Policy Alert

Advance Care Planning – Goals of Care Policy
April 12, 2011

The Winnipeg Health Region has revised the policy in regard to Advance Care Planning. Several changes have been made to enhance the use and effectiveness of the policy and the form used to document a patient/resident/client's health-care goals.

The newly entitled 'Advance Care Planning – Goals of Care' policy is intended to strengthen communication between individuals and health care professionals. It helps ensure patients, their substitute decision maker and members of their health-care team engage in important conversations about the patient's health and heath-care goals.

The revisions are based on results of an external review of the previous policy and extensive stakeholder consultations. It includes:

- New focus on 'Goals of Care'
- New Advance Care Planning – Goals of Care form
- Enhanced focus on communication
- Emphasis on reaching consensus
- New definitions
- Expanded use/requirements for health-care teams

Summary of Key Changes:

Goals of Care

The Advance Care Planning – Goals of Care policy focuses on "Goals of Care." This replaces the previously used "Levels of Intervention." There are three categories for Goals of Care: Comfort Care, Medical Care, and Resuscitation. Each one represents the intended purpose of health care interventions and support as recognized by both the patient or substitute decision maker and the health-care team.

"C" Comfort Care is directed at maximizing comfort, symptom control and maintenance of quality of life **excluding attempted resuscitation.**

"M" Medical Care includes appropriate investigations and interventions that can be offered **excluding attempted resuscitation.**

"R" Resuscitation stands for medical care including appropriate investigations and interventions that can be offered **including attempted resuscitation**.

Advance Care Planning – Goals of Care form

A new Advance Care Planning – Goals of Care form has been created to replace the previous form. This form is a single page with English on one side and French on the other. It includes a number of prompts to encourage accurate and complete documentation. The form must only be filled out if consensus on Goals of Care has been reached.

Communication

There is an enhanced focus on communication between the patient or the substitute decision maker and the health-care team. A number of new resources along with existing supports are available for health-care professionals as well as patients. That includes Q & As, videos and an ACP patient workbook. Resources are available at: http://www.winnipeghealthregion.ca/acp.

The policy now clearly articulates the need for the patient or substitute decision maker to receive 'full and complete information'. It also outlines the key information that must be shared.

Consensus

The policy recognizes that the process of reaching consensus for an Advance Care Planning – Goals of Care form may require one discussion or several conversations over a period of time. The policy outlines available resources should the patient, substitute decision maker and the health-care team be unable to reach consensus.

Note: The policy is not intended to address situations of unresolved conflict other than to encourage continued dialogue.

Definitions

The revised Advance Care Planning – Goals of Care policy includes definitions for: 'Goals of Care', 'Goals of Care Document', 'Health Care Team', 'Collaborative Process', 'Capacity', and 'Consensus". The definition of 'Substitute Decision Maker' has been changed to be consistent with other policies in the Winnipeg Health Region.

Policy Use and Requirements

The policy now clearly states that Advance Care Planning – Goals of Care conversations do not replace any requirements within the regional policy on Informed Consent.

Advance Care Planning – Goals of Care discussions are now required for patients who are undergoing a procedure that requires general/regional anesthesia or procedural sedation and have indicated that they would not accept aggressive medical therapies (example: the patient has requested no resuscitation and/or would not accept admission to an intensive care unit).

Who it affects

Everyone. You never know when someone could face an unexpected event or illness and will be unable to guide decisions about their health care. Advance Care Planning discussions are particularly important to have with seniors and those living with a chronic disease.

When to refer to this policy

It is important to always keep the Advance Care Planning – Goals of Care policy in mind and to incorporate it into the regular practice of health-care professionals.

Advance Care Planning allows for clarity of goals and expectations, provides an opportunity to explore realistic expectations for care options, and minimizes the conflict that can arise when assumptions rather than dialogue form the basis of a care plan.

While ongoing discussions about care options remain important as an individual's illness evolves or as new issues arise, Advance Care Planning forms a solid foundation on which to base an overall approach to care.

Resources available:
A number of regional resources have been developed to support this policy including:

Advance Care Planning – Goals of Care Policy

Advance Care Planning – Goals of Care Form

ACP patient workbook

Education module outlining the key changes to the policy and form

“It’s all about Communication” education module featuring Dr. Mike Harlos, Medical Director of Palliative Care for the Winnipeg Health Region

Video scenarios for Advance Care Planning communication

Q & A