Identifying Information:

ADVANCE CARE PLANNING (ACP) RECORD

For use by all members of the health care team

Patient Name: _____

Physician(s): _____

☐ Advance Care Planning conversation initiated: _____ _____

Date Signature

Guidelines for Use: (continued on back of form)

1. This form is for use by all members of the health care team (e.g. nurses, counsellors, physicians) as a written communication tool to record information relevant to advance care planning. This could include: conversations about the patient's health status, goals, values, wishes, withholding / withdrawing support, comfort care, etc.
2. Discussions with patient, family and/or substitute decision maker are documented, along with the subsequent action taken (e.g. Physician notified, or *'So You've Been Diagnosed with Cancer' and/or 'My Voice'* Guide introduced).
3. This form is placed in the green sleeve (green page protector) behind the ORDERS and with other advance care planning documents. All Advance Care Planning records are to remain in the green sleeve, and are to be reviewed at each visit/admission with changes in health status, or more frequently as determined by the program/team.

Advance care planning conversations with patient, family or substitute decision maker

Date	Brief summary of ACP discussion/focus	Action	Staff Name

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Identifying Information:

Guidelines for Use: (continued)

- Before initiating conversations, please ask if '*So You've Been Diagnosed with Cancer' and/or* '*My Voice'* Guide was previously provided. Ask to obtain copies of previous Goals of Care, Provincial No CPR, ACP Record, Advance Care Plan, Advance Directive, or Representation Agreement. Review and place in the **GREENSLEEVE**
- On transfer, the **GREENSLEEVE** contents accompany the adult.
- On discharge, retain the chart copy; give a copy of the ACP record to the adult. With consent from the adult or substitute decision maker, fax a copy to family physician. In primary care, give a copy of ACP record to the adult.

CORE ELEMENTS:

ACP conversations are ongoing and may 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/Temporary Decision Maker** (Representative appointed or TSDM)
   - Thought about **Preferences** for treatment options.
   - Any previously **Expressed Wishes** (e.g. Advance Care Plan, Living Will)
   - Written an **Advance Directive** (Instructions) appointed or Representative

   Then assess the adult and/or SDM's:
   - Level of **Knowledge** regarding diagnosis, treatment options, risks and benefits.
2. **Learn about and understand the adult and what important to them. Involve Substitute Decision Maker(s).**
   Possible questions to ask:
   - What does it mean to live well? What gives your life meaning?
   - What does quality of life mean to you? Tell me your thoughts about quality of life.
   - What fears/concerns do you have?
   - How has your changing health status impacted you and your family? What is acceptable risk?
   - Who or what gives you support in times of difficulty?
3. **Clarify understanding and provide medical information about the disease progression, prognosis and treatment options.**
   What is the medical assessment?
   - Diagnosis and implications now and in the future
   - Expected prognosis: Months to years? Weeks to months? Days to weeks? Hours to days?
   - How might this disease progress (include discussion regarding resuscitation (CPR) and other life prolonging treatments (dialysis, tube feeds, ventilation support, etc.)
   - What are the expected benefits and burdens of treatment?
4. **Ensure interdisciplinary involvement and utilize available resources.**
   - Ensure process is interdisciplinary. Utilize available resources and expertise including MD, NP, Social work, Palliative Care, Community resources (Alzheimer's, Parkinson's or Hospice Society)
   - If treatment is not available in current location, does the adult wish to be transferred from their current location? Options may include acute care, hospice residences, residential care and home.
5. **Define goals of care, document and create plan**.
   - Discuss specifics of plan to ensure understanding of possible complications and how to manage them.
   - If goal may not be attainable, what are the alternatives?

WHO MAKES MEDICAL DECISIONS?

(1) Capable Adult (19 years of age or older); ALWAYS first if adult is able to provide consent
(2) Personal Guardian/Committee of Person (court-appointed) under the *Patients Property Act*

ONLY IF the adult is no longer able to provide informed consent then BC's hierarchical healthcare decision making list as dictated by provincial law for substitute consent applies. To obtain substitute consent to provide major or minor health care to an adult, a health care provider must choose the first, in listed order, of the following who is available and qualifies as dictated by BC provincial law for substitute consent.

(3) Representative: under the Representation Agreement Act (Section 9 - agreement required for life sustaining consent)
(4) Advance Directive (if no Representative is appointed) **
(5) Temporary Substitute Decision Maker: If there is no Representative or Committee of Person, under the Adult Guardianship and Planning Statues Amendment Act, a health care provider must choose the nearest relative as ranked below:
   (a) The adult's spouse (common law, 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 grandparents (equally ranked)
   (f) The adult's grandchildren (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

Duties of a substitute decision maker: A person chosen to give or refuse substitute consent to health care for an 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. Before giving or refusing substitute consent, the SDM(s) must comply with any instructions or wishes the adult expressed while she or he was capable.

When no one from the ranked list of substitute decision makers is available or qualified or there is a dispute between two equally ranked substitutes that cannot be resolved by the health care provider, the health care provider must contact a Health Care Decisions Consultant at the Public Guardian and Trustee at 1-877-511-4111