Eastern Health

ADVANCE CARE PLANNING AND GOALS OF CARE DESIGNATIONS	Patient/Resident/Client Care PRC-002

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Overview

Advance care planning (ACP) is an ongoing process in which patients, their families, and their healthcare providers

- reflect on the patient's goals, values, and beliefs;
- discuss how they should inform current and future medical care; and ultimately,
- use this information to accurately document their future health care choices.

ACP is intended to provide direction for a time when a person cannot make his or her own health care decisions.

ACP conversations allow for respectful understanding of patient's wishes concerning general focus of care and limits of specific interventions. The timing and nature of ACP conversations may vary depending on whether the person is healthy, has mild to moderate chronic illness, or an advanced, life-limiting illness. ACP discussions have been associated with better patient outcomes, less expensive medical care and increased consideration of hospice or home care resources.

Goals of Care Designations (R-M-C) will be used to describe, communicate and document the general focus of care for the patient:

Resuscitation **(R)** - Medical Care and interventions including resuscitation.

Medical Care **(M)** – Medical Care and interventions, excluding resuscitation.

Comfort Care **(C)** – Medical Care and interventions, focused on comfort.

POLICY

- Eastern Health (EH) respects human dignity by providing care that is clinically indicated, ethically appropriate, and seeks to understand patient values regarding care provision.

- Advance care planning will be the process by which clinicians and patients/substitute decision-makers (SDM) consider future treatment(s) and care for a patient. This process will include communication between health care professionals, patients, and when appropriate, substitute decision makers.

- Health care providers will utilize Goals of Care Designations (R-M-C) to describe and communicate the general focus of care for the patient. These designations will include direction regarding the acceptance and refusal of specific clinically-indicated life-saving and life-sustaining interventions (see Attachment A).

- In acute care, a Goals of Care Designation order must be written by the Most Responsible Physician (MRP) (or Designate) and documented in the Health Record.

- In the absence of a Goals of Care Designation on the health record, clinically appropriate life support interventions are provided as required.

Scope

This policy applies to all physicians, employees and agents who have professional clinical responsibilities to patients receiving health care services from EH.

Note: This policy does not replace the requirements within the Consents policy (Eastern Health LEG-050).

Purpose

- To promote a standardized regional approach to operationalize advance care planning throughout Eastern Health.
- To guide health care teams, patients and SDM regarding the general intentions of clinically indicated health care, specific interventions, and the service locations where such care will be provided.
- To serve as a communication tool for health care professionals when rapid decision-making in the clinical environment is required.

Policy Details

For detailed descriptions of Goals of Care Designations, and important clinical features embedded in them, see Attachment A, *Goals of Care Designations.*

1. Advance Care Planning and Goals of Care Designations

1.1 Goals of Care Designations will be utilized throughout Eastern Health to denote general care directions, locations of care including transfer considerations for current and future care for patients.

1.2 While prescriptive, a Goals of Care Designation order results from consultation between the current MRP (or Designate) and the patient/SDM and is based on the premise that the delivery of that care provides a reasonable benefit to the patient.

1.3 In Acute Care, ACP and Goals of Care Designations are the clinical responsibility of the MRP (or Designate) and although all related decisions shall be informed by discussions with patients and SDM's, consent is not required in emergency situations to make a Goals of Care Designation order.

2. ACP and Goals of Care Conversations

2.1 Every patient or SDM will be offered the opportunity to participate in ACP conversations. These discussions explore the patient's wishes and goals for treatment framed within clinically appropriate therapeutic options for the patient's condition. Goals of Care conversations shall take place as early as possible in a patient's course of treatment and must occur in consultation with the patient, or with the SDM if the patient lacks capacity.

2.2 Advance care planning is voluntary and focuses primarily on an individual's rights and values. If a patient chooses not to participate in ACP discussions or refuses clinically indicated intervention(s), this choice shall be honored within the bounds of applicable laws and documented in the patient's health record. Further conversations regarding patient refusal may be required.

2.3 General guidance for when it would not be clinically indicated or appropriate for a Goals of Care conversation include, but are not limited to:

a) conversations that would compromise health;
b) conversations which could delay emergency intervention; and/or
c) conversations which are not relevant to the current clinical scenario or care pathway for the patient.

2.4 ACP conversations may be initiated and undertaken by any member of the health care team:

a) **Acute Care** - The MRP is ultimately responsible for ensuring that a clinically indicated Goals of Care Designation Order has been discussed, established and documented. In collaboration with other members of the health care team, the MRP (or designate) should ensure that ACP and Goals of Care Designations include:

i) information about the nature of the patient's current condition, prognosis, treatment options, and the expected benefits or burdens of those options;
ii) exploration of the patient's values, understanding, hopes, wishes and expected outcomes of treatment;
iii) consultation with available resources such as Social Work, Pastoral Care and Ethics, Palliative Care, and Quality, Patient Safety and Risk Management to provide support and guidance to the patient (or SDM) as needed.

b) **Long Term Care** – ACP conversations are held with the Resident and/or SDM as soon as possible after admission to discuss the resident's health care wishes for the purpose of completing ACP-Advance Health Care Directive, Long Term Care (CH -1265).

c) **Community-Based Care/ Ambulatory Care Settings –** health care professionals will raise awareness about ACP and Goals of Care Designations through conversation and education of clients as appropriate. ACP conversations and support must be documented in the health record.

2.5 While all pediatric patients who are admitted to a health care service or facility shall have the opportunity for ACP, most will present for care that is not of the nature requiring ACP/Goals of Care Designation conversations. Most pediatric patients will be represented by their parents or others who serve as their SDM. The *AHCD Act (Section 7: b and c)* states that where there is no evidence to the contrary:

b) that a person who is 16 years of age or older is competent to make health care decisions; and

c) that a person who is younger than 16 years of age is not competent to make health care decisions.

The EH Consent Policy (Eastern Health Leg-050) gives direction regarding mature minors.

3. Advance Health Care Directives

3.1 Where patients or their SDM identify the existence of an Advance Health Care Directive (AHCD), ACP conversations are to focus on a review of the AHCD and may include subsequent updating and documentation of appropriate Goals of Care Designations arising from these conversations**.**

Note: Wishes outlined in an AHCD come into effect when patients cease to be competent to make and communicate health care decisions. The AHCD continues to be effective for the duration of that period. In cases where an AHCD is presented by a capable patient, the AHCD may inform discussion, however, the conversation with the patient takes precedence.

3.2 Instructions from an AHCD or SDM will generally be followed as the wishes of patients. However, when such requests are deemed futile, contrary to accepted health care or legal practices or are contrary to the law of the province of Newfoundland and Labrador, then support services for decision making may be required. These include, but are not limited to, Social Work, Legal Services, Pastoral Care and Ethics, Clinical Expert Consultations and Quality, Patient Safety and Risk Management.

Note: For Patients certified under the Mental Health Care and Treatment Act (MHCTA Section 35), the most responsible physician may, taking into account the best interests of the involuntary patient, perform or prescribe diagnostic procedures to determine the existence or nature of a mental disorder, and administer or prescribe medication or other treatment relating to the mental disorder without the consent of the involuntary patient during the period of detention.

4. Supporting Decisions/Conflict Resolution for ACP

4.1 When circumstances bring significant complexities to the advance care planning process (as above), support for decision making may be required. In the event that there is uncertainty, distress, or disagreement regarding the appropriateness of life support interventions or the Goals of Care Designation between the patient, SDM, family, and most responsible physician (or delegate), or members of the health care team, supportive measures may be initiated. These include, but are not limited to Social Work, Pastoral Care and Ethics, Clinical Expert Consultation, and Quality, Patient Safety and Risk Management.

4.2 The MRP or a member of the health care team shall ensure that the patient and/or SDM is informed of, and has access to, the avenues of decision support within Eastern Health.

5. Review of Goals of Care Designation Orders

5.1 A Patient's Goals of Care Designation order shall be reviewed by the MRP

(or Designate) Or the ACP- AHCD Designation by the health care professional :

a) at the request of the patient, SDM, or Physician/health care team, or

b) if there is a change in the patient's condition or circumstances that may be relevant to the choice of Goals of Care Designation.

Note: For long-term care residents, annual review is required.

5.2 When a patient is transferred within Eastern Health, the Goals of Care Designation order completed at the sending location of care shall remain in effect unless a review is required.

6. Documentation of ACP Goals of Care Designations

6.1 Documentation of Goals of Care Designations on Admission to Acute Care and Long Term Care are completed on program-specific forms:

a) Acute Care: "*Advance Care Planning (ACP) – Goals of Care Designation Orders: Adult and Pediatrics Acute Care"* (CH-1264).
b) Long Term Care: *"Advance Care Planning (ACP) – Advance Health Care Directive: Long Term Care"* (CH-1265).

Note: For Community-Based Care/ Ambulatory Care Patients, ACP conversations must be documented in the Health Record.

6.2 Whenever there is a change in Goals of Care Designations (R-M-C), a new form must be completed.

6.3 In Acute Care, Medical Residents/Nurse Practitioners can write and sign ACP orders. If a Goals of Care Designation order indicates no resuscitation, the Designate must document that a discussion with the Most Responsible Physician has taken place. The Nurse signs the ACP Goals of Care Designation order to indicate receipt and transcription of the order.

6.4 The Goals of Care Designation documentation form must remain on the chart for the duration of the admission and accompany the patient throughout their episode of care.

Procedure

1. Each admission shall require the completion of a new ACP Goals of Care Designations program specific form.

Acute Care. The MRP (or Designate) documents the Goals of Care

Designations order and supporting details. The completed order will be kept in the Physician's Orders section of the health record.

Long Term Care. The designated member of the health care team in consultation with the resident (or SDM, where applicable) completes the AHCD form. The completed AHCD form will be kept in the Admissions section of the resident's health record. Signature by the MRP (or Designate) indicates that the form has been reviewed.

2. When review of a Goals of Care Designation does not result in a revision or change, the fact that the review occurred shall be noted in the Review section of the program-specific ACP form and shall be communicated to the health care team.

3. When review of a Goals of Care Designation does result in a revision or change in its specific directions, a new program-specific ACP form must be completed.

   Acute Care. The current ACP order must be voided by writing "NO LONGER IN EFFECT" diagonally across the ACP order form and shall include the date and signature of the MRP (or Designate).

   Long Term Care. The current ACP form must be voided by writing "NO LONGER IN EFFECT" diagonally across the form and shall include the date and signature of the health care professional completing the ACP AHCD form with the resident or SDM.

4. Health care team members engaging patients or SDM's in ACP conversations shall document supporting ACP conversations in the progress notes of the health record.

5. If patients or SDM choose not to participate in ACP discussions or refuses clinical interventions, this must be documented in the health record.

Supporting Documents *(References, Industry Best Practice, Legislation, etc.)*

- Alberta Health Services (2011). Advance Care Planning – Goals of Care Policy.
- Alberta Health Services (2012). Advance Care Planning – Goals of Care Procedure
- Advance Health Care Directives Act – NL Legislation http://www.assembly.nl.ca/Legislation/sr/statutes/a04-1.htm
- Canadian Pediatric Society (2008). Advance Care Planning for Pediatric Patients (Position Statement). www.cps.ca
- Canadian Hospice Palliative Care Association (2012). Advance Care Planning in Canada: National Framework

Linkages

- Advance Care Planning (ACP) Advance Health Care Directive Long Term Care http://pulse.easternhealth.ca/Pages/ImageLoader.aspx?FormID=1551
- Doctor's Order Sheet Advance Care Planning (ACP) – Goals of Care Designation Orders Adult & Pediatric Acute Care http://pulse.easternhealth.ca/Pages/ImageLoader.aspx?FormID=1553
- Canadian Hospice Palliative Care Association http://www.chpca.net/
- Dunbrack, J. (2008). Implementation guide to advance care planning in Canada: a case of two health authorities. Prepared for Health Canada. Available from: http://www.hc-sc.gc.ca/hcs-sss/pubs/palliat/2008-acp-guide-pps/index-eng.php
- Eastern Health (2012). Consents (LEG-050) – policy
- Eastern Health (2008). Positive Patient Identification (PRC-130) - policy
- Eastern Health (2013). Privacy and Confidentiality (ADM-030) - policy
- It's Your Decision: How to Make an Advance Health Care Directive http://assembly.nl.ca/Legislation/sr/statutes/a04-1.htm
- Mental Health Care Treatment Act as retrieved January 28, 2013 from http://www.health.gov.nl.ca/health/mentalhealth/mentalhealthact.html
- Singleton, R. (2012). Foundations for Advance Care Planning, Eastern Health.
- Speak Up http://www.advancecareplanning.ca/

Key Words

- Advance Care Planning
- ACP
- Advance Health Care Directives
- AHCD
- Substitute Decision Maker
- SDM
- Do Not Resuscitate
- DNR
- Resuscitation-Medical Care-Comfort Care
- R-M-C
- RMC
- Goals of Care Designations

Definitions & Acronyms

Acute Care	Inpatient Adult and Pediatric Programs (including Mental Health)

Advance Care Planning	The overall process of dialogue, knowledge sharing, and informed decision-making that needs to occur at any time when future or potential life threatening illness treatment options and goals of care are being considered or revisited.
Advance Health Care Directive	As per the Advance Health Care Directives legislation of NL, a document in which a person sets out his/her instructions or general principles regarding health care treatment in the event he/she cannot make decisions for him/herself. It allows a person to appoint a substitute decision maker(s) (SDM) to act on their behalf when a decision regarding health and treatment must be made.
Capacity	An individual has capacity to make health care decisions if he or she is able to understand the information that is relevant to making a decision and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
Community Based Care	Community Health Nursing and Home and Community Supports Programs
Episode of Care	A period of hospitalization (inpatient or outpatient) in which care was received for a presenting problem beginning with registration and terminating with discharge.
Goals of Care	The intended purposes of health care interventions and support as recognized by both a patient or substitute decision maker, health care team or both
Goals of Care Designations	A letter code (R-M-C) that provides direction regarding specific health interventions, transfer decision, location of care, and limitations on interventions for a patient as established after consultation between the health care team and patient.
Health Care Team	Refers to the health care professionals who are directly involved with the patient's care.

Life Support Interventions	Interventions typically undertaken in the Intensive Care Unit (ICU) but which occasionally are performed in other locations in an attempt to restore normal physiology. These may include: chest compressions, mechanical ventilation, defibrillation and physiological support.
Life-Sustaining Measures	Therapies that sustain life without supporting unstable physiology. Such therapies can be used in multiple clinical circumstances. When viewed as life-sustaining measures, they are offered in either a) the late stages of an illness in order to provide comfort or prolong life, or b) to maintain certain bodily functions during the treatment of intercurrent illnesses. Examples include: enteral tube feeding and parenteral hydration.
Long Term Care	Nursing Homes and Community Protective Care Residences
Most Responsible Physician, MRP, (or Designate)	MRP means the medical staff member who, by direct admission or transfer, accepts overall responsibility for directing and coordinating the care and management of a patient in an Eastern Health acute care / long term care facility. Designate means a physician who has the appropriate credentials and privileges accorded to them by Eastern Health; medical resident, who is under the direct supervision of the MRP; or nurse practitioner (NP), who has competency in ACP processes and is a member of the patient's health care team.
Patient	Patient shall mean patient, resident, and client except where the specific term is used to be more precise.
Resuscitation	The initial effort undertaken to reverse and stabilize an acute deterioration in a patient's vital signs. This may include chest compressions for pulselessness, mechanical ventilation, defibrillation, cardioversion, pacing, and intensive medications. Patients who have opted to not have chest compressions and/or mechanical ventilation may still be considered for other resuscitative measures (see Designation R3).

Substitute Decision Maker	A person appointed by the maker of an advance health care directive to make a health care decision on his/her behalf or who is designated to do so under Section 10 of the Advance Health Care Directives Act: a. the incompetent's person's spouse b. the incompetent's person's children; c. the incompetent's person's parents; d. the incompetent's person's siblings; e. the incompetent's person's grandchildren; f. the incompetent's person's grandparents; g. the incompetent's person's uncles and aunts h. the incompetent's person's nephews and nieces i. another relative of the incompetent person; j. the incompetent person's health care professional who is responsible for the proposed healthcare (Section 10, Health Care Directives Act)

ATTACHMENT A

Goals of Care Designation

The Goals of care Designation order provides direction regarding specific health interventions, transfer decisions, locations of care, and limitations on interventions for a patient as established after consultation between the most responsible health practitioner and patient or alternate decision-maker where appropriate

A Goals of Care order is the subject to clinical judgment of the current MRP (or Designate). Decisions made by the MRP (or Designate) and health care team regarding the level of medical care delivered to a patient must be based on the premise that the delivery of that care provides a reasonable benefit to the patient.

R

Medical Care and Interventions including Resuscitation

R – May intervene with medical care, including Resuscitative Care if required

Goals of Care: directed at cure or control of a patient's condition. The patient would desire ICU care if it was required, and would benefit from ICU if their medical condition warranted it.

R1 – Medical Care including ICU admission if required, with intubation and chest compressions

Goals of care are directed at cure or control of a patient's condition. Treatment or illness may include transfer to an acute or tertiary care facility with admission to ICU if indicated. Intubation and chest compression may be provided.

GUIDE:

General Guidelines	Patients would benefit from, and are accepting of, any appropriate investigations and interventions that the health system can offer, including physiological support in an ICU setting if required. All appropriate supportive therapies are offered, including intubation. Chest compressions and intubation are performed during a resuscitation effort when clinically indicated.
Resuscitation	Undertaken for cardio-respiratory arrest or acute deterioration.
Life Support Interventions	Usually undertaken.
Life Sustaining Measures	Used when appropriate within overall goals of care.
Major Surgery	Considered when appropriate. The possibility of intra-operative complications including death and the requirement for physiological support post-operatively should be addressed with the patient in advance of the proposed surgery, and general decision-making guidance agreed upon.

Transfer	Considered from current location of care if an alternative location is required for diagnosis and treatment.

R2 - Medical care including ICU admission if required, with intubation but without chest compressions

Goals of care are directed at cure or control of a patient's condition. Treatment of illness may include transfer to an acute or tertiary care facility with admission to the ICU if required. Intubation can be considered when indicated but chest compressions are not performed.

GUIDE:

General Guidelines	Patients would benefit from, and are accepting of, any appropriate investigations and interventions that the health system can offer, including physiological support in an ICU setting if required, excluding chest compressions.
Resuscitation	Undertaken for acute deterioration, but chest compressions should not be performed.
Life Support Interventions	May be offered, without chest compressions.
Life Sustaining Measures	Used when appropriate within overall goals of care.
Major Surgery	Considered when appropriate. The possibility of intra-operative complications including death and the requirement for physiological support post-operatively should be addressed with the patient in advance of the proposed surgery, and general decision-making guidance agreed upon.
Transfer	Considered from current location of care if an alternative location is required for diagnosis and treatment.

R3 - Medical care including ICU admission if required, without intubation or chest compressions

Goals of care are directed at cure or control of a patient's condition. Treatment of illness may include transfer to an acute or tertiary care facility with admission to the ICU if required, but chest compressions or intubation should not be performed.

GUIDE:

General Guidelines	Patients would benefit from, and are accepting of, any appropriate investigations and interventions that the health system can offer, including physiological support in an ICU setting if required, excluding intubation and chest compressions.
Resuscitation	Undertaken for acute deterioration, but intubation and chest compressions should not be performed.

Life Support Interventions	May be offered, without intubation and chest compressions.
Life Sustaining Measures	Used when appropriate within overall goals of care.
Major Surgery	Considered when appropriate. The possibility of intra-operative complications including death and the requirement for physiological support post-operatively should be addressed with the patient in advance of the proposed surgery, and general decision-making guidance agreed upon.
Transfer	Considered from current location of care if an alternative location is required for diagnosis and treatment.

M

Medical Care and Interventions, Excluding Resuscitation

M - May intervene with medical care, excluding tertiary level ICU

Goals of Care: directed at cure or control of a patient's condition. These patients either choose to not receive care in an ICU or would not benefit from ICU care.

M1 - Medical care with transfer to Acute Care when required without the option for life–saving ICU care.

The goals of care are aimed at cure or control in any location of care, without accessing a tertiary level ICU. Treatment of illness may include transfer to an acute or tertiary facility without admission to a tertiary level ICU.

GUIDE:

General Guidelines	All active medical and surgical interventions aimed at cure and control of conditions are considered, within the bounds of what is clinically indicated, and excluding the option of admission to a tertiary level ICU for life-saving interventions. If a person deteriorates further and is no longer amenable to cure and control interventions, the goals of care designation should be changed to focus on comfort primarily.
Resuscitation	Not undertaken for cardio-respiratory arrest.
Life Support Interventions	Should not be initiated, or should be discontinued after discussion with patient.
Life Sustaining Measures	Used when appropriate within overall goals of care.
Major Surgery	Considered when appropriate. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the patient to prior level of function. The possibility of intra-operative death or life threatening intra-operative

	deterioration should be discussed with the patient in advance of the proposed surgery, and general decision-making guidance agreed upon.
Transfer	Considered from current location of care if receiving location provides more appropriate circumstances for necessary diagnosis and treatment.

M2 - Medical care without transfer to Acute Care and without the option for life-saving ICU care.

The goals of care are aimed at cure or control, almost always within the patient's current care environment. Treatment of illness may be undertaken in the current location without transfer to acute or tertiary care should that condition deteriorate.

GUIDE:

General Guidelines	Interventions that can be offered in the current location of care are considered. If a person deteriorates further and is no longer amenable to cure or control interventions, the goals of care designation should be changed to focus on comfort primarily.
Resuscitation	Not undertaken for cardio-respiratory arrest.
Life Support Interventions	Should not be initiated, or should be discontinued after discussion with patient.
Life Sustaining Measures	Used when appropriate within overall goals of care.
Major Surgery	Usually not undertaken, but can be contemplated for procedures aimed at symptom relief. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the patient to prior level of function. The possibility of intra-operative death or life threatening intra-operative deterioration should be discussed with the patient in advance of the proposed surgery, and general decision-making guidance agreed upon.
Transfer	Not usually undertaken but can be contemplated if symptom management or diagnostic efforts aimed at understanding symptoms can best be undertaken at another location.

C

Medical Care and Interventions, Focused on Comfort

C - Provide Comfort Care

Goals of Care: directed at symptom control rather than at cure or control of a patient's underlying condition that is expected to result in death. All interventions are for symptom relief.

C1 - Symptom Comfort Care

Goals of Care are for maximal symptom control and maintenance of function, without cure or control of the underlying condition. A diagnosis exists which is expected to cause eventual death.

GUIDE:

General Guidelines	A diagnosis exists which is expected to cause eventual death. New illnesses are not generally treated unless control of symptoms is the goal.
Resuscitation	Not to be undertaken in the event of cardio-respiratory arrest/failure. Chest compressions or intubation should not be performed.
Life Support Interventions	Should not be initiated, or should be discontinued after discussion with patient.
Life Sustaining Measures	Consider for goal-directed symptom management.
Major Surgery	Usually not undertaken, but can be contemplated for procedures aimed at symptom relief. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the patient to prior level of function. The possibility of intra-operative death or life threatening intra-operative deterioration should be discussed with the patient in advance of the proposed surgery, and general decision-making guidance agreed upon.
Transfer	Should be contemplated if symptom management or diagnostic efforts are aimed at understanding symptoms can best be undertaken at another location. Transfer to an ICU is warranted if ICU is deemed to be the best location for palliation, especially in the Pediatric environment.

C2 - End-of-Life Care

Goals of Care are aimed at preparation for imminent death (usually within hours or days), with maximal efforts directed at symptom control.

GUIDE:

General Guidelines	Expert end-of-life care can be provided in any location.
Resuscitation	Not to be undertaken in the event of cardio-respiratory arrest/failure. Chest compressions or intubation should not be performed.
Life Support Interventions	Should not be initiated, or should be discontinued after discussion with patient.
Life Sustaining Measures	Should be discontinued unless required for goal-directed symptom management.
Major Surgery	Not appropriate.
Transfer	Not usually undertaken.

Adapted from Alberta Health Service