ADVANCE CARE PLANNING
GOALS OF CARE FORM

ADDRESSOGRAPH

Refer to Southern Health-Santé Sud Policy
CLI.5910.PL.008 prior to completing this form.

Is there an existing Health Care Directive?..... ☐ Yes ☐ No
(If yes, it will guide further discussions as an indication of the individual's wishes at the time of writing)

Advance Care Planning (ACP) is the overall process of dialogue, knowledge sharing and informed decision making that needs to occur when future or potential life threatening illness, treatment options and Goals of Care are being considered or revisited. This form is used to record agreed upon Goals of Care reached through full and complete ACP discussions with the Patient/Resident/Client or Substitute Decision Maker about the nature of the individual's current condition, prognosis, treatment/procedural/investigation options, and expected benefits or burdens of those options.

GOALS OF CARE (Check the box that best describes the Patient's Goals of Care. See back of this form for definitions of terms used on this form, as well as ideas to guide a meaningful discussion about Advance Care Planning – Goals of Care)

☐ **C** **Symptom and Comfort Care** – Goals of Care and interventions are directed at maximizing comfort, symptom control and maintenance of quality of life *excluding* attempted resuscitation.
- Resuscitation is **not** undertaken.
- Life sustaining measures are used only to maximize comfort, symptoms and quality of life.

☐ **M** **Medical Care and Interventions, Excluding Resuscitation** – Goals of Care and interventions are for care and control of the patient's condition. The consensus is that the Patient may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered *excluding* attempted resuscitation.
- Resuscitation is **not** undertaken for cardio respiratory arrest.
- Life sustaining measures are used when appropriate.

☐ **R** **Medical Care and Intervention, including Resuscitation** – Goals of Care and interventions are for care and control of the patient's condition. The consensus is that the patient may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered *including* attempted resuscitation.
- Resuscitation is undertaken for acute deterioration.
- Life sustaining measures are used when appropriate.

☐ **PD** **Patient Declined Discussion about Goals of Care**

☐ **NC** **No Consensus –** unable to reach consensus (see details of discussion below)

Indicate all individuals who participated in Goals of Care discussion(s).

☐ Patient Print Name: _____

☐ Family Member(s) Print Name(s): _____

☐ Substitute Decision Maker(s) Print Name(s): _____

☐ Health Care Provider(s) Print Name(s): _____

Document details of the Patient specific instructions or wishes and/or details of discussion with the individuals indicated above. (Refer to date/time of Progress Note entry if more space is required):

Name & Designation of Health Care Provider	Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee)	DAY-MONTH-YEAR

The Goals of Care were reviewed with the Patient or Substitute Decision Maker and no change in the form is required.

Name & Designation of Health Care Provider	Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee)	DAY-MONTH-YEAR

If review results in any changes to the Patient Goals of Care, a new form must be completed.

PROVIDE COPY OF COMPLETED FORM TO PATIENT/CLIENT/RESIDENT OR SUBSTITUTE DECISION MAKER

Definitions

Resuscitation: means the initial effort undertaken to reverse an acute deterioration in the patient's vital signs. This may include chest compressions for pulselessness, mechanical ventilation, cardioversion, pacing and intensive medications.

Life sustaining measures: mean therapies that sustain life without supporting unstable physiology. Such therapies can be used in multiple clinical circumstances. When viewed as life sustaining measures, they are offered either in (a) the late stages of an illness to provide comfort or prolong life, or (b) to maintain certain bodily functions during the treatment of intercurrent illnesses. Examples include tube feeding and parenteral hydration.

Just Ask – Talking to Patients/Clients/Residents, Families and Substitute Decision Makers about Advance Care Planning

Consider Asking:

- **What do you understand about your illness, prognosis, your planned treatment (e.g. surgery) or what's happening to you?**
  - Offer to provide your view of the illness, disease process, expected outcomes etc.
  - Check who they may want present for this conversation.

- **What do you understand about treatments or procedures that may be offered relevant to your illness/disease?**
  - Offer to explain treatments which may or are being offered, such as; cardiopulmonary resuscitation, dialysis, feeding tubes, intravenous line, chemotherapy, tracheostomy, transfusion, or ventilation.
  - Clearly explain expected benefits and burdens associated with each option.
  - Each option may not apply to the patient/client/resident, but represent common treatment decisions that people find difficult to make or have not carefully considered.

- **What types of treatments do you want provided in different situations, such as during a surgery?**

- **If we need to make decisions about your care and you were unable to speak for yourself, whom would you want me to speak to about your care?**
  - Leads to natural exploration of role of the Substitute Decision Maker and need for someone.

- **Have you talked to your Substitute Decision Maker (or anyone else) about your wishes or preferences for health care that may come up? May I ask what you discussed?**
  - Explore discussions with family, Substitute Decision Maker, other health care providers.