CancerCare Manitoba
ActionCancerManitoba

GOVERNING DOCUMENTS

Policy and Procedure

Title:	**Advance Care Planning and Goals of Care**	
Policy Number	10.004	Section: Patient Care – Patient Care
Effective Date:	February 2005	
Revised Date:	October 4, 2023	
Approving Body:	Chief Medical Officer of CancerCare Manitoba (CCMB)	
Authority:	The Health System Governance and Accountability Act	
Responsible Officer:	Chief of Clinical Operations	
Contact:	Director(s) of Patient Services, Outpatient Clinic Services Program, Systemic Therapy Program	
Applicable to:	All CCMB Staff and Physicians	

1.0 BACKGROUND:

1.1 Advance Care Planning is an ongoing, Collaborative Process in which Patients, their Families, and their Health Care Team reflect on the Patient's goals, values and beliefs; discuss how these should inform current and future medical care; and, ultimately, use this information to accurately document their future health care choices.

1.2 Advance Care Planning is intended to provide direction for a time when a person cannot make their own health care decisions.

1.3 Advance Care Planning conversations allow for respectful understanding of the Patient's wishes concerning general focus of care and limits of specific interventions. The timing and nature of Advance Care Planning conversations may vary depending on whether the person is healthy, has mild to moderate illness, or an advanced, life-limiting illness. Advance Care Planning discussions have been associated with better patient outcomes, less expensive medical care, and increased consideration of hospice or home care resources.

2.0 PURPOSE:

2.1 To promote an ongoing, Collaborative Process for Advance Care Planning to ensure the Goals of Care of the Patient/Client are identified and addressed.

2.2 To promote a standardized approach to Advance Care Planning.

2.3 To recognize that Advance Care Planning is a valued process of communication, while acknowledging there will be occasions when Consensus cannot be reached. This policy is not intended to address situations of unresolved conflict, other than to encourage continued dialogue.

2.4 To promote Patient safety, by:

- Following policy "to identify critical client information and ensure that this information is always available to team members providing services"1 to a Patient/Client. See 3.6, Definition Critical Information.

- Partnering "with the client to ensure they know what information all the care providers need to know when moving between services." (Accreditation Canada. See References, 6.14)

3.0 DEFINITIONS:

3.1 **Advance Care Planning (ACP)** – The overall process of dialogue, knowledge sharing, and informed decision-making that needs to occur at any time when future or potential life-threatening illness treatment options and Goals of Care are being considered or revisited.

An Advance Care Plan should include the Manitoba Health Care Directive form (to comply with The Health Care Directives Act of Manitoba), but can include additional information and expanded details specific to each Patient and their health care needs.

3.2 **Capacity** – An individual has capacity to make health care decisions if they are able to understand the information that is relevant to making a decision, and are able to appreciate the reasonable, foreseeable consequences of a decision or lack of a decision.

3.2.1 The Health Care Directives Act of Manitoba presumes that, unless there is evidence to the contrary, a person who is 16 years of age or older has Capacity to make health care decisions, and therefore to make a Health Care Directive.

3.2.2 With respect to Capacity, The Health Care Directives Act is subject to The Mental Health Act. When there is conflict between these two acts, The Mental Health Act prevails.

3.3 **Clinician** – An authorized practitioner of medicine practicing within the scope of practice for their designation and may include Oncologists, Hematologists, Family Practitioners in Oncology, Nurse Practitioners, Residents, Fellows, Physician Assistants, and Clinical Assistants.

3.4 **Collaborative Process** – When the Health Care Team engages in joint planning for the care of the Patient with shared responsibility and decision-making that includes the Patient and Family/Substitute Decision Makers (SDM). A Collaborative Process for ACP provides opportunities for Health Care Team members to work to the full scope of practice of their respective disciplines. It also supports Patients/Families/SDMs as equal members of the team.

3.5 **Consensus** – General agreement and the process of getting to such agreement. For a Consensus to be considered valid, the Patient's/SDM's wishes regarding Goals of Care should be understood and considered feasible by the Health Care Team. Other members of the Patient's support network may or may not need to agree, according to the Patient's/SDM's discretion.

3.6 **Critical Information** – Information required by other teams that if missed might cause harm to the client (e.g. allergies, do not resuscitate [DNR] orders, advanced care plans, infection issues.).

3.7 **Family** – Any individual or group of individuals that a Patient identifies as Family. Every effort shall be made to include as many Family members in Advance Care Planning conversations as the Patient would like to have involved.

3.8 **Goals of Care (GOC)** – The intended purpose of health care interventions and support as recognized by both a Patient/SDM and the Health Care Team. This may be related to long-term, end-of-life goals, or a current issue/diagnosis that is curative. Goals of Care can differ for a person with cancer when discussing their end-of-life treatment goals related to their cancer (e.g., no intensive care unit admission, intubation, resuscitation, etc.) versus a separate diagnosis (e.g., pneumonia, motor vehicle accident, etc.).

3.9 **Goals of Care Designations** – A letter (C-M-R-PD-NC) used to indicate specific direction regarding health interventions, transfer decisions, location of care, and limitations on interventions for a Patient as established after consultation between the Health Care Team and Patient/SDM(s).

3.9.1 **Comfort Care (C)** – Goals of Care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life, excluding attempted resuscitation.

3.9.2 **Medical Care (M)** – Goals of Care and interventions are for care and control of the Patient/Client's condition. The consensus is that the Patient/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered, excluding attempted resuscitation.

3.9.3 **Resuscitation (R)** – Goals of Care and interventions are for care and control of the Patient/Client's condition. The consensus is that the Patient/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered, including attempted resuscitation.

3.9.4 **Patient Declined (PD)** – Patient declined to have discussion on Goals of Care.

3.9.5 **No Consensus (NC)** – Patient and the Health Care Team were unable to reach Consensus on Goals of Care due to the patient being undecided and needs time to reflect.

3.10 **Goals of Care Form** – The form used to document Goals of Care as reached by Consensus through ACP discussions, hereafter referred to as the GOC Form, or Form (See Appendix B).

3.11 **Health Care Directive (HCD)** – A Health Care Directive is a self-initiated form used as part of an ACP that complies with the provisions of The Health Care Directives Act. In Manitoba, a Health Care Directive may indicate the type and degree of health care interventions the individual would consent or refuse to consent to and/or may indicate the name(s) of an individual(s) who has been delegated to make decisions (i.e. a proxy).

3.12 **Health Care Team** – Health Care Team is used to describe health care professionals from multiple disciplines who are providing health care services to a Patient at a CCMB site and/or at a Community Cancer Program partner site.

3.13 **Most Responsible Health Practitioner (MRHP)** – This refers to the health practitioner who has responsibility and accountability for the specific treatment/procedure(s) provided to the Patient and who is authorized by CCMB to perform duties required to fulfill the delivery of such treatment/procedure(s) within the scope of their practice. Currently in Manitoba, the MRHP is usually a physician. In some circumstances within a clinical team or program, a nurse practitioner may be named the MRHP.

3.13.1 Patients sometimes have multiple physicians, and the primary responsibility for some care and decisions can change depending on the Patient's circumstances. Therefore, wisdom and clinical judgement needs to be exercised by the various physicians regarding who will be responsible for current and future care directives. Most importantly, those various physicians need to communicate effectively amongst themselves.

3.14 **Nearest relative** – The adult relative of whole blood being preferred to relatives of the same description of half-blood and the elder or eldest of two or more relatives preferred to the other of those relatives regardless of gender.

3.15 **Other Health Care Provider(s)** – Other Health Care Provider(s) is used to denote health care professional(s) separate from CCMB who is/ are currently providing, or may have occasion to provide in future, health care services to a Patient in other settings, e.g. primary care, emergency departments, other medical sub-specialties.

3.16 **Patient** – A person who is registered and receiving medical services from a CCMB site, or a CCMB Community Oncology Program partner site. The term patient shall also be used to reference the inclusion of SDM/family/caregiver/support person and/or significant other.

3.17 **Power of Attorney/Enduring Power of Attorney** – Legal document in which one person (called the donor) gives authority to another person (called the attorney) to manage some or all of the donor's financial affairs. A Power of Attorney deals only with financial affairs, and not with personal decisions. An Enduring Power of Attorney is a clause in the Power of Attorney document allowing the attorney to continue acting even if the donor later becomes mentally incompetent. For a Power of Attorney to be involved in personal/health care decisions, they must also be named a proxy/SDM by the Patient.

3.18 **Provincial Cancer Patient Record (PCPR)** – Patient's Electronic Chart.

3.19 **Resuscitation** – 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, defibrillation, cardioversion, pacing, and intensive medications.

3.20 **Substitute Decision Maker (SDM)** – A Substitute Decision Maker refers to a third party identified to participate in decision-making on behalf of an individual at a time that the individual lacks Capacity to make their own decision. A person can be named an SDM if they are 18 years of age or older. The task of an SDM is to faithfully represent the known preferences, or if the preferences are not known, the interest of the individual lacking Capacity. The following, in order of priority, may act as SDMs:

3.20.1 A proxy (or proxies) appointed by the individual under The Health Care Directives Act of Manitoba;

3.20.2 A committee appointed under The Mental Health Act of Manitoba, if the committee has the power to make health care decisions on the individual's behalf; or SDM appointed pursuant to The Vulnerable Persons Living with a Mental Disability Act of Manitoba, if the individual has authority to make health care decisions;

3.20.3 Nearest relative of the Patient, in the following order:

- Parent or legal guardian of the individual, if the individual is a child under the age of 16 years;
- Spouse (including a person who, although not married to the Patient, cohabited with the Patient as a common-law partner for at least 6 months immediately prior to referral, but does not include a spouse from whom the Patient is living separate and apart);
- Son or daughter;
- Parent of the individual, if the individual is an adult;
- Brother or sister;
- Person with whom the individual is known to have a close personal relationship;
- Grandparent;
- Grandchild;
- Aunt or uncle;
- Nephew or niece.

4.0 POLICY:

4.1 ACP discussions shall occur in consultation with:

a) The Patient, if the Patient has Capacity;
b) Proxy if a proxy has been named in an ACP and/or HCD;
c) The SDM(s) as defined in 3.18 if the Patient lacks Capacity.

4.1.1 ACP may require one discussion or several sessions of discussion over a period of time to achieve Consensus. The Health Care Team member(s) that will be responsible for initiating a Goals of Care dialogue will be determined by each setting/specialty, taking into consideration rapport with the Patient availability of all parties for discussion, and location where the conversation will take place.

4.2 Advance Care Planning (ACP) discussion between the Patient and Health Care Team members and shall be completed at the following times:

a) Before initiation of a treatment plan, e.g. systemic therapy, radiation therapy, surgery;

b) Whenever there is significant change in the Patient's clinical status and the treatment plan needs to be modified;

c) At the request of the Patient;

d) At the request of any member of the Health Care Team.

4.2.1 ACP conversations may be initiated by any member of the Health Care Team, as appropriate for the individual's discipline and scope of practice.

4.2.2 When an ACP conversation is initiated between a Patient and a member of the Health Care Team other than the MRHP, it is the responsibility of that member to communicate this information to the MRHP.

4.2.3 It remains the responsibility of the MRHP to undertake a full ACP conversation with the Patient.

4.3 A valid ACP and/or HCD completed by the Patient shall be respected, unless requests made within the HCD are not consistent with accepted health care practices and/or professional standards of practice of regulatory bodies.

4.4 The MRHP shall ensure that the Patient receives full and complete information about the nature of the individual's current condition, prognosis, procedure/treatment/investigation options and the expected benefits or burdens of those options. (See Appendix C for the Degree of Clinical Benefit).

4.4.1 The MRHP shall ensure the Patient has opportunity to discuss questions and concerns regarding the information received.

4.4.2 The MRHP shall ensure these discussions precede completion or revision of the GOC Form.

4.5 The MRHP shall ensure the SDM is provided with information involved in being a substitute decision maker, and that the SDM is given opportunity to discuss questions and concerns accordingly.

4.6 The Health Care Team shall request the services of a trained health interpreter when a Patient has limited English language proficiency, as per CCMB Policy 01.017, Language Access – Interpreter Services.

4.7 The MRHP shall provide the Patient with information describing resources within the health care system (e.g. Ethics Service, Psychosocial Oncology, Spiritual Health, Patient Representatives, clinical experts) available to assist them in addressing uncertainties and/or conflicts which may arise in the process of developing or revising an ACP and/or a GOC Form.

4.8 The Goals of Care form shall be completed for all ACP discussions in which a goals of care designation (C-M-R-PD-NC) has been determined and the GOC form scanned into the PCPR under Advance Directive note type. The details of the discussion shall be documented in a progress note in the PCPR.

4.8.1 Should the Health Care Team and the Patient be unable to achieve consensus, resources shall be made available to the Patient or to Health Care Team members, as appropriate for the circumstances. The MRHP shall ensure that the necessary referrals take place.

4.8.1.1 Resources for the Patient may include, but are not limited to:

- Spiritual Care,
- Psychosocial Oncology,
- Patient Representatives,
- Clinical experts,
- Representatives from CCMB Administration/Management.

NOTE: In addition to any/all resources listed above, members of the Health Care Team may wish to consult with the CCMB Clinical Ethics Committee.

4.8.2 If the Goals of Care Designation is No Consensus (NC) or Patient Declines (PD), resuscitation efforts shall be undertaken in circumstances where warranted.

4.8.3 If the patient has indicated that they would not accept aggressive medical therapies (i.e. Patient has requested no resuscitation and/or would not accept admission to an intensive care unit) and is planned to undergo a procedure that requires general or regional anesthesia (i.e., block/spinal) or procedural sedation the Health Care Team shall ensure that a discussion takes place with the Patient regarding the response to potential life-threatening problems that may occur during the perioperative period. The results of such discussions shall be documented in the PCPR.

4.9 Audit of ACP documentation in the PCPR shall be conducted for quality assurance purposes at intervals determined by CCMB Senior Leadership.

4.9.1 Key Performance Indicators will include Number of Goals of Care Physician Orders per CCMB site, by key Patient cancer journey points

- Before initiating a treatment plan;
- With significant change in Patient's clinical status requiring treatment modification;
- When requested by Patient.

4.10 Refer to CancerCare Manitoba Policy 'COMPASS Tool' Number pending.

5.0 PROCEDURE:

NOTE: Responsibilities of the nurse and unit clerk in ACP procedures may be contingent upon specified clinical roles, and upon staff resources at a particular site.

5.1 If a Health Care Team member is made aware that an ACP and/or HCD exists, a copy shall be:

a) Obtained to guide further discussion as an indication of the Patient's wishes at the time of writing,

b) Scanned into the PCPR using the appropriate note type of Advance Directive.

5.2 The Health Care Team shall address any ACP questions included on the COMPASS tool that are checked as 'Yes' (see Appendix D).

5.2.1 If a patient indicates they do not understand what ACP is or would like information on ACP in the COMPASS tool, patient resources shall be provided to the patient.

The patient resources include but are not limited to:

5.2.1.1 CCMB Website - Cancer and Advance Care Planning

5.2.1.2 CCMB Patient ACP Workbook – *It's About Conversations*

5.2.1.3 CCMB Patient ACP Bookmark

5.2.1.4 Patient Video - CancerCare Manitoba - Advance Care Planning

5.2.2 If a Patient indicates desire for an ACP discussion, the discussion should be arranged in a timely fashion and the Patient should be provided with resource material (see 5.2.1.1-5.2.1.4) to review before the appointment where the discussion will take place.

5.2.3 If a patient indicates 'there has been a change in your ACP preferences since your last visit', an ACP discussion should be arranged in a timely fashion.

5.3 Initiating the Goals of Care/Advance Care Planning Discussion.

5.3.1 The clinician/MRHP shall introduce the topic (See Appendix A) and ensure the discussion includes but is not limited to:

a) Exploration of the Patient's values, understanding, hopes, wishes and expected outcomes of treatment;

b) Identification of the SDM, and the roles/responsibilities involved;

c) The Patient's prognosis and the anticipated outcome of current treatment or possible future treatment options;

d) The role of life support interventions and/or life sustaining measures and their expected degree of benefit (See Appendix C).

e) Information regarding comfort measures; and if appropriate, an offer for involvement of resources such as:
   a. Palliative Care,
   b. Social Work,
   c. Clinical Ethics consultation, or
   d. Spiritual Care

5.4 Documenting the Goals of Care/Advance Care Planning Discussion.

5.4.1 Once a Goals of Care discussion has occurred, the clinician shall enter a Goals of Care physician order entry (POE) in the PCPR. The POE shall include the follow:

a) The goals of care designation (C-M-R-PD-NC)

b) Who agreed to the goals of care designation, the patient and/or the substitute decision maker

c) If this is the first goals of care, revised goals of care or goals of care designation is unchanged

5.4.2 Once the POE has been entered the Unit Clerk shall:

NOTE: These steps shall be completed every time a goals of care POE is entered, regardless if there's a change to the goals of care or not.

5.4.2.1 Print the Goals of Care form from the physician 'orders by date' tab.

5.4.2.2 Handwrite the names of the meeting attendees on the Goals of Care form.

NOTE: If a substitute decision maker was an attendee but their name was not populated on the GOC form, submit a notification of change form to Health Information Services.

5.4.2.3 Have the completed form scanned into the PCPR using the Advanced Directive note type.

5.4.2.4 Provide the patient with a copy of the GOC form and the *It's About Conversations* guide booklet, if not already given, and instruct the patient to make this form available to their family/SDM.

NOTE: The Patient should be provided with a copy in as timely a manner as possible, recognizing the Physicians Order may be processed after the Patient leaves the appointment.

NOTE: If the GOC designation is PD (Patient Declined) or NC (No Consensus) it is not necessary to give the Patient a copy.

5.4.2.5 Initiate the appropriate goals of care patient status icon in the PCPR.

NOTE: There is no icon option for circumstances when there is No Consensus (NC) or the Patient Declines (PD).

NOTE: If the appropriate patient status icon is different from the previously initiated icon, ensure to uncheck the previous icon. There shall only be one goals of care icon selected at a time.

5.4.2.6 Once 5.4.2.1 to 5.4.2.5 have been completed the goals of care physician order shall be transcribed.

6.0 REFERENCES:

6.1 Government of Manitoba (n.d.). Health Care Directives in Manitoba. Retrieved September 12, 2023 from: https://www.gov.mb.ca/health/livingwill.html

6.2 CancerCare Manitoba (n.d.) Cancer and Advance Care Planning. Retrieved September 13, 2023 from: www.advancecareplanningincancer.ca

6.3 CancerCare Manitoba (2023). COMPASS. Policy No. pending.

6.4 CCMB POLICY NO.01.017 Language Access – Interpreter Services. Language Access – Interpreter Services

6.5 CCMB POLICY NO.07.011 Organizational Ethical Framework for Decision Making & Ethical Issues Organizational Ethical Framework

6.6 Winnipeg Regional Health Authority (2015) *Advance Care Planning - Goals of Care*. Retrieved September 13, 2023 from: http://home.wrha.mb.ca/corp/policy/files/110.000.200.pdf

6.7 Ferrell, B. et al. (2017) *Integration of Palliative Care into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update*. Integration of Palliative Care into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update - PubMed (nih.gov)

6.8 ESMO Clinical Practice Guidelines on palliative care: advanced care planning (2014). Retrieved September 13, 2023 ESMO Clinical Practice Guidelines on palliative care: advanced care planning† - Annals of Oncology

6.9 Government of Manitoba (2023). *The Vulnerable Persons Living with a Mental Disability Act of Manitoba, C.C.S.M. c. V90*. Retrieved September 13, 2023 from: https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=v90

6.10 Government of Manitoba (2023). *The Mental Health Act of Manitoba, C.C.S.M. c. M110*. Accessed online 14 March 2018 at: The Mental Health Act

6.11 Government of Manitoba (2023). *The Health Care Directives Act of Manitoba, C.C.S.M. c. H27*. Retrieved September 13, 2023 from: The Health Care Directives Act, C.C.S.M. c. H27 (gov.mb.ca)

6.12 Canadian Anesthesiologists' Society Committee on Ethics (2019). Peri-Operative Status of "Do Not Resuscitate (DNR)* Orders and other Directives that Limit Interventions. Retrieved September 13, 2023 from: Canadian Anesthesiologists' Society Committee on Ethics

6.13 Alberta Health Services (May 2018). Advance Care Planning and Goals of Care Designation Policy. Retrieved September 13, 2023 from: https://extranet.ahsnet.ca/teams/policydocuments/1/clp-advance-care-planning-hcs-38-01-procedure.pdf

6.14 Accreditation Canada Qmentum Standards for Cancer Care for Surveys Starting After: January 1, 2019. Copyright © 2018. Providing Safe and Effective Services, Criterion 13.4, pp. 42-43; Criterion 9.11, p. 20.

Policy Contact:
All enquiries relating to this policy should be directed to:

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DOCUMENTATION	
Policy Location: This policy is located (hard and e-copy formats):	
1.	The original signed and approved policy is on file in the Executive Office, CCMB
2.	The e-copy is on file in the CCMB Governing Documents Library, SharePoint

REVISION HISTORY:

Date	Version	Status	Author	Summary of Changes
Feb 2005	1	Initial		
18/07/2011	2	Revision		
04/04/2018	3	Revision	ACP Working Group	Approved by CPMT pending final revisions
01/06/2018	4	Final	T. Carpenter-Kellet, Z. Poole	Final revisions made by ACP working group
13/09/2023	5	Revision	OCSP Nurse Educators	Updates to formatting, references and links
04/10/2023	6	Final		Final review and approval

APPROVAL RECORD:

Date	Name / Title	Signature
October 4, 2023	Ken Borce, Chief of Clinical Operations, CancerCare Manitoba (CCMB)	*Original signed by K. Borce*

FINAL APPROVAL:

Date	Name / Title	Signature
October 4, 2023	Dr. Arbind Dubey, Chief Medical Officer, CancerCare Manitoba (CCMB)	*Original signed by Dr. A. Dubey*

APPENDIX A

Introducing ACP to the Patient

How can I introduce the topic of ACP/GOC in a sensitive way?

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

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 Goals of Care discussions with family, agent or health care providers.

Additional information is available at:

www.advancecareplanninginoncologypractice.ca

www.advancecareplaning.ca

APPENDIX B
ACP FOALS OF CARE FORM

Version Date: July 18, 2011

CancerCare Manitoba
ActionCancerManitoba

ADVANCE CARE PLANNING
GOALS OF CARE
Refer to CCMB Advance Care Planning Policy # 03.10.185
Prior to completing this form

Is there an existing Health Care Directive? ☐ No ☐ Yes
(If yes, it shall guide further discussions as an indication of the patient/Client/Resident's wishes at the time of writing)

Advance Care Planning (ACP) is the overall process of dialogue, knowledge sharing and informed decision making that needs to occur at any time when future or potential life threatening illness treatment options and Goals of Care are being considered or revisited. This form is used to record agreed upon Goals of Care reached through full and complete ACP discussions with the Patient/Client and/or Substitute Decision Maker about the nature of the individual's current condition, prognosis, treatment/procedural/investigation options, and expected benefits or burdens of those options.

GOALS OF CARE (Check the box that best describes the patient/Resident/Client Goals of Care)

☐ **C =** Comfort Care - Goals of Care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life *excluding* attempted resuscitation.

☐ **M =** Medical Care - Goals of Care and interventions are for care and control of the Patient/Client condition. The Consensus is that the patient/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered *excluding* attempted resuscitation.

☐ **R =** Resuscitation - Goals of Care and interventions are for care and control of the Patient/Client condition. The consensus is that the Patient/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered *including* attempted resuscitation.

Indicate all individuals who participated in Goals of Care discussion (s) by checking appropriate box(es).

☐ Patient/Client Print Name: _____
☐ Family Member(s) Print Name(s): _____
☐ Substitute Decision Maker Print Name(s): _____
☐ Health Care Provider(s) Print Name(s): _____

Document details of the Patient/Client specific instructions or wishes and/or details of discussion with the individuals indicated above (refer to date/time of Progress Note entry if more space is required):

_____
_____
_____
_____
_____

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y Y

The Goals of Care were reviewed with the Patient/Client and/or Substitute Decision Maker and no change to the form is required.

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y Y

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y Y

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y Y

If review results in any changes to the Patient/Client Goals of Care, a new form must be completed.
PROVIDE COPY OF COMPLETED FORM TO PATIENT/CLIENT OR SUBSTITUTE DECISION MAKER

APPENDIX C
Degree of Clinical Benefit

Degree of Clinical Benefit has three categories:

a) Likely to Benefit:
In the opinion of the most responsible health practitioner, there is a reasonable chance that cardiopulmonary resuscitation, 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.

b) Benefit is Uncertain:
It is unknown or uncertain whether cardiopulmonary resuscitation, physiological support and life support interventions will restore functioning. The subsequent prognosis or the likelihood of adverse consequences is also unknown or uncertain.

c) Certainly will not Benefit:
There is no reasonable chance that the person will benefit clinically from cardiopulmonary resuscitation, physiological support, and life support interventions.

See References, 7.4
Alberta Health Services (May 2018), *Advance Care Planning and Goals of Care Designation* Policy.

APPENDIX D

COMPASS Tool

Room #_____

Today's Date:
___/___/_____
D M Y

CancerCare Manitoba
COMPASS
COMPREHENSIVE PROBLEM AND SYMPTOM SCREENING

Place patient label here
(Must include CR)

1. Edmonton Symptom Assessment System Revised (ESAS-R)

Please circle the number that best describes how you feel NOW:

1. No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
2. No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
3. No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
4. No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
5. No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
6. No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
7. No Depression *(Depression) = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
8. No Anxiety *(Anxiety – feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
9. Best Wellbeing *(Wellbeing – how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
10. No _____	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Other problem *(for example: night sweats, wound issues)*

3. Medications

Have there been any **changes** since your last visit?
❒Yes (If yes, please list):

❒No **change** in medication

4. Other

Have you smoked in the past six weeks?
❒ Yes ❒ No

Are you interested in quitting smoking?
❒ Yes ❒ No

2. Canadian Problem Checklist

Please check all of the following items that have been a concern or problem for you in the PAST WEEK INCLUDING TODAY:

Physical:
- ❒ Concentration/Memory
- ❒ Sleep
- ❒ Weight
- ❒ Constipation
- ❒ Diarrhea
- ❒ Swallowing
- ❒Mouth sores
- ❒Falling/Loss of balance
- ❒Vision or hearing changes
- ❒Heartburn/Indigestion
- ❒Numbness/Tingling
- ❒Changes to skin/nails
- ❒Bleeding/Bruising
- ❒ Bladder problems

Practical:
- ❒ Work / School
- ❒ Finances
- ❒ Accommodation
- ❒Getting to and from appointments
- ❒Child/Family/Elder care
- ❒Trouble with my daily activities

Emotional:
- ❒ Fears / Worries
- ❒ Sadness
- ❒ Frustration/Anger
- ❒Changes in appearance
- ❒ Intimacy / Sexuality
- ❒ Fertility
- ❒ Coping
- ❒Loss of interest in everyday things
- ❒ Loss/grief

Dignity:
- ❒ Loss of control
- ❒ Embarrassment/shame
- ❒ Not feeling respected/understood
- ❒ Not feeling worthwhile/valued
- ❒ Feeling like I am no longer the person I once was

Spiritual:
- ❒Meaning/Purpose of life
- ❒Faith

Informational:
- ❒ Understanding my illness and/or treatment
- ❒ Talking with the health care team
- ❒ Making treatment decisions
- ❒ Knowing about available resource

Social/Family:
- ❒ Feeling a burden to others
- ❒ Worry about family/ friends
- ❒ Feeling alone
- ❒ Relationship difficulties

Advance Care Planning: *is for everyone and can be done at anytime* ❒ Prefer not to answer

1. Do you need information and resources on Advance Care Planning? ❒ Yes ❒ No
2. Do you want to discuss Advance Care Planning at your appointment today? ❒ Yes ❒ No
3. Has there been a change in your Advance Care Plan since your last visit? ❒ Yes ❒ No