purpose of this DST is to provide direction and structure for health care professionals (HCPs) and most responsible practitioners (MRPs) in Advance Care Planning (ACP) conversations and documentation processes.

Outcomes

To ensure that clients receive medical care that is consistent with their personal values, goals, beliefs and preferences during serious and chronic illness. This is critical to achieving safe, person-centred, value-aligned and culturally responsive care.

All HCPs and MRPs use current ACP best practices and processes as endorsed by Fraser Health. These include:

- ACP, Serious Illness and Goals of Care conversation tools
  - (see Clinician Quick Reference – Conversation Tools),
- ACP documentation standards:
  - ACP Record
  - Identification of Substitute Decision Maker form (IDSDM)
  - Medical Order for Scope of Treatment (MOST).

Applicability

- This DST applies to all clients, including children, where clinically relevant.
- This DST applies in all Fraser Health Authority programs and care settings.
- British Columbia Emergency Health Services (BCEHS) recognizes and honours the Fraser Health MOST.

Practice Level and Education

This DST applies to all MRPs, HCPs, employees, contracted service providers, students, and other persons acting on behalf of Fraser Health Authority (FHA).

Foundational Competency:
Leadership supports all MRPs and HCPs to gain the foundational knowledge to engage in ACP processes with clients by completing this module during orientation:

- ACP online module (30 minutes)

Intermediate and Advanced Competency:
Leadership supports all MRPs and HCPs actively engaged in ACP to complete ACP education within 3 months of role:

- See Learning Hub for education options.

Leadership supports all MRPs to complete:

- MOST online module (20 minutes)

Note: MRP specific ACP and Serious Illness conversations education available upon request.

All employees are encouraged to use the Competency Standards to self-assess their current ACP knowledge and competency. See Clinician Quick Reference - Competency Standards.

Policy Statements

The Advance Care Planning process includes ACP, Serious Illness, and Shared Goals of Care conversations, documentation of these conversations, and medical orders that result from these conversations. Fraser Health Authority supports all MRPs and HCPs in all settings of care to engage in ACP conversations with clients, and if applicable their families, friends, substitute decision makers (SDMs), others who matter to them throughout their care journey, and to adhere to standardized documentation processes.

Advance Care Planning

1. ACP conversations occur early and are ongoing.[1, 2] Conversations begin when clients are healthy, if they experience a health event, new diagnosis, injury, or experience fluctuating health due to chronic illness or injury progression.

2. Serious Illness conversations take place during times of increasing needs and/or declining prognosis with life expectancy of 1-2 years.[3, 4]

3. Shared Goals of Care conversations take place when a treatment decision is required.[5, 6] These discussions align the clients' values, beliefs and preferences with the current clinical context.

4. MRPs, HCPs and clients reach medical decisions using a shared decision-making process[7]. This may result in a medical order for the use or non-use of cardio-pulmonary resuscitation (CPR), and other lifesaving or sustaining treatments, or for another plan of care.

5. When the client is a child, MRPs and HCPs include them in ACP conversations, where appropriate. This includes providing an opportunity to share what's important to the child and contribute to the shared decision-making process.

6. All MRPs and HCPs participate in ACP conversations (see Clinician Quick Reference – Conversation Tools).

7. All MRPs and HCPs document ACP conversations as per guidelines below. Failure to follow the ACP documentation process can result in care errors or client harm. In the event of errors or a near miss, follow PSLS guidelines.

Advance Directives and Representation Agreements

1. Information about the option to name a Representative and/or make an Advance Directive will be provided to clients and SDM(s), including the roles, responsibilities, and authority these options provide as described in the *Health Care (Consent) and Care Facility (Admission) Act*[8] and *Representation Agreement Act*[9]

2. An Advance Directive that meets the legislative requirements set out in the *Health Care (Consent) and Care Facility (Admission) Act* must legally be followed unless MRPs or HCPs reasonably believes that it:
   - Does not deal with the health care decision at issue,
   - Is so unclear that it cannot be determined if the client has given or refused consent to the health care,
   - Does not reflect significant changes in the client's wishes, values, or beliefs (made while they were capable) in relation to the decision, or
   - Was made prior to significant changes in medical knowledge, practice, or technology that might substantially benefit the client unless it expressly states that it applies regardless of changes in medical knowledge, practice or technology.

3. Clients and SDM(s) are responsible to notify the MRPs and HCPs if ACP conversations have taken place and an Advance Directive, Advance Care Plan, or Representation Agreement is completed. See Clinician Quick Reference– Health Care Planning Legislation.

Medical Order for Scope of Treatment (MOST)

1. The Medical Orders for Scope of Treatment (MOST) form is a medical order signed by the MRP. **MOST is not a client consent form.**

2. MOST is not required for all clients. It is recommended for people living with advanced medical illness.

3. Complete MOST orders after ACP, Serious Illness, and Shared Goals of Care conversations with clients and/or those who matter to them.

4. Communicate with the client in a clear, consistent manner that is respectful of language, abilities, and diverse backgrounds.

5. Provide clients with the necessary information, support, time and opportunity to participate in discussions within a shared decision-making model.

6. All members of the health care team can contribute to a MOST designation by engaging in ACP conversations and documenting conversation outcomes.

7. MRPs select a MOST designation based on their clinical judgment of the client's current health status (For further description of designations, see Clinician Quick Reference – MOST Designation)

8. To clarify MOST designations:
   - CPR is defined as chest compressions and rescue breaths (Basic Life Support). Further resuscitation treatment (Advanced Cardiac Life Support) escalation is a continuum and highly contextual, and requires the MRP's clinical judgement. [10]
   - DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) designations do not mean airway issues are not treated. If a client is choking, a HCP is expected to attempt to clear the airway. If obstruction escalates to a cardiac arrest, the DNACPR order applies.

9. Designation terminology

Critical care	Specialized interdisciplinary care provided to clients with life threatening or potentially life threatening conditions, typically involving one or more organ system failures. E.g. Patients who benefit from critical care interventions range from, but are not limited to those with severe respiratory illnesses requiring ventilator support (pneumonia, Acute Respiratory Distress Syndrome (ARDS), airway obstruction, etc), those with critical infections requiring blood pressure support and invasive monitoring (sepsis, necrotizing fasciitis), and others with severe physiologic alterations (diabetic ketoacidosis (DKA), myxedema coma, thyroid storm, ventricular tachycardia (VT) storm, hyponatremia).

Site transfer	Transfer to higher level of care if medical treatments at current location are not meeting client's needs. E.g. Patients who benefit from site transfer to higher level of care range from, but are not limited to, those who require urgent specialist assessment (acute ischemic stroke, urgent dialysis, ST Elevation Myocardial Infarction (STEMI), etc) to patients who require specialized care (Palliative Complex Care Unit admission, specific psychiatric unit), and others who require symptom assessment and management.
Reversible Conditions	A condition that requires intervention to resolve in a reasonable time. E.g. Patients who benefit from treating a reversible condition range from, but are not limited to those with new organ dysfunction, arrhythmias, bony fractures, blood clots, infections, etc.
Symptom Control	Investigations, treatments, or procedures that relieve discomfort associated with physical, emotional, psychosocial or spiritual concerns; may or may not include disease-modifying therapies. E.g. Patients who benefit from symptom control range from, but are not limited to those with distressing symptoms, refractory disease with no further treatment options, patients who prefer minimal intervention, and those who are nearing end of life.

10. MOST designations are outcome based and consider the following:
    - Is the designation medically indicated (appropriate/relevant) for this client at this time?
    - Is the client likely or expected to benefit from the treatments considered?
    - Does the designation align with the client's goals and priorities?

11. Discussion of preferences for specific interventions (ie. Blood products, cardioversion, noninvasive ventilation, enteral or parenteral nutrition, dialysis) must be documented on the ACP Record.

12. Treatments, interventions, and procedures that are not medically indicated are not offered, and rationale is communicated to the client and, if applicable, those that matter to them.[11, 12] Document on the ACP Record. See documentation section for further information.

13. To void an invalid (outdated, updated, etc.) paper MOST form, the MRP puts a line through the form and signs their initials.

14. Provide clients their MOST form and encourage them to keep it at home in a Greensleeve, and to bring it to health care visits, Emergency Department visits, and admissions to hospital.

MOST Completion Timeframes

1. A MOST is valid for 12 months from the date signed.

2. In all urgent or non-urgent circumstances, an outdated MOST (more than 12 months) is temporarily valid if:

- the MRP is satisfied that the document is current and valid as far as can be reasonably determined
- there is no indication that the client's wishes or instructions have changed
- the designation continues to be medically indicated.

The MRP completes a new MOST based on their clinical judgment as soon as possible. The MRP must inform the client and/or if applicable, others that matter to them.

3. When medically indicated, a MOST will be filled out and signed by MRP within the following timeframes: (If a client has a previously existing MOST that is both valid (within 12 months) and medically appropriate, then a new MOST is not required.)

Care Area	**Time**
Acute Care	Within twenty-four (24) hours of admission to hospital and prior to discharge. At the time of significant change in health status or circumstances (for example visit to Emergency Department).
Surgery	Prior to surgery, and prior to discharge See Surgical Network workflow process.
Long Term Care	Sixty (60) days after admission and at least every twelve (12) months.
Assisted Living, Home Health, Primary Care and clinic settings	At least every twelve (12) months.
Outpatient Specialty Services (e.g. Dialysis services, outpatient specialty clinics such as Lung Health, Heart Function, Diabetes, Neurology, Kidney Care, Seniors Clinic)	Ninety (90) days and at least every twelve (12) months.
Hospice Residences	Prior to admission.

4. A MOST review can be requested by the client and, if applicable, by others that matter to them.

Urgent Circumstances

1. Another physician or nurse practitioner may complete a MOST, provided they document on the MOST form and ACP record, and discuss the situation with the MRP.

2. In unusual circumstances, a MOST may be given by telephone to a registered nurse, registered psychiatric nurse or licensed practical nurse by an attending MRP. The nurse will write the MOST designation as a medical order, clarifying both CPR and medical treatment levels (e.g. CPR C2; DNACPR M2). The MRP or designate will complete a MOST form as soon as possible.

Unexpected and Reversible Reaction

In the event of an unexpected and reversible reaction (during or immediately after a test or procedure), the attending MRP uses their clinical judgment, which may contradict the current MOST designation.

External Orders (Another Health Authority's MOST, or Provincial No CPR form)

1. An external MOST or a similar set of orders, such as Provincial No CPR, Goals or Options for Care remains in place until the MRP reviews it.

2. The receiving MRP completes a new MOST within the designated time frames noted above.

Witness/Unwitnessed Cardiac Arrest

1. CPR is not attempted on an adult client who has suffered an unwitnessed cardiac arrest unless the individual was observed within minutes of the event. This does not apply to children. See Code Blue: Adult and Pediatric – Management.

2. When a cardiac arrest is witnessed, in the absence of a relevant MOST or other medical order, and CPR is medically indicated, CPR is provided and appropriate orders clarified as soon as possible. See Code Blue: Adult and Pediatric – Management.

3. In community settings where a designation has not been clarified by the MRP (no MOST or Provincial No CPR order in place), 911 is called. See Code Blue: Adult and Pediatric – Management.

Children

1. When clinically relevant, children may have a MOST completed as part of their care plan.

2. Children have the right to participate in pediatric ACP conversations, and the consent process as developmentally appropriate.[13]

**Please note. Fraser Health's Consent to Health Care Policy and the Ministry of Health's Health Care Providers Guide to Consent to Health Care [14] provides guidance and information about provincial legislation and standards of professional practice.*

**Please note. Fraser Health's Complex Consent to Treatment Clinical Practice Guideline and the Canadian Medical Association, the Canadian Healthcare Association, the Canadian Nurses Association, and the Catholic Healthcare Association of Canada Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care [15] provides guidance when concerns and disagreements arise.*

Assessment & Intervention

Regardless of age, health status, or clinical context of client, the five steps of ACP (Think, Learn, Decide, Talk and Record) guide all ACP interventions. See Clinician Quick Reference – 5 Steps.

Use the following guidelines to assess clients and apply the most appropriate intervention:

- **Assessment & Intervention Guidelines: General (adults)**
  Advance Care Planning Framework and Toolkit
- **Assessment & Intervention Guidelines: Life Limiting Conditions and Illness Complexity (adults)**
  Clinical Protocol: Advance Care Planning in Adults Living with Life Limiting Conditions
- **Assessment & Intervention Guidelines: (children)**
  Canuck Place ACP Guidelines

Monitoring

MRPs and HCPs self-evaluate an intervention's success and impact on clients. It is recommended that MRPs and HCPs use the teach-back method [16] to check for understanding and comprehension of ACP concepts

and engagement. Each intervention will contribute to the overarching goal of achieving value-aligned and culturally responsive care.

Documentation

Fraser Health Clinical Documentation Policy applies to all ACP documentation. All MRPs and HCPs are required to document ACP information using the following three forms:

Document and description:	Completed by:	Information to document:	Client applicability:
Advance Care Planning Record (Form ID: ADDI101231) A form to document ACP conversations. See example: Clinical Quick Reference: Documenting on ACP Record	• HCP • MRP	Provide a brief summary of key concepts: • What was discussed? • What information was shared by the HCP? • What information was provided by the client, family, friend, SDMs or others important to them? • What are the client's values, beliefs, preferences, and goals? • What was the outcome of conversations? • What resources or education provided to the patient	• Adults • Children
Identification of Substitute Decision Maker (Form ID: ADDI106819) A pre-planning tool that identifies potential SDM should the adult not be capable to make decisions.	• HCP • MRP	• Review with client and fill in all that apply	• Adults only
Medical Order for Scope of Treatment (Form ID: ADDI105016) A pre-printed order that designates medically indicated interventions.	MRP only	• Section 1: **Select one** designation for CPR and medical intervention • Section 2: **Select all** supporting documentation that was reviewed • Section 3: **Select one** option to indicate who informed the MOST designation • This form **must include** MRP signature, date, time, college ID.	• Adults • Children

All MRPs and HCPs are responsible for reporting client safety events (near misses, hazards etc.) related to ACP, consent, and MOST through the Patient Safety and Learning System (PSLS). For information about reporting ACP events see Clinician Quick Reference – Reporting PSLS Events.

Storage and Scanning

- All ACP forms are scanned and then stored in a central standardized single source of truth area in Meditech (Risk/Legal). This is viewable in UCI and CareConnect and ensures access across care settings. See Clinician Quick Reference: Locating Scanned ACP documents in Meditech, UCI & CareConnect.
- In settings using paper forms, completed ACP forms are placed in the Greensleeve at the front chart, and are scanned into Meditech
- In settings without a scanning process all ACP documentation forms must be faxed to the number listed at the bottom of the form, where they will be scanned into Meditech.

Client Education

MRPs and HCPs assess client education needs and utilize the available resources as appropriate:

- Internal Link: Advance care planning - Resources for clients
- External/Public Link: Advance Care Planning

Evaluation

The Regional Advance Care Planning Team will conduct generalized monitoring of:

- Annual randomized chart audits (review documentation)
- Quarterly counts of barcoded documents
- Annual PSLS event counts/reviews

Further monitoring of MRP and HCP skill requirement, documentation adherence, and overall general practice will be the responsibility of leadership, individuals, teams, and departments.

Related Resources

ACP Forms:

- Medical Order for Scope of Treatment (MOST) – Pre-Printed Order
- Advance Care Planning (ACP) Record - Form
- Identification of Substitute Decision Maker - Form
- Fraser Health ACP Framework and Toolkit

ACP Related DSTs:

- Complex Consent to Treatment Resolution – Clinical Practice Guideline
- Advance Care Planning – Adult – Living with Life Limiting Conditions – Clinical Protocol

Clinician Quick References:

- Clinician Quick Reference - Locating a Scanned ACP Record and/or MOST in Meditech
- Clinician Quick Reference – Documenting on ACP Record
- Clinician Quick Reference – Substitute Decision Maker Hierarchy
- Clinician Quick Reference - Choosing A Medically Indicated MOST Designation
- Clinician Quick Reference – Legislation Summary/Legal Documents
- Clinician Quick Reference – Core Competencies
- Clinician Quick Reference – The 5 Steps
- Clinician Quick Reference – Conversation Tools
- Clinician Quick Reference – Reporting PSLS Events

FH Related Policies and Standards:

- Consent for Health Care - Policy Code Blue: Adult and Pediatric – Management - Policy
- Fraser Health Diversity Competency Standards

Serious Illness Resources:

- Serious Illness Conversation Guide – A Conversation Tool for Clinicians – Form
- Serious Illness Conversations Guide – Substitute Decision Maker - A Conversation Tool for Clinicians – Form

Pediatric and Neonatal Resources:

- Advance care planning (ACP) for maternal, infant, child and youth (Pulse Page)
- Serious Illness Conversation Guide (SICG) Pediatric Adaptation Tool (a conversation tool for any health care professional)
- Serious Illness Conversation Guide (SICG) Neonatal Tool (a conversation tool for any health care professional)
- Serious Illness Care Program: Reference Guide for Inter-professional Clinicians in the Pediatric Setting

Key Points/Need to Know

1. This policy provides direction and structure for MRPs and HCPs to understand and engage in ACP best practices and processes. MRPs and HCPs support clients at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.

2. ACP includes Serious Illness, and Shared Goals of Care conversations; documentation of these conversations, and medical orders that result from these conversations.

3. ACP interventions endorse a shared decision-making framework. This recognizes that clients are the experts in their values, goals, and preferences; HCPs and MRPs are the experts in medically indicated treatment options that honour the client's perspective. Treatment recommendations then translate values and goals into a care plan.

4. Fraser Health Authority supports all MRPs and HCPs in all settings of care to engage in ACP conversations with clients, their families, friends, substitute decision makers (SDMs), and others who matter most to them throughout their care journey, and to adhere to documentation processes.

Definitions

Advance Care Planning (ACP): a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of advance care planning is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness (International Consensus Definition - Sudore et al., 2016). [17] For children see pediatric advance care planning.

Advance Care Plan: a recorded summary of the capable adult's advance care planning conversations, including values, goals, and preferences, to guide family, friends, substitute decision makers and HCPs in shared decision-making.

Advance Directive (AD): a written instruction made by a capable adult that gives or refuses consent to future health care interventions. It becomes effective only when the adult is not capable to make informed choices about health care in the type of situation the directive specifies.

Adult: for health care decisions in British Columbia refers to a person 19 years of age or older.

Capability: 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, the decision must be based on whether the adult demonstrates that he or she:

- Understands the information being given about the health condition
- Understands the nature of the proposed health care intervention
- Understands how the information provided applies to them

Cardio-Pulmonary Resuscitation (CPR): Conventional CPR involves chest compressions (pushing down hard and fast on the centre of the chest) and artificial respiration (rescue breathing or mouth-to-mouth breaths) in order to provide oxygen to essential organs such as the heart and brain.

Client: for purposes of this document the word client(s) refers to anyone utilizing services, including children under the age of 19.

Culturally Responsive Care: Centers the experiences of those receiving care. It is the intentional and consistent decision healthcare providers make to see, respect and celebrate the aspects that make each person unique. It is an acknowledgement of intersectional existence and how this shapes ones experiences. In practice, this involves asking the question “what do people need?”

Health Care Professionals (HCPs): nursing and allied health professionals of technical, therapy, social/community, and clinical assisting occupations and regulated professions

Identity: personal identity may include culture, customs, ethnicity, gender identity, language, religion, sexual orientation and more. These aspects of identity shape our personal values or guiding principles.

Life Sustaining Treatments (LST): medications or medical devices (also known as life support) using mechanical or other artificial means to support or replace vital organ function on either a temporary or permanent basis. Life-sustaining treatments are distinct from therapy in that LSTs merely sustain rather than restore organ function. Moreover, LSTs are not routine medical interventions; rather, they are specialized measures that require specialized medical staff, specialized locations, and significant resources. Accordingly, ongoing use of LSTs necessitates admission to a specialized area such as an ICU within an acute care hospital. Life-sustaining treatments can include mechanical ventilation, pharmacological or mechanical hemodynamic support, and hemodialysis.[37]

Medical Treatments: The use of treatments, procedures, or interventions in an attempt to cure or mitigate a disease, condition, or injury.

Medically Indicated: A proposed treatment, intervention or procedure that has evidence-based benefit and/or recognized as appropriate within the HCP’s profession, scope and clinical judgement.

Most Responsible Practitioner (MRPs): Physicians and Nurse Practitioners.

Pediatric Advance Care Planning: pACP is a lifelong process of reflection and communication to identify values, wishes and beliefs in relation to the kind of health and/or personal care a child, or parent may want for their child, to guide future healthcare decisions at times of great uncertainty. In pediatrics, this also includes considering the child's ability to understand, participate and make specific decisions in regards to their care. pACP involves the concept of parallel planning – planning for both the life of the child while also planning for deterioration/death to allow for the child's full potential. This primes the mobilization of services and healthcare professionals when necessary. An Advance Care Plan may at times look like an anticipatory care plan – laying

out actions to be taken if or when a child's illness is unstable or deteriorates or they develop life threatening complications due to their illness.

Representative: a person named by a capable adult in a Representation Agreement to make health care decisions on behalf of the adult if they become incapable.

Representation Agreement: the document in which a capable adult names a representative and sets out the type and scope of decisions that the representative may make on behalf of the adult if the adult becomes incapable.

Resuscitation: An intervention applied following cardiac or respiratory arrest with the potential to prevent premature death or to prolong inevitable death. Resuscitation may or may not include CPR.[37]

Serious Illness Conversations: HCP initiated conversations with clients who are seriously ill and a prognosis of one to two years. The intention is to clarify prognosis and explore values and priorities that will inform future care.

Shared Goals of Care Conversations: HCP initiated conversations that take place when a treatment decision is required. These discussions put the clients' values and preferences into the current clinical context. Medical decisions are reached using a shared decision-making process. This may result in a medical order for the use or non-use of CPR and other lifesaving or sustaining treatments, or for another plan of care**.**

Substitute Decision Maker (SDM): an appointed capable person with authority to make healthcare decisions on behalf of an incapable adult. There are two types of SDMs in the following hierarchical order:

1) **Formal Substitute Decision Makers** Committee of Person/Personal Guardian (Under the *Patient's Property Act* - court ordered) Representative (under the *Representation Agreement Act*)

2) **Temporary Substitute Decision Makers (TSDM)** A family member or close friend who is legally qualified and available to make health care decisions on behalf of an incapable adult. The HCP must select a TSDM from the list in the *Health Care Consent and Care Facility Admission Act* in the designated order.TSDM appointment is time limited and applies only to the specific health issue at hand (See Health Care Consent Policy).

Unwitnessed Arrests: Literature Review underway for current definition.

Values: personal values are the things that are important to us; our central beliefs and priorities. Personal values are the main driver behind our behaviors and actions, including decisions we make regarding our health care. See My Voice in Action Workbooks (step one: think for more information).

References
Reference List

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Approved by:	Dr Ralph Belle, Vice President Medicine		
Revision history:	**Version**	**Date**	**Description or key changes**
	1.0	June 2012	Initial Policy released
	2.0	October 2015	Revised
	3.0	October 2017	Revised
	4.0	July 2019	Revision
	4.1	May 2020	Content edited: Appendix D updated
	5.0	August 2, 2023	• Formatting and design: medical treatment description table is moved from the back to the front of the MOST • MOST language updated from Do Not Resuscitate (DNR) to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) • Specific Interventions section moved from the MOST to the ACP Record • Surgical Resuscitation area removed from MOST • Children included when medically indicated
	5.1	Dec 19, 2023	Content edited to: • Clarify designation meaning in the event of partial or fully obstructed airway. • Clarify MOST completion timeframes.