Policy Name		Policy Number: **0185**
ADVANCE CARE PLANNING GOALS OF CARE DESIGNATION		Effective Date: April 1, 2009
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Classification: Delivery of Care to Residents and Families		Page No: Page 1 of 8

POLICY:

To standardize the processes for:

1) Advance Care Planning and Goals of Care Designation
2) Communication and documentation of Advance Care Planning and Goals of Care
3) Dispute resolution mechanisms regarding these issues.

The Resident and their family are central members of the team at The Salvation Army Agapé Hospice. By respecting the Resident's dignity, values, beliefs, and wishes, we strive to individualize physical, social, emotional and spiritual care. Utilizing the Goals of Care Designation will guide healthcare professionals in making decisions regarding care.

Advance Care Planning information is to be kept in the "Green Sleeve" in the front of the Resident's health record. The "Green Sleeve" includes Goals of Care Designation Order form, and Advance Care Planning Tracking Record. It may also include either the original or a copy of the Personal Directive, Wills, Power of Attorney or Enduring Power of Attorney. Any original documents are to be returned to the family at the time of Resident's death or transfer. Photocopies of the documents are to be placed on the Resident's health record.

Goals of Care Designation are to be documented on the health record of every Resident admitted to Agapé Hospice. In addition, Residents, or their family/representative, are required to sign the "Memorandum of Understanding for Palliative Care at Agapé Hospice" upon admission. Where the Memorandum of Understanding applies to Advance Care Planning and Goals of Care Designation, it is noted that the Resident and/or their legal representative agree to:

- not receiving heroic measures for resuscitation such as chest compressions or intubation or any aggressive or invasive treatment intended to cure disease;
- receive care and intervention focused on Comfort.

As part of the admission process, the Registered Nurse is to document the initial conversation held with the Resident and/or their family/representative on the Advance Care Planning Tracking Record.

PROCEDURE:

1. Advance Care Planning Goals of Care

The two primary roles for Advance Care Planning Goals of Care are:

1) to serve as a communication tool for healthcare professionals to assist in decision making.
2) to guide healthcare professionals and Residents regarding the locations and general intentions of the care and interventions that are to be provided. If new circumstances or health issues arise, it is crucial that the Goals of Care Designation be reviewed to validate its sustained relevance or demonstrate a need to re-examine choices that would lead to a new Goals of Care Designation.

2. Goals of Care Designation

Detailed description of The Goals of Care Designation and important clinical features embedded in them are attached (Appendix A).

3. Goals of Care Conversations

3.1 These conversations take place early in the Resident course of care at Agapé Hospice. The discussion should explore the Resident's wishes and goals for treatment framed within the therapeutic options appropriate for hospice care. If a Personal Directive is available, a copy should be placed on the Resident's health record.

3.2 Conversations about Goals of Care Designation should take place with the Resident who has capacity and/or their representative. If no representative is known, then family members and informal caregivers, who are significant to the Resident, may be included in the conversation.

3.3 Although any member of the healthcare team can initiate and undertake Advance Care Planning Goals of Care conversation, the physician (or designate) is ultimately responsible for the discussion and the appropriate Goals of Care Designation order. Conversations should include:

- the prognosis and anticipated outcome of current treatment;
- exploration of the Resident's values, understanding, hopes, wishes and expected outcome of treatment;
- information regarding comfort measures;
- an offer for involvement of resources such as social work, spiritual care, clinical ethics consultation, palliative care consultation, volunteer resources to assist the Resident with his/her needs.

Pertinent details of this communication are documented in the Resident's health record, including the Advance Care Planning Tracking Record (Appendix B).

3.4 In a time sensitive situation, if there are no expressed wishes by the Resident in regards to Goals of Care Designation, and no known family/representative, the

physician (or designate), in consultation with members of the healthcare team, will initiate the most clinically-appropriate Goals of Care Designation order.

3.5 Attempts to reconcile any disagreement regarding Goals of Care Designation order shall follow the dispute resolution process set out in Section 8 of this policy.

4. Personal Directive or Resident Request

4.1 If a Resident has a Personal Directive; staff shall make a reasonable effort to obtain a copy for the Resident's health record.
4.2 In the circumstance that a known Personal Directive, or a Resident's request, includes a limit on care and/or treatment, it is the physician's (or designate) responsibility to provide the appropriate Goals of Care Designation order.
4.3 Where the provisions of a Personal Directive or a Resident's request gives clear and relevant instructions requesting intervention that certainly will not benefit, these interventions are not provided. (Also see Dispute Resolution Mechanism Section 8).

5. Documentation of the Goals of Care Designation

5.1 A Goals of Care Designation Order shall be written by the physician (or designate) and documented on the Resident's health record. The conversation about the Goals of Care Designation held with the Resident and/or their family/representative shall be clearly documented in the progress notes and/or the Advance Care Planning Tracking Record.

5.2 Goals of Care Designation Order will be placed in a prominent location on the Resident's health record in a timely manner. It shall be placed in the "Green Sleeve" in the front of the Resident's health record on admission to Agapé Hospice.

6. Goals of Care Designation Across the Continuum of Care

6.1 When a Resident is transferred between sectors of care, the Goals of Care Designation order completed at the sending location of care shall remain in effect until reviewed by the physician (or designate) at the receiving location.
6.2 Prior to receiving a Resident from an acute care facility, Agapé Hospice should receive the Goals of Care Designation signed order completed during that admission to acute care.
6.3 A Goals of Care Designation order issued in the community will be recognized by Agapé Hospice.

7. Review of Goals of Care Designation order

7.1 A Resident's Goals of Care Designation order shall be reviewed at the request of the Resident after transfer, or if there is a significant change in the Resident's condition or circumstances that may be relevant to the Goals of Care Designation.

7.2 Goals of Care Designation order shall continue to be in effect until revoked or renewed. Agapé Hospice Residents should have their Goals of Care Designation order reviewed a minimum every twelve (12) months.

7.3 Discussions with the Resident for review and renewal of the Goals of Care Designation order are based on the clinical judgment of the physician (or designate). Any changes in the Resident's Goals of Care Designation order shall be discussed with the Resident and/or their family or representative.

8. Goals of Care Designation Decision Dispute Resolution

In the event there is a disagreement regarding the Goals of Care Designation, whether between the Resident and the physician (or designate), the Resident and members of healthcare team, or among the healthcare team themselves, the steps below shall guide dispute resolutions. Although the steps are presented in the order they would likely occur; several steps may be undertaken simultaneously.

8.1 Communication and Clarification

Confirm that the steps outlined in Procedure Section 3.3 have been carried out.

8.2 Members of the healthcare team and the Resident have access to Agapé Hospice and the Alberta Health Service, Calgary zone, resources to assist in decision making.

8.3 Second Opinion

If a Resident does not accept a plan of treatment and/or Goals of Care Designation Order, a second opinion shall be sought in an expedient manner from a physician with relevant knowledge and skills.

- If, after a second opinion, disagreement remains regarding the Goals of Care Designation, the Resident shall be informed regarding the Dispute Resolution mechanism including access to the Alberta Health Service, Calgary zone resources.

8.4 External Legal Resources

Agapé Hospice recognizes and upholds a Resident's right to pursue external legal resources for dispute resolutions relating to the Goals of Care Designation decisions (as noted in Policy 0912 - Complaint Management).

8.5 If a member of the healthcare team has reasonable belief that a Resident's representative is not acting in the Resident's best interest, action shall be taken in accordance with Protection of Persons in Care Act.

REQUIRED FORMS AND EQUIPMENT:

- Goals of Care Designation Order Form
- Advance Care Planning/Goals of Care Designation Tracking Record

RELATED TERMS:

REFERENCE:

Alberta Health Services. (2014). HCS-38 Advance Care Planning and Goals of Care Designation Policy. August 16, 2016.
Alberta Health Services. (2014). HCS-38-01 Advance Care Planning and Goals of care Designation Procedure. August 16, 2016.

Protection for Persons in Care Act. *Statures of Alberta, 2009 Chapter P-29.1, Current as of February 20, 2015.* Province of Alberta. Web http://www.qp.alberta.ca/documents/Acts/P29P1.pdf [October 21, 2016]

Appendix A:
Goals of Care Designations – Guide for Clinicians

R: Medical Care and Interventions, Including Resuscitation if required followed by Intensive Care Unit admission. Focus of Care and interventions are for cure or control of the Patient's condition. The Patient would desire and is expected to benefit from attempted resuscitation and ICU care if required.

R1: Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including attempted resuscitation and ICU care.

- **Resuscitation:** is undertaken for acute deterioration, and may include intubation and chest compression
- **Life Support Interventions:** are usually undertaken
- **Life Sustaining Measures:** are used when appropriate
- **Major Surgery:** is considered when appropriate.
- **Transfer:** is considered for diagnosis and treatment, if required

R2: Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including attempted resuscitation, intubation, and ICU care, but excluding chest compression

- **Resuscitation:** is undertaken for acute deterioration, but chest compression should not be performed
- **Life Support Interventions:** may be offered without chest compression
- **Life Sustaining Measures:** are used when appropriate
- **Major Surgery:** is considered when appropriate
- **Transfer:** is considered for diagnosis and treatment, if required

R3: Patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including attempted resuscitation and ICU care, but excluding intubation and chest compression

- **Resuscitation:** is undertaken for acute deterioration but intubation and chest compression should not be performed
- **Life Support Interventions:** may be offered without Intubation and without chest compression
- **Life Sustaining Measures:** are used when appropriate
- **Major Surgery:** is considered when appropriate
- **Transfer:** is considered for diagnosis and treatment, if require

M: Medical Care and Interventions, Excluding Resuscitation. Focus of Care and interventions are for cure or control of the Patient's condition. The Patient either chooses to not receive or would not be expected to benefit from attempted resuscitation followed by life sustaining care in an ICU. In Pediatrics, ICU can be considered if that location is deemed the best location for delivery of specific short-term symptom-directed care.

M1: All clinically appropriate medical and surgical interventions directed at cure and control of condition(s) are considered, excluding the option of attempted life-saving resuscitation followed by ICU care. See above, regarding Pediatrics and ICU.

- **Resuscitation:** is **not** undertaken for cardio respiratory arrest.
- **Life Support Interventions:** should **not** be initiated, or should be discontinued after discussion with the Patient.
- **Life Sustaining Measures:** are used when appropriate.

- **Transfer:** to another location of care is considered if that location provides more appropriate circumstances for diagnosis and treatment
- **Major Surgery:** is 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 deterioration should be discussed with the Patient in advance of the proposed surgery and general decision-making guidance agreed upon and documented.

M2: All clinically appropriate interventions that can be offered in the current non-hospital location of care are considered. If a patient does not respond to available treatments in this location of care, discussion should ensue to change the focus to comfort care. Life-saving resuscitation is not undertaken except in unusual circumstances (see below in Major Surgery). See above, regarding Pediatrics and ICU.

- **Resuscitation:** is **not** undertaken for cardio respiratory arrest.
- **Life Support Interventions:** should **not** be initiated, or should be discontinued after discussion with the Patient.
- **Life Sustaining Measures: are** used when appropriate.
- **Transfer:** is not usually undertaken, but can be contemplated if symptom management or diagnostic efforts aimed at understanding symptoms can be best undertaken at that other location.
- **Major Surgery:** can be considered, in order to prevent suffering from an unexpected trauma or illness. 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 deterioration should be discussed with the Patient in advance of the proposed surgery and general decision-making guidance agreed upon and noted as special circumstances on the GCD Order Form and Tracking Record

C: Medical Care and Interventions, Focused on Comfort. Focus of Care and interventions are for the active palliative treatment of the Patient who has a terminal illness, and support for those close to them. This includes medical care for symptom control and psychosocial and spiritual support in advance of death. Care can be provided in any location best suited for these aims, including an ICU, a Hospice or any location that is the most appropriate for symptom-based care for this Patient.

C1: All care is directed at maximal symptom control and maintenance of function without cure or control of an underlying condition that is expected to cause eventual death. Treatment of intercurrent illnesses can be contemplated only after careful discussion with the Patient about specific short-term goals.

- **Resuscitation:** is not undertaken.
- **Life Support Interventions:** should **not** be initiated, or should be discontinued after discussion with the Patient.
- **Life Sustaining Measures: are** used only for goal directed symptom management.
- **Major Surgery:** is not usually 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, but this would be a rare circumstance. The possibility of intra-operative death or life-threatening deterioration should be discussed with the Patient in advance of the proposed surgery and general decision-making guidance agreed upon and documented.

• **Transfer:** to any appropriate location of care can be considered at any time, to better understand or control symptoms.

C2: All care is directed at preparation for imminent death [usually within hours or days] with maximal efforts directed at symptom control.

• **Resuscitation:** is not undertaken.
• **Life Support Interventions:** should not be initiated, or should be discontinued after discussion with the Patient.
• **Life Sustaining Measures:** should be discontinued unless required for symptom management.
• **Major Surgery:** is not appropriate.
• **Transfer:** is usually not undertaken but may be considered if required.