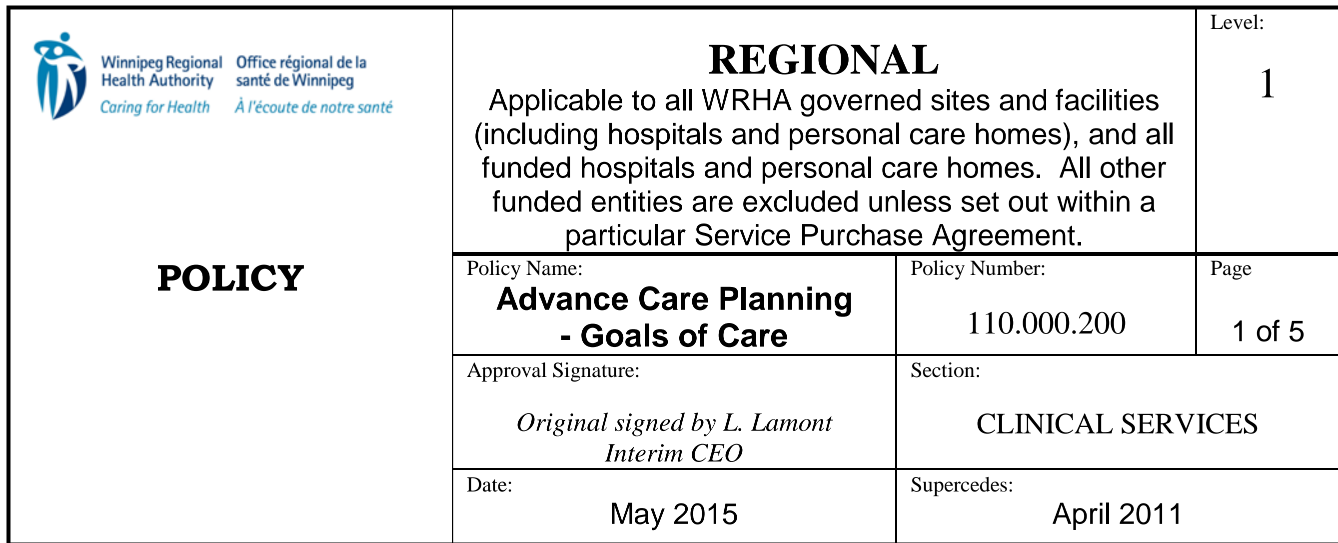

POLICY	REGIONAL Applicable to all WRHA governed sites and facilities (including hospitals and personal care homes), and all funded hospitals and personal care homes. All other funded entities are excluded unless set out within a particular Service Purchase Agreement.		Level: 1
	Policy Name: **Advance Care Planning - Goals of Care**	Policy Number: 110.000.200	Page 1 of 5
	Approval Signature: *Original signed by L. Lamont Interim CEO*	Section: CLINICAL SERVICES	
	Date: May 2015	Supercedes: April 2011	

1.0 **PURPOSE:**

1.1 To promote a collaborative ongoing process for Advance Care Planning to ensure the Goals of Care of the Patient/Client/Resident are identified and addressed.

1.2 To promote a standardized regional approach to Advance Care Planning.

1.3 To recognize that Advance Care Planning is a valued process of communication while acknowledging that there will be occasions when consensus can not be reached. This policy is not intended to address situations of unresolved conflict other than to encourage continued dialogue.

2.0 **DEFINITIONS:**

2.1 Advance Care Planning (ACP)
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.

2.2 Health Care Directive: A self-initiated document used in advance care planning that complies with the provisions of the *Health Care Directives Act*. In Manitoba, a Health Care Directive may indicate the type and degree of health care interventions the patient/resident/client would consent, refuse, or withdraw treatment to and/or may indicate the name(s) of an individual(s) who has been delegated to make decisions (i.e. a 'Proxy').
Refer to: http://web2.gov.mb.ca/laws/statutes/ccsm/h027e.php

In the absence of evidence to the contrary, a person who is 16 years of age or older is presumed to have the capacity to make a Health Care Directive.

Generally speaking, a Health Care Directive is binding on health care professionals, unless the request for interventions is illegal or inconsistent with accepted standards of practice.

DISCLAIMER: Please be advised that printed versions of any policy, or policies posted on external web pages, may not be the most current version of the policy. Although we make every effort to ensure that all information is accurate and complete, policies are regularly under review and in the process of being amended and we cannot guarantee the accuracy of printed policies or policies on external web pages. At any given time the most current version of any WRHA policy will be deemed to apply. Users should verify that any policy is the most current policy before acting on it. For the most up to date version of any policy please call 204-926-7000 and ask for the Regional Policy Chair's office.

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

2.4 "Advance Care Planning - Goals of Care" Form
The Form available across the region and used to document Goals of Care as reached by Consensus through Advance Care Planning discussions.

2.5 Substitute Decision Maker
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 following, in order of priority, may act as Substitute Decision Makers:

2.5.1 A proxy appointed by the individual under *The Health Care Directives Act*;
2.5.2 A committee appointed pursuant to *The Mental Health Act* if committee has the power to make health care decisions on the individual's behalf; or
A Substitute Decision Maker appointed pursuant to *The Vulnerable Persons Living with a Mental Disability Act* if the individual has authority to make health care decisions.
2.5.3 A parent or legal guardian of the individual, if the individual is a child;
2.5.4 A spouse, with whom the individual is cohabiting, or a common-law partner;
2.5.5 A son or a daughter;
2.5.6 If the individual is an adult, a parent of the individual;
2.5.7 A brother or a sister;
2.5.8 A person with whom the individual is known to have a close personal relationship;
2.5.9 A grandparent;
2.5.10 A grandchild;
2.5.11 An aunt or uncle;
2.5.12 A nephew or niece

2.6 Patient
Patient shall mean patient/resident/client.

2.7 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.

2.8 Health Care Team
Refers to the health care professionals that are directly involved with the Patient's care.

2.9 Collaborative 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.

2.10 Consensus
General agreement and the process of getting to such agreement.

3.0 POLICY:

3.1 Advance Care Planning is primarily a process of communication between the Patient/Substitute Decision Maker and the Health Care Team. Such discussions shall be completed in advance of anticipated deterioration or acute illness including surgery.

3.2 A valid Health Care Directive completed by a Patient shall be respected unless requests made within the Health Care Directive are not consistent with accepted health care practices.

3.3 The Health Care Team shall ensure that the Patient or Substitute Decision Maker receives full and complete information about the nature of the individual's current condition, prognosis, procedure/treatment/investigation options (i.e. all available interventions ranging from those least recommended to most recommended by the Health Care Team), and the expected benefits or burdens of those options. The Health Care Team shall ensure that such discussion precedes completion or revision of the "Advance Care Planning - Goals of Care" Form. The Health Care Team shall request the services of a trained health interpreter when Patients have limited English proficiency (refer to WRHA policy 10.40.210 Interpreter Services – Language Access, http://home.wrha.mb.ca/corp/policy/files/10.40.210.pdf)

3.4 This policy does not replace the requirements within the Policy 110.000.005 Informed Consent (for procedures, treatments and investigations): http://home.wrha.mb.ca/corp/policy/files/110.000.005_InformedConsentPolicy_July2007.pdf

3.5 The Health Care Team shall provide the Patient or Substitute Decision Maker with information describing resources within the health care system (e.g. Ethics, Social Work, Spiritual Care, Patient Representatives, Clinical Experts) available to assist them in addressing uncertainties and/or conflicts which may arise in the process of developing or revising a "Advance Care Planning - Goals of Care" Form.

3.6 The goal of the process is to achieve Consensus among the Health Care Team, Patient or Substitute Decision Maker. If Consensus cannot be reached, the "Advance Care Planning - Goals of Care" Form shall not be completed. In such situations, health care professionals will continue to be guided by the standards of practice of their respective regulatory bodies.

4.0 PROCEDURE:

4.1 If a Health Care Team member is made aware that a Health Care Directive exists, a copy shall 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. It shall guide further discussions as an indication of the Patient's wishes at the time of writing.

4.2 Advance Care Planning shall be 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 Personal Care Home (PCH), or through community based services. In some instances, this may be appropriate to do routinely on admission (e.g. PCH) or even prior to admission (e.g. in Pre-Operative Assessment Clinic). Timing is dictated by the clinical situation.

4.3 Advance Care Planning discussions shall occur in consultation with:

4.3.1 The Patient, if the patient has Capacity. If a Proxy has been named in a Health Care Directive, the Patient shall be reminded to consider whether having the Proxy participate in the development or revision of the "Advance Care Planning - Goals of Care" Form would be of value. The Patient may also choose others to participate.

4.3.2 The Substitute Decision Maker(s) as defined in 2.5 if the Patient lacks Capacity.

4.4 The Health Care Team shall engage the Patient and others, as appropriate, in the discussion regarding his/her Goals of Care. This process may require one discussion or several sessions of discussion over a period of time to achieve Consensus. Should the Health Care Team and the Patient or Substitute Decision Maker be unable to achieve Consensus as outlined in this policy, the resources available to the Health Care Team and the Patient or Substitute Decision maker may include:

- Ethics
- Spiritual Care
- Social Work
- Patient Representatives
- Clinical Experts
- Administration / Management

4.5 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 shall complete the Form.

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

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

4.8 The Health Care Team shall ensure that the existence of a Health Care Directive and / or "Advance Care Planning - Goals of Care" Form is noted on the Patient's care plan/kardex. Details of the Advance Care Planning discussion shall be documented on the "Advance Care Planning - Goals of Care" Form. If additional space is required to fully document these discussions, a progress note entry will be made. The date and time of the corresponding progress note entry will be documented on the "Advance Care Planning - Goals of Care" Form.

4.9 The Patient or Substitute Decision Maker shall be offered a copy of the completed "Advance Care Planning - Goals of Care" Form.

4.10 Upon transfer, the Health Care Team shall ensure a copy of the "Advance Care Planning - Goals of Care" Form accompanies the Patient.

4.11 The Goals of Care shall be 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 or Substitute Decision Maker
- at the request of the Health Care Team
- at minimum, the Goals of Care should be reviewed annually.

4.12 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 (examples: patient has requested no resuscitation and/or would not accept admission to an intensive care unit), the Health Care Team shall 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 such discussions shall be documented in the health care record. The “Advance Care Planning -Goals of Care” Form shall be revised as indicated.

4.13 If the Patient or Substitute Decision Maker requests a review of the Goals of Care, the Health Care Team shall respond within 72 hours or sooner if the Patient’s clinical status warrants more immediate attention.

4.14 When a review of Goals of Care does not result in a revision, the fact that a review occurred shall be noted on the “Advance Care Planning - Goals of Care” Form.

When a review of Goals of Care necessitates revision, the current “Advance Care Planning - Goals of Care” Form shall be voided by writing “NO LONGER IN EFFECT” diagonally across the form along with the date and signature of the Health Care Team member. The “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.

5.0 **REFERENCES**:

5.1 *Calgary Health Region. (2008). Goals of Care Designation Order*
5.2 *SBGH. (2004). Advance Care Planning regarding “End of Life” Care Policy*
5.3 *WRHA. (2003). Advance Care Planning Policy*
5.4 *American College of Surgeons. (1994). (ST-19). Statement on advance directives by patients: “Do not resuscitate” in the operating room. Retrieved October 12, 2010 from http://www.facs.org/fellows_info/statements/st-19.html*
5.5 *Canadian Anesthesiologists’ Society Committee on Ethics. (2002). Peri-operative status of “do not resuscitate (DNR) orders and other directives that limit treatment. Retrieved October 12, 2010 from http://www.cas.ca/members/sign_in/guidelines/do_not_resuscitate/*

Policy Contact: *Lori Lamont, WRHA Vice President & Chief Nursing Officer*