Advance Care Planning / Goals of Care Designations

Conversations Matter

Planning for your future healthcare

Alberta Health Services

Supporting Albertans in advance care planning.

In Alberta advance care planning includes:

- Having a personal directive
- Having a Goals of Care Designation order, when medically appropriate
- Using a Green Sleeve to hold and transport advance care planning documents

Copyright © (2019) Alberta Health Services. This material is protected by Canadian and other international copyright laws. All rights reserved. These materials may not be copied, published, distributed or reproduced in any way in whole or in part without the express written permission of Alberta Health Services. These materials are intended for general information only and are provided on an “as is”, “where is” basis. Although reasonable efforts were made to confirm the accuracy of the information, Alberta Health Services does not make any representation or warranty, express, implied or statutory, as to the accuracy, reliability, completeness, applicability or fitness for a particular purpose of such information. These materials are not a substitute for the advice of a qualified health professional. Alberta Health Services expressly disclaims all liability for the use of these materials, and for any claims, actions, demands or suits arising from such use.

What is Advance Care Planning?

Advance care planning is a way to help you plan and document your wishes for the type of healthcare you wish to receive now and in the future. It is for every adult, especially for people with health issues. It is best done when you're healthy, before there's actually an urgent need for a plan.

Advance care planning is particularly significant for people who have a chronic illness, more than one disease, are older or may have cognitive impairment.

Planning ahead brings peace of mind to you and to people who are important to you.

Advance care planning is a process that helps you

- think about values and wishes for medical treatments you may or may not want
- talk about your healthcare goals
- make a plan that reflects your values and wishes
- document your plan

If you could not speak for yourself will your family know your healthcare wishes?

Imagine your elderly mother slipped on the ice, hit her head and is in a coma? Her healthcare team is now asking you questions about her values and wishes.

Do you know her wishes for care?

If she could communicate, what would she say her goals are?

Imagine this was you. Who would speak for you? Do they know what you want?

How do I begin?

Think LEARN CHOOSE COMMUNICATE DOCUMENT

STEP 1

Think about your values and goals.

Consider your values and preferences when you think about the questions below.

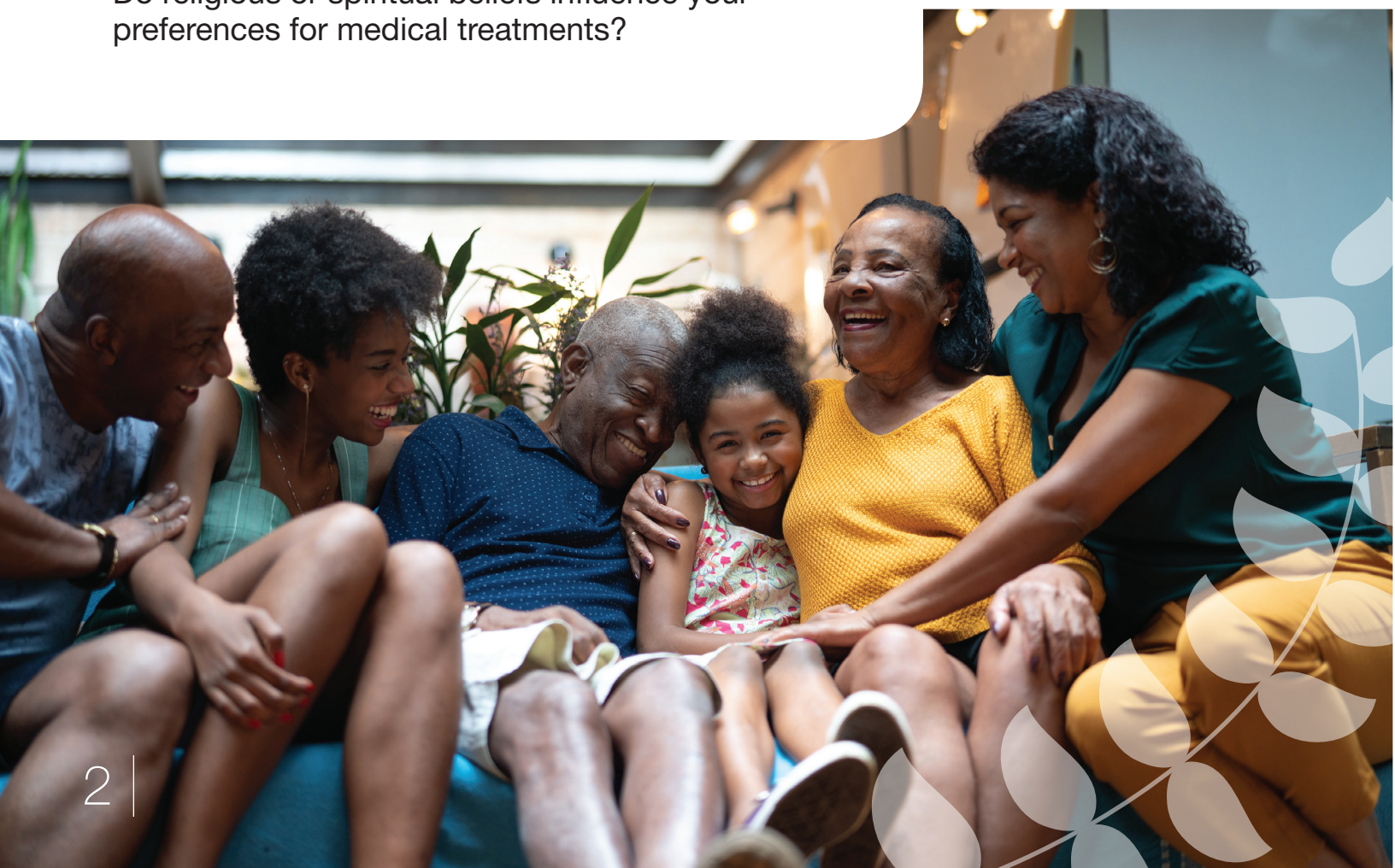
There are no wrong answers to these questions.

Past experiences of health

- Have you had past experiences of healthcare that influence what you'd like from your future care? These may be positive or negative experiences that happened to you or others you know.

Your future health

- What does quality of life mean to you? Being able to talk with your family? Looking after yourself?
- Who are the important people in your life?
- Do religious or spiritual beliefs influence your preferences for medical treatments?



STEP 2

Learn about your own health.

- Do you feel you have a good understanding of your current health?

If you have an existing medical condition talk to your doctor or other healthcare providers about:

- Your prognosis, that is, what you might expect to experience in the future as a result of your medical condition.
- Possible medical treatments for your condition.
- What to expect from these treatments. It's helpful to understand the types of healthcare decisions you may need to make.

STEP 3

Choose someone to make healthcare decisions for you if you couldn't.

Who will speak for you?

Unexpected or sudden medical events can leave you unable to communicate your wishes. Other medical conditions can slowly take away your ability to communicate or make decisions about care.

It is important to choose and legally appoint someone who can speak for you in the event you are unable to make medical decisions for yourself. In Alberta this person is referred to as your agent.

Ask yourself:

- Do I trust this person to make healthcare decisions with my healthcare team based on my values and wishes?
- Are they able to communicate clearly?
- Would they be able to make difficult decisions in stressful situations?
- Is this person willing and available to speak for me if I were unable to make healthcare decisions for myself?

STEP 4

Communicate your wishes and values about your healthcare to your family and healthcare team.

Make a list of the most important things you want to talk about during your conversation.

Conversation starters:

- My health is good right now, but I want to talk to you about my wishes if I was sick or injured in the future.
- I have been thinking about my wishes for organ and tissue donation. Can we talk about that?
- My doctor asked me to think about and write down my wishes for future healthcare should I get sicker. You are important to me, can we talk?

STEP 5

Document in a personal directive

In Alberta, a personal directive (sometimes called a “PD”) is the legal document that allows you to choose who your decision-maker will be and may provide guidance about your wishes.

- Your personal directive only comes into effect if or when the time comes that you are unable to make decisions about your healthcare.
- Share your personal directive with your decision-maker (agent), family and healthcare providers.
- Your personal directive can and should be reviewed any time you have a change in your health circumstances or your wishes and values.
- To create your personal directive, the Office of the Public Guardian has a free template (with instructions) or you can have your lawyer create one.

If you don’t have a personal directive and it’s determined you’re incapable of providing informed consent:

- you don’t get to choose who will make decisions for you
- a healthcare provider may ask your nearest relative to make decisions for you
- a family member or friend may have to go to court to become your guardian, which takes time and money.

For information about personal directives contact the Office of the Public Guardian 310-0000 (toll-free in Alberta)

www.alberta.ca
search Personal Directive

What is a Goals of Care Designation Order (GCD)?

- A medical order that describes the general focus of your care.
- Helps the healthcare team match your unique values and preferences to care that is most appropriate for you and your healthcare condition.
- Written by a doctor or nurse practitioner.
- Ideally created after conversation between you and members of the healthcare team.
- Recognized in all care settings in Alberta.
- Changes as your health changes; any doctor can update your GCD order.

Deciding your most appropriate GCD is a process. Factors considered:

Questions to consider:

- Do I fully understand my healthcare conditions and prognosis?
- What are my treatment risks and benefits?
- Are life saving measures like cardio-pulmonary resuscitation (CPR) likely to benefit me?
- What would I be willing to go through for more time? Is quality of life more important than living longer?
- What treatments are available where I live so I don't have to go to the hospital?

Who needs a GCD Order?

It is important for individuals to have a GCD order when full resuscitative care is not what they want or is not medically appropriate. Without a GCD order stating otherwise, full resuscitative care is provided when someone's heart stops beating or they stop breathing.

To find out if you need a GCD order talk to your healthcare provider. They can help determine if you need a GCD order.

If you have a GCD order it can and should change as your health changes. Talk with your healthcare team if:

- your current health situation, values and wishes have changed
- you are not sure what your GCD order includes
- you are not comfortable with your current GCD order

Three general approaches to care

What treatments will help me live the way I want and where I want?

With this illness what can I expect my life to look like in 1 month? 6 months? 1 year?

If I get sicker are there medical treatments that I feel strongly about either having or not having?

Medical Care

In this approach to care, a person is expected to benefit from and values any appropriate medical tests and treatments that can be offered, excluding intensive care (ICU) and resuscitative care. Locations for care (e.g., at home, hospital, and care facility) are considered depending on what is medically appropriate and in keeping with the patient's wishes and values.

M1 means using any appropriate medical and surgical treatments, including going to the hospital, to try to "fix the fixables" with a focus to live as long as possible and maintain your desired quality of life. The team will not use pushing on the chest ("CPR"), a breathing machine ("ventilator") or intensive care unit ("ICU"). M1 communicates that there are limits to what resuscitation and life support can achieve for you.

When is M1 appropriate?

M1 is appropriate in situations when a person is unlikely to survive an attempted resuscitation, or when resuscitation is unlikely to leave the person in a state of living they value.

M2 means you will be treated at home or a care facility and avoid hospital admission. Medical treatments available in the home or a care facility will be used to try to "fix the fixables". If you don't respond to home-based treatments, your healthcare team will talk to you about re-evaluating your wishes and goals, which may include changing your focus of care to comfort care.

When is M2 appropriate?

M2 is for people who are frail or chronically ill and their health is more likely to worsen rather than improve with going to the hospital. It is also appropriate when a person no longer wants the kind of treatments available in the hospital or when hospitalization is unlikely to leave the person in a state of living that they value.

Comfort Care

In this approach to care, the aim of medical tests and treatments is to manage symptoms of the disease and maintain function when cure or control of an underlying condition is no longer possible or desired. Transfer to a hospital may occur in order to better understand or control symptoms.

C1 means that the focus of care is to provide comfort, with symptom control and using medical treatments that maximize your quality of life rather than focusing on your length of life.

When is C1 appropriate?

C1 is appropriate in situations where a person is very frail or living with serious illness and is unlikely to respond to medical treatments aimed at prolonging life. It is appropriate when the person wants to focus on their quality of life more than their length of life.

C2 means that you are in the final hours or days of life and all treatments are focused on your comfort and support of those close to you.

When is C2 appropriate?

C2 is only appropriate when a person is imminently dying (i.e., final hours or days) and treatments can no longer prolong life.

Resuscitative Care

In this approach to care, a person is expected to benefit from any appropriate medical tests and treatments that can be offered and may include intensive care (ICU) and resuscitation.

R1 means that any appropriate medical and surgical treatments including pushing on the chest ("CPR") a breathing machine ("ventilator") and intensive care unit ("ICU") will be used to try to prolong your life during a critical illness.

When is R1 appropriate?

R1 is most appropriate in situations where a person is likely to recover from an illness and return to how they were before. The person wants this attempt made to prolong life, even if it may leave them with permanent changes to their health and abilities.

R2 means that any appropriate medical and surgical treatments including a stay in the intensive care unit care and breathing machine ("ventilator") will be used to try to prolong your life during critical illness. The team will not use pushing on the chest, referred to as resuscitation. This means "No CPR."

When is R2 appropriate?

R2 is appropriate in situations where a person's heart is unlikely to restart if it stops but they have an illness that might benefit from a breathing machine and intensive care. R2 is also appropriate when CPR is unlikely to leave a person in a state of living that they value.

R3 means that any appropriate medical and surgical treatments including a stay in the intensive care unit will be used to try to prolong your life. The team will not use pushing on the chest "No CPR" nor use a breathing machine "No ventilator."

When is R3 appropriate?

R3 is appropriate in situations where resuscitation and a breathing machine are unlikely to be able to prolong a person's life but they have an illness that might respond to intensive care. R3 is also appropriate when use of CPR and a ventilator is unlikely to leave a person in a state of living that they value.

Your Green Sleeve

A Green Sleeve is a plastic pocket that holds your advance care planning forms. Think of it like a medical passport.

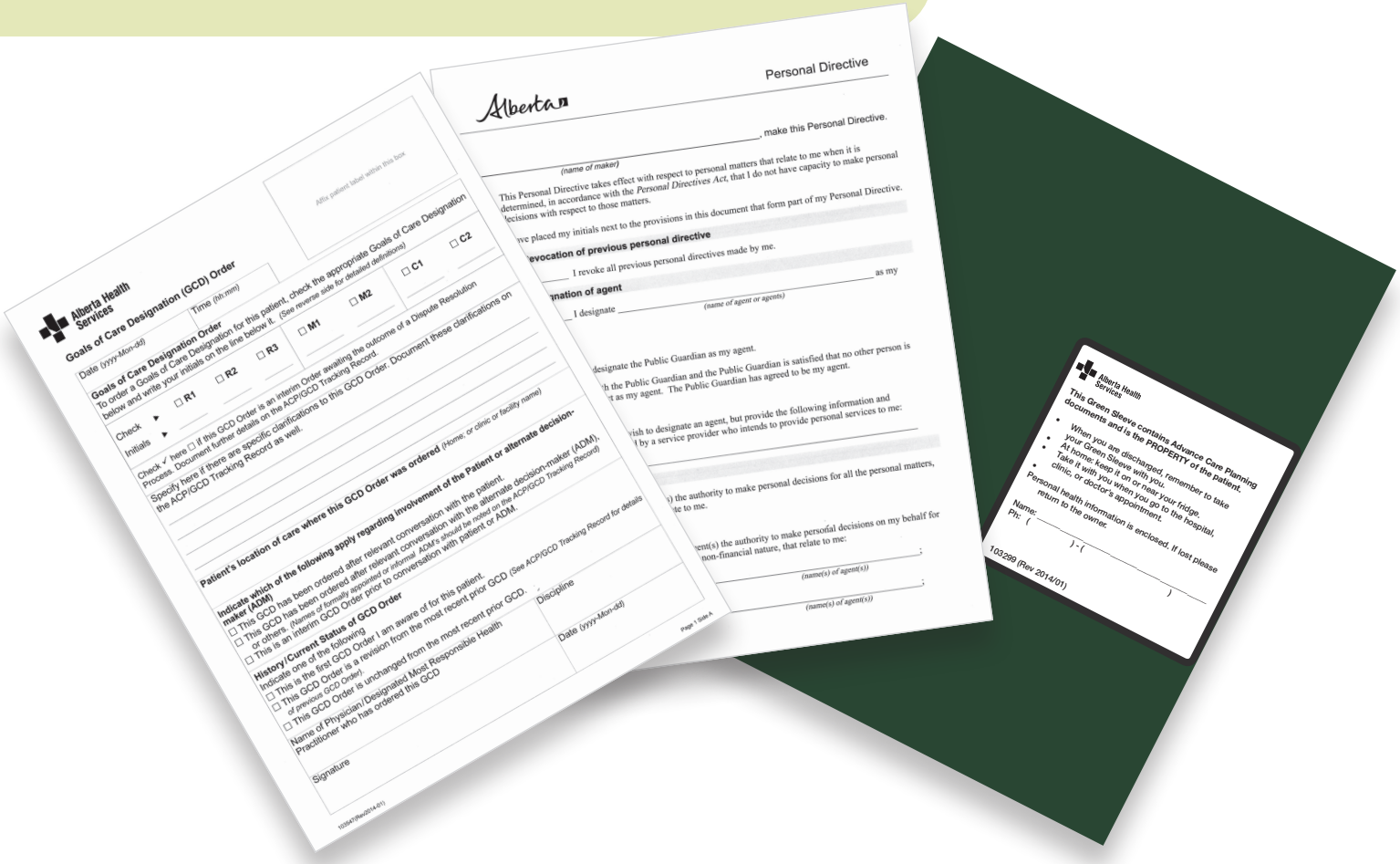
- There are two ways to get a Green Sleeve: from your healthcare provider or you can order one online.
- It is your property. When you are at home, keep your Green Sleeve on or near your fridge.
- Healthcare providers in all settings may ask if you have a Green Sleeve.
- If you go to the hospital or a healthcare appointment take your Green Sleeve with you. Be sure it comes home with you.

For more information:

www.ahs.ca and search advance care planning

To order a Green Sleeve:

myhealth.alberta.ca and search Green Sleeve

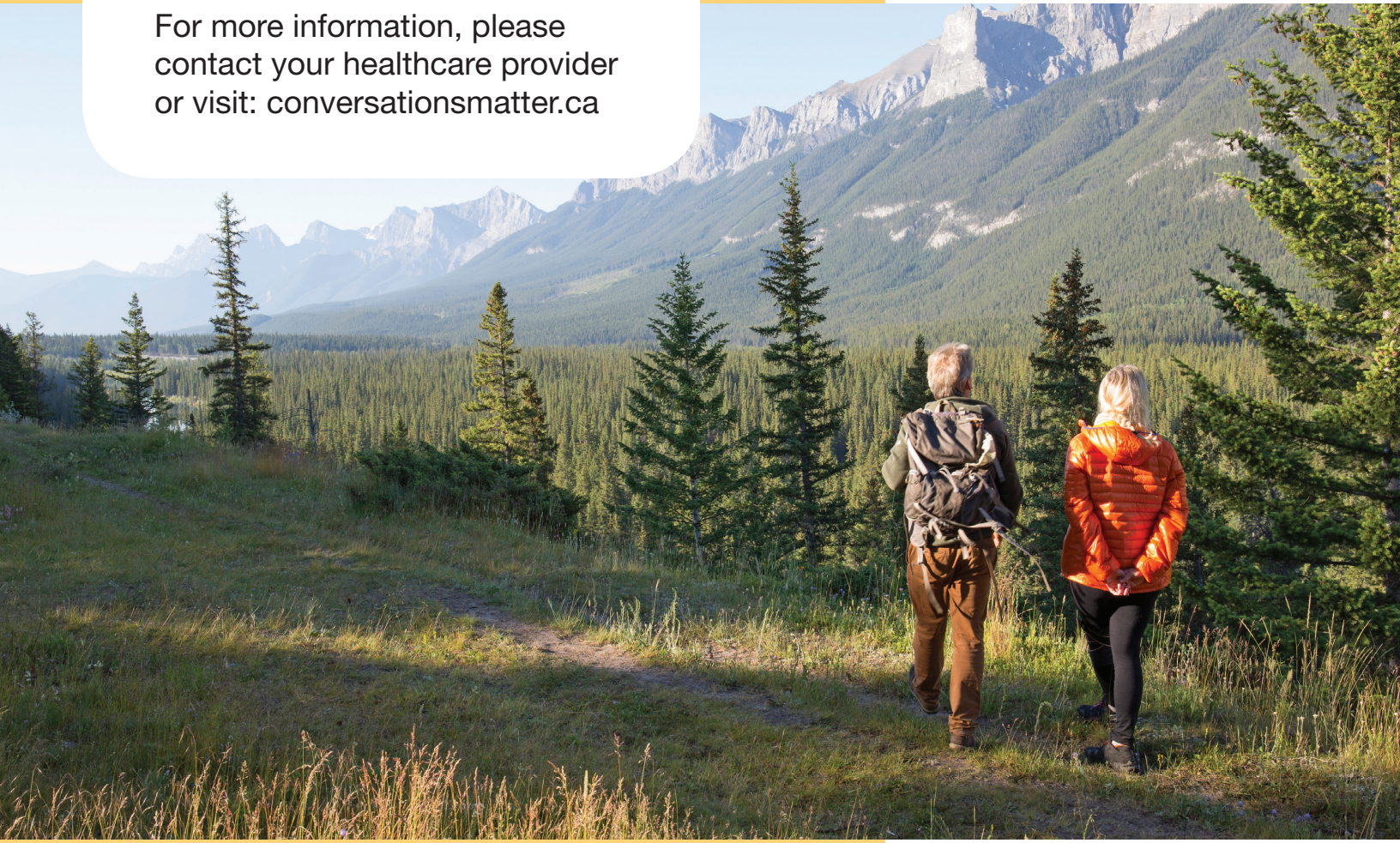


Advance Care Planning Checklist

- ❑ I have thought about my values and wishes and healthcare goals.
- ❑ I have thought about organ and tissue donation and I have communicated my wishes to my family and registered my donation intent on Alberta's Organ and Tissue Donation Registry.
- ❑ I have asked my healthcare provider(s) about my current health and what future healthcare decisions I might need to make.
- ❑ I have completed a personal directive and named my decision-maker (agent).
- ❑ I have spoken to my decision-maker (agent) about my wishes and given him or her a copy of my personal directive.
- ❑ I have discussed my healthcare treatment wishes with those closest to me.
- ❑ My doctors and I have discussed the Goals of Care Designation that best reflects my current situation.
- ❑ I have a Green Sleeve to hold my documents (including my personal directive and Goals of Care Designation Order) and I have placed it on or near my fridge.
- ❑ Whenever I go to the hospital or a healthcare appointment, I will bring my Green Sleeve with me.

Alberta Health Services

For more information, please contact your healthcare provider or visit: conversationsmatter.ca



286A (2019 08)