island health

Advance Care Planning:
making the **MOST** of **CONVERSATIONS**

Advance Care Planning (ACP) Notes and Conversations

CORE ELEMENTS OF ACP CONVERSATIONS:

1. **Introduce and/or review ACP (see back).**
2. **Learn about and understand the adult and what is important to them.**
3. **Clarify adult's understanding, answer questions and provide medical information about disease, prognosis, and treatment options.**
4. **Ensure interdisciplinary involvement and utilize available resources/options for care (ex. Palliative care, SW conference)**
5. **Define goals of care, document and create plan (including potential complications).**

Reviewed, Copy in Greensleeve:

Advance Care Planning Documentation:

- ☐ Representation Agreement
- ☐ Advance Directive (consent)
- ☐ Advance Care Plan (wishes)
- ☐ Other

Provider orders:

- ☐ Medical Orders for Scope of Treatment (MOST)
- ☐ Provincial NO CPR Order Form

Other:

- ☐ Committee of Person

Date of discussion dd/mm/yyyy	**Topic/core elements of conversation** (indicate #'s)	**Key decisions/next steps/outcomes of today's discussions are documented below.** Include any forms given to patient or forms completed If applicable, document details in the patient's health record	**Who was involved in today's discussion?** **e.g. patient, family, healthcare provider** Include name & relationship/discipline
Healthcare provider recording conversation (name and discipline)		Site	Signature
Healthcare provider recording conversation (name and discipline)		Site	Signature
Healthcare provider recording conversation (name and discipline)		Site	Signature

THIS DOCUMENT IS NOT TO BE USED AS A SOURCE OF CONSENT OR REFUSAL OF TREATMENT

This document resides in the Greensleeve.

01 - 01 - 102936 - 0 Island Health acknowledges Fraser Health as the author of this form adapted for use by Island Health

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GUIDELINES FOR USE:

1. This form is for use by all members of the health care team to document conversations related to ACP/goals of care.
2. Record who was involved in the conversation (client, family, substitute decision maker, and health care provider(s).
3. If applicable, document details of the conversation in the patient/client/resident's health record.
4. Record actions taken (e.g. Physician notified, Family conference scheduled).
5. Place this form (original) in the Greensleeve, located in the front section of the patient/client chart.
6. If a person is transferred make a copy of this document to send to the receiving site.
   On discharge give the adult a copy to share with their Health Care Providers.
7. If applicable, document that there is an active AGA (abuse or neglect) concern with a SDM which impacts their ability to act as a SDM.

CORE ELEMENTS:
ACP conversations are ongoing and include any combination of the five [5] Core Elements:

1. **S.P.E.A.K to adult about Advance Care Planning**

Determine if the adult has:

- Chosen a **substitute decision maker** (appointed a Representative if not , HCP appoints a TSDM)
- Thought about **preferences** for treatment options.
- Any previously **expressed wishes**
- Written an **Advance Directive**

Then assess the adult and/or SDM's:

- Level of **knowledge** regarding diagnosis, treatment options, risks and benefits.

2. **Learn about & understand the adult & what is important to him/her.**

- What does it mean to **live well**? What gives your life meaning? What fears/concerns do you have?
- What does quality of life mean to you?
- How has your changing health status impacted you and your family? Who or what gives you support in times of difficulty?

3. Clarify understanding & provide medical information about the disease progression, prognosis & treatment options.

- Diagnosis and implications now and in the future.
- Risks, benefits of treatment, information about diagnosis & prognosis.
- How might this disease progress (include discussion regarding resuscitation (CPR) and other life prolonging treatments.

4. Ensure interdisciplinary team involvement and utilize available resources

- Ensure process is interdisciplinary. Utilize available resources and expertise including MD, NP, Social worker and/or other community resources.
- If treatment is not available in current location, does the adult wish to be transferred from their current location?

5. Define goals of care, document & create plan

- Discuss specifics of plan of care & document summary of ACP, goals of care conversations.

WHO MAKES MEDICAL DECISIONS IN RANKED ORDER?

1. Capable adult (19 years of age or older):

2. Personal Guardian/Committee of Person (court-appointed) under the *Patients Property Act*

3. Representative under the *Representation Agreement Act* (Section 9 agreement required for life sustaining consent)

4. Advance Directive that was made after Sept 1, 2011 and is consistent with statutory requirements.

5. Temporary Substitute Decision Maker (TSDM); appointed by the Health Care Provider in the below order:

(a) The adult's spouse (incl. common law and/or same sex);
(b) The adult's children (equally ranked);
(c) The adult's parents (equally ranked);
(d) The adult's brothers or sisters (equally ranked);
(e) The adult's grandparent (equally ranked)
(f) The adult's grandchild (equally ranked)
(g) Anyone else related by birth or adoption to the adult
(h) A close friend of the adult
(i) A person related immediately to the adult by marriage
(j) Another person appointed by Public Guardian and Trustee

Qualifications of a TSDM: the adult must be 19 years of age or older, have had communication within the last 12 months with the adult and not be in dispute with the adult, be capable of giving, refusing or revoking substitute consent.

Duties of a substitute decision maker: Before giving or refusing substitute consent, the Substitute Decision Maker(s) must comply with any instructions or wishes the adult expressed while he or she was capable.

When no one from the ranked list of SDM's is available or qualified, or there is a dispute between two equally ranked substitutes that cannot be resolved by, the health care provider must contact a Health Care Decisions Consultant at the Public Guardian and Trustee at. 1.877.511.4111