BC CANCER
Provincial Health Services Authority

GOALS OF CARE (GOC) ORDERS

To be completed by physician

SECTION ONE: CODE STATUS: IF ADULT HAS NO PULSE AND IS NOT BREATHING

☐ **Attempt CPR (**Cardiopulmonary Resuscitation**), Full Code.**

☐ **Do Not Attempt** Cardiopulmonary Resuscitation **(DNACPR: no chest compressions or other direct means of restarting the heart). Please initial below.**

SECTION TWO: GOALS OF CARE ORDER BASED ON DOCUMENTED CONVERSATIONS (initial appropriate level)

1	**No CPR, No Intubation, Supportive Care**	No CPR, supportive care, symptom management, continued management of chronic conditions, and comfort measures. Allow natural death.
2	**No CPR, No Intubation, Therapeutic Care**	No CPR. Option 1 plus therapeutic measures and medications to manage acute conditions within the current setting.
3	**No CPR, No Intubation, Acute Transfer,**	No CPR. Option 2 plus admission to an acute care hospital (if not already admitted) for medical/surgical treatment as indicated. No referral to Critical Care.
4	**No CPR, No intubation, Critical care**	No CPR. Maximum therapeutic effort as in Option 3 including referral to Critical Care but not intubation and ventilation.
5	**No CPR, May intubate, Critical care**	No CPR. Maximum therapeutic effort as in Option 4 including referral to Critical Care and including intubation and ventilation.

SECTION THREE: DURING CHEMOTHERAPY

IF DURING CHEMOTHERAPY ADULT HAS NO PULSE AND IS NOT BREATHING:

☐ Waive DNR for duration of chemotherapy infusions**, attempt *CPR***

☐ Do Not Attempt Cardiopulmonary Resuscitation ***DNR***

SECTION FOUR: GOALS OF CARE ORDER WRITTEN AS A RESULT OF: (check all that apply)

☐ Conversations/Consensus

- ☐ Capable adult
- ☐ Representative Name:_____Date:_____
- ☐ Temporary Substitute Decision Maker (TSDM) Name:_____Date:_____

☐ Physician Assessment

☐ Supporting Documentation:

- ☐ Representation Agreement (see over) Name:_____Date:_____
- ☐ Advance Directive: (see over) Date:_____
- ☐ Other Goals of Care Order eg. Fraser Health MOST
- ☐ Provincial No Cardiopulmonary Resuscitation Form Date:_____

☐ copy to patient ☐ copy to GP

Date (dd/mm/yr): Physician Signature: Print name:

Guidelines for Advance Care Planning Discussions: (back/p.2 of Goals of Care Orders form)

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