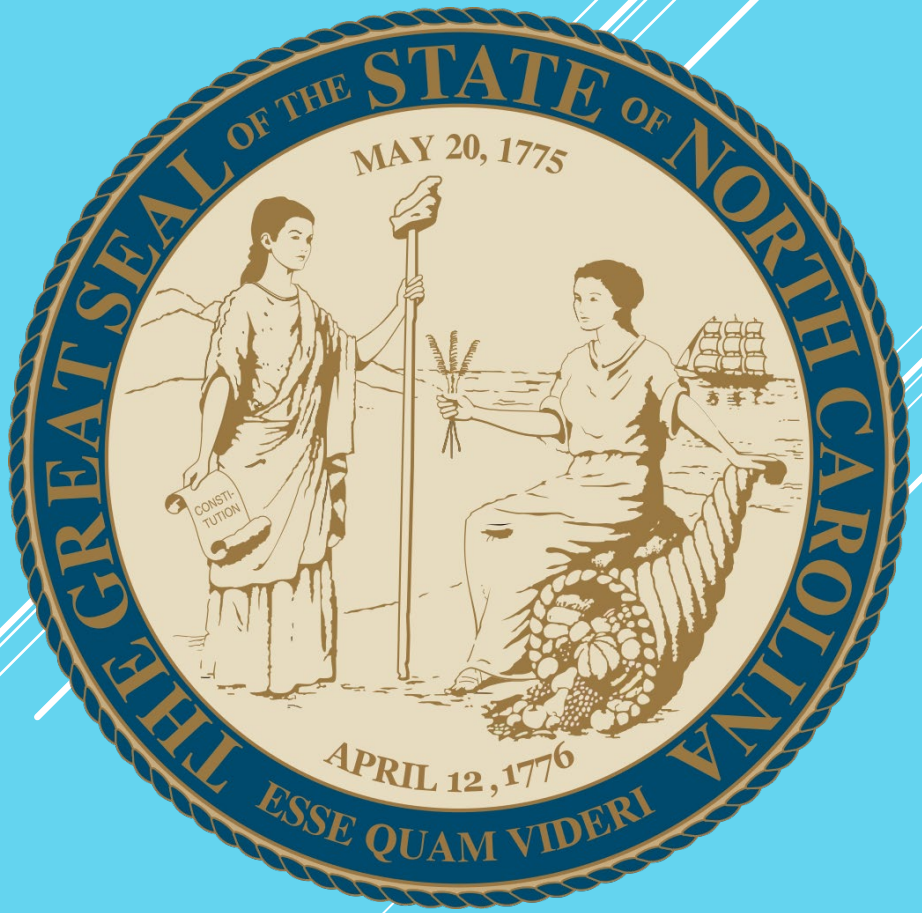
NORTH CAROLINA ADVANCE DIRECTIVES & CODE STATUS

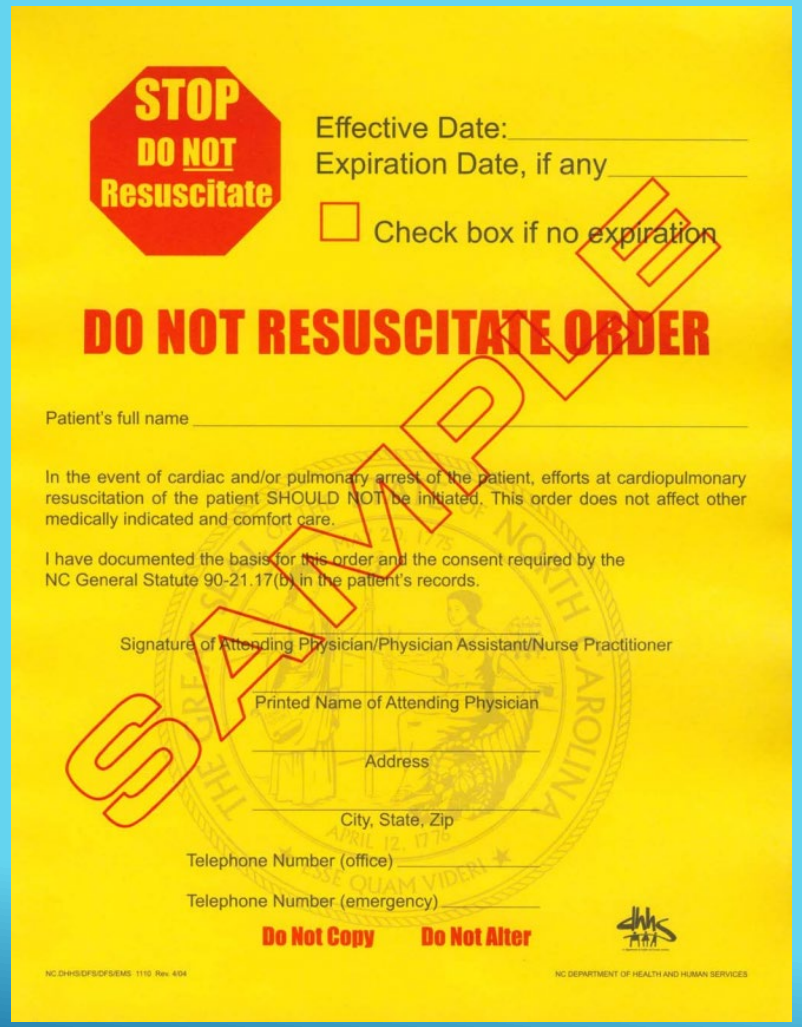


OBJECTIVES

1. Overview
2. Portable DNR
3. MOST Form

“ *MY MOM DOES NOT WANT TO BE ON A BREATHING MACHINE. IS THERE A FORM WE COULD FILL OUT TO LET OTHERS KNOW THAT?* ”

NC ADVANCE DIRECTIVES



STOP
DO NOT
Resuscitate

Effective Date:_____
Expiration Date, if any_____

☐ Check box if no expiration

DO NOT RESUSCITATE ORDER

SAMPLE

Patient's full name _____

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

Signature of Attending Physician/Physician Assistant/Nurse Practitioner

Printed Name of Attending Physician

Address

City, State, Zip

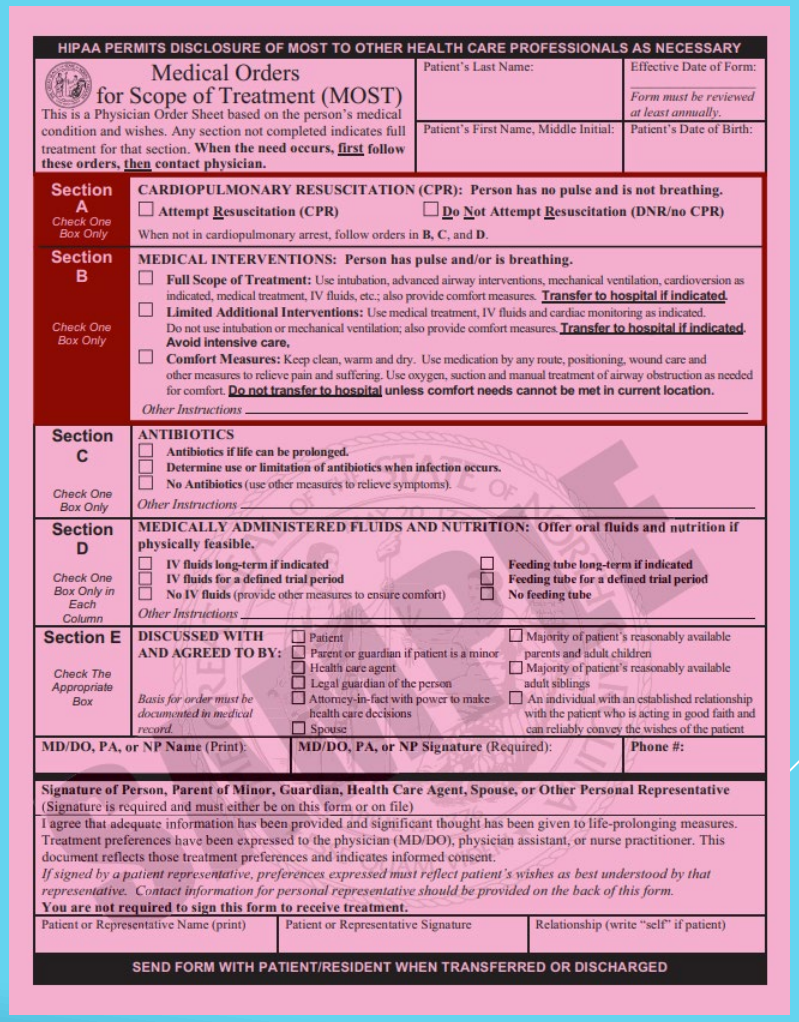
Telephone Number (office)

Telephone Number (emergency)

Do Not Copy Do Not Alter

NC DHHS/DFS/DFS/EMS 1110 Rev. 4/04

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES



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 person'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: *Form must be reviewed at least annually.*

Patient's First Name, Middle Initial:

Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Person 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: Person 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; 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 life can be prolonged.**
☐ **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 long-term 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
☐ Legal guardian of the person
☐ 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** (Required):	**Phone #:**

Signature of Person, 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.

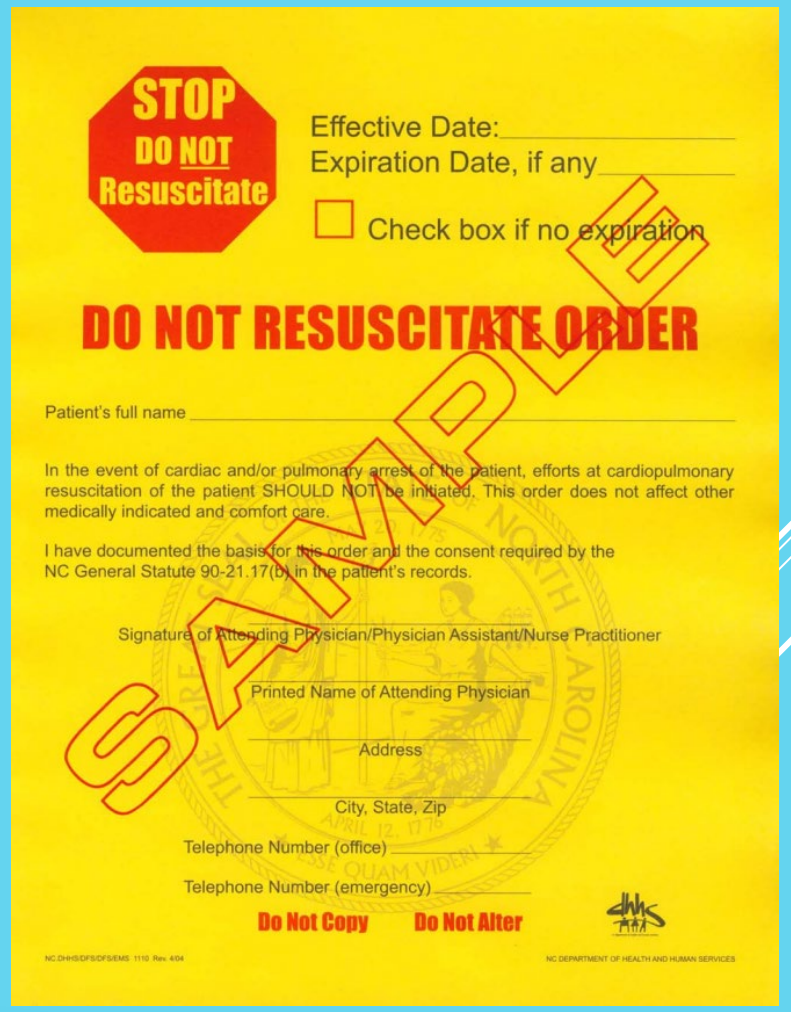
You are not required to sign this form to receive treatment.

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

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

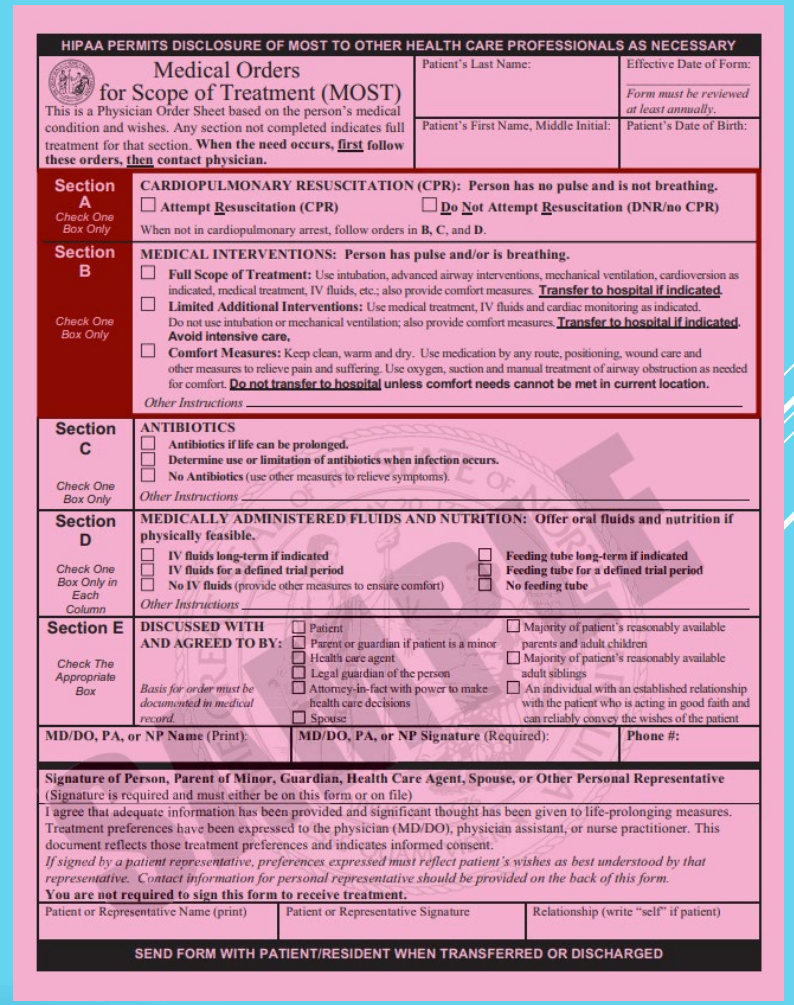
GOLDENROD PORTABLE DNR

- Form **only** applies to patients who **do not have a pulse** (sometimes misunderstood as including respiratory failure/arrest)
  - Patients who do not want additional life saving measures (i.e. vent) need a **pink MOST form** for clarification
- Make sure you check the no expiration box if applicable (almost always applicable)
- In other words, CPR or no CPR



PINK MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) FORM

- Also called a POLST in many states
- Clarifies potential ambiguity of the **goldenrod portable DNR** form
- Even if you only have time to complete the first 2 parts and signature sections it can be very helpful
- Form can be updated and re-signed for additional directives at a later point



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 Last Name: | Effective Date of Form: *Form must be reviewed at least annually.*

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

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Person 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: Person 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; 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 life can be prolonged.**
☐ **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 long-term 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:

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 person
☐ 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** (Required): | **Phone #:**

Signature of Person, 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

MOST FORM TOP SECTION – PATIENT INFORMATION

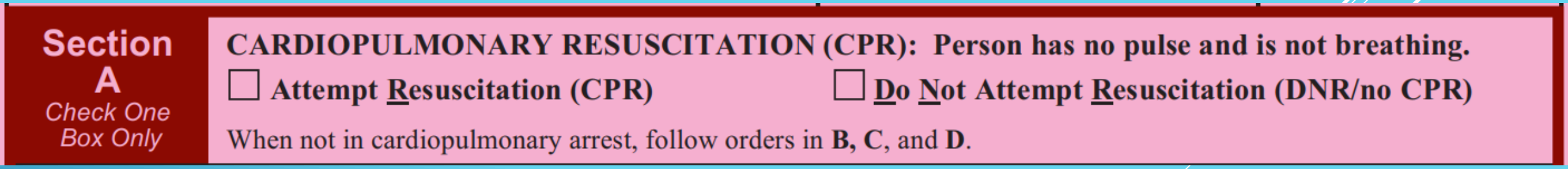
- Top section: Demographic Information and Date

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 person'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: *Form must be reviewed at least annually.*
	Patient's First Name, Middle Initial:	Patient's Date of Birth:

MOST FORM SECTION A – CPR OR DNR

- Select DNR as applicable (only likely scenario in the ED)
- A MOST form is potentially unnecessary, outside of specific circumstances, unless a patient is DNR with some specified degree of additional desired interventions



Section A *Check One Box Only*	**CARDIOPULMONARY RESUSCITATION (CPR): Person 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**.

MOST FORM SECTION B – SCOPE OF TREATMENT

- Full can include cardioversion, **intubation**, and other invasive measures
- Limited can include BiPAP (**not intubation**), IV fluids, IV ABX, and non-invasive but potentially life-prolonging measures
- Comfort includes comfort medications, possibly PO ABX in limited cases (i.e. symptomatic UTI, COPD exacerbations).

Section B	MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.
Check One Box Only	☐ **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; also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**
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	Other Instructions _____

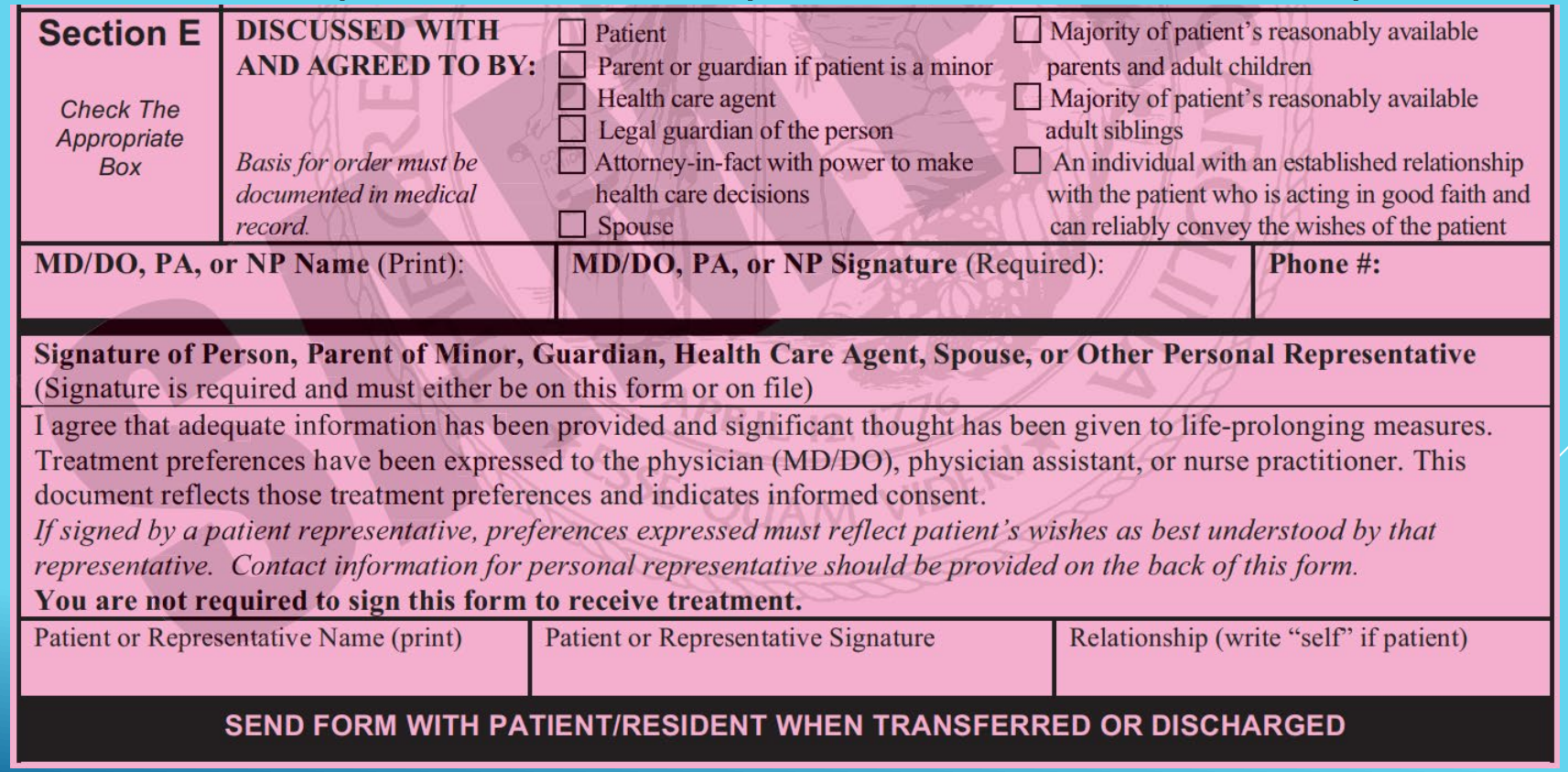
MOST FORM SECTIONS C AND D – OPTIONAL

- Covers antibiotics, IV fluids, and feeding tube
- NOT needed for form to be valid, however recommend they mark as indicated – typically will give antibiotics/IVF

Section C *Check One Box Only*	**ANTIBIOTICS** ☐ **Antibiotics if life can be prolonged.** ☐ **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 long-term 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* _____

MOST FORM SECTION E – AUTHORIZATION

- Indicate those involved in preparation of form, obtain signatures from patient or representative, and print/sign



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 person ☐ 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** (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

NC NEXT OF KIN HIERARCHY

Decision Maker Priority

(Listed in order of priority):

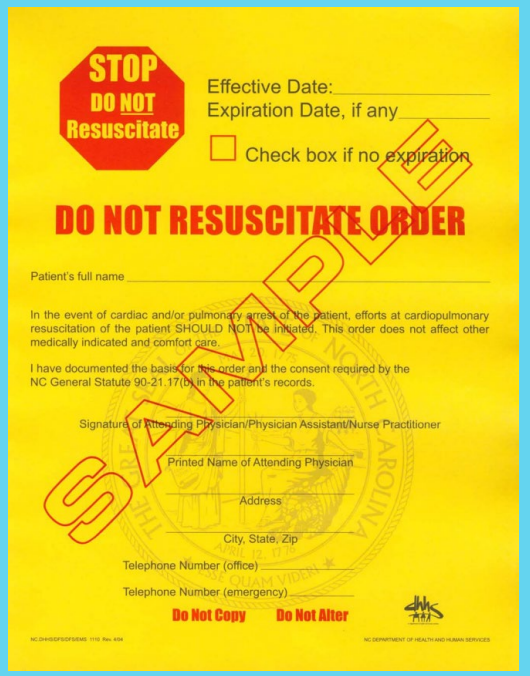
1. Parent or guardian if patient is a minor

When the **adult** patient is incompetent or incapacitated -

1. Health Care Agent
2. Legal guardian of the person
3. Attorney-in-fact with power to make health care decisions
4. Spouse
5. Majority of reasonably available parents and adult children
6. Majority of patient's reasonably available adult siblings
7. An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient
8. If none of the above is available, the attending physician may, with the agreement of a second physician, direct that life-prolonging measures be withheld or discontinued

SUMMARY

- A **goldenrod portable DNR** takes seconds to fill out and can be invaluable later
- A **pink MOST form** is valid even if you only have time complete the code status, scope of treatment, and patient information/signature sections (sections A, B, and E)
- Code status and ACP documents can be accessed from Epic's StoryBoard


STOP
DO NOT Resuscitate

Effective Date:
Expiration Date, if any
Check box if no expiration

DO NOT RESUSCITATE ORDER

SAMPLE

Patient's full name

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

Signature of Attending Physician/Physician Assistant/Nurse Practitioner

Printed Name of Attending Physician

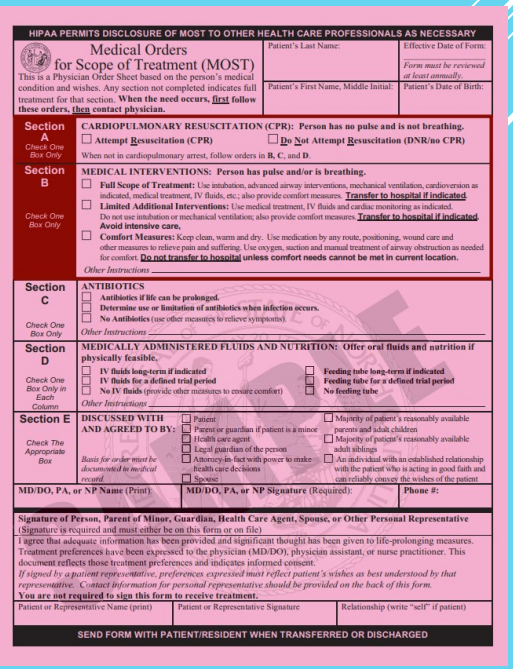
Address

City, State, Zip

Telephone Number (office)

Telephone Number (emergency)

Do Not Copy Do Not Alter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Section A *Check One Box Only*

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

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

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Other Instructions

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ANTIBIOTICS

☐ **Antibiotics if life can be prolonged.**
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Other Instructions

Section D *Check One Box Only in Each Column*

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☐ **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
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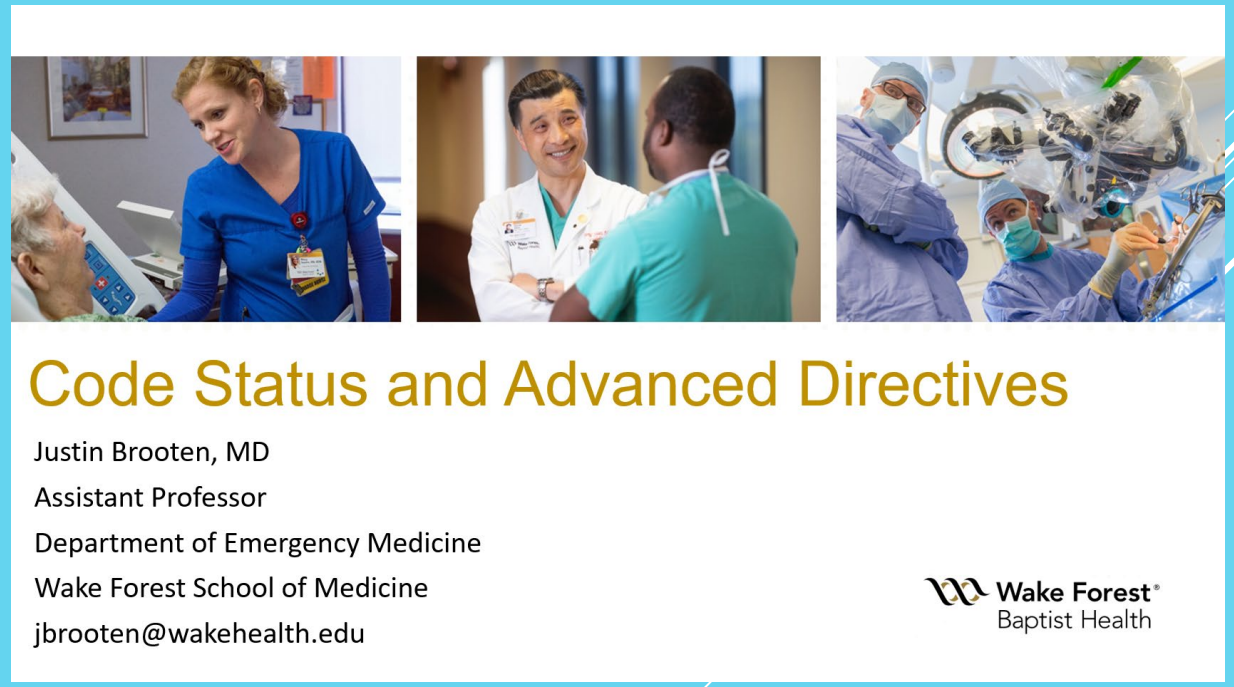
REFERENCES

Adapted from presentation materials previously prepared by:

- Justin Brooten, MD, Assistant Professor of Emergency Medicine, Atrium Health Wake Forest Baptist




PalliEM.org