“Revised” Advance Care Planning/Goals of Care Designation Policy and Procedure

The complexity of modern health care, and the need for safe transitions between care environments where unfamiliar care teams encounter patients, requires a better communication tool. Previously, Levels of Care and DNR Orders were defined differently, depending on the setting. This created confusion and the potential for error. Assuring conversations that address patients’ values and desires, together with medically appropriate options supports good practice.

The revised Advance Care Planning/Goals of Care Designation (ACP/GCD) policy standardizes collaborative health care decision making into one unified framework. The process for documentation of Goals of Care Designations and Advance Care Planning is now standardized.

What are the key features of the revised Level 1 Advance Care Planning Goals of Care Designation (ACP/GCD) policy and procedure?

The ACP/GCD policy and procedure provides:

1. A clear, consistent approach to health care decisions and communication of those decisions where ever patients receive care within Alberta.

2. A standardized documentation process to ensure that there is clarity and consistency in communicating health care values and wishes wherever care is being received across Alberta.

3. A collaborative patient centered approach that focuses on shared healthcare decision making for present and future health-care decisions.

4. Defined Decision Support resources and a Dispute Resolution process to ensure that patients, families and clinicians are supported when complex decision making or conflicting perspectives arise.

5. Alignment with the Alberta Personal Directives Act, which provides a legislative framework for personal directives.

What is Advance Care Planning?

Advance Care Planning is a way to help patients think about, talk about and document wishes for health care in the event that they become incapable of consenting to or refusing treatment or other care.

What are Goals of Care Designations (GCD)?
GCDs are physician (or designate) orders that codify specific and general care intentions, locations of care and transfer opportunities for current and future care of patients.

The architecture that forms the foundation for the policy is Alberta-made, and is clinically relevant for naming and communicating care choices and decisions.

**What is a Goals of Care Designation Order?**

A Goal of Care Designation Order is a medical order that specifies general care intentions, location of care and transfer opportunities for current and future care, and is signed by the most responsible health practitioner. A GCD is determined by aligning the patient’s values, beliefs and care wishes with expert clinical advice regarding appropriate medical care that matches a person’s wishes. A GCD is brought into effect in a health care situation in which a person is unable to communicate their own health care wishes.

**What is meant by a GCD conversation?**

These conversations explore the goals for treatment and the patient’s wishes framed within the therapeutic options that are appropriate for the patient’s current clinical condition, and which may be relevant for the patient’s future clinical conditions.

**Who should receive an Advance Care Planning and Goals of Care Designation discussion?**

All adults should be given the opportunity to participate in an ACP discussion. While these discussions should ideally be initiated by the family physician as part of the patient’s routine health care, they can occur in any health care setting. They can also be initiated by patients.

**When should GCD conversations occur?**

Conversations are best started early in the patient’s course of care and/or treatment and/or when clinically appropriate to the patient’s care. Conversations and decisions about GCD are carried out with the patient or with the patient’s alternate decision-maker if the patient lacks capacity to make such decisions.

**Who can initiate and conduct Advance Care Planning/Goals of Care conversations?**

A patient can ask to have this conversation. Any member of the patient’s health care team can initiate the conversation and conduct appropriate parts of the discussion; however, the Most Responsible Health Practitioner (MRHP) is ultimately responsible for the discussion and documentation of the most clinically appropriate Goals of Care Designation Order.

Discussions may include:

- A 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 about comfort measures.

• If appropriate, offer for involvement of resources such as palliative care, social work, clinical ethics consultation, or spiritual care to assist the patient with their needs.

Who is the Most Responsible Health Practitioner?

Most responsible health practitioner (MRHP) means the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to a patient and who is authorized by Alberta Health Services to perform the duties required to fulfill the delivery of such a treatment/procedure(s) within the scope of his/her practice. Currently in Alberta, the MRHP is usually a physician. In some circumstances, with delegation by a clinical team or program, a Nurse Practitioner can be named the MRHP.

The MRHP definition is deliberately broad, to allow the flexibility to adapt to a change of clinical leadership or responsibility in any situation, or as new or existing disciplines develop in authority.

Since patients sometimes have multiple physicians and since the primary responsibility for some care and decisions can change depending on the patient’s circumstances, wisdom and clinical judgment needs to be exercised by the various physicians regarding who will be responsible for current and future care directions. Most importantly, those various physicians need to communicate effectively amongst themselves.

Examples:

1. A community patient’s family doctor may well be the MRHP for the general care of this individual. If the patient is admitted to hospital for surgery, under care of the surgical team, the attending surgeon becomes the MRHP for that episode of care.

2. Nurse Practitioners (NP) can determine and sign a GCD order if that is a function agreed to by the clinical team in which the NP works.

What if the MRHP changes?

If a patient’s most responsible health practitioner changes, the previous Goals of Care Designation order remains applicable unless changed by the new most responsible health practitioner.

When should a GCD be reviewed with a patient?
Goals of Care Designations should be reviewed when new circumstances or health issues arise, when a patient is transferred to a new location of care, or if the patient or alternate decision-maker requests it.

A Goals of Care Designation order is prescriptive – it guides the clinical team regarding the course of care and interventions but is also subject to clinical judgement of the current most responsible health practitioner. If the current GCD no longer makes clinical sense or seems to be in conflict with the patient’s desires, it should be reviewed and can be changed if necessary.

**How can I introduce the topic of ACP/GCD without upsetting the patient?**

Every clinical situation is unique; however, the following two questions offer a non-threatening way to ask about ACP/GCD.

1. A question we ask all of our patients is about current and future health care decision making. Have you heard about advance care planning? Do you have a personal directive?

2. It is important for the health care team to know your wishes if you were seriously ill and could not make decisions for yourself. Have you talked with anyone about your wishes or preferences for health care decisions that may come up (e.g. resuscitation)? May I ask what you discussed?

Explore discussions with family, agent or health care providers.

These questions lead to natural exploration of wishes, or may help you be aware if the patient has appointed an alternate decision maker (ADM) or agent.

**Dispute Resolution**

Decision-making by patients and the health care professionals who provide care to them is an integral component of health care. When circumstances bring significant complexities, including disagreement in what care is to be provided, additional decision support may be required.

The following are some examples of circumstances where dispute resolution may need to be initiated:

- Patient/Alternate Decision-maker: refusal of treatment;
- Patient/Alternate Decision-maker: demand for treatment that is not within standard of care;
- Disagreement with ADM regarding patient’s wishes, best interests, values, beliefs;
Clinician focused: disagreement on what treatment is clinically indicated and in the patient’s best interest

Emergency circumstances – if time critical decisions are required that contradict the ADM’s information

The most responsible health practitioner (MHRP) has a responsibility to ensure a patient is informed of, and has access to, the decision support and dispute resolution resources found in the Advance Care Planning and Goals of Care Designation Procedure paragraph 7 and in Appendix C.

AHS has a formal dispute resolution mechanism. Information about this resource can be accessed on Insite at http://insite.albertahealthservices.ca/8738.asp.

Patient Refusal

Patient refusal of specific clinically indicated intervention(s) shall be honoured, within the bounds of applicable laws. Further conversations regarding patient refusal may be required.

Clinical judgment should determine the degree to which further conversations regarding patient refusal should be considered and could include invoking a dispute resolution process.

Informed Consent

Advance Care Planning and Goals of Care Designations are the clinical responsibility of the most responsible health practitioner. It is standard clinical practice to engage the patient or alternate decision maker in all related discussions and decisions. Informed consent and patient signature are not required to make a Goal of Care Designation order.

Communicating and Documenting the ACP/GCD Process

What is a Green Sleeve?

The Green Sleeve is a plastic pocket that holds important Advance Care Planning documents and other forms that outline a patient’s goals for health care. It is given to patients cared for in AHS who have had discussions or completed documents that refer to decision-making about their current or future care.

The information contained in the Green Sleeve is intended to ensure that all health care providers in any setting have access to important decisions related to the patient’s goals of care and guidelines for direction of interventions that have been discussed with the patient.

What goes into a Green Sleeve?

1. Goals of Care Designation order, when one exists.
2. Advance Care Planning Goals of Care Tracking Record.
3. Personal Directive copies, if they exist.
4. Guardianship Orders, if one is in place for the individual.

It is important that these documents reflect the patients’ most current information and serve as one source of truth.

### Green Sleeve handling process:

When the patient is receiving care or is admitted, the Green Sleeve should be placed at the front of the patient’s chart.

The Green Sleeve is to accompany the person as they transfer between care providers and/or sites and should be kept on or near the fridge when the patient is at home (EMS knows to look for the Green Sleeve here).

### Why is the ACP/GCD Tracking Record always the original? Not a copy?

The original Tracking Record is kept in the Green Sleeve to allow care providers at each site access to and the ability to document the full record of conversations that have occurred over time. Having multiple versions/copies of the Tracking Record contribute to confusion and possible miscommunication. If multiple, sequential Goals of Care conversations have occurred, and a Tracking Record is full after noting each of these conversations, begin a new Tracking Record for the next conversation and keep the full prior Tracking Record in the Greensleeve, stapled behind the current Tracking Record.

### What do I do with multiple completed GCD order forms?

When there are multiple completed order forms (e.g. as a result of transfers or changes to health status) the following may assist in organizing the patient’s Green Sleeve:

- The most current GCD order form should be at the front of the Green Sleeve.
- Prior GCD order forms may be housed within the Green Sleeve but should be filed sequentially by date in descending order (most recent on top).
- Alternatively, the prior GCD order forms can be filed in/with the health record providing that the prior GCD orders are accurately captured on the ACP Tracking Record.
- “VOID” may be written on any prior GCD order forms.

### How do GCD Orders in electronic format and paper work together?

The GCD paper order form should be stored in a Green Sleeve except in areas that use electronic order entry.

In areas using an electronic health record the GCD order will be entered and viewed in electronic format. When a patient is transferred from an electronic health record entry site to a
paper order entry site, the sending unit shall print the GCD order and place it in the Green Sleeve giving it to the patient. This process also occurs if the patient is transferred to their home.

**Goals of Care Designation Questions**

**What is the difference between an M2 designation and a C1 designation?**

Intention of care and sometimes location of care distinguish these two designations.

M2 designated patients are seeking interventions and care that can stabilize, control or cure all or some of their primary co-morbidities, but are not accepting of or would not benefit from ICU and resuscitative care.

A person with an M2 designation may be living with illness but are still accepting of interventions in their current location of care to control their condition. Current locations of care would include Supportive Living, Long Term Care (LTC) or their private residence. When interventions provided in the current location of care are not successful in treatment of an illness, or the patient/resident continues to deteriorate, the healthcare team and patient should discuss the next decisions related to ideal symptom management including a C1 designation.

After discussion about their health condition and the medical appropriateness of potential care and interventions, patients with an M2 designation seek interventions and care treatment options available where they currently live. They do not wish to be transferred to acute care. They say “care for me as well as you can within the limitations of where I live, attempting to cure or control my health conditions. But I don’t want to be in hospital, or leave this place where I live.”

There are circumstances - such as a broken hip or other unexpected trauma when an M2 designated patient may have a goal directed transfer to Acute Care. In such an instance there is an expectation of timely return to the person's living environment once the unexpected illness has been addressed. Such a person’s Designation would remain M2 in Acute Care with the particular circumstances noted in the Medical Orders, progress notes and Tracking Record.

C1 designated patients are seeking interventions and care that address ideal symptom management, but not cure or control of an underlying illness from which they are expected to die in a reasonably predictable and shorter time frame. A diagnosis exists which is expected to cause eventual death.

After discussion about their health condition and the medical appropriateness of potential care and interventions, patients with a C1 designation seek interventions and care that address symptom management for comfort and maintenance of function so that they can live as well as possible until death. They say –“I know I have an illness that will cause me to die soon. Keep me as comfortable as you can so I don’t suffer and keep me as functional as you can so that I can accomplish limited goals in my remaining weeks or months.” New illnesses that occur should be treated only if they can help reduce suffering.
A simple way of looking at this is to ask – What is the goal of care? Are we initiating an intervention in order to cure or control an illness or to relieve a symptom and get someone better so that they can live longer (M2)? Or are we intervening solely to relieve a symptom, with no expectation that treatment would meaningfully increase the duration of their life (C1)?

A C1 designated patient can be cared for in any number of health care settings, including hospital, if that is the best place to relieve their symptoms. An M2 designated patient is rarely cared for in hospital (except in the example described above that contemplates acute repair of a fractured hip or major laceration, followed by return to home or supported living).

By way of further example, a person with an M2 designation who develops a new pneumonia would receive treatment aimed at cure of the pneumonia, but only in the current location of care. If that treatment was not successful, the patient accepts the limitations of the living environment and would not seek transfer to hospital for more intense treatment. But a person with a C1 designation who develops pneumonia might seek treatment that would relieve potential pain, dyspnea and distress, whether or not the treatment could fully resolve the pneumonia. Sometimes antibiotics would be contemplated for such a patient, with the sole intent of relieving symptoms.

**What is the main difference between C1 and C2?**

The main differentiating point is proximity to death.

C1 designated patients may have weeks to live, or even many months. Through conversation they have expressed a desire to have all medical interventions directed at ideal symptom control and maintenance of function, while acknowledging the eventual terminal nature of their illness.

C2 designated patients are expected to die within hours or perhaps a few days, and seek maximal symptom relief and withdrawal of any life prolonging measures, in preparation for imminent death. Changing a goal of care designation to C2 is a method of communicating to the health care team that the end of the patient’s life is imminent. Care should be directed at compassionate symptom control as well as emotional and spiritual support of the patient and family in preparation for death. Patients with a C2 designation are typically not considered for transfer, since they are so close to death that you would be worried they might die during transfer.

**Why are chest compressions and intubation separate in the R designations?**

Chest compression, intubation and ventilation are deliberately separated to describe specific actions that are:

- Clinically appropriate interventions for a patient; or interventions that the patient is unwilling to undergo.
R1: The patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including resuscitation followed by ICU care.

R2: The patient is expected to benefit from and is accepting of any appropriate investigations/interventions including ICU care and intubation, but excluding chest compressions.

R3: The patient is expected to benefit from and is accepting of any appropriate investigations/interventions that can be offered including ICU care, but excluding ventilation and chest compressions.

What is the main differentiating point for the three R sub-categories?

The differentiation of the subcategories is based on the intensity of interventions appropriate for the patient.

For instance, an R3 designated patient would not request, nor be expected to benefit from intubation and chest compression. Example: A person in a monitored CCU setting, with a correctable rhythm disturbance, and a serious chronic illness, but who wishes to live longer to accomplish some important goals, might have this designation so that the symptomatic rhythm disturbance could be treated. Treatment could include cardioversion or medication. Treatment would not include chest compression or intubation if the patient suffered cardiopulmonary arrest.

How are M sub-categories differentiated?

The subcategories of M are based on decisions about location of care. An M1 designated person – often someone in chronic Home Care or in Supported Living such as LTC – might seek and would be appropriate for interventions in a more acute setting, but not resuscitations and ICU interventions.

However, an M2 designated person residing at home or in LTC would not be transferred to acute care, should their condition deteriorate. They would be treated with the interventions that are available in their current setting with the goals of controlling underlying illness, cure intercurrent illness and symptom relief.

Hospitalized patient with M1 designation:

An M1 designated patient currently in hospital is someone who would not be appropriate for resuscitative measures followed by ICU should they have a cardio respiratory arrest. They would still be offered other interventions that are appropriate to cure or control their underlying illness and to treat intercurrent illnesses.
M1:
Here is an example of decision-making for a person with an M1 designation. Mr. Jones, a 70 year old man at home, living with diabetes and heart failure, develops pneumonia. He and his physician have agreed on an M1 GCD. He is treated with oral antibiotics, but deteriorates. He would next be appropriately sent to acute care for investigation and potential treatment with IV antibiotics.

M2:
Mrs. Smith, a 70 year old woman in LTC with COPD, diabetes and debilitating arthritis indicates that she never wants to see the inside of a hospital again. She has an M2 designation. She develops pneumonia and is appropriately started on oral antibiotics. However she deteriorates and only hospital care and IV antibiotics could potentially help her recover. With an M2 designation, she would not be transferred to hospital and would be treated with palliative intent. If there is time, she should have her designation changed to C1 or if very close to death, C2. Even in the M2 category, as with all categories, comfort and symptom control measures are still important, and should be employed.

Goals of Care Designation and the use of an AED
An AED lead placement will assist in diagnosing, especially during the time required to call a code team for assistance (assistance does not imply resuscitation).

In the rare circumstances that a shock alone will revive someone, it is reasonable to try this, recognizing that without the benefits of full CPR, chances for success are limited. But a failed, limited attempt (e.g. a shock) would usually be in compliance with the R2 designated patient's wishes.

An R3 designated patient is really not looking for resuscitation attempts for cardiorespiratory arrest. But occasionally, such patients with known conditions will benefit from controlled cardioversion with electricity and drugs, dialysis, etc in an ICU. That is really what the R3 designation is for. We want such patients to be able to be admitted to an ICU, with limited and defined interventional goals.

When a patient collapses as a result of a malignant arrhythmia that renders them pulseless, they have essentially died and the chances that an AED can restore life without also requiring chest compressions, ICU and intubation are very small. The concept of R3 was to allow for situations where patient is already in a critical care area but either would not want or would not benefit from chest compressions or ventilation. The issue of providing defibrillation to these patients is tricky but not without justification. This only really makes sense in a highly monitored environment where a malignant arrhythmia can be acted on quickly enough that a patient has a reasonable chance of survival without CPR. If an R3 designated patient on non CCU/ICU wards [or out-patient area] develops a malignant arrhythmia, they are most likely to survive only with the benefit of all resuscitative measures – but they and their care teams have placed limits preventing the use of all those technologies. A shock, if available, can be tried,
but should not be repeatedly employed at risk to the dying patient’s dignity. The GCD wording was very specific - the term chest compression was used and defibrillation was left out to allow for appropriate use in this critical care setting.

**Can chest compressions to alleviate choking be initiated on a non R1 patient?**

One of the fears of people (staff, patients and families) encountering decision-making around GCD is that if a GCD of anything other than R1 is chosen the person will be "denied" help if they are choking on food and may die prematurely (not from their underlying disease process but from a potentially reversible cause).

Healthcare providers and passersby should be encouraged to feel that they can intervene for a choking person (hopefully starting before they become unconscious) using chest thrusts, suction (e.g. in acute care) or whatever intervention is currently available. If the choking person dies during the attempt to relieve the obstruction (becomes pulseless and apneic) the known GCD becomes relevant, and resuscitation is not started/continued.

There is a risk that the choking intervention will not be welcomed by the individual or family if the person's life is prolonged. On reflection the patient may say "don't ever do that to me again". In this circumstance, a specific caveat may need to be added to the person’s GCD.

By way of example, consider a person with ALS, with known swallowing problems, who has a C1 goal of care designation. That person has chosen to eat "for comfort" but requests no attempt be made to reverse a choking episode (in the event of choking a reassuring presence stays with the individual, and midazolam could be given by another provider). Or, such a person might request not to treat aspiration pneumonia resulting from inhaled oral secretions, fluid etc.

There are "risks of harm" by intervening in choking but there are also risks in not intervening. Harms might include the potentially premature death of an individual and the moral distress to all those who witnessed it while standing by. Since we do not always know how a person would like us to respond with either technologic or non-technologic responses to such an emergency, it is important to explicitly discuss patient-relevant scenarios, and to document clearly the results of those conversations.

**How does interventional cardiology in acute care respond to referrals for angioplasty when the patient has an M1 GCD?**

There is a risk that M1 designated patients might be inappropriately turned down for angioplasty simply due to their GCD. As always, good conversation, considering functional status/risk/benefit and patient goals will help determine suitability for the procedure. This conversation must include the risk that peri-procedural arrest could occur, and must determine guidance regarding what will be undertaken to resuscitate a patient in the event of an arrest. Some patients will direct that no attempt at resuscitation should occur. But M1 designated patients can receive attempts at resuscitation, with their advance agreement, along with the
limitation that an ICU stay or prolonged dependence on life-support would not be considered. Eventual withdrawal of life support interventions, after appropriate conversations, would be considered ethically and legally permissible. Such instructions should be clearly indicated on the health record and within the GCD Order.

**M1 GCD states:**

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.

A Cardiology colleague has provided the following general direction:

A GCD designation of M1 should never be the sole reason a patient would be turned down for angioplasty (PCI). There would, however, be concerns in general with accepting an M1 patient for a PCI procedure. Specifically,

1. Why does the patient have an M1 designation in the first place, and what does this say of the risk/benefit ratio of invasive cardiac procedures in such a patient, and/or the real wishes of the patient? The advantages of invasive cardiac procedures in the "cure and control" of illness in general patient populations who present primarily with acute cardiac problems has been difficult to prove (as opposed to optimal medical therapy). Patients with general illnesses leading to GCD other than R1 don't get into clinical trials (so few estimates as to potential benefits exist), and often have co-morbid conditions making complications from the proposed procedure far more likely (e.g. complication rates will overwhelm any possible benefit). In other words, the question becomes, why is the procedure, in this patient, desired in the first place?

2. Invasive cardiac procedures commonly involve short term, life threatening complications that can be overcome by skillful teams with the full therapeutic arsenal available. This includes chest compressions, DCC, mechanical ventilation, hemodynamic support. Without these therapies, complication rates in high risk patients would overwhelm any potential benefits.

3. In distinction to other major surgical procedures, PCI procedures are done with conscious sedation as opposed to general anesthesia. The patient will be awake, and aware of at least the initial phases of resuscitation, and needs to be completely "on side" that a full array of support will be used, if needed.

As a result, physicians agree to invasive cardiac procedures when the GCD is M1 if:

1. The health care team is convinced of the need for such a procedure (a large burden for the referring physician); and

If the patient agrees to an R1 designation during the procedural and peri-procedural interval, until such time as we believe the patient is entirely stable (or in the event of a severe
complication, irredeemably ill). We also insist that all of the above be fully discussed with the patient in advance of arriving in the catheterization laboratory.

Can the MET / Code 66 team be called for patients with non R designations?

Yes:

- The MET / Code 66 team will see any patient that staff is concerned about as per the criteria, and will respond to multiple calls for the same patient as necessary.
- Contact should always be initiated with the patient’s attending physician before or at the time of the MET / Code 66 call.
- The MET / Code 66 outreach teams do see both C and M designated patients because there may be ways that they can help to assess and manage the patient’s immediate deterioration, but it is possible that the MET / Code 66 team may not be able to suggest any further intervention.

When is a MET / Code 66 call inappropriate?

- A MET / Code 66 would not be called if the unit staff and attending are present and can manage the situation.
- A MET / Code 66 would not be called if the patient was quickly approaching an expected death (C2) and other resources such as palliative consult staff were available to address symptoms.
- A MET / Code 66 would not be called if a non R designated patient was already pulseless.

Is cardioversion/provision of electricity married to chest compressions in all resuscitation attempts?

The R3 GCD was specifically designed for patients in heart monitored situations whose malignant rhythm disturbance might be correctable by electricity and/or cardiac drugs, but who have chosen to not receive chest compressions and mechanical ventilation.

If such a person has a monitored rhythm disturbance requiring appropriate cardiac interventions, those interventions are undertaken when required.

If such a person is found pulseless, appropriate and limited cardiac interventions can be undertaken (electricity and/or cardiac drugs). It is understood by the patient and the team that the restriction against chest compressions might limit the chances for success. If return of a functional output to re-establish a pulse is not achieved, the person has died.
In an unmonitored situation (on the street or on a ward) a pulseless person with a GCD prohibiting chest compressions and mechanical ventilation has died. It would be exceedingly unlikely to revive such a person with only electricity.

That said it would not be unreasonable for a code team or a first responder to place leads, assess the displayed rhythm and attempt electricity, without going further. However, it is also reasonable for a first responder in the community to not place leads or an AED on such a patient if it was known and undisputed that the patient carried a non R1 GCD. This is a clinical judgment call.

In a controlled ICU setting, the staff and physicians would know which interventions can be undertaken for each R3 designated patient, should their monitored rhythm deteriorate, or if they are found pulseless. Since the GCD is determined after fulsome conversation with the patient, it is also presumed that the patient would understand the implications of a choice to limit full CPR.

**Why are M and C designated patients excluded from consideration for ICU admission, and how this is characterized on the Pocket Cards?**

No patient is absolutely excluded simply as a result of a previously determined GCD. "In the moment" decision-making by the current care team may lead to revocation of a GCD Order and potential admission for ICU care, if that is felt to be warranted, all things considered.

However, in general, M and C designated patients are not candidates for ICU admission. Of course, patients who are already in ICU sometimes have their goals altered to palliation and withdrawal of life-sustaining interventions, with a change in their GCD to C1 or C2. The C2 designated patients would be expected to die in the ICU as a result of that change in therapies.

Special circumstances exist for some patients - including sometimes for people who may require a short and defined period of post-operative ventilator support or monitoring in ICU, as part of an emergency surgical intervention that has been provided to manage symptom suffering. The benefit of characterizing their ICU stay in this way is that it remains clear for the staff that if the short and goal-directed ICU stay is not achieving the goals, then those interventions can be discontinued after appropriate conversations and decision-making. The patient (or alternate decision-maker), in advance of the procedure, would ideally have been made aware of this potential, and agreed to this course of action.

In the Pediatric world, patients are often admitted to ICU for end of life care; as, outside of Pediatric Hospices, the ICU is often felt to be the place where ideal symptom management and preparation for death can best occur.

For this reason, the pocket cards show that for the special circumstances of end of life symptom management, children with M and C GCDs are eligible for ICU admission. ICU leaders have been clear that signaling to general adult care staff that M and C designated patients might be candidates for ICU admission sends the wrong message to staff and patients, and would inappropriately deploy ICU outreach teams for involvement with ward
patients that are not usually eligible for ICU admission. So for adult patients, M and C designations do not include that option on the pocket cards. That applies generally, but of course does not absolutely prohibit considering the ICU for any patient. The pocket cards provide general guidance.

**Clarifying Policy Elements**

**Policy 1.7**

“All patients and all alternate decision-makers (when applicable) shall be made aware of Advance Care Planning and the Goals of Care Designation structure.”

What is meant by aware?

Health care teams and the most responsible health practitioner will make an effort to inform the patient and their family and/or alternate decision-maker about the Advance Care Planning and Goals of Care Designation structure; this can include a verbal conversation and or providing the patient and/or family with educational resources.

**Policy 1.8**

“Where a Goals of Care Designation has been ordered, patients or their alternate decision-makers should be made aware of their specific Goals of Care Designation.

In a situation where it is determined that providing such information may negatively impact the health or safety of the patient, it may not be appropriate to inform the patient of his/her Goals of Care Designation. In this case, it is recommended that the most responsible health practitioner consider consulting with, but not limited to:

a) colleagues;

b) Clinical Ethics Services;

c) College of Physicians and Surgeons of Alberta;

d) Canadian Medical Protective Association; and/or,

As with all clinical decisions, the MRHP will need to be able to justify the important reasons for withholding this information, if challenged.

Why wouldn’t a patient be told what their GCD is?

Some examples of circumstances in which a GCD is not discussed with a patient could include:

- Certain mental health conditions such as unresolved paranoia regarding the health system.
- When an otherwise healthy pediatric patient undertaking surgical treatment will be presumed to have an R1 Designation.
Clarifying Procedure Elements

Procedure 2.1

“Goals of care conversations shall take place, where clinically indicated with the patient, as early as possible in a patient’s course of care and/or treatment.”

Goals of care conversations should take place, where clinically indicated and should include but are not limited to:

- During an admission to a hospital or care facility;
- Before surgery;
- When a patient is transferred from one healthcare facility to another;
- When a patient attends an emergency department or urgent care centre;
- During an annual check-up with the family doctor;
- Any time there is a change in patients’ health circumstances; and/or
- At patient’s discretion, e.g. whenever they are preparing or reviewing their advance care plan.

What is a Personal Directive?

A Personal Directive is a legal document that a person creates while capable of making their own decisions. It allows the person to name a decision maker (called an “agent”) and provide written instructions in the event the person no longer has the capacity to make their own decisions.

A Personal Directive names an agent for decision-making about personal matters. It can provide direction about personal matters including, medical treatments, where to live and legal decisions. A Personal Directive does not cover financial matters; to leave instructions for managing personal finances, an enduring power of attorney is required.

When is it used?

A Personal Directive may be brought into effect after a capacity assessment has been completed and a person is deemed unable to make safe personal decisions. When this happens, the person named as the agent will be given the legal authority to make decisions on an individual’s behalf based on the information in the Personal Directive.

As per Alberta Legislation, a Personal Directive is in effect when it is in writing, dated, signed and the patient lacks capacity for a particular item listed, until death or it is revoked and/or replaced.