2019 Dementia Education Conference: Review of Advanced Care Planning

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Objectives

- **Dementia at End of Life Overview**
- **Hospice or Palliative Care?**
- **Hospice FAST Scale for Dementia**
- **Facilitate better understanding of Advance care documents:**

Objectives

- **Living Will / Healthcare power of Attorney / Medical Orders for Scope of Treatment (MOST) / Golden Rod**
- **Understanding North Carolina Hierarchy for surrogate decision makers**
- **Do Not Resuscitate (DNR) vs. Do Not Intubate (DNI) status**

Dementia at End of Life Overview

Case Example

Alma had been forgetful for years, but even after her family knew that Alzheimer's disease was the cause of her forgetfulness, they never talked about what the future would bring. As time passed and the disease eroded Alma's memory and ability to think and speak, she became less and less able to share her concerns and wishes with those close to her.

- **This made it harder for her daughter Sylvia to know what Alma needed or wanted. When the doctors asked about feeding tubes or antibiotics to treat pneumonia, Sylvia did not know how to best reflect her mother's wishes. Her decisions had to be based on what she knew about her mom's values, rather than on what Alma actually said she wanted.**

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Dementia at End of Life Overview

- People can live with Alzheimer's or Parkinson's dementia for several years
- However, these are considered incurable, terminal diseases that eventually result in death.
- Dementia causes the gradual loss of thinking, remembering, and reasoning abilities
- Limits loved ones who want to provide supportive care at the end of life to know what is needed.

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Dementia at End of Life Overview

- **Quality of life is an important issue when making healthcare decisions for people with dementia**
- **Some medicines may help to control some of the behavioral symptoms associated with the disease or to delay the progression in cases especially to mild to moderate Alzheimer's dementia.**

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Dementia at End of Life Overview

- When making decisions for someone else near the end of life, consider the goals of care and weigh the benefits, risks, and side effects of the treatment
- Many people are unprepared to deal with the legal and financial consequences of a serious illness such as Alzheimer's disease.

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Dementia at End of Life Overview

- **“Legal and medical experts encourage people recently diagnosed with a serious illness-particularly one that is expected to cause declining mental and physical health-to examine and update their financial and health care arrangement as soon as possible!”**

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Dementia at End of Life Overview

- **Basic legal and financial instruments, such as a Living Will, a living trust, and Advanced Directives documents are available to ensure that the persons late stage or end-of-life healthcare and financial decisions are carried out.**

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Hospice or Palliative Care?

Palliative Care

- Treatments that support alleviating symptoms of chronic, life-threatening diseases. (Heart failure, COPD, Parkinson's, and dementias)
- Patient's health approach is a curative plan

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Hospice or Palliative Care?

Hospice Care

- **Treatments that support and facilitate comfort and transitioning from life to death.**
- **When conventional treatments have failed, illness remain incurable, or the progression of a disease has not slowed down**

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Hospice or Palliative Care?

Hospice Care

- Hospice can be offered in the home, skilled nursing or assisted living facilities, or Hospice Houses.
- Many patients and families wait too long to consider hospice care services.

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Hospice or Palliative Care?

Hospice Care

- **The FAST Scale is a 16-item scale designed to parallel the progressive activity limitations associated with Alzheimer's disease.**
- **Stage 7 identifies the threshold of activity limitation that would support six-month prognosis; however all sub stage FAST Scale indicators under stage 7 must be present.**

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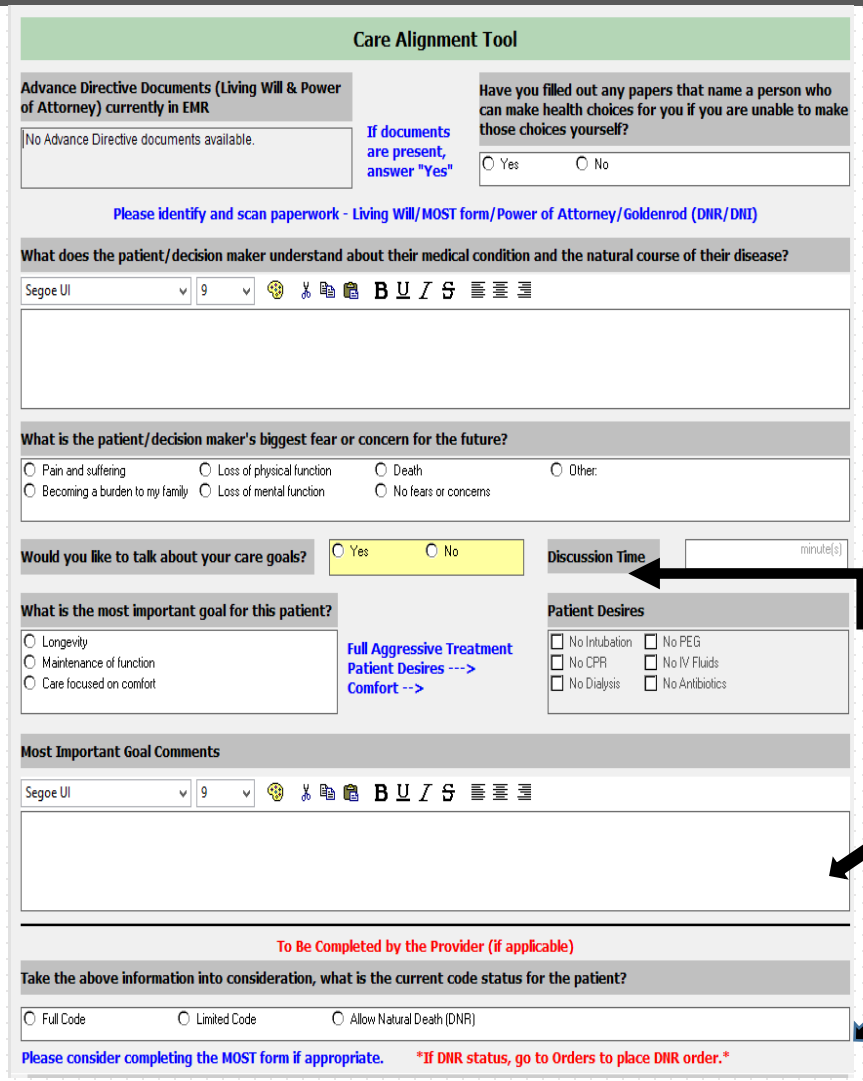
Advance Care Planning

- **Process by which patients and their clinicians engage in discussions about future goals of care and preferences at the end of life**
- **Patients should be encouraged to discuss their care preferences with not only their clinician but also their loved ones**
- **Fully informed patients with decisional capacity have the right to forgo or terminate life-sustaining treatments**

Care Alignment Tool (CAT)



Care Alignment Tool

Advance Directive Documents (Living Will & Power of Attorney) currently in EMR

No Advance Directive documents available.

If documents are present, answer "Yes"

Have you filled out any papers that name a person who can make health choices for you if you are unable to make those choices yourself?

○ Yes ○ No

Please identify and scan paperwork - Living Will/MOST form/Power of Attorney/Goldenrod (DNR/DNI)

What does the patient/decision maker understand about their medical condition and the natural course of their disease?

Segoe UI 9

What is the patient/decision maker's biggest fear or concern for the future?

○ Pain and suffering ○ Loss of physical function ○ Death ○ Other:
○ Becoming a burden to my family ○ Loss of mental function ○ No fears or concerns

Would you like to talk about your care goals? ○ Yes ○ No

Discussion Time minute(s)

What is the most important goal for this patient?

○ Longevity
○ Maintenance of function
○ Care focused on comfort

Full Aggressive Treatment
Patient Desires --->
Comfort -->

Patient Desires

☐ No Intubation ☐ No PEG
☐ No CPR ☐ No IV Fluids
☐ No Dialysis ☐ No Antibiotics

Most Important Goal Comments

Segoe UI 9

To Be Completed by the Provider (if applicable)

Take the above information into consideration, what is the current code status for the patient?

○ Full Code ○ Limited Code ○ Allow Natural Death (DNR)

Please consider completing the MOST form if appropriate. *If DNR status, go to Orders to place DNR order.*

- Guide for GOC Discussions
- Complete on admission, ED encounters, SNFs, or with changes in advance directives
- Obtain permission to talk about goals
- Document goal comments
- Designate Code Status
- Complete MOST or DNR if appropriate

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Care Alignment Tool (CAT): Final Report

Document Type:	Care Alignment Tool Form - Text
Document Date:	February 01, 2019 10:54 EST
Document Status:	Auth (Verified)
Document Title/Subject:	Care Alignment Tool
Performed By/Author:	WILLIAMS , MELISSA V NP on February 01, 2019 13:08 EST
Verified By:	WILLIAMS , MELISSA V NP on February 01, 2019 13:08 EST
Encounter info:	6434203657, CMC, OBS - Observation, 2/1/2019 -

*** Final Report ***

Care Alignment Tool Entered On: 2/1/2019 13:10 EST
Performed On: 2/1/2019 10:54 EST by WILLIAMS , MELISSA V NP

Care Alignment Tool

Advance Directive Documents (Living Will & Power of Attorney) currently in EMR : No Advance Directive documents available.

Have you filled out any papers that name a person who can make health choices for you if you are unable to make those choices yourself? : No

What does the patient/decision maker understand about their medical condition and the natural course of their disease? : Patient verbalizes understanding of her overall health, and she states compliance with medications and follow-up PCP appointments. Her daughter at bedside also understands the patient's past medical history. She assist the patient with transportation to appointments.

Biggest Fear/Concern : No fears or concerns
Agree to Goals of Care Discussion : Yes
CAT Discussion Time : 20 minute(s)
Most Important Goal : Care focused on comfort
Patient Desires : No Intubation, No CPR, No Dialysis, No PEG
Most Important Goal Comments : Patient states that her primary goal is to maintain her current level of independence and to be comfortable. She states that at this juncture of her life, that she would decline resuscitative interventions to prolong her life in the event of cardiac arrest. She desires to experience a natural death. Extended discussion regarding MOST form which was completed at bedside. The original document was scanned into the patient's EMR and then return to the daughter at bedside with instructions for maintenance and renewal.

Take the above information into consideration, what is the current code status for the patient? : Allow Natural Death (DNR)
WILLIAMS , MELISSA V NP - 2/1/2019 13:08 EST

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Advance Directives – Living Will

- **Living Will:**
  - **Provides information about an individual's end-of-life care preferences to help guide surrogate decision makers**
  - **Comes into effect when patient has a terminal illness with no chance of recovery**
  - **Signed by declarant, with 2 witnesses and notary**
  - **Can be completed by Pastoral Care in the hospital**

Living Will

ADVANCE DIRECTIVE FOR A NATURAL DEATH ("LIVING WILL")

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: *You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.*

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. ***Do not sign this form until*** *two witnesses and a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State:* http://www.nclifelinks.org/ahcdr/

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply ***IF*** my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES.

_____ *(Initial)* I have an incurable or irreversible condition that will result in my death within a relatively short period of time.

_____ *(Initial)* I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.

_____ *(Initial)* I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations I have initialed in Section 1, I direct that my health care providers:

NOTE: INITIAL ONLY IN ONE PLACE.

_____ *(Initial)* may withhold or withdraw life-prolonging measures.

_____ *(Initial)* shall withhold or withdraw life-prolonging measures.

3. Exceptions — "Artificial Nutrition or Hydration"

NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN PARAGRAPH 2.

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

_____ *(Initial)* I *DO* want to receive BOTH artificial hydration AND artificial nutrition (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL THIS BLOCK IF ONE OF THE BLOCKS BELOW IS INITIALED.

_____ *(Initial)* I *DO* want to receive ONLY artificial hydration (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL THE BLOCK ABOVE OR BELOW IF THIS BLOCK IS INITIALED.

_____ *(Initial)* I *DO* want to receive ONLY artificial nutrition (for example, through tubes) in those situations.

NOTE: DO NOT INITIAL EITHER OF THE TWO BLOCKS ABOVE IF THIS BLOCK IS INITIALED.

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

_____ *(Initial)* Follow Advance Directive: This Advance Directive will **override** instructions my health care agent gives about prolonging my life.

_____ *(Initial)* Follow Health Care Agent: My health care agent has authority to **override** this Advance Directive.

NOTE:* DO NOT INITIAL BOTH BLOCKS. *IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.

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Living Will

7. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

8. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

9. I have the Right to Revoke this Direction

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

This the ____ day of _____, _____.

Signature of Declarant_____

Type/print name _____

I hereby state that the declarant, _____, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(type/print name of declarant)

_____
(type/print name of witness)

_____
(type/print name of witness)

Date _____

(Official Seal)

_____
Signature of Notary Public

_____, Notary Public
Printed or typed name

My commission expires: _____

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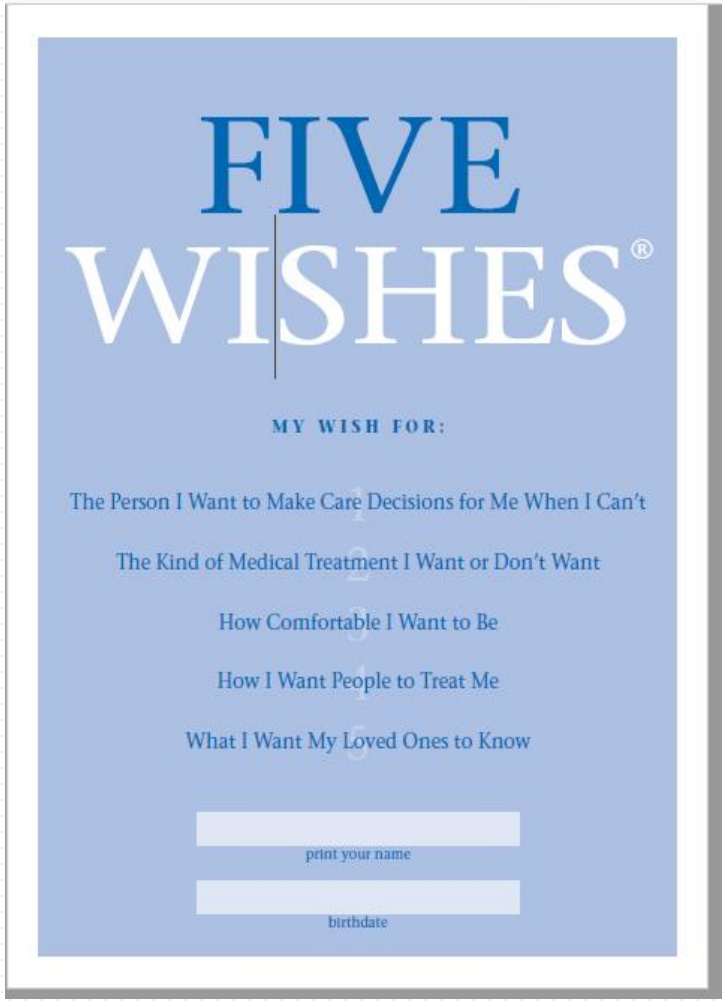
Living Will



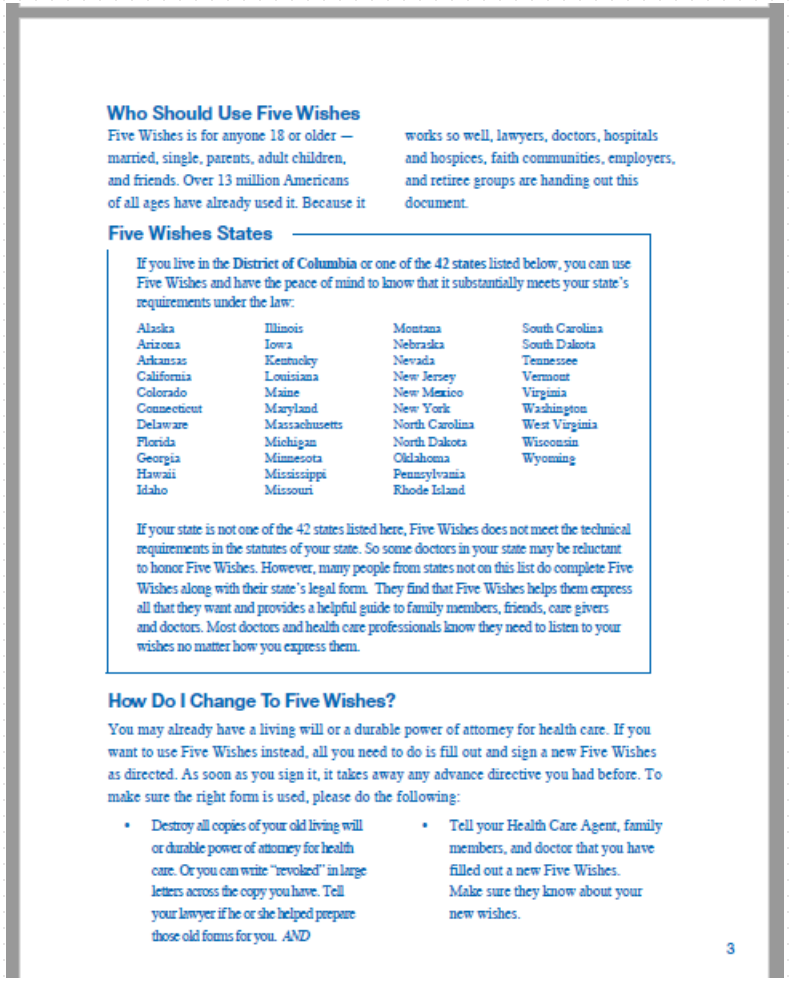
FIVE WISHES®

MY WISH FOR:

1. The Person I Want to Make Care Decisions for Me When I Can't
2. The Kind of Medical Treatment I Want or Don't Want
3. How Comfortable I Want to Be
4. How I Want People to Treat Me
5. What I Want My Loved Ones to Know

print your name

birthdate



Who Should Use Five Wishes

Five Wishes is for anyone 18 or older — married, single, parents, adult children, and friends. Over 13 million Americans of all ages have already used it. Because it works so well, lawyers, doctors, hospitals and hospices, faith communities, employers, and retiree groups are handing out this document.

Five Wishes States

If you live in the **District of Columbia** or one of the **42 states** listed below, you can use Five Wishes and have the peace of mind to know that it substantially meets your state's requirements under the law:

Alaska	Illinois	Montana	South Carolina
Arizona	Iowa	Nebraska	South Dakota
Arkansas	Kentucky	Nevada	Tennessee
California	Louisiana	New Jersey	Vermont
Colorado	Maine	New Mexico	Virginia
Connecticut	Maryland	New York	Washington
Delaware	Massachusetts	North Carolina	West Virginia
Florida	Michigan	North Dakota	Wisconsin
Georgia	Minnesota	Oklahoma	Wyoming
Hawaii	Mississippi	Pennsylvania	
Idaho	Missouri	Rhode Island	

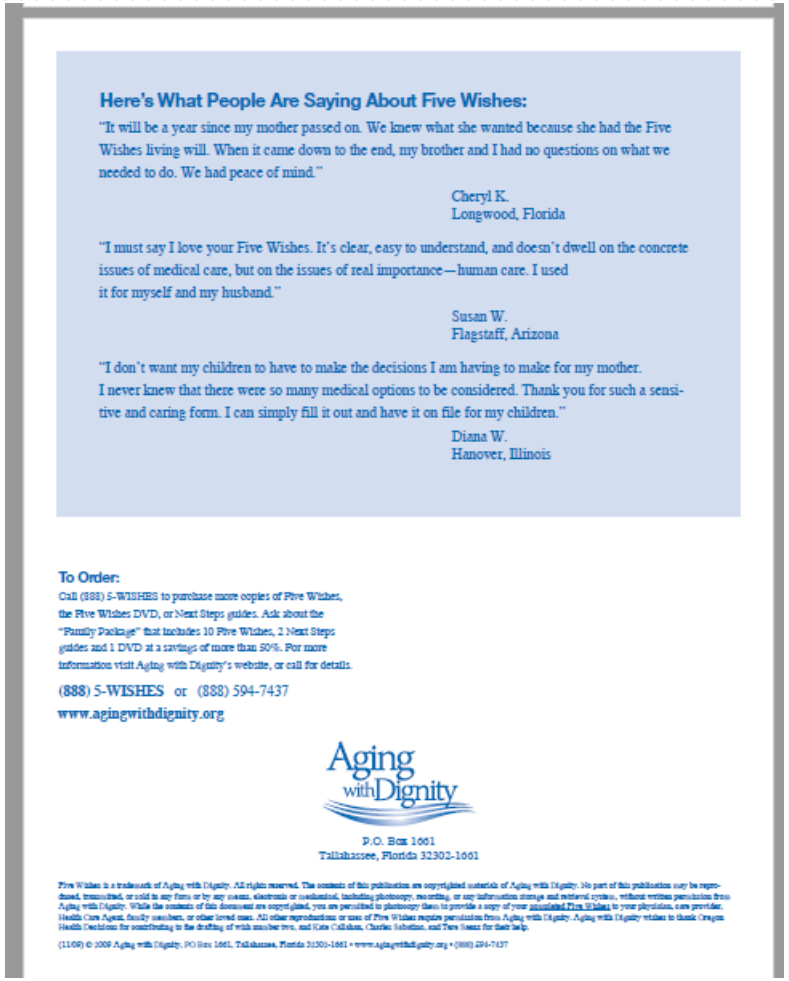
If your state is not one of the 42 states listed here, Five Wishes does not meet the technical requirements in the statutes of your state. So some doctors in your state may be reluctant to honor Five Wishes. However, many people from states not on this list do complete Five Wishes along with their state's legal form. They find that Five Wishes helps them express all that they want and provides a helpful guide to family members, friends, care givers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

How Do I Change To Five Wishes?

You may already have a living will or a durable power of attorney for health care. If you want to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will or durable power of attorney for health care. Or you can write "revoked" in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you. *AND*
- Tell your Health Care Agent, family members, and doctor that you have filled out a new Five Wishes. Make sure they know about your new wishes.

3



Here's What People Are Saying About Five Wishes:

"It will be a year since my mother passed on. We knew what she wanted because she had the Five Wishes living will. When it came down to the end, my brother and I had no questions on what we needed to do. We had peace of mind."

Cheryl K.
Longwood, Florida

"I must say I love your Five Wishes. It's clear, easy to understand, and doesn't dwell on the concrete issues of medical care, but on the issues of real importance—human care. I used it for myself and my husband."

Susan W.
Flagstaff, Arizona

"I don't want my children to have to make the decisions I am having to make for my mother. I never knew that there were so many medical options to be considered. Thank you for such a sensitive and caring form. I can simply fill it out and have it on file for my children."

Diana W.
Hanover, Illinois

To Order:

Call (888) 5-WISHES to purchase more copies of Five Wishes, the Five Wishes DVD, or Next Steps guides. Ask about the "Family Package" that includes 10 Five Wishes, 2 Next Steps guides and 1 DVD at a savings of more than 50%. For more information visit Aging with Dignity's website, or call for details.

(888) 5-WISHES or (888) 594-7437

www.agingwithdignity.org

Aging with Dignity

P.O. Box 1661
Tallahassee, Florida 32302-1661

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HEALTH CARE POWER OF ATTORNEY

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

EXPLANATION: *You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.*

This document gives the person you designate as your health care agent ***broad powers*** *to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.*

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. ***Do not sign this form until*** *two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State:* http://www.nclifelinks.org/ahcdr/

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

A. Name: _____
Home Address: _____
_____
Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____

B. Name: _____
Home Address: _____
_____
Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____

C. Name: _____
Home Address: _____
_____
Home Telephone: _____
Work Telephone: _____
Cellular Telephone: _____

Any successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent, and shall serve any time his or her predecessor is not reasonably available or is unwilling or unable to serve in that capacity.

2. Effectiveness of Appointment.

My designation of a health care agent expires only when I revoke it. Absent revocation, the authority granted in this document shall become effective when and if one of the physician(s) listed below determines that I lack capacity to make or communicate decisions relating to my health care, and will continue in effect during that incapacity, or until my death, except if I authorize my health care agent to exercise my rights with respect to anatomical gifts, autopsy, or disposition of my remains, this authority will continue after my death to the extent necessary to exercise that authority.

1. _____ *(Physician)*
2. _____ *(Physician)*

If I have not designated a physician, or no physician(s) named above is reasonably available, the determination that I lack capacity to make or communicate decisions relating to my health care shall be made by my attending physician.

3. Revocation.

Any time while I am competent, I may revoke this power of attorney in a writing I sign or by communicating my intent to revoke, in any clear and consistent manner, to my health care agent or my health care provider.

4. General Statement of Authority Granted.

Subject to any restrictions set forth in Section 5 below, I grant to my health care agent full power and authority to make and carry out all health care decisions for me. These decisions include, but are not limited to:

A. Requesting, reviewing, and receiving any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

B. Employing or discharging my health care providers.

C. Consenting to and authorizing my admission to and discharge from a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consenting to and authorizing my admission to and retention in a facility for the care or treatment of mental illness.

E. Consenting to and authorizing the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment."

F. Giving consent for, withdrawing consent for, or withholding consent for, X-ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, podiatrist, or other health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorizing the withholding or withdrawal of life-prolonging measures.

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9. Miscellaneous Provisions.

A. Revocation of Prior Powers of Attorney. I revoke any prior health care power of attorney. The preceding sentence is not intended to revoke any general powers of attorney, some of the provisions of which may relate to health care; however, this power of attorney shall take precedence over any health care provisions in any valid general power of attorney I have not revoked.

B. Jurisdiction, Severability and Durability. This Health Care Power of Attorney is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this power of attorney are severable, so that the invalidity of one or more powers shall not affect any others. This power of attorney shall not be affected or revoked by my incapacity or mental incompetence.

C. Health Care Agent Not Liable. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of my health care agent's acts or omissions, except for my health care agent's willful misconduct or gross negligence.

D. No Civil or Criminal Liability. No act or omission of my health care agent, or of any other person, entity, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this Health Care Power of Attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, entity, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this Health Care Power of Attorney may interpose this document as a defense.

E. Reimbursement. My health care agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

This the _____ day of _____, 20____.

_____(SEAL)

I hereby state that the principal, _____, being of sound mind, signed (or directed another to sign on the principal's behalf) the foregoing Health Care Power of Attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician or mental health treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an employee of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(type/print name of signer)

_____
(type/print name of witness)

_____
(type/print name of witness)

Date _____

(Official Seal)

_____
Signature of Notary Public

_____, Notary Public
Printed or typed name
My commission expires: _____

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Surrogate decision maker

- **Most states and the VA have laws or policies designating a hierarchy of legal surrogate decision makers for patients who lack decision making capacity**
- **Surrogate decision makers should also have the mental capacity to serve in this role**
- **Frail elderly couples often choose their adult children instead of spouses**

Surrogate decision maker

- **If the patient does not have family to fill the role of health care surrogate, the clinician can petition the court to appoint a legal guardian**
- **Surrogate decision makers are expected to make decisions they believe the patient would have made through applying substituted judgement/based on the patient's best interests**

North Carolina Hierarchy

ORDER OF HEALTHCARE DECISION-MAKING
Patient
Healthcare Power of Attorney
Legal Guardian
General POA with Healthcare Power
Spouse
Majority of reasonably available parents and children over 18
Majority of reasonably available siblings over 18
Individual with established relationship with patient who is acting in good faith and can reliably convey patient's wishes
If none of the above, then Attending Physician

Reasonably Available:
Able to be contacted without undue effort and be willing and able to act in a timely manner

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Medical Orders

- **POLST (Physician Orders for Life-Sustaining Treatment)**
  - **Helps to identify patient's preferences about treatments such as resuscitation, feeding tubes and antibiotics**
  - **Serve as physician orders that are active outside the hospital and are honored by paramedics**

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Medical Orders

- **Names of these forms can vary across states**
  - **MOLST (Medical Orders for Life Sustaining Treatment)**
  - **MOST (Medical Orders for Scope of Treatment)**
  - **POST (Physician Orders for Scope of Treatment)**

Atrium Health

Golden Rod

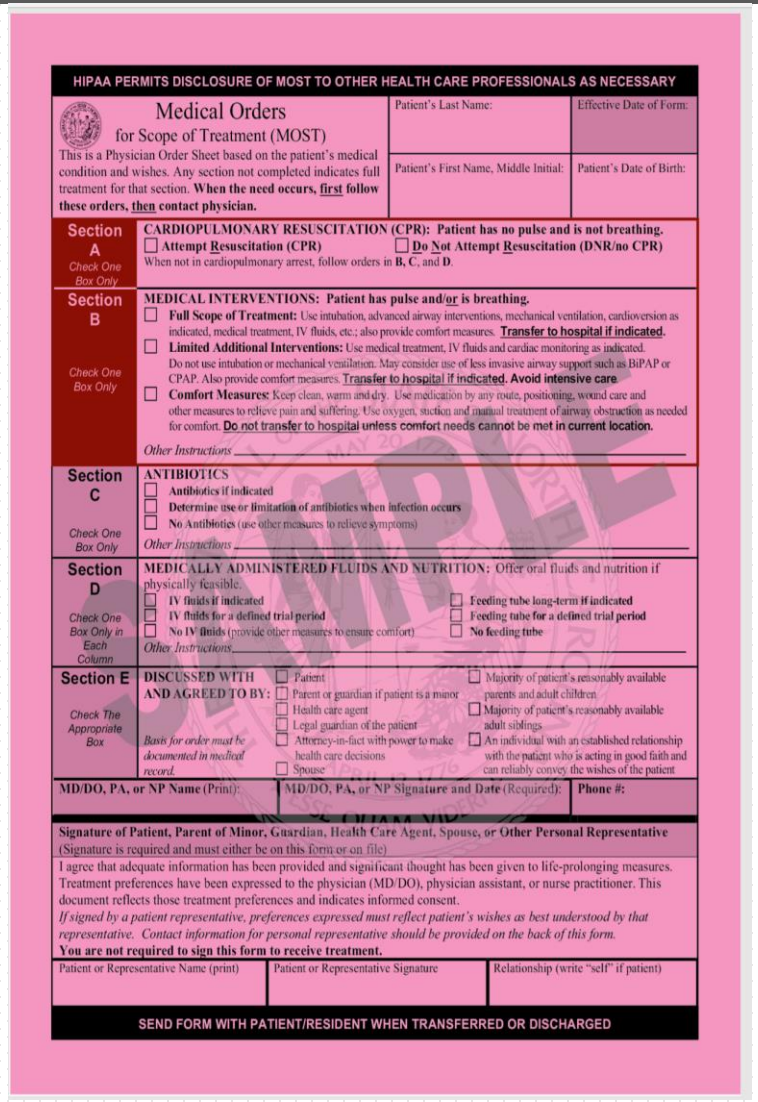
- Signed medical order indicating no attempts should be made to resuscitate
- Honored by EMTs
- Medical Order
- Issued by MD/ACP
- Not hypothetical; immediately “in effect”
- No interpretation
- Immediately directs care in the event of a cardiac arrest

Atrium Health

“DNR ≠ DO NOT TREAT!”

Atrium Health

Medical Orders for Scope of Treatment: (MOST)



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D**.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions _____

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY: *Basis for order must be documented in medical record.*

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the patient
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available parents and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

MD/DO, PA, or NP Name (Print): | **MD/DO, PA, or NP Signature and Date** (Required): | **Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

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You are not required to sign this form to receive treatment.

Patient or Representative Name (print) | Patient or Representative Signature | Relationship (write "self" if patient)

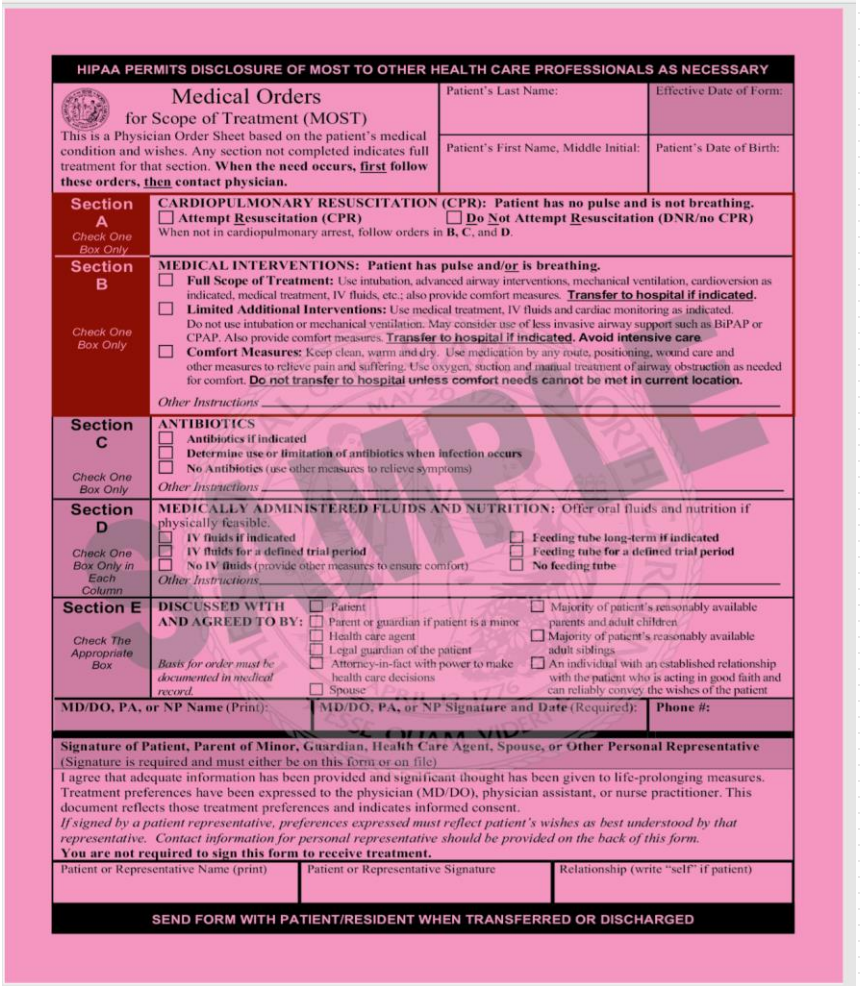
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

- Specifies wishes for end of life
- Portable
- Medical Order, Condenses Living Will
- Effective in non-arrest scenarios
- Option to receive or withhold treatment
- Requires patient or proxy signature
- Includes specifics on other medical interventions, not just code status

Atrium Health

MOST Form : Components

- **Code Status**
- **Medical Interventions**
- **Antibiotics**
- **Medically administered fluids and nutrition**
- **Discussed with and agreed to by…**



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

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Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D**.

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions

Section C (Check One Box Only)

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY: ☐ Patient ☐ Parent or guardian if patient is a minor ☐ Health care agent ☐ Legal guardian of the patient ☐ Attorney-in-fact with power to make health care decisions ☐ Spouse ☐ Majority of patient's reasonably available parents and adult children ☐ Majority of patient's reasonably available adult siblings ☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print): | **MD/DO, PA, or NP Signature and Date** (Required): | **Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is required and must either be on this form or on file)

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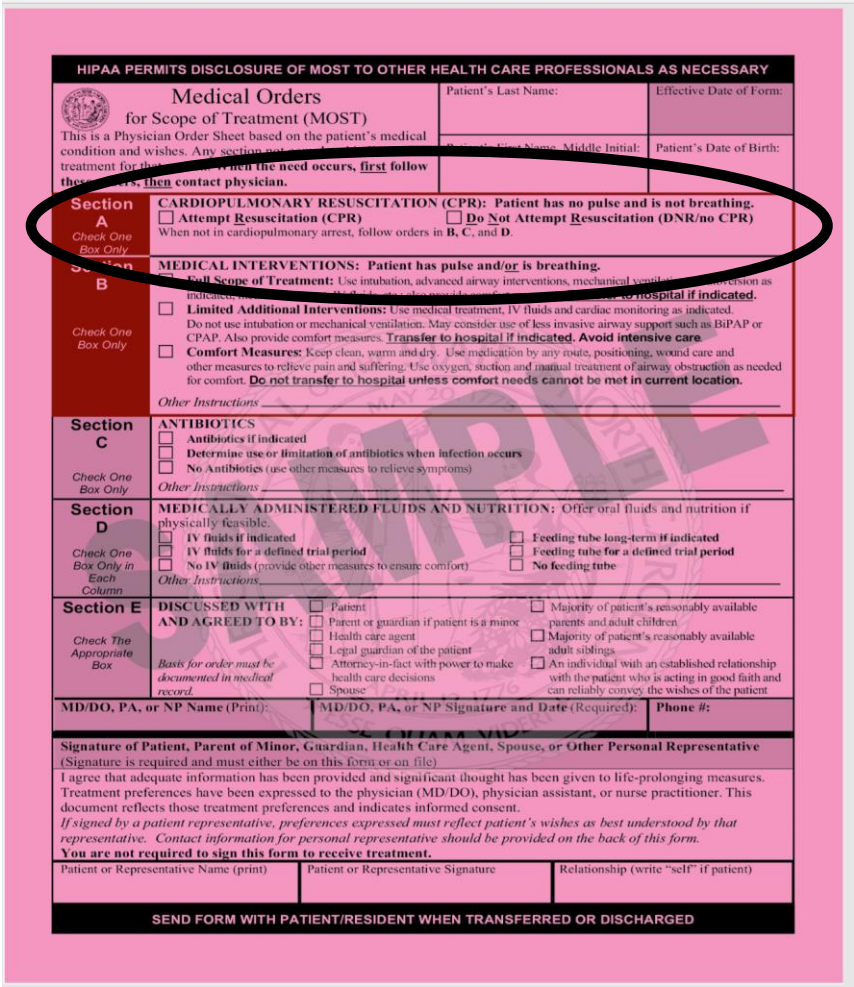
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE

Atrium Health

Section A: Cardiopulmonary Resuscitation

- **Attempt Resuscitation (CPR)**
- **Do not attempt resuscitation (DNR/No CPR)**
- **Only one should be selected**
- **Only if no pulse and no breathing (Cardiopulmonary arrest)**



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

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Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ Attempt Resuscitation (CPR) ☐ Do Not Attempt Resuscitation (DNR/no CPR)

When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, defibrillation/cardioversion as indicated. Transfer to hospital if indicated.

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. Transfer to hospital if indicated. Avoid intensive care.

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital unless comfort needs cannot be met in current location.

Other Instructions

Section C (Check One Box Only)

ANTIBIOTICS

☐ Antibiotics if indicated

☐ Determine use or limitation of antibiotics when infection occurs

☐ No Antibiotics (use other measures to relieve symptoms)

Other Instructions

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ IV fluids if indicated ☐ Feeding tube long-term if indicated

☐ IV fluids for a defined trial period ☐ Feeding tube for a defined trial period

☐ No IV fluids (provide other measures to ensure comfort) ☐ No feeding tube

Other Instructions

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY:

☐ Patient ☐ Parent or guardian if patient is a minor ☐ Health care agent ☐ Legal guardian of the patient ☐ Attorney-in-fact with power to make health care decisions ☐ Spouse ☐ Majority of patient's reasonably available parents and adult children ☐ Majority of patient's reasonably available adult siblings ☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

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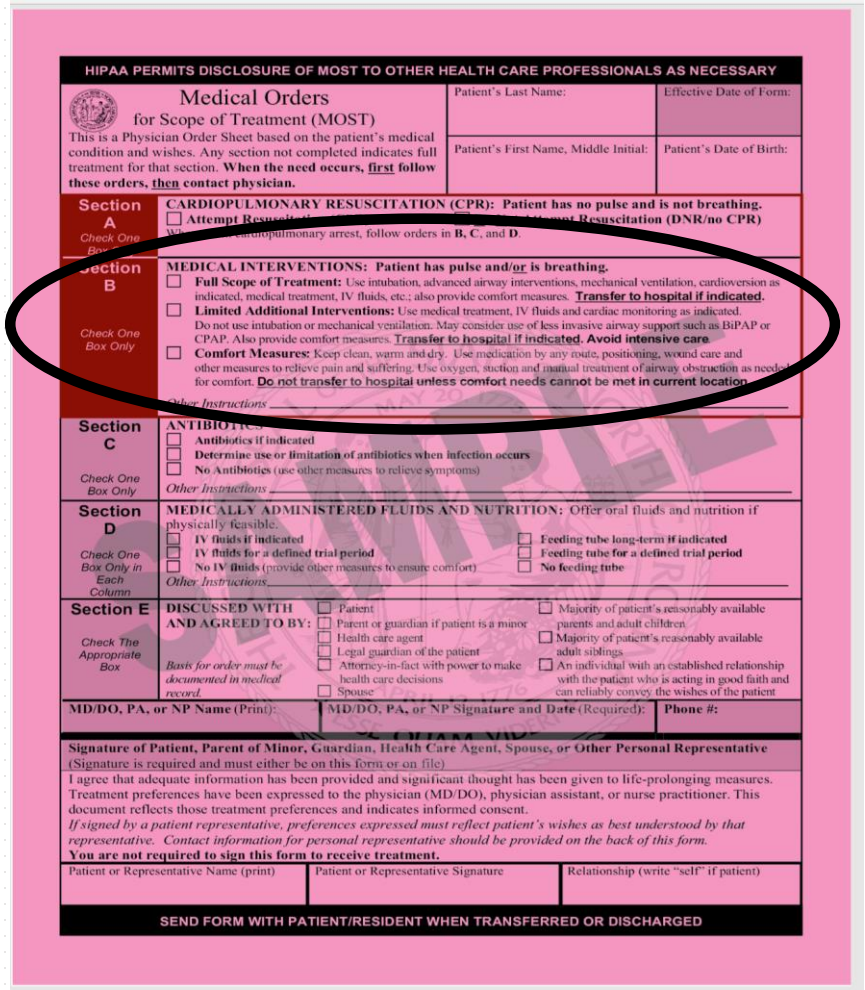
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Atrium Health

Section B: Medical Interventions

- Patient is not experiencing cardiopulmonary arrest (no indication for CPR); has pulse and/or is breathing
- Note all mention “provide comfort measures”



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C (Check One Box Only)

ANTIBIOTICS:

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions _____

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY:

☐ Patient

☐ Parent or guardian if patient is a minor

☐ Health care agent

☐ Legal guardian of the patient

☐ Attorney-in-fact with power to make health care decisions

☐ Spouse

☐ Majority of patient's reasonably available parents and adult children

☐ Majority of patient's reasonably available adult siblings

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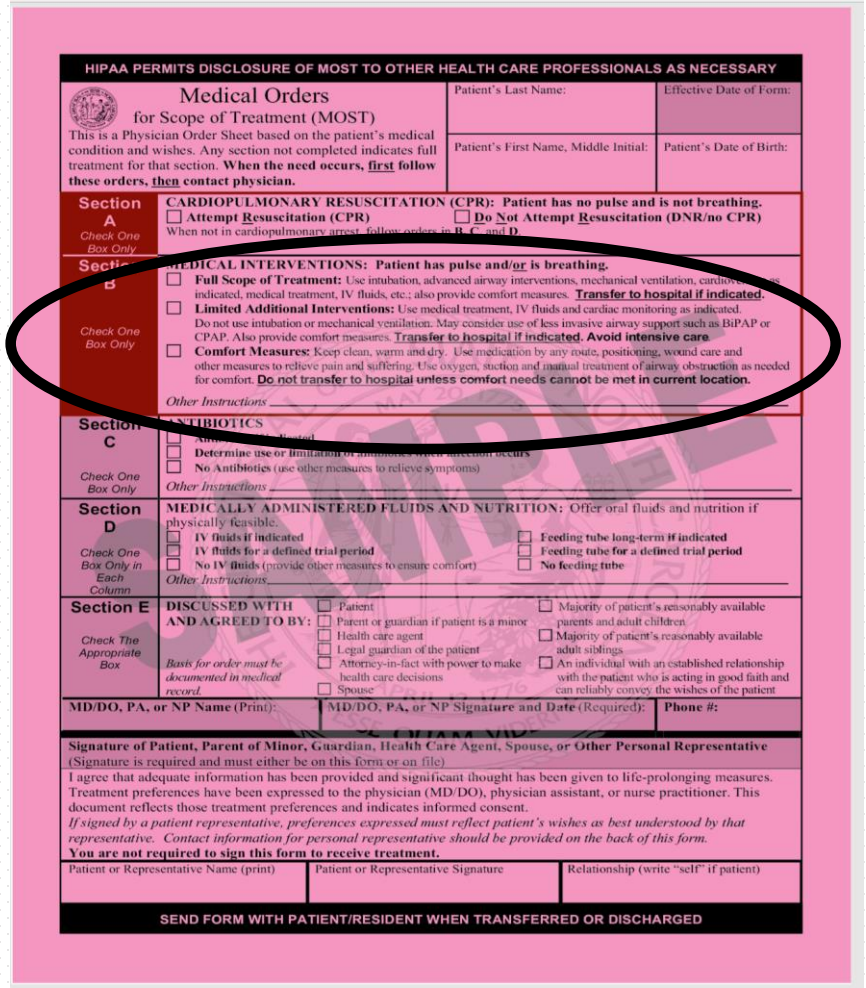
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE

Atrium Health

Section B: Medical Interventions

- **Full Scope of Treatment**
- **Intubation/mechanical ventilation**
- **Cardioversion**
- **ICU admission**
- **Transport to hospital**
- **All other appropriate treatment**
- ***"Goal is usually longevity"***



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in B, C, and D.

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C (Check One Box Only)

ANTIBIOTICS

☐ [illegible]

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions _____

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY:

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the patient
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
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SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

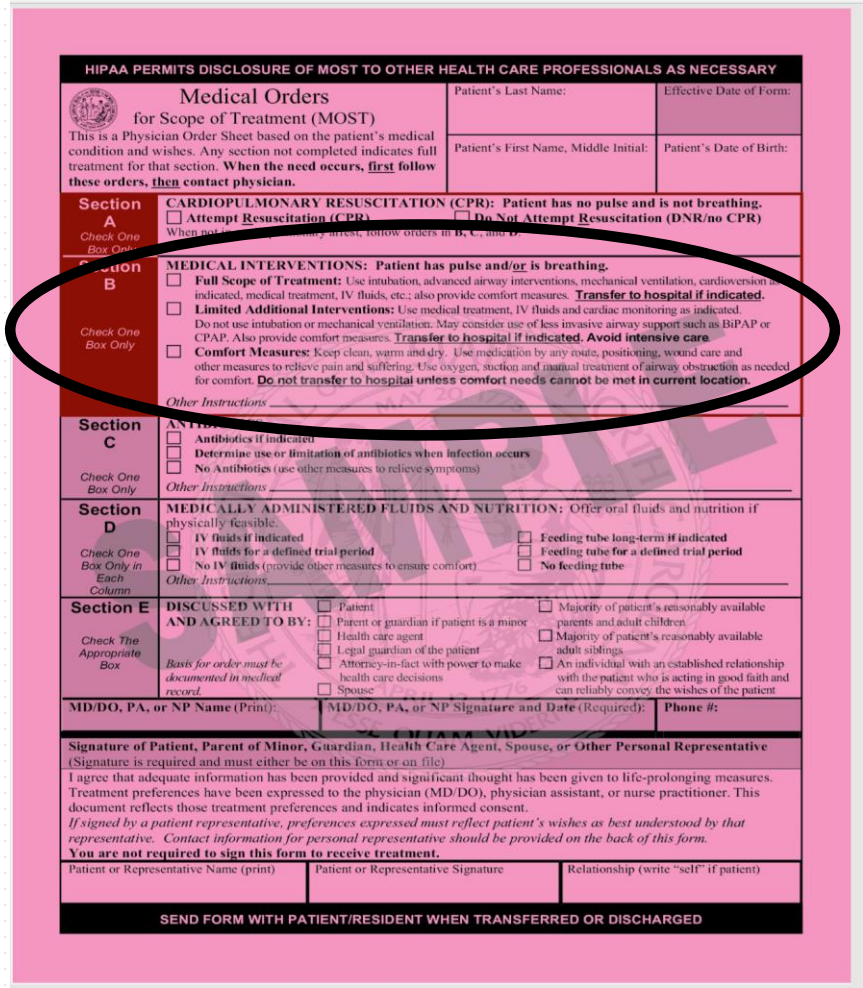
Atrium Health

Section B: Medical Interventions

Limited Additional Interventions

- **No intubation/mechanical ventilation**
- **No cardioversion**
- **No ICU admission; avoid**
- **Transport to hospital if indication**

"Goals: not usually longevity, more function"



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

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Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in B, C, and D:

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions

Section C (Check One Box Only)

ANTIBIOTICS:

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY:

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☐ Majority of patient's reasonably available parents and adult children

☐ Majority of patient's reasonably available adult siblings

☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

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MD/DO, PA, or NP Name (Print): | **MD/DO, PA, or NP Signature and Date** (Required): | **Phone #:**

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Patient or Representative Name (print) | Patient or Representative Signature | Relationship (write "self" if patient)

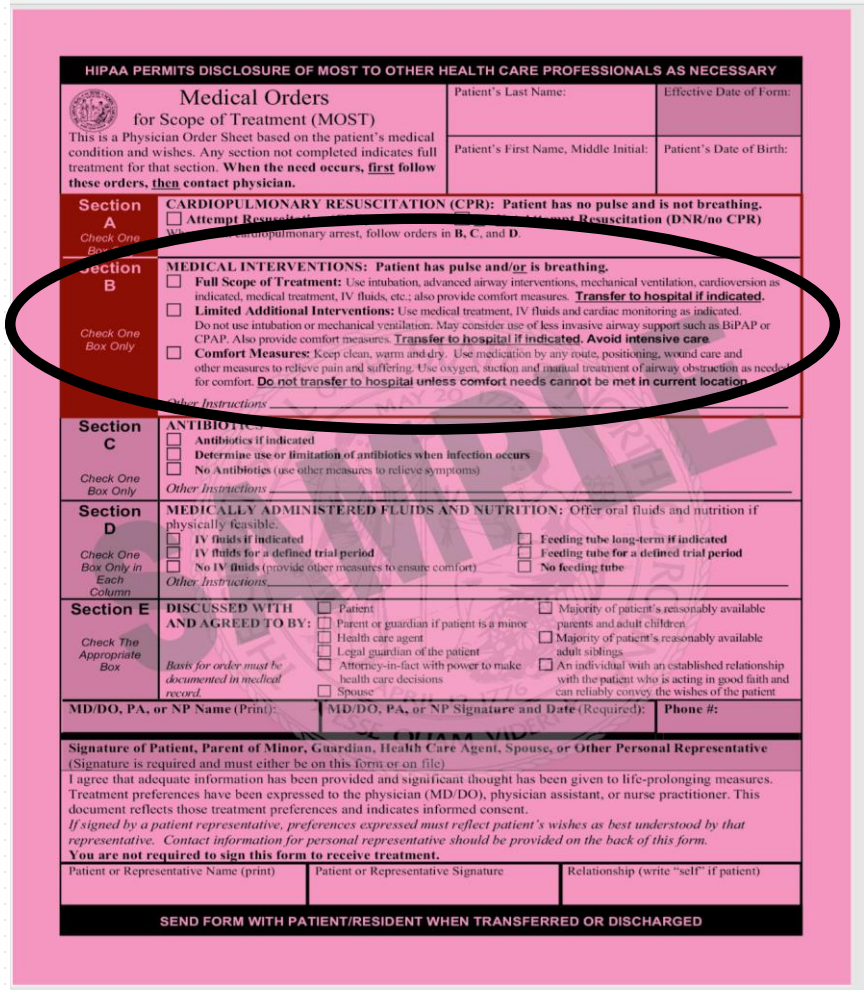
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Atrium Health

Section B: Medical Interventions

Comfort Measures

- **No intubation/mechanical ventilation**
- **No cardioversion**
- **No ICU admission**
- **Transport to hospital ONLY if comfort can't be met in current location**
- ***"Goals: Comfort/Hospice"***



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Medical Orders for Scope of Treatment (MOST)

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Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): **Patient has no pulse and is not breathing.**

☐ **Attempt Resuscitation** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: **Patient has pulse and/or is breathing.**

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

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Other Instructions _____

Section C (Check One Box Only)

ANTIBIOTICS:

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

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Other Instructions _____

Section E (Check The Appropriate Box)

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Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print) | Patient or Representative Signature | Relationship (write "self" if patient)

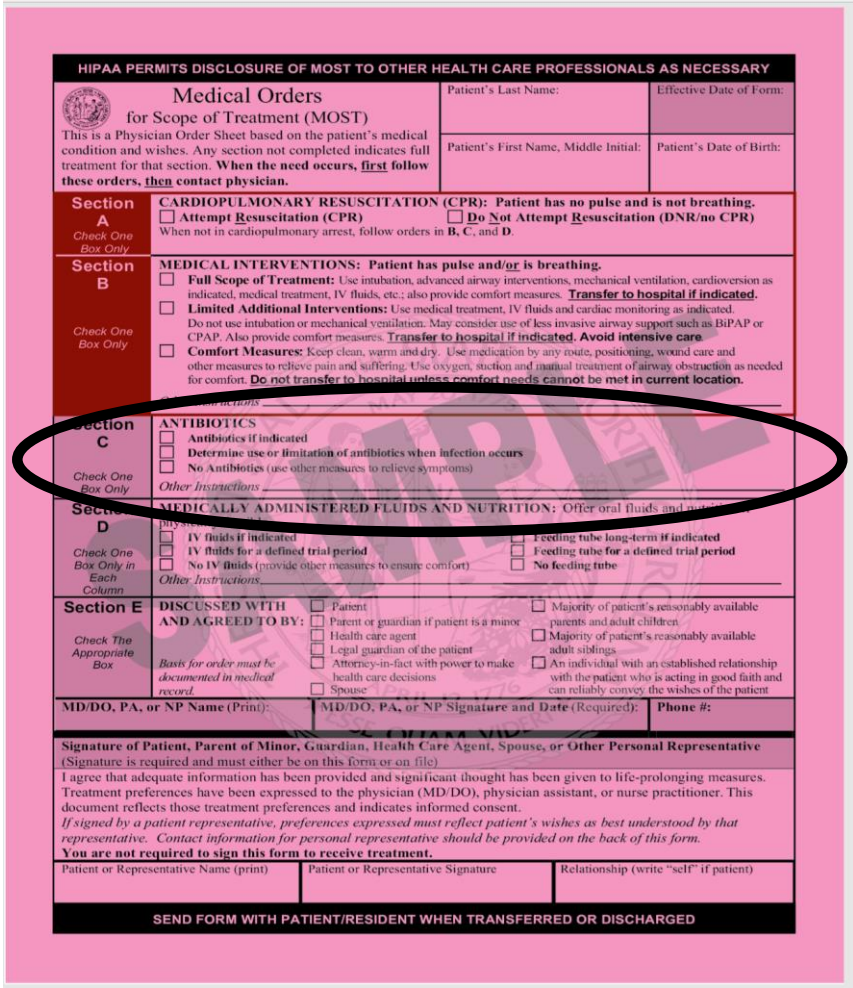
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE

Atrium Health

Section C: Antibiotics

- **Antibiotics**
- **If life can be prolonged**
- **Determine use or limitation of antibiotics when infection occurs**
- **No antibiotics (Use other measures to relieve symptoms)**



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions

Section C (Check One Box Only)

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition by mouth if feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY:

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the patient
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available parents and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print): | **MD/DO, PA, or NP Signature and Date** (Required): | **Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

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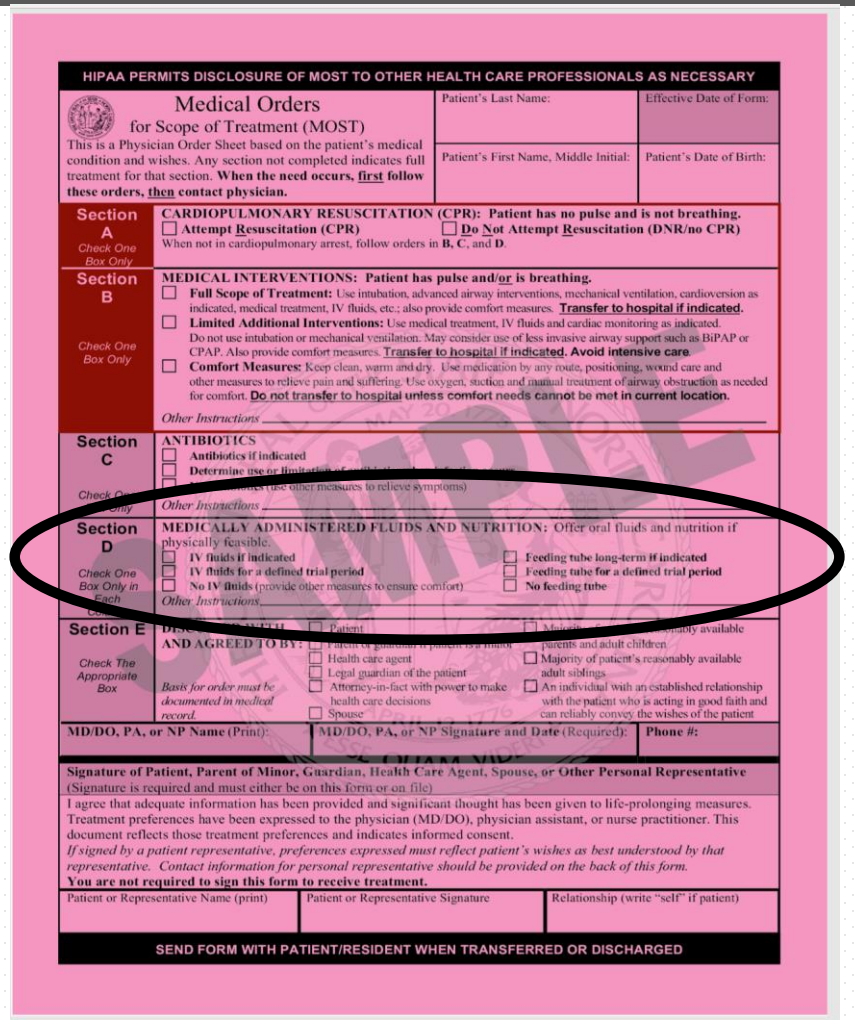
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Atrium Health

Section D: MEDICALLY ADMINISTERED FLUIDS AND NUTRITION

- **IV fluid options**
  - **To receive long-term if indicated**
  - **To receive for defined trial**
  - **No IV (provide other measures for comfort)**
- **Feeding tube options**
  - **To receive long-term if indicated**
  - **To receive for defined trial period**



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D**.

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions

Section C (Check One Box Only)

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics if infection occurs** (use other measures to relieve symptoms)

Other Instructions

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions

Section E (Check The Appropriate Box)

DISCUSSED WITH: AND AGREED TO BY:

☐ Patient ☐ Majority of patient's reasonably available parents and adult children

☐ Health care agent ☐ Majority of patient's reasonably available adult siblings

☐ Legal guardian of the patient

☐ Attorney-in-fact with power to make health care decisions ☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

☐ Spouse

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print): | **MD/DO, PA, or NP Signature and Date** (Required): | **Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print) | Patient or Representative Signature | Relationship (write "self" if patient)

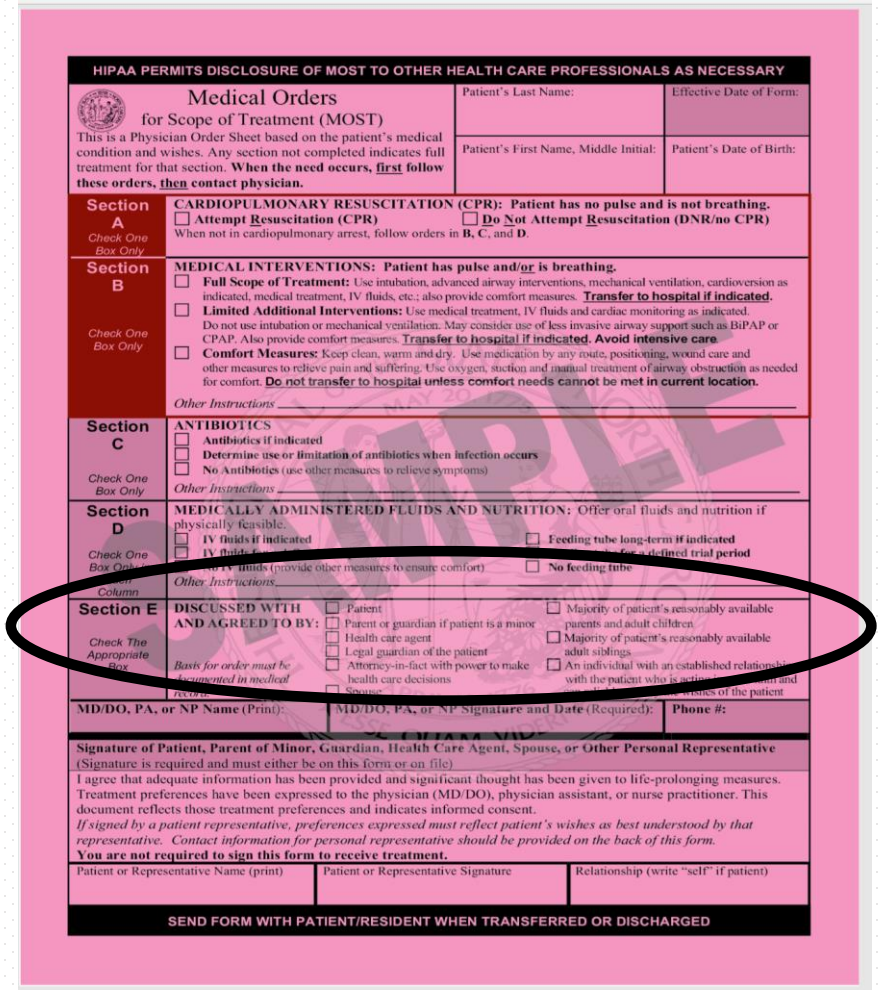
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE

Atrium Health

Section E: DISCUSSED WITH AND AGREED TO BY:

- **Patient**
- **Healthcare agent**
- **Legal guardian**
- **Attorney in fact (DPOA) with power to make healthcare decisions**
- **Spouse**



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D**.

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C (Check One Box Only)

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D (Check One Box Only)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids** for a defined trial period

☐ **No IV fluids** (provide other measures to ensure comfort) ☐ **No feeding tube**

Other Instructions _____

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY: *Basis for order must be documented in medical record*

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the patient
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available parents and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual with an established relationship with the patient who is [illegible] and knowledgeable of the wishes of the patient

MD/DO, PA, or NP Name (Print): | **MD/DO, PA, or NP Signature and Date** (Required): | **Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

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You are not required to sign this form to receive treatment.

Patient or Representative Name (print) | Patient or Representative Signature | Relationship (write "self" if patient)

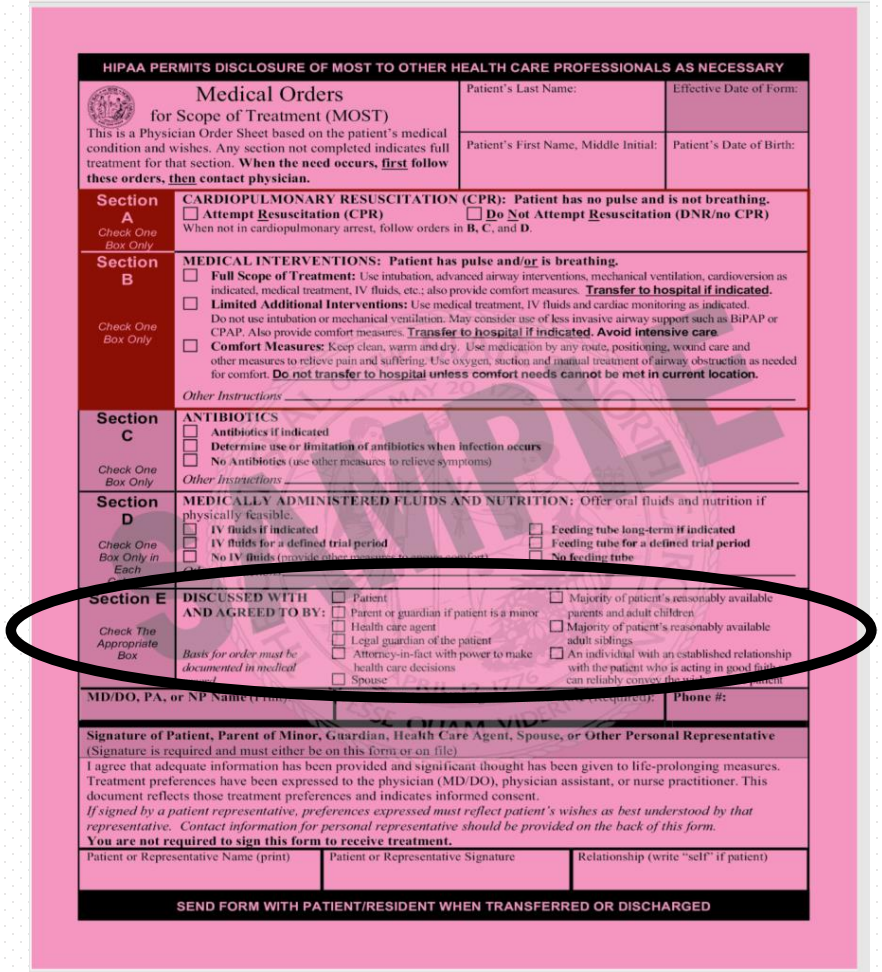
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE

Atrium Health

Section E: DISCUSSED WITH AND AGREED TO BY:

- **Majority of reasonably available parents and adult children**
- **Majority of reasonably available adult siblings**
- **An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient**



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D**.

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions

Section C (Check One Box Only)

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions

Section D (Check One Box Only in Each)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated** ☐ **Feeding tube long-term if indicated**

☐ **IV fluids for a defined trial period** ☐ **Feeding tube for a defined trial period**

☐ **No IV fluids** (provide other measures for comfort) ☐ **No feeding tube**

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY:

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the patient
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available parents and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical

MD/DO, PA, or NP Name | **Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
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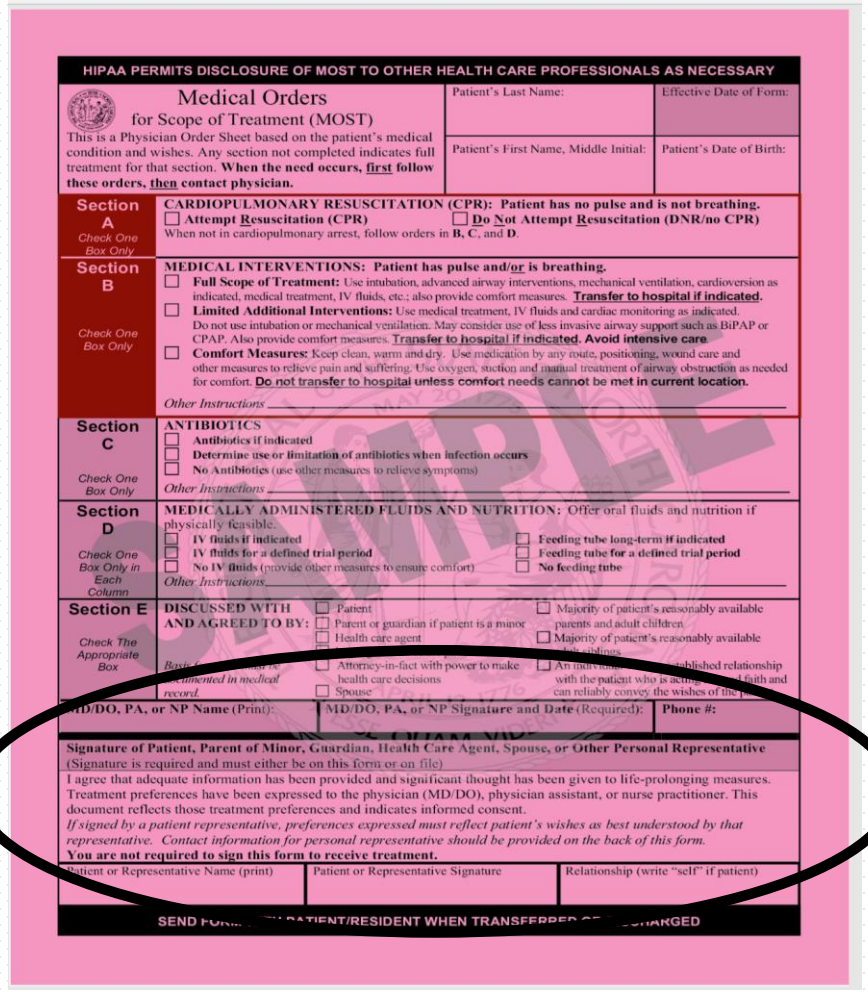
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE

Atrium Health

Validation Signatures: Provider, Patient/ Proxy, and Renewal Signatures



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: | Effective Date of Form:

Patient's First Name, Middle Initial: | Patient's Date of Birth:

Section A (Check One Box Only)

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D**.

Section B (Check One Box Only)

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

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☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions

Section C (Check One Box Only)

ANTIBIOTICS

☐ **Antibiotics if indicated**
☐ **Determine use or limitation of antibiotics when infection occurs**
☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions

Section D (Check One Box Only in Each Column)

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated**
☐ **IV fluids for a defined trial period**
☐ **No IV fluids** (provide other measures to ensure comfort)
☐ **Feeding tube long-term if indicated**
☐ **Feeding tube for a defined trial period**
☐ **No feeding tube**

Other Instructions

Section E (Check The Appropriate Box)

DISCUSSED WITH AND AGREED TO BY:

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available parents and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual who has established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for decision documented in medical record.

MD/DO, PA, or NP Name (Print): | **MD/DO, PA, or NP Signature and Date** (Required): | **Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is required and must either be on this form or on file)

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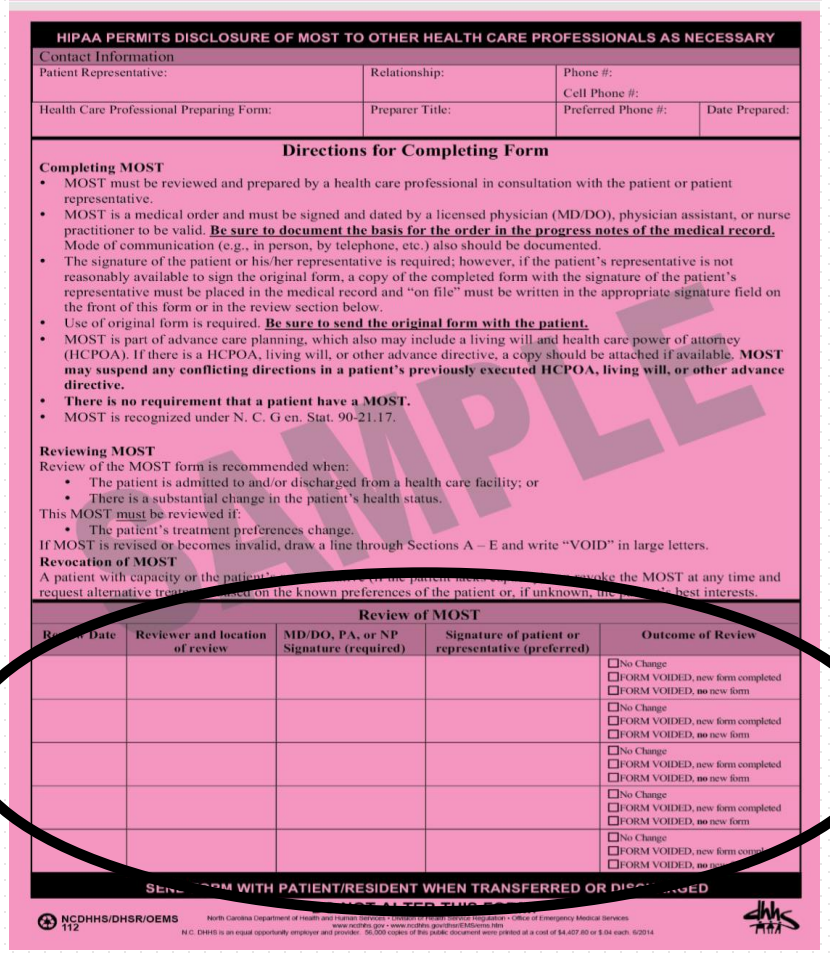
SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative: | Relationship: | Phone #: / Cell Phone #:

Health Care Professional Preparing Form: | Preparer Title: | Preferred Phone #: | Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N. C. G en. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

A patient with capacity or the patient's [illegible] may revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, no new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

NCDHHS/DHSR/OEMS 112

North Carolina Department of Health and Human Services • Division of Health Service Regulation • Office of Emergency Medical Services
www.ncdhhs.gov • www.ncdhhs.gov/dhsr/EMS/emsi.htm
N.C. DHHS is an equal opportunity employer and provider. 56,000 copies of this public document were printed at a cost of $4,407.60 or $.04 each. 6/2014

SAMPLE

Atrium Health

Questions

Atrium Health

References

GRS 9 Teaching slides

ACP power point Cindy Stafford, ACP

http://compassionatecarenc.org/wp-content/uploads/2016/03/Using-the-MOST-Form-Guidance-for-HC-Professionals1.pdf

http://compassionatecarenc.org/wp-content/uploads/2016/03/FAQ-MOST.pdf

http://compassionatecarenc.org/wp-content/uploads/2018/08/Key-Facts-about-MOST.pdf

http://compassionatecarenc.org/ncpcc-provider-resources/

Atrium Health

References

http://www.agingwithdignity.org

End of life: helping with comfort and care. (2016). Bethesda, MD: National Institute on Aging, National institutes of Health, U.S. Dept. of Health and Human Services

https://www.arborhospice.org/healthcare-professionals/disease-indicators/dementia/#targetText=The%20Reisberg%20Functional%20Assessment%20Staging,limitations%20associated%20with%20Alzheimer's%20disease.

Atrium Health