calgary health region

REGIONAL POLICY

Subject/Title: **ADVANCE CARE PLANNING: GOALS OF CARE DESIGNATION (ADULT)**		Former Reference: **1440** Resuscitation (Adults); **1452** Resuscitation of Residents in Continuing Care	POLICY NO. **NEW**
		Effective Date: **JULY 2008** **NB: HOLD PENDING IMPLEMENTATION – NOV. 08**	Revised Date:
Approving Authority: EXECUTIVE MANAGEMENT		Last Review:	Next Review:
Classification: **CLINICAL**	Category: PATIENT RIGHTS, PRIVACY, AND PROTECTION	Page: 1	

REASON FOR POLICY

To standardize the processes for:
- Advance Care Planning and Goals of Care;
- Communication and documentation of Advance Care Planning and Goals of Care decisions; and
- Dispute resolution mechanisms regarding these issues.

POLICY STATEMENT

The Calgary Health Region ("the Region") respects human dignity by providing care that is clinically and ethically appropriate and, through Advance Care Planning, seeks to understand Patient values regarding care choices. The Region will utilize Goals of Care Designation Orders (see Appendix "A") to guide care decision-making about specific interventions, such as transfer to an Acute Care facility and Life Support Interventions, throughout the Region's adult health care sectors.

An Order reflecting the Goals of Care Designation shall be documented on the health record of every Patient receiving care and treatment in a Region-owned or contracted Acute Care facility, Long Term Care facility, Designated Assisted Living (Supportive Living) and Hospice Care facility. Goals of Care Designations are determined through respectful discussion between every Patient with whom such a conversation may be clinically relevant, and the members of the Patient's health care team.

A Goals of Care Designation decision shall be discussed with the Patient in the spirit of open communication. In the event of distress or dispute in reaching a Designation decision, the Patient should be made aware of decision support and dispute resolution resources that are available (see Section 8 and Appendix "B"). A clinically relevant Goals of Care Designation Order may be written by the Most Responsible Health Professional (or designate) without the agreement of the Patient regarding the selected Designation; however, this circumstance is considered the exception and shall adhere to the processes defined in this policy.

The Region supports Advance Care Planning and use of the Goals of Care Designation Order for Patients who receive care and treatment in a Region-owned or contracted Personal Care Home (Supportive Living), or under the Region's Home Care Program.

If a Goals of Care Designation is not documented on a Patient's health record, then appropriate Life Support Interventions are provided, unless it is known that the Patient has specifically refused such Interventions.

APPLICABILITY

This policy applies to all staff (including employees, independent contractors, medical, dental, podiatry, and midwifery staff), students, volunteers, contracted service providers and other persons acting on behalf of the Region. The provisions of this policy are for the benefit of adult Patients who receive care and treatment within the Region's care programs as defined in the policy and for Patients' family and/or Representative(s).

PROCESS

1. Advance Care Planning Goals of Care

There are two primary roles for the Advance Care Planning Goals of Care Designation: (a) to serve as a communication tool for health care professionals to assist in rapid decision making in times of crisis; and (b) to guide health care professionals and Patients regarding the locations and general intentions of the care and interventions that are to be provided. While a Designation Order is prescriptive under most circumstances, if new circumstances or health issues arise, it is crucial that the Goals of Care Designation be reviewed in order to validate its sustained relevance, or demonstrate a need to re-examine choices that would lead to a new Goals of Care Designation.

2. Goals of Care Designation

Goals of Care Designations are Region-wide. Detailed descriptions of the Goals of Care Designations, and important clinical features embedded in them, are included in Appendix "A" of this policy. Any change to the Region's Designation categories shall be coordinated through the Regional administrative structure(s) designated by the Region's Chief Clinical Officer.

3. Goals of Care Conversations

3.1 Advance Care Planning and Goals of Care conversations shall take place early in a Patient's course of care and/or treatment. These discussions explore Patients' wishes and goals for treatment framed within the therapeutic options that are appropriate for their condition. A Personal Directive may exist and a reasonable effort shall be made to obtain it in order to inform conversations regarding Goals of Care.

3.2 Conversations about Goals of Care are undertaken with the Patient or, if the Patient lacks Capacity to make such decisions, with the Patient's Representative (see also Consent for Treatment policy). If the Patient's Representative cannot be contacted or if no Representative is known to exist, conversations may include family members and informal caregivers who are known to be significant to that Patient.

3.3 Any member of a Patient's health care team may initiate and undertake an advance care planning Goals of Care conversation. The Most Responsible Health Professional, however, is ultimately responsible for the discussion and documentation of the clinically relevant Goals of Care Designation Order. In collaboration with other members of the health care team, the Most Responsible Health Professional (or designate) shall ensure that Advance Care Planning Goals of Care discussions include:

- the Patient's prognosis and the anticipated outcomes of current treatment;
- exploration of the Patient's values, understanding, hopes, wishes and expected outcomes of treatment;
- the role of Life Support Interventions and/or Life Sustaining Measures and their expected Degree of Benefit;

- information regarding comfort measures;
- an offer for involvement of Regional resources such as the palliative care program, social work, clinical ethics consultation, or spiritual care to assist the Patient with his/her needs; and
- documentation of pertinent details of this communication in the Patient's health record.

3.4 In a time sensitive health crisis, if there are no expressed wishes by the Patient in regard to Goals of Care Designation, the Most Responsible Health Professional, in consultation with members of the health care team, shall assess the potential benefits and harms of Life Support Interventions and initiate the most clinically relevant Goals of Care Designation Order.

3.4.1 In the event that the Most Responsible Health Professional is not available to provide an Order for intervention or withholding of intervention during a time sensitive health crisis, the Patient will receive available Life Support Interventions, including transportation to a facility that can provide assessment to determine appropriate care.

3.5 Attempts to reconcile any disagreement regarding the Goals of Care Order shall follow the dispute resolution process set out in Section 8 of this policy.

4. Personal Directive or Patient Request

4.1 Where a Patient's Personal Directive is known to exist, staff shall make reasonable effort to obtain a copy for placement on the health record (see also Personal Directives policy #1407).

4.2 During care provision within the health care sectors defined in this policy, the Most Responsible Health Professional (or designate) shall be notified of the following when clinically relevant:

- when a Patient makes a request limiting Life Support Interventions*;* or
- a Personal Directive contains clear and relevant instructions requesting limits to Life Support Interventions.

4.3 In the circumstance that a known Personal Directive or Patient request includes a limit on care and treatment, it is the Most Responsible Health Professional's (or designate's) responsibility to promptly translate such preferences into a relevant Goals of Care Designation Order, after discussing these limitations with the Patient, where possible. If a Goals of Care Designation Order is not available, the requests to limit care and treatment as outlined in a Personal Directive, or which has been expressed by the Patient, shall be followed, notwithstanding the provisions included in 4.4 below.

4.4 Where the provisions of a Personal Directive or a Patient gives clear and relevant instructions requesting interventions that Certainly will not Benefit, those interventions are not provided (See also Decision Support and Dispute Resolution Resources, Section 8).

5. Documentation of the Goals of Care Designation

5.1 A Goals of Care Designation Order shall be written by the Most Responsible Health Professional and documented on the Patient's health record. The conversation about the Goals of Care held with the Patient shall be clearly documented on the health record.

5.2 The Goals of Care Designation Order shall be placed in a prominent location on the Patient's health record in a timely manner. This includes:

a) Acute Care Facility – with admission orders;
b) Emergency Department – When a Goals of Care Designation Order is clinically relevant, or with admission orders for a holding bed;
c) Long Term Care – within forty-five (45) days of admission;
d) Designated Assisted Living (Supportive Living) – within ninety (90) days of admission
e) Hospice facilities – with admission orders;
f) Outpatient and day surgery or assessment clinics – accompanying any orders for planned interventions in which a Goals of Care Designation is clinically relevant.

5.3 Documentation of Goals of Care Designation Orders in the health record of Patients in Home Care, and Personal Care Homes (Supportive Living) is not mandatory. However, best efforts should be undertaken to have such Patients receive the benefit of Advance Care Planning conversations, and to have a Goals of Care Designation determined and documented by the Most Responsible Health Professional.

6. Goals of Care Designation Across the Continuum of Care

6.1 When a Patient is transferred between sectors of care within the Region, or between services within a Regional facility, the Goals of Care Designation Order completed at the sending location of care shall remain in effect until reviewed by the Most Responsible Health Professional (or designate) in the receiving location of care. The review shall take place within forty-five (45) days of admission to Long Term Care, and within ninety (90) days of admission to Supportive Living Care (Designated Assisted Living, Personal Care Home).

6.2 When a Patient is discharged from an Acute Care facility, the Goals of Care Designation Order completed during admission shall be included in the discharge summary and forwarded to the community physician (where known) and, where applicable, to the Home Care team or receiving facility.

6.3 Tools for Advance Care Planning and the Goals of Care Designation information will be made available to the community at large. The Goals of Care Designation order issued in the community will be recognized by the Region when Patients receive Regional services.

7. Review of Goals of Care Designation Orders

7.1 A Patient's Goals of Care Designation Order shall be reviewed at the request of the Patient, after transfer, or if there is a significant change in the Patient's condition or circumstances that may be relevant to the Goals of Care.

7.2 A Goals of Care Designation Order shall continue in effect until revoked or renewed. Goals of Care Designation Orders shall be reviewed and renewed at least every thirty (30) days for Patients in an Acute Care facility, or as soon thereafter as reasonably practical. Patients who receive Home Care, Long Term Care, or Supportive Living Care (Designated Assisted Living, Personal Care Home) shall have their Goals of Care Designation Order reviewed and renewed when such an Order exists, at least every twelve (12) months.

7.3 Discussion with the Patient for review and renewal of the Goals of Care Designation Order is based on the clinical judgement of the Most Responsible Health Professional. Changes in a Patient's Designation Order shall be discussed with the Patient.

8. Goals of Care Designation Decision Support and Dispute Resolution

When circumstances bring significant complexities, decision support may be required. In the event that there is uncertainty, distress, or disagreement regarding the appropriateness of Life Support Interventions, or the Goals of Care Designation, whether between the Patient and Most Responsible Health Professional, or the Patient and members of the health care team, or among the members of the Patient's health care team, the steps outlined in Appendix "B" –Decision Support and Dispute Resolution Resources Related to Advance Care Planning and Goals of Care Designations shall guide decision support and dispute resolution. The Most Responsible Health Professional (or designate) shall ensure that the Patient is informed of, and has access to, the avenues of decision support and dispute resolution.process.

When the avenues of decision support and dispute resolution as set out in Appendix "B" have been explored, including consultation with the designated medical administrator, if the disagreement or dispute regarding a Patient's Goals of Care Designation remains, the Most Responsible Health Professional (or designate), in his/her professional judgement, may issue a clinically relevant Goals of Care Designation Order.

DEFINITIONS

For the purposes of this policy and Appendix "A" and "B":

Acute Care means care provided in a health facility understood to be part of the Region's Acute Care sector.

Advance Care Planning means a process by which people can think about their values regarding future health care choices; explore medical information that is relevant to their health concerns; communicate wishes and values to their loved ones, their Representatives and their health care team; and record those choices.

Capacity means the ability to understand the information that is relevant to the making of a personal decision, and the ability to appreciate the reasonably foreseeable consequences of the decision.

Cardiopulmonary Resuscitation (CPR) means the act of chest compressions initiated in response to pulselessness.

Goals of Care means the intended purposes of health care interventions and support as recognized by a Patient, health care team, or both.

Goals of Care Designation is a letter/number code that provides direction regarding specific health interventions, transfer decision, locations of care, and limitations on interventions for a Patient as established after consultation between the Most Responsible Health Professional and Patient (see Appendix "A").

Goals of Care Designation Order means the documented order for the Goals of Care Designation as written by the Most Responsible Health Professional (or designate).

Home Care means care and services provided in a community setting and delivered through the Region's Home Care Program.

Hospice Care means care provided in a hospice through the Region's Hospice Palliative Care Service.

Intensive Care means an advanced and highly specialized care provided to Patients whose conditions are life-threatening and require comprehensive care and constant monitoring, usually administered in specially equipped units of a health care facility (National Library of Medicine, 1992).

Degree of Benefit has three categories:

i). **Likely to Benefit:** In the opinion of the Most Responsible Health Professional, there is a reasonable chance that CPR, physiological support and Life Support Interventions will restore and/or maintain organ function. The likelihood of the person being discharged from an Acute Care hospital is high.

ii). **Benefit is Uncertain:** It is unknown or uncertain whether CPR, physiological support and Life Support Interventions will restore functioning. The subsequent prognosis or the likelihood of adverse consequences is also unknown or uncertain.

iii)Certainly will not Benefit: There is no reasonable chance that the person will benefit clinically from CPR, physiological support, and Life Support Interventions.

Life Support Interventions mean interventions typically undertaken in the Intensive Care Unit but which occasionally are performed in other locations in an attempt to restore normal physiology. These may include chest compressions, mechanical ventilation, Resuscitation, defibrillation and physiological support.

Life Sustaining Measures mean therapies that sustain life without supporting unstable physiology. Such therapies can be used in many other clinical circumstances. When viewed as life sustaining measures, they are offered in either a) the terminal stages of an illness in order to provide comfort or prolong life, or b) to maintain certain bodily functions during the treatment of intercurrent illnesses. Examples include enteral tube feeding and intravenous hydration. These measures should be clinically relevant and congruent with the Patient's goals.

Most Responsible Health Professional means the Health Professional who has overall responsibility and accountability for the care and treatment provided to a Patient admitted to a facility or program under his/her care. In most circumstances, the Most Responsible Health Professional is a physician; however, dependent upon the nature of the program and/or sector, the Most Responsible Health Professional is the health professional authorized by the Region to perform the duties required to fulfil the provisions of this policy.

Patient means an individual receiving health care and/or services in the Region as defined in this policy. The term "Patient" shall also be interpreted to mean:

- "Client" and "Resident" within the Supported Living and Home Care programs/sectors; and
- the Patient's Representative and/or family, as appropriate.

Personal Directive means a written document that enables individuals to give direction and clarification to health professionals and other service providers in accordance with the *Personal Directives Act* (Alberta). A Personal Directive is effective legally only when the maker of the Personal Directive lacks Capacity. While a personal directive from another province or country may not be valid in Alberta, the document may serve as a guide to help decision-making.

Physiological Support means measures undertaken to support major irregularities in physiology for a finite period of time. Including, but not limited to: positive airway pressure, endotracheal intubation, mechanical ventilation, temporary cardiac pacing, electrical stimulation of the heart rhythm, inotrope/vasopressor therapy, intra-aortic balloon counterpulsation, renal replacement therapy, or other extra-corporeal support.

Representative includes, without limitation, a member of the Patient's family, a parent who has legal guardianship of a minor child, a person appointed as a legal representative/guardian by a court of competent jurisdiction, or a person designated as an agent in a Personal Directive.

Resuscitation means the initial effort undertaken to reverse and stabilize an acute deterioration in a Patient's vital signs. This may include chest compressions for pulselessness, mechanical ventilation, electrical stimulation of the heart rhythm, and intensive medications. Patients who have refused to have chest compressions and/or mechanical ventilation may still be considered for resuscitative measures (see Designation R3).

Standard of Care means the care provided by a reasonable health care professional who possesses and exercises the skill, knowledge and judgment of the normal prudent practitioner of his or her special group (Picard and Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 1996).

Supportive Living means care and services provided in designated assisted living and/or personal care home living settings and delivered by the Region's Supported Living Program.

REFERENCES

- Appendix "A" Goals of Care Designations
- Appendix "B" – Decision Support and Dispute Resolution Resources Related to Advance Care Planning and Goals of Care Designations
- Calgary Health Region advance care planning program: "My Voice – Planning Ahead"
- Joint Statement on Resuscitative Interventions (Update 1995), Canadian Medical Association
- Regional Policy
  - Consent to Treatment (#1414)
  - Protection for Persons in Care (#1408)
  - Personal Directives (#1470)

APPENDIX "A"

GOALS OF CARE DESIGNATION

The Goals of Care Designation provides direction regarding specific health interventions, transfer decisions, locations of care, and limitations on interventions for a Patient as established after consultation between the Most Responsible Health Professional and Patient.

The Region's Goals of Care Designations replace the levels of care ("code levels") identified in the former Regional policies: Adult Resuscitation (#1440), Resuscitation for Residents in Continuing Care (#1452), and all department/program policies that address resuscitation. The Goals of Care Designations are INDEPENDENT of the Patient's current location. The Designation Order follows a Patient in order to guide the "receiving" health care providers if new conditions occur. However, flexibility to make appropriate and altered clinical decisions given new information or new conditions is always retained.

Transfer of a Patient from long term or supportive living care to Acute Care is a consideration in determining a Designation. The goal of such a transfer is aimed at cure or control of the medical condition. A decision not to transfer under such circumstances implies that, if the Patient's condition worsens despite treatments in the Patient's current environment and becomes irreversible, a mode of care focusing on comfort and symptom control is adopted and a natural death occurs. Transfer may still occur for such Patients if the goals is to investigate or treat symptoms, and if efforts aimed at this is best undertaken at another location.

R **Medical Care and Interventions, Including Resuscitation**	**R - May intervene with medical care, including Resuscitative Care if required** **Goals of care:** directed at cure or control of a Patient's condition. The Patient would desire ICU care if it was required, and would benefit from ICU if their medical condition warranted it. **R1 = Medical Care including ICU admission if required, with intubation and chest compressions** *Goals of care are directed at cure or control of a Patient's condition. Treatment of illness may include transfer to an acute or tertiary care facility with admission to the ICU if indicated. Intubation or chest compression may be provided.* *GUIDE:* **i) General guidelines** – this designation is for Patients who would benefit from, and are accepting of, any appropriate investigations and interventions that the health system can offer, including physiologic support in an ICU setting if required. All appropriate supportive therapies are offered, including intubation. Chest compressions and intubation are performed during a resuscitative effort when clinically relevant. **ii) Resuscitation** – is undertaken for cardio respiratory arrest or acute deterioration. **iii) Life Support Interventions –** are usually undertaken **iv) Life Sustaining Measures –** are used when appropriate within overall goals of care. **v) Major surgery** – is considered when appropriate. The possibility of intra-operative complications including death and the requirement for physiological support post operatively should be addressed with the Patient in advance of the proposed surgery, and general decision-making guidance agreed upon. **vi) Transfer** from current location of care – is considered if an alternative location is required for diagnosis and treatment.

R **Medical Care and Interventions, Including Resuscitation**	**R2 = Medical Care including ICU admission if required, with intubation but without chest compressions** *Goals of care are directed at cure or control of a Patient's condition. Treatment of illness may include transfer to an acute or tertiary care facility with admission to the ICU if required. Intubation can be considered when indicated but chest compressions are not performed.* *GUIDE:* **i) General guidelines** – this designation is for Patients who would benefit from, and are accepting of, any appropriate investigations and interventions that the health system can offer, including physiologic support in an ICU setting if required, but excluding chest compressions. **ii) Resuscitation -**is undertaken for acute deterioration, but chest compressions should not be performed. **iii) Life Support Interventions** – may be offered, without chest compressions. **iv) Life Sustaining Measures –** are used when appropriate within overall goals of care. **v) Major surgery** – is considered when appropriate. The possibility of intra-operative complications including death and the requirement for physiological support post operatively should be addressed with Patient in advance of the proposed surgery, and general decision-making guidance agreed upon. **vi) Transfer** from current location of care – is considered if an alternative location is required for diagnosis and treatment. **R3 = Medical Care including ICU admission if required, without intubation or chest compressions** *Goals of care are directed at cure or control of a Patient's condition. Treatment of illness may include transfer to an acute or tertiary care facility with admission to the ICU if required, but chest compressions or intubation should not be performed.* *GUIDE:* **i) General guidelines** – this designation is for Patients who would benefit from, and are accepting of, any appropriate investigations and interventions that the health system can offer, including physiologic support in an ICU setting if required, but excluding intubation and chest compressions. **ii) Resuscitation -**is to be undertaken for acute deterioration but chest compressions or intubation should not be performed. **iii) Life Support Interventions -** may be offered without intubation or chest compressions. **iv) Life Sustaining Measures –** are used when appropriate within overall goals of care. **v) Major surgery** – is considered when appropriate. The possibility of intra-operative complications including death and the requirement for physiological support post operatively should be addressed with Patient in advance of the proposed surgery, and general decision-making guidance agreed upon. **vi) Transfer** from current location of care – is considered if an alternative location is required for diagnosis and treatment.

M

Medical Care and Interventions, Excluding Resuscitation

M - May intervene with medical care, excluding tertiary level ICU

Goals of care: directed at cure or control of a Patient's condition. These Patients either choose to not receive care in an ICU or would not benefit from ICU care.

M1 = Medical care with transfer to Acute Care when required and without the option for ICU care

The goals of care are aimed at cure or control in any location of care, without accessing a tertiary level ICU. Treatment of illness may include transfer to an acute or tertiary care facility without admission to a tertiary level ICU.

GUIDE:

i) General guidelines – all active medical and surgical interventions aimed at cure and control of conditions are considered, within the bounds of what is clinically relevant, and excluding the option of admission to a tertiary level ICU.

ii) Resuscitation – is not undertaken for cardio respiratory arrest.

iii) Life Support Interventions –should not be initiated, or should be discontinued after discussion with Patient..

iv) Life Sustaining Measures – are used when appropriate within overall Goals of Care.

v) Major surgery – is considered when appropriate. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the Patient to prior level of function. The possibility of intra-operative death (option: life-threatening intra-operative deterioration) should be discussed with Patient in advance of the proposed surgery, and general decision-making guidance agreed upon.

vi) Transfer to another location of care – is considered if that location provides more appropriate circumstances for necessary diagnosis and treatment.

M2 = Medical care without transfer to Acute Care and without the option for ICU care

The goals of care are aimed at cure or control, almost always within the Patient's current care environment. Treatment of illness may be undertaken in the current location without transfer to acute or tertiary care should that condition deteriorate.

GUIDE:

i) General guidelines – all interventions that can be offered in the current location of care are considered. If a person deteriorates further and is no longer amenable to cure or control interventions in that location, the Goals of Care Designation should be changed to focus on comfort primarily.

ii) Resuscitation – is not undertaken for cardio respiratory arrest or acute deterioration.

iii) Life Support Interventions – should not be initiated or should be discontinued after discussion with Patient.

iv) Life Sustaining Measures – are used when appropriate within overall Goals of Care.

v) Major surgery – is not usually undertaken, but can be contemplated for procedures aimed at symptom relief. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the Patient to prior level of function. The possibility of intra-operative death (option: life-threatening intra-operative deterioration) should be discussed with the Patient/family in advance of the proposed surgery, and general decision-making guidance agreed upon.

vi) Transfer to another location of care – is not usually undertaken, but can be contemplated if symptom management or diagnostic efforts aimed at understanding symptoms can best be undertaken at that other location.

C **Medical Care and Interventions, Focused on Comfort**	**C - Provide comfort care** **Goals of care:** directed at symptom control rather than at cure or control of a Patient's underlying condition that is expected to result in death. All interventions are for symptom relief. **C1 – Symptom Comfort Care** *Goals of care are for maximal symptom control and maintenance of function, without cure or control of the underlying condition. A diagnosis exists which is expected to cause eventual death.* *GUIDE:* **i) General guidelines** – A diagnosis exists which is expected to cause eventual death. New illnesses are not generally treated unless control of symptoms is the goal. **ii) Resuscitation** – is not to be undertaken in the event of cardio respiratory arrest/failure. Chest compressions or intubation should not be performed. **iii) Life Support Interventions -** should not be initiated, or should be discontinued after discussion**.** **iv) Life Sustaining Measures –** can be used for goal directed symptom management. **v) Major Surgery** – is not usually undertaken, but can be contemplated for procedures aimed at symptom relief. Resuscitation during surgery or in the recovery room can be considered, including short term physiologic and mechanical support in an ICU, in order to return the Patient to prior level of function. The possibility of intra-operative death (option: life-threatening intra-operative deterioration) should be discussed with the Patient/family in advance of the proposed surgery, and general decision-making guidance agreed upon. **vi) Transfer-** to tertiary/ Acute Care is not usually undertaken. Transfer should be contemplated if symptom management or diagnostic efforts aimed at understanding symptoms can best be undertaken at another location. **C2 – Terminal care** *Goals of care are aimed at preparation for imminent death (usually within hours or days), with maximal efforts directed at symptom control.* *GUIDE:* **i) General guidelines –** expert terminal care can be provided in any location. **ii) Resuscitation** – is not to be undertaken in the event of cardio respiratory arrest/failure. Chest compressions or intubation should not be performed. **iii) Life Support Interventions –** should not be initiated, or should be discontinued after discussion. **iv) Life Sustaining Measures** – should be discontinued unless required for goal directed symptom management**.** **v) Major Surgery** – is not appropriate. **vi) Transfer** to another site is usually not undertaken.

APPENDIX "B"

DECISION SUPPORT AND DISPUTE RESOLUTION RESOURCES RELATED TO ADVANCE CARE PLANNING AND GOALS OF CARE DESIGNATIONS

Preamble
Decision-making by Patients and the health care professionals caring for them is an integral component of health care. When circumstances bring significant complexities, including disagreement, additional decision support may be required. This Appendix details the decision support and dispute resolution resources available within the Calgary Health Region. When required, the Most Responsible Health Professional has a responsibility to ensure a Patient is informed of, and has access to, any relevant decision support and dispute resolution resources necessary for their circumstances.

Focus
The Advance Care Planning: Goals of Care Designation (Adult) policy advocates that Patients and health care professionals engage in conversations that lead to defined Goals of Care. Some members of the interprofessional team have received Advance Care Planning skills training, have been introduced to available resources, and are knowledgeable about the details of the Goals of Care designations. These staff and physicians may act as resources to their colleagues to provide support and knowledge about the Advance Care Planning progress and the Goals of Care designations.

The role of health care professionals offering decision support or dispute resolution is to assist Patients, families, physicians, and staff:

- who require additional information, time, and conversation related to Advance Care Planning and decision-making; and
- with reaching consensus on a Goals of Care Designation.

1. Decision Support Resources Available
The following identified services can be accessed using the current referral process:

1.1 Interprofessional Health Care Teams
Generally, staff and physicians providing care to a Patient have the required knowledge and experience with Advance Care Planning and Goals of Care Designations.

1.2 Second Opinion
The Most Responsible Health Professional (or designate) shall expeditiously seek a second opinion from a physician with knowledge and skills relevant to the circumstances of the Patient's condition.

1.3 Regional Programs
Additional Professionals are available on a consult basis, as follows:

- *Social Work* provides information and support regarding a Patient's and family's social, emotional, economic, and environmental issues.
- *Spiritual Care Services* provides information and support regarding whole-person spiritual care, which may involve questions of identity, meaning, and fundamental issues of life and death.

- *Hospice Palliative Care Service* provides support and information regarding symptom management during terminal illness and preparation for the end of life.

1.4 Specialized Services

Other specialized services can provide information and support with regard to specific issues. These include:

- *Ethics Services* – An ethics consultation provides a guided discussion for decision-makers, including Patients, families, and health care professionals, about ethical dilemmas in clinical practice.
- *Regional Capacity Assessment Team* – The Capacity Assessment Team provides multidisciplinary cognitive capacity assessments for Patients within the Region's urban Acute Care facilities.
- *Healthy Diverse Populations* – This service provides expert perspectives regarding diverse cultural and religious issues to Regional programs, services, and case consultation teams.
- *Legal Services* – Legal Services' Clinical Counsel provides legal opinion and guidance on matters related to the care provided to Patients.

2. Avenues for Dispute Resolution

In the event that a dispute or disagreement regarding a Patient's treatment plan and/or Goals of Care Designation remains after appropriate avenues of decision support have been pursued, the Most Responsible Health Professional shall consult with the designated medical administrator. It is not the role of the designated medical administrator to assist in the determination of a Goals of Care Designation, but rather to lend guidance and support for due process in making clinically and ethically sound decisions regarding care and Goals of Care Designations.

3. Goals of Care Designation Orders Following Dispute Resolution

If, after appropriate avenues of decision support and dispute resolution have been explored, including consultation with the designated medical administrator, the disagreement or dispute between the care team and the Patient regarding the Patient's Goals of Care Designation remains:

3.1 the Most Responsible Health Professional (or designate) may issue, based on his/her professional judgement, a clinically relevant Goals of Care Designation Order;

3.2 the Region's support for this decision, via the designated medical administrator will be noted on the Patient's health record; and

3.3 the Most Responsible Health Professional (or designate), or the designated medical administrator, shall advise the Patient that he/she may pursue relief from the Courts via external legal counsel.