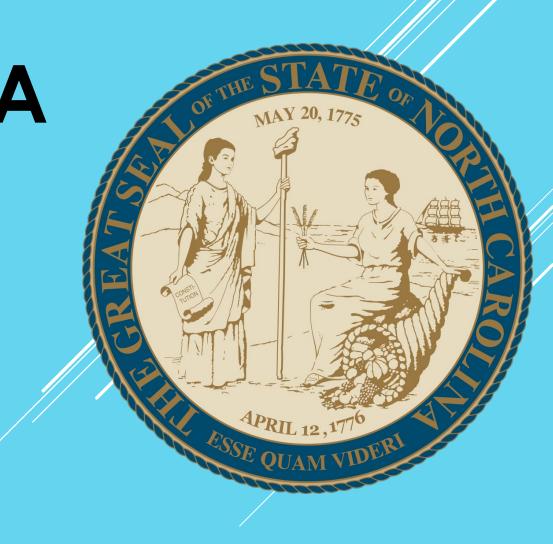
NORTH CAROLINA ADVANCE DIRECTIVES & CODE STATUS



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?



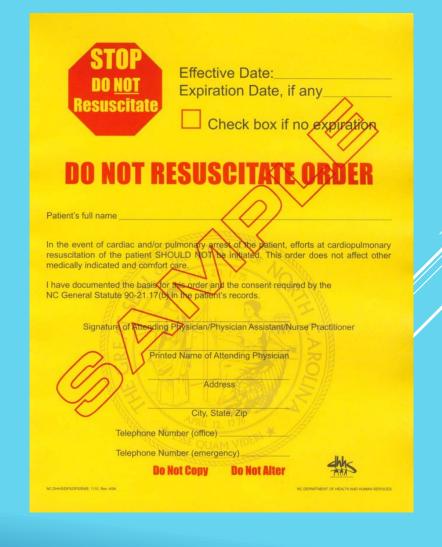
NC ADVANCE DIRECTIVES

STOP DO NOT Resuscitate Effective Date: Expiration Date, if any Check box if no expiration
DO NOT RESUSCITATE ORDER
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 CHRISDESCHSEMS: 1110 Rev. 494 NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
I have documented the basistor this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records. Signature of Attending Physician Assistant/Nurse Practitioner Printed Name of Attending Physician Address City, State, Zip Telephone Number (office) Telephone Number (emergency)

Medical Orders			Effective Date of Form
Scope of Treatment (MOST)			Form must be reviewed at least annually.
vishes. Any section not completed indicates full nat section. When the need occurs, <u>first</u> follow	Patient's First N	ame, Middle Initial:	Patient's Date of Birth
Attempt Resuscitation (CPR)	Do Not Att	The second secon	
Full Scope of Treatment: Use intubation, advaindicated, medical treatment, IV fluids, etc.; also per Limited Additional Interventions: Use medi Do not use intubation or mechanical ventilation; al Avoid intensive care, Comfort Measures: Keep clean, warm and dry other measures to relieve pain and suffering. Use o	anced airway interver rovide comfort meas cal treatment, IV flu iso provide comfort. Use medication by oxygen, suction and it	ntions, mechanical ver sures. <u>Transfer to he</u> ids and cardiac monito measures. <u>Iransfer to</u> any route, positioning manual treatment of air	ospital if indicated. oring as indicated. o hospital if indicated. t, wound care and the way obstruction as needer
physically feasible, IV fluids long-term if indicated IV fluids for a defined trial period		eeding tube long-ter eeding tube for a de	m if indicated
Health care agent Legal guardian of the Basis for order must be Attorney-in-fact with documented in medical frealth care decisions	patient is a minor e person	parents and adult ch Majority of patient adult siblings An individual with with the patient who	
	P Signature (Rec		Phone #:
equired and must either be on this form or on file) equate information has been provided and signific erences have been expressed to the physician (MI cts those treatment preferences and indicates info	ant thought has b D/DO), physician rmed consent.	een given to life-p	rolonging measures. practitioner. This
	wishes. Any section not completed indicates full at section. When the need occurs, first follow hen contact physician. CARDIOPULMONARY RESUSCITATION Attempt Resuscitation (CPR) When not in cardiopulmonary arrest, follow orders i MEDICAL INTERVENTIONS: Person has Full Scope of Treatment: Use inubation, advaindicated, medical treatment, IV fluids, etc.; also pt Limited Additional Interventions: Use medi Do not use intubation or mechanical ventilation; al Avoid intensive care, Comfort Measures: Keep clean, warm and dry other measures to relieve pain and suffering. Use of for comfort Do not transfer to hospital unlet Other Instructions ANTIBIOTICS Antibiotics if life can be prolonged. Determine use or limitation of antibiotics when No Antibiotics (use other measures to relieve sym Other Instructions MEDICALLY ADMINISTERED FLUIDS A physically feasible. IV fluids long-term if indicated No IV fluids for a defined trial period No IV fluids for defined trial period No IV fluids for other measures to ensure coother Instructions DISCUSSED WITH AND AGREED TO BY: Parent or guardian if health care agent Legal guardian of the Basis for order must be documented in medicial feasible. The parent of Minor, Guardian, Health Carequired and must either be on this form or on file) quate information has been provided and signature (minormation has been provided and signature).	wishes. Any section not completed indicates full lat section. When the need occurs, first follow hen contact physician. CARDIOPULMONARY RESUSCITATION (CPR): Person Attempt Resuscitation (CPR)	wishes. Any section not completed indicates full lat section. When the need occurs, first follow hen contact physician. CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and Attempt Resuscitation (CPR)

GOLDENROD PORTABLE DNR

- Form <u>only</u> applies to patients who <u>do not have a pulse</u> (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 resigned for additional directives at a later point

	RMITS DISCLOSURE OF MOST TO OTHER H Medical Orders	Patient's Last Name		Effective Date of For
for	Scope of Treatment (MOST)			Form must be reviewe
This is a Physic	cian Order Sheet based on the person's medical			at least annually.
condition and	wishes. Any section not completed indicates full	Patient's First Name	e, Middle Initial:	Patient's Date of Birth
	nat section. When the need occurs, <u>first</u> follow then contact physician.			
Section	CARDIOPULMONARY RESUSCITATION	(CPR): Person ha	s no pulse and i	is not breathing.
A	Attempt Resuscitation (CPR)	Do Not Attem	pt Resuscitation	(DNR/no CPR)
Check One Box Only	When not in cardiopulmonary arrest, follow orders in	n B, C, and D.		
Section	MEDICAL INTERVENTIONS: Person has	pulse and/or is bre	athing.	
В	☐ Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as			
	indicated, medical treatment, IV fluids, etc.; also pr Limited Additional Interventions: Use medi			
Check One Box Only	Do not use intubation or mechanical ventilation; al			
Box Only	Avoid intensive care, Comfort Measures: Keep clean, warm and dry.	Use medication by an	v route positioning	wound care and
	other measures to relieve pain and suffering. Use o	xygen, suction and mar	nual treatment of air	way obstruction as neede
	for comfort. Do not transfer to hospital unles Other Instructions	ss comfort needs ca	innot be met in c	urrent location.
Section	ANTIBIOTICS	~~~		
C	Antibiotics if life can be prolonged.			
	Determine use or limitation of antibiotics when			
Check One Box Only	Other Instructions	ptoms).		
Section	MEDICALLY ADMINISTERED FLUIDS A	ND NUTRITION:	Offer oral flui	ds and nutrition if
D	physically feasible,		Mes M	
Check One	☐ IV fluids long-term if indicated ☐ IV fluids for a defined trial period		ding tube long-terr ding tube for a def	
Box Only in Each	No IV fluids (provide other measures to ensure co		feeding tube	med trial period
Column	Other Instructions		ALL CONTRACTOR	
Section E	DISCUSSED WITH Patient AND AGREED TO BY: Parent or guardian if		Majority of patient's	s reasonably available
Check The	Health care agent		Majority of patient's	reasonably available
Appropriate	Basis for order must be Legal guardian of the		dult siblings	an established relationshi
Box	documented in medical health care decisions	SPECIFIC	with the patient who	is acting in good faith ar
MD/DO PA	or NP Name (Print): MD/DO, PA, or NF			Phone #:
MD/DO, FA,	Williams (Fint).	Signature (Requi	ed).	rione #.
	erson, Parent of Minor, Guardian, Health Car	re Agent, Spouse, o	r Other Person	al Representative
Signature of F	equired and must either be on this form or on file)		40/19	
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(Signature is re I agree that add Treatment pref document refle If signed by a prepresentative.	erences have been expressed to the physician (MI cts those treatment preferences and indicates info	rmed consent. t reflect patient's wi		

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, <u>then</u> 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 <u>Resuscitation</u> (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, <u>intubation</u>, and other invasive measures
- Limited can include BiPAP (<u>not intubation</u>), 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).

B BEDICAL 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

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) Other Instructions MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically and nutrition if physically feasible. Feeding tube long-term if indicated Feeding tube for a defined trial period No feeding tube

MOST FORM SECTION E – AUTHORIZATION

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

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
	erson, Parent of Minor,	MD/DO, PA, or NP Signature (Re Guardian, Health Care Agent, Spous	Phone #: se, or Other Personal Representative
I agree that ade Treatment prefe document reflect If signed by a prepresentative.	erences have been express ets those treatment prefere atient representative, prej	n provided and significant thought has ed to the physician (MD/DO), physician ences and indicates informed consent. Ferences expressed must reflect patient personal representative should be proving the proving	's wishes as best understood by that
Patient or Repres	entative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)
	SEND FORM WITH PA	TIENT/RESIDENT WHEN TRANSFE	RRED OR DISCHARGED

NC NEXT OF KIN HIERARCHY

Decision Maker Priority

(Listed in order of priority):

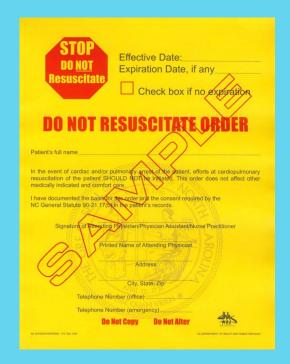
Parent or guardian if patient is a minor

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
- 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



	Medical Orders	Patient's Last Name:	Effective Date of Fe
for	Scope of Treatment (MOST)	100000000000000000000000000000000000000	Form must be revie
	cian Order Sheet based on the person's medical		at least annually.
	wishes. Any section not completed indicates full	Patient's First Name, Middle Initial:	Patient's Date of B
	hat section. When the need occurs, <u>first</u> follow then contact physician.		
Section	CARDIOPULMONARY RESUSCITATION	(CPR): Person has no pulse and	is not breathing.
A Check One	Attempt Resuscitation (CPR)	Do Not Attempt Resuscitation	n (DNR/no CPR)
Box Only	When not in cardiopulmonary arrest, follow orders in	in B, C, and D.	
Section	MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.		
В	☐ Full Scope of Treatment: Use intubation, adv.		
	indicated, medical treatment, IV fluids, etc.; also p Limited Additional Interventions: Use med		
Check One Box Only	Do not use intubation or mechanical ventilation; a		
	Avoid intensive care, Comfort Measures: Keep clean, warm and dry	Use medication by any mute positioning	wound care and
	other measures to relieve pain and suffering. Use of	oxygen, suction and manual treatment of air	rwny obstruction as no
	for comfort. Do not transfer to hospital unle	ss comfort needs cannot be met in	current location.
	Other Instructions		
Section	ANTIBIOTICS Antibiotics if life can be prolonged.		
С	Determine use or limitation of antibiotics when	infection occurs.	
Check One	No Antibiotics (use other measures to relieve syn	optoms).	
Box Only	Other Instructions	0.12	
Section	MEDICALLY ADMINISTERED FLUIDS A physically feasible.	AND NUTRITION: Offer oral flu	ids and nutrition
D	IV fluids long-term if indicated	Feeding tube long-ter	en if indicated
Check One	☐ IV fluids for a defined trial period	Feeding tube for a de	
Box Only in Each	No IV fluids (provide other measures to ensure or	omfort) No feeding tube	
Column	Other Instructions Patient	☐ Majority of patient	
Section E	AND AGREED TO BY: Parent or guardian if		
Check The	AND AGREED TO BY: Parent or guardian if	Majority of patient	
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REFERENCES

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Code Status and Advanced Directives

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Palli Emmorg