

How can I prepare for these conversations?

Talk with your health care providers, family and loved ones about your wishes and instructions for future health care treatment; this is called **Advance Care Planning**.

Your health care team will ask you about advance care planning, your goals of care, and treatment options. Talking with them will help you to better understand your health condition, possible treatment choices, and options for care that are best for you.

From these advance care planning conversations, your doctor or nurse practitioner will write a **MOST**.



Questions to consider asking your health care provider:

- How might my illness progress?
- What treatment decisions might I have to make in the future?
- What are the possible complications I might experience with my illness, and what are the possible treatments?
- What are the risks and benefits of certain medical interventions I might receive (for example; cardiopulmonary resuscitation)?

Advance Care Planning:
making the **MOST** of
CONVERSATIONS



Advance Care Planning lets you have a say in the health care you will receive if you are unable to **speak for yourself**.

Information about Advance Care Planning, including the *My Voice* guide, is available online by searching for "Advance Care Planning" at the following websites:

[Island Health
islandhealth.ca]

[Provincial
seniorsbc.ca
healthlinkbc.ca]

[National
advancecareplanning.ca]

Advance Care Planning

E-mail: Advancecareplanning@viha.ca

Telephone: 250.370.5687



Medical Orders for Scope of Treatment

[MOST]

Why should I have a **MOST**?

In an emergency or urgent situation, if you are unable to express your wishes, a **MOST** will help ensure your health care treatment aligns with your wishes.



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What is **[MOST]**?

MOST stands for:

Medical **O**rders for **S**cope of **T**reatment.

A **MOST**:

- Is written by your doctor or nurse practitioner
- Has 6 different levels of treatment that range from comfort care to critical care (e.g., palliative care to intensive care)



A **MOST** reflects your wishes and guides your health care team in the event that you are not able to speak for yourself.

For example:

- Your heart stops
- Your breathing stops
- You need urgent medical care

A **MOST** is written after you have had a conversation with your health care provider about advance care planning and an opportunity to understand the options available to you.

Advance care planning is a process of learning, deciding, and talking about what health care you want in the future if you are unable to make or communicate these decisions yourself.

Who should have a **[MOST]**?

A **MOST** is an option for all adults. However, **MOST** is especially important for adults with an advancing illness or chronic condition that is life limiting or life threatening.

Even if you have a **MOST**, you will always be asked to provide direction for your health care as long as you are capable.

How is a **[MOST]** determined?

MOST decisions arise out of conversations with your health care providers, family and loved ones about:

- Advance care planning; your wishes and goals of care for future health care
- Current and future treatment options available to you
- Your health condition and prognosis

Following these conversations, your doctor or nurse practitioner will complete a **MOST** to guide other members of the health care team in a medical emergency.

Can my **[MOST]** be changed?

Yes, it can be changed at any time. It is recommended that you review and update your **MOST** with your doctor or nurse practitioner at least once a year and if:

- You have changed your mind about treatment
- Your health condition has changed
- You move into a supportive care facility, such as Assisted Living or Residential Care

If you go to the hospital, it is recommended that you bring a copy of your **MOST**.

What might my health care provider discuss with me?

Talking with your health care provider can help you understand your choices and plan for what is best for you.

They may discuss:

- What is important to you (your goals of care)
- Your health, and what it might look like in the future
- Your options for care and medical treatments (including CPR)
- End-of-life care
- Who will speak for you if you cannot speak for yourself (substitute decision maker)

making the **[MOST of CONVERSATIONS]**

