TITLE: Decision Making and Planning

Topic: 7

Planning and decision making about a person's health can be difficult to discuss. Decision-making can be more complicated and distressing at end of life if the goals of care have not been addressed earlier in the illness trajectory.

The idea of patient/personal autonomy is an important concept for most people especially when facing end of life decisions. The most effective way to ensure that a person's wishes are forefront in decision-making is to discuss them in advance and document them clearly.

There can be confusion related to many of the terms we use associated with advance care planning. There are 2 government or regional health authority forms that are meant to document both the goals of care and to name a person(s) that can speak to health care decisions on your behalf if you are unable to do so.

Health Care Directive (document)

- AKA, "living will", "advanced care directive"
- Documents the health care proxy or substitute decision maker(s).
- Documents specific interventions that a patient does or does not want.
- This document must be signed and dated but does not have to be witnessed.
- http://www.gov.mb.ca/health/documents/hcd.pdf

Advance Care Planning/ Goals of Care (document)

- A regional health authority form that is completed when a patient enters care.
- This form should be updated regularly as the patient's status changes.
- ACP is a process that involves dialogue, knowledge sharing and informed decision making that needs to occur at any time when future or potential life-threatening treatment options and goals of care are being considered or revisited.

GOALS OF CARE (Check the box that best describes the Patient/Resident/Client Goals of Care)

C = Comfort Care - Goals of Care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life ***excluding*** attempted resuscitation.

M = Medical Care - Goals of Care and interventions are for care and control of the Patient/Resident/Client condition. The Consensus is that the Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered ***excluding*** attempted resuscitation.

R = Resuscitation – Goals of Care and interventions are for care and control of the Patient/Resident/Client condition. The Consensus is that the Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered ***including*** attempted resuscitation.

http://www.wrha.mb.ca/professionals/acp/

http://www.wrha.mb.ca/professionals/acp/video06.php

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