Team Name: Regional Palliative Care Team Team Lead: Regional Director – Seniors, Palliative Care & Cancer Care Approved by: Executive Director – East	Reference Number: CLI.5910.PL.008 Program Area: Palliative Care Policy Section: General
Issue Date: January 10, 2016 Review Date: Revision Date: September 27, 2019	Subject: Advance Care Planning – Goals of Care

Use of pre-printed documents: Users are to refer to the electronic version of this document located on the Southern Health-Santé Sud Health Provider Site to ensure the most current document is consulted.

POLICY SUBJECT:
Advance Care Planning – Goals of Care

PURPOSE:
To help the health care team best understand the patient's/client's/resident's goals of care allows and best align the care provided to what is most important to the patient.

To ensure the Goals of Care of the patient/client/resident are identified and addressed through a collaborative ongoing process.

To promote a standardized regional approach to Advance Care Planning (ACP) – Goals of Care.

ACP – Goals of Care is a valued process of communication. There may be occasions when consensus cannot be reached. This policy is not intended to address situations of unresolved conflict other than to encourage continued dialogue.

BOARD POLICY REFERENCE:
Executive Limitation 2: Treatment of Clients

POLICY:
1. Southern Health-Santé Sud values and respects every individual at every stage of life. This includes the individual's inherent right to make choices and decisions about health care based on the individual's values and beliefs, and to accept or refuse medical care or treatment

2. Determining ACP – Goals of Care is an ongoing process of communication between the Patient/Client/Resident/Substitute Decision Maker and the Health Care Team.
3. The Health Care Team is responsible for initiating the discussion regarding ACP – Goals of Care.
4. Discussions about ACP – Goals of Care are completed in advance of anticipated deterioration of health status or acute illness including surgery, in all care settings (acute care, transitional centres, home care, primary care, palliative care, or personal care homes).
5. A valid Health Care Directive completed by the patient is respected unless the requests made within the Health Care Directive are not consistent with accepted health care practices.
6. The Health Care Team ensures that the Patient/Client/Resident/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 those most recommended by the Health Care Team) and the expected benefits or burdens of those options. The Health Care Team will endeavor to request the services of a trained health interpreter when clients have limited English proficiency in accordance with the policy: *Interpreter Services – Language Access* (ORG.1010.PL.002).
7. This policy does not replace the requirements for informed consent.
8. The Advance Care Planning – Goals of Care Form (CLI.5910.PL.008.FORM.01) describes the Patient's/Client's/Resident's/Substitute Decision Maker's wishes at the time it is completed.
9. The Health Care Team provides the Patient/Client/Resident/ Substitute Decision Maker with information describing resources within the health care system (e.g. Ethics, Social work, Spiritual Care) available to assist them in addressing uncertainties and/or conflicts which may arise in the process of developing or revising the individual's Goals of Care.
10. The patient's/client's/resident's ACP – Goals of Care are discussed:
    a. Whenever the Patient's/Client's/Resident's clinical status changes significantly;
    b. At the request of the Patient/Client/Resident/Substitute Decision Maker;
    c. Annually; and
    d. On or shortly after transfer to another health care facility or program.
11. The ACP – Goals of Care discussion is documented in the progress notes and a new form is completed as necessary.
12. The goal of the process is to achieve understanding of the patient's/client's/resident's wishes. If those wishes are inconsistent with accepted health care practices, ongoing discussions are necessary in an attempt to reach consensus. These are recorded on the ACP – Goals of Care Form and in the progress notes if more space is required. Health care professionals will be guided by the standards of practice of their respective regulatory bodies.

DEFINITIONS:

Advance Care Planning	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.
Advance Care Planning – Goals of Care Form	The form available across the region and used to document Goals of Care as reached through an Advance Care Planning discussion.
Collaborative Process	When the Health Care Team engages in joint planning for the care of the Patient/Client/Resident with shared responsibility and decision making that includes the Patient/Client/Resident/Substitute Decision Maker.
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 a decision. A person may have capacity respecting some treatments and not others and may have the capacity respecting a treatment at one time and not at another. In a clinical setting a request for assessment of capacity is the same as a request for assessment of competency.
Committee	A person, or persons, including the Public Trustee, appointed by a Court or the Chief Provincial Psychiatrist pursuant to *The Mental Health Act* under an Order of Committeeship to manage the personal and/or financial affairs of an incompetent person.
Consensus	General agreement and the process of getting to such agreement.
Goals of Care	The intended purposes of health care interventions and support as recognized by both a Patient/Client/Resident/Substitute Decision Maker and the Health Care Team.
Health Care Directive	The Health Care Directives Act recognizes that mentally capable individuals have the right to consent or refuse to consent to health care treatment. Further, the Act indicates that this right should also be respected after individuals are no longer able to participate in decisions respecting their health care treatment. A Health Care Directive is a self-initiated form 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 individual would consent or refuse to consent 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.
Health Care Team	Refers to the health care professionals and support staff that are directly involved with the Patient's/Client's/Resident's care.
Patient/Client/Resident	Any individual that is the recipient of health care services.
Substitute Decision Maker	A Substitute Decision Maker refers to a third party identified to participate in decision-making on behalf of a person 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 interests of the individual lacking capacity. The following, in order of priority, may act as Substitute Decision Makers: 1. The proxy appointed by the individual under *The Health Care Directives Act;* 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 person has authority to make health care decisions; 3. A parent or legal guardian of the individual, if the individual is a child; 4. A spouse with whom the individual is co-habiting or a common-law partner; 5. A son or a daughter; 6. If the individual is an adult, a parent of the individual; 7. A brother or a sister; 8. A person with whom the individual is known to have a close personal relationship; 9. A grandparent; 10. A grandchild; 11. An aunt or uncle; 12. A nephew or niece.

IMPORTANT POINTS TO CONSIDER:

- ACP – Goals of Care forms and Health Care Directives do not take the place of discussion with the patient/resident/client or their substitute decision maker when care decisions need to be made. These documents generally provide a broad direction and should be used to guide discussions about care.
- Health care providers should be careful not to assume that they understand everything about what the patient/resident/client wants based on the broad ACP care designation.
- The ACP – Goals of Care Form does not replace a Health Care Directive and/or a Notification of Anticipated Death at Home Form (CLI.5910.PL.005.FORM.01) in the community.

PROCEDURE:

1. Designate a member of the Health Care Team to initiate the discussion about ACP – Goals of Care with the Patient/Client/Resident or Substitute Decision Maker.
2. If a Health Care Team member is made aware that a Health Care Directive exists, a copy is obtained and filed in the health record, or scanned into an electronic health record. The Health Care Directive guides further discussions as an indication of the Patient's/Client's/Resident's wishes at the time of writing.
3. ACP – Goals of Care discussions are 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 (e.g. Home Care, or Palliative Care). In some instances, this may be appropriate to do routinely on admission (e.g. PCH) or even prior to admission (e.g. in a Pre-Operative Assessment Clinic). Timing is dictated by the clinical situation.
4. ACP – Goals of Care discussions occur in consultation with:
   4.1. The Patient/Client/Resident, if the individual has capacity. If a proxy has been named in the Health Care Directive, the Patient/Client/Resident is 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/Client/Resident may also choose others to participate.
   4.2. The Substitute Decision Maker (as outlined in the definition above) if the Patient/Client/Resident lacks capacity.
      - When the Patient/Client/Resident lacks capacity and has a Substitute Decision Maker:
        - Involve the Patient/Client/Resident as much as possible within their cognitive ability;
        - If the Patient/Client/Resident is under the Public Trustee, the Public Trustee may request completion of the Public Trustee's Form 3-F-5 F1: Request for Consent for Do Not Resuscitate Orders; Goals of Care, Comfort Care Orders and Withholding Treatment. If completion of this form is requested, the attending physician must review and sign the form. The completed, signed

form is then forwarded to the Public Trustee. The form is obtained from the Public Trustee.
    - Document who participated in and the outcome of all discussions in the Patient's/Client's/Resident's health record.

4.3. When the Patient/Client/Resident lacks capacity and does not have a Substitute Decision Maker:
- Involve the Patient/Client/Resident as much as possible within their cognitive ability;
- Consult with the Patient/Client/Resident, as appropriate and nearest relative(s) to identify a Substitute Decision Maker.
- If the Patient/Client/Resident and nearest relative(s) are unable to identify a Substitute Decision Maker, the Health Care Team will identify a Substitute Decision Maker. Ideally, this is done in consultation with the nearest relative(s). For the Health Care Team to feel confident in identifying a Substitute Decision Maker within this category, it will be necessary, within reason to:
    - Understand relationships, dynamics, hierarchy and values;
    - Ascertain that there exists acceptance from involved nearest relatives in the designation of the Substitute Decision Maker;
    - Clarify as necessary the role of the Substitute Decision Maker in the determination of ACP – Goals of Care for all interested parties.

5. The Health Care Team engages the Patient/Client/Resident and others, as appropriate, in the discussion regarding their Goals of Care.
    - Questions to prompt a discussion can be found on the back of the ACP – Goals of Care Form.
6. The Health Care Team provides the Patient/Client/Resident/Substitute Decision Maker with the handout "Advance Care Planning – Sharing Your Wishes" (CLI.5910.PL.008.SD.01).
7. Should the Health Care team and the Patient/Client/Resident 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/Client/Resident or Substitute Decision Maker may include:
    - Ethical Decision Making Framework (ORG.1810.PL.005)
    - Spiritual Care
    - Social Work
    - Clinical Experts
    - Administration/Management
8. A member of the Health Care team documents the patient's/client's/resident's broad Goals of Care and discussion on the ACP – Goals of Care Form.
9. When the Patient/Client/Resident is a client of the Public Trustee, a physician's signature is required. The physician is required to communicate either verbally or in writing directly with the Public Trustee.
10. The completed ACP – Goals of Care Form is filed in the Patient's/Client's/Resident's health record, along with a copy of the current Health Care Directive, if available.
11. The Health Care Team documents the existence of a Health Care Directive or ACP – Goals of Care Form on the Patient's/Client's/Resident's care plan.

12. Details of the ACP – Goals of Care discussion should 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.
13. The Patient/Client/Resident or Substitute Decision Maker is offered a copy of the completed ACP – Goals of Care Form.
14. Upon transfer, the Health Care Team:
    14.1. Ensures a copy of the Advance Care Planning – Goals of Care Form accompanies the Patient/Resident/Client. The original Advance Care Planning – Goals of Care Form is maintained as part of the health record.
    14.2. Ensures a copy of an existing Health Care Directive accompanies the Patient/Resident/Client if the Health Care Team is in possession of a copy of the Health Care Directive. If the Health Care Team does not have a copy of an existing Health Care Directive, it is the Patient's/Client's/Resident's/Substitute Decision Maker's responsibility to provide a copy to the Health Care Directive to other care providers.
15. The ACP – Goals of Care are discussed and revised as necessary:
    - On each admission;
    - Whenever there is an unanticipated significant improvement or deterioration in the Patient's/Client's/Resident's clinical status;
    - On or shortly after transfer to another facility;
    - At the request of the Patient/Client/Resident or Substitute Decision Maker;
    - At the request of the Health Care Team; and
    - Annually, at minimum.
16. For Patients/Clients/Residents who are undergoing a procedure that requires general/regional anesthesia (i.e. blocks/spinal) or 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 initiates a discussion with the Patient/Client/Resident or Substitute Decision Maker regarding the response to potential life-threatening problems that may occur during the perioperative period. The results of such discussions are documented in the health care record. The ACP – Goals of Care Form is revised as needed.
17. If the Patient/Client/Resident or Substitute Decision Maker requests a review of the ACP – Goals of Care, the Health Care Team responds within 72 hours or sooner if the Patient's/ Client's/Resident's clinical status warrants more immediate attention.
18. When a review of ACP – Goals of Care does not result in a revision, the fact that a review occurred is documented on the ACP – Goals of Care Form.
19. When a review of ACP – Goals of Care necessitates revision, the current ACP – Goals of Care Form is voided by writing "NO LONGER IN EFFECT" diagonally across the form along with

the date and signature of the Health Care Team member. The ACP – Goals of Care Form that is no longer in effect is retained in the permanent health record.

SUPPORTING DOCUMENTS:

CLI.5910.PL.008.FORM.01	Advance Care Planning – Goals of Care Form
CLI.5910.PL.008.SD.01	Advance Care Planning – Sharing Your Wishes

REFERENCES:

ORG.1010.PL.002 *Interpreter Services – Language Access*

CLI.5910.PL.005.FORM.01 *Notification of Anticipated Death at Home Form*

ORG.1810.PL.005 *Ethical Decision Making Framework*

CancerCare Manitoba (2016). *Advance Care Planning – Goals of Care Form (Draft).*

Manitoba Health (2016). *Health Care Directive (Living Will).* Available on-line: http://www.gov.mb.ca/health/livingwill.html. Retrieved 23 July 2019.

National Advance Care Planning Task Group (2016). *Speak Up Campaign*. Available on-line: http://www.advancecareplanning.ca/. Retrieved 23 July 2019.

Winnipeg Health Region (2011). *Advance Care Planning – Goals of Care Policy.*

Winnipeg Health Region (2016). *Think about it, Talk about it, Share it Campaign*. Available on-line: http://www.wrha.mb.ca/acp/index.php. Retrieved 23 July 2019.