Advance Care Planning
Frequently Asked Questions

What are the key changes to the WRHA Advance Care Planning Policy?

Overall Focus

- The policy more clearly emphasizes that the Advance Care Policy (ACP) process is based on consensus between the patient/substitute decision maker and the health care team. The policy is not intended to address situations of unresolved conflict other than to encourage continued dialogue.
- The overall focus of the policy has changed from "Levels of Intervention" to ***"Goals of Care"***.

Purpose

- The purpose of the ACP policy has been simplified from five to three statements. However the intent remains unchanged.

Definitions

- Definitions for Goals of Care, Goals of Care Document, Health Care Team, Collaborative Process, and Consensus have been added.
- The definition for Substitute Decision Maker has been changed to be consistent with other WRHA policies.

Policy/Procedure Statements

- The policy focuses on communication. The policy also emphasizes the need for "full and complete discussion with the patient".
- The ***ACP Goals of Care*** form must be signed by a Health Care Provider. If patient is a client of the Public Trustee, the form must be signed by the physician due to existing legislative requirements.
- The WRHA consent policies have been referenced to make it clear that informed consent is required even in the presence of a completed ***ACP Goals of Care*** form. The ***ACP Goals of Care*** form does not replace but rather guides ongoing dialogue with the patient.
- There is now a requirement for health care teams to engage all patients about to undergo anesthesia in ACP discussions.
- The approach taken when consensus can not be reached has been clarified. The policy directs the health care team to address each treatment and care decision on a case by case basis. The policy prompts the health care team to notify the appropriate administrative person(s) when timely resolution is essential or if conflict or potential conflict exists.

Form

- The form which accompanies the ACP policy has changed significantly. The ***ACP Goals of Care*** are now categorized around **Resuscitation (R)**, **Medical Care (M)**, and **Comfort Care (C)** and replace the previous numerical levels - Advanced Care Plans One to Four.

What is Advance Care Planning?

Advance Care Planning (ACP) is the overall ***Collaborative Process*** of dialogue, knowledge sharing, and informed decision-making that needs to occur at any time when

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future or potential life threatening illness treatment options and ***Goals of Care*** are being considered or revisited.

What is a "Collaborative Process"?

A ***Collaborative Process*** refers to the process when the Health Care Team engages in joint planning for the care of the Patient with shared responsibility and decision making that includes the Patient and family / Substitute Decision Maker.

What are "Goals of Care"?

Goals of Care are the intended purposes of health care interventions and support as recognized by both a ***Patient*** or ***Substitute Decision Maker*** and the ***Health Care Team***.

The ***Patient*** refers to a Patient, a Resident or a Client.

A ***Substitute Decision Maker*** refers to a third party identified to participate in decision-making on behalf of an individual who lacks ***Capacity***. The task of a Substitute Decision Maker is to faithfully represent the known preferences, or if the preferences are not known, the interest of the individual lacking ***Capacity***.

The ***Health Care Team*** refers to the health care professionals that are directly involved with the Patient's care.

What does "Capacity" mean?

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.

What is "Consensus"?

Consensus refers to general agreement and the ***Collaborative Process*** of getting to such agreement.

When is the process of Advance Care Planning initiated?

The process of Advance Care Planning is initiated whenever future treatment options or ***Goals of Care*** need to be considered or revised, whether care is occurring in an acute care facility, in a Personal Care Home, or through community based services. Timing is dictated by the clinical situation.

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This process may require one discussion or several discussions over a period of time to achieve consensus between the Patient or Substitute Decision Maker and the Health Care Team.

What is a "Health Care Directive"?

A ***Health Care Directive*** is a self-initiated form used in Advance Care Planning that complies with the provisions of the Health Care Directives Act.

If a Health Care Team member is made aware that a ***Health Care Directive*** exists when future treatment options or the Goals of Care need to be considered or revised, a copy of the ***Health Care Directive*** should be obtained and filed behind the designated tab of the paper health record or scanned into the Contacts/Directive section of an electronic patient record. This existing ***Health Care Directive*** guides the ***Advance Care Planning*** process and discussions.

What is an "Advance Care Planning - Goals of Care" Form?

The ***"Advance Care Planning - Goals of Care" Form*** is a form available across the region used to document a patient's Goals of Care once consensus has been reached between the Patient or Substitute Decision Maker and the Health Care Team through Advance Care Planning discussions.

The ***Advance Care Planning - Goals of Care*** are categorized as **Comfort Care (C)**, **Medical Care (M)**, and **Resuscitation (R)**.

C = Comfort Care refers to goals of care and interventions that are directed at maximal comfort, symptom control and maintenance of quality of life ***excluding*** attempted resuscitation.

M = Medical Care refers to goals of care and interventions that are for care and control of the patient's condition. The consensus reached between the patient and health care team is that the patient may benefit from, and is accepting of, any appropriate investigations / interventions that can be offered ***excluding*** attempted resuscitation.

R = Resuscitation refers to goals of care and interventions that are for care and control of the patient's condition. The consensus reached between the patient and health care team is that the patient may benefit from, and is accepting of, any appropriate investigations / interventions that can be offered ***including*** attempted resuscitation.

Who completes the "Advance Care Planning - Goals of Care" Form?

Once there is Consensus among those involved in the development of the "Advance Care Planning – Goals of Care" Form, a member of the Health Care Team completes the form.

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If the Patient is a client of the Public Trustee, a physician's signature is required. The physician is required to communicate either verbally or in writing directly with the Public Trustee.

Where is a completed "Advance Care Planning - Goals of Care" Form filed?

The completed "Advance Care Planning – Goals of Care" Form is filed behind the designated tab in the Patient's health record.

The Health Care Team ensures that the existence of an "Advance Care Planning – Goals of Care" Form is noted in the Patient's care plan / kardex.

Does a completed "Advance Care Planning - Goals of Care" Form accompany a Patient during transfer?

If the Patient is transferred, a copy of the "Advance Care Planning – Goals of Care" Form accompanies the Patient

When are Goals of Care reviewed?

The Goals of Care are reviewed

- on each admission
- whenever there is an unanticipated significant improvement or deterioration in clinical status
- on or shortly after transfer to another facility
- at the request of the Patient of Substitute Decision Maker
- at the request of the Health Care Team
- at minimum, the Goals of Care should be reviewed annually

For Patients who are undergoing a procedure that requires ***general / regional anesthesia*** (i.e. blocks / spinal) / ***procedural sedation*** and have indicated that they would not accept aggressive medical therapies such as resuscitation and / or admission to an intensive care unit, the Health Care Team should ensure a discussion takes place with the Patient or Substitute Decision Maker regarding the response to potential life-threatening problems that may occur during the perioperative period. The results of these discussions are documented in the health record and the "Advance Care Planning - Goals of Care" Form is revised as indicated.

When a review of the Goals of Care ***does not result in a revision***, the fact that a review occurred is noted on the "Advance Care Planning – Goals of Care" Form.

When a review of the Goals of Care ***necessitates revision***, the current "Advance Care Planning – Goals of Care" Form is voided by writing "NO LONGER IN EFFECT" diagonally across the form along with the date and signature of the Health Care Team Member. The

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“Advance Care Planning – Goals of Care” Form that is no longer in effect is filed immediately behind the most current “Advance Care Planning – Goals of Care” Form if any.