CancerCare Manitoba
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GOVERNING DOCUMENTS

Policy and Procedure

Title:	**Advance Care Planning And Goals Of Care**
Policy Number:	10.004
Effective Date:	February 2005
Revised Date:	June 1, 2018
Approving Body:	President and CEO
Authority:	CancerCare Manitoba Act
Responsible Officer:	President and CEO
Delegate:	Chief Medical Officer (CMO)
Contact:	Ms. Tara Carpenter-Kellett
Applicable to:	CCMB Staff and Physicians at all CCMB Sites

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. *See Appendix A, Introducing ACP to the Patient.*

1.4 Goals of Care Designations that shall be used to describe, communicate, and document the general focus of care for the Patient/ Client are **C, M, R, PD, NC**:

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

ii. **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.

iii. **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.

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

v. **No Consensus (NC)** – Patient/ Client and the Health Care Team were unable to reach Consensus on Goals of Care.

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:

i. 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.*

ii. Partnering "with the client to ensure they know what information all the care providers need to know when moving between services."[2]

[1-2] Accreditation Canada. See References, 7.10

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 **Health Care Directive (HCD):** *The Health Care Directives Act* of Manitoba *(see References, 7.6)* recognizes that mentally capable individuals have the right to consent or refuse to consent to health care treatment. Further, the Act indicates that this right should also be respected after individuals are no longer able to participate in decisions respecting their health care treatment. 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). *Refer to:* http://www.gov.mb.ca/health/livingwill.html

3.3 **Goals of Care (GOC):** The intended purpose of health care interventions and support as recognized by both a Patient or Substitute Decision Maker 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 ICU, intubation, resuscitation, etc.) versus a separate diagnosis (e.g., pneumonia, MVA, etc.).

3.4 **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).

3.5 **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, CCMB Goals of Care Form.*

3.6 **Critical Information:** *Accreditation Canada Qmentum Standards for Cancer Care* define critical information as "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.)" *See References, 7.10.*

3.7 **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.

3.8 **Patient:** A person who is registered and receiving medical services from a CancerCare Manitoba site, or a CCMB Community Oncology Program partner site. For purposes of this policy the term is synonymous with Client; but it is recognized that, in certain settings, the term Resident may be used.

3.9 **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 a SDM if they are 18 years of age or older. The task of a 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:

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

3.9.2 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 Ac*t of Manitoba *(see References, 7.7)*, if the individual

has authority to make health care decisions;

3.9.3 Nearest relative of the Patient, in the following order (definition adapted from *The Mental Health Act. See References, 7.5*) —
" 'Nearest relative' means, with respect to a Patient…the adult person first listed in the following clauses, relatives of whole blood being preferred to relatives of the same description of half-blood and the elder or eldest of two or more relatives described in any clause being preferred to the other of those relatives regardless of gender:"

- 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.

3.10 **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.

3.11 **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 decision.

3.11.1 *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.

3.11.2 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.

3.12 **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 CancerCare Manitoba 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.

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

3.12.2 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.

3.13 **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 CancerCare Manitoba (CCMB) Site and/ or at a Community Cancer Program Partner Site.

3.14 **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.

3.15 **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/ SDM(s). 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.

3.16 **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 be in agreement, according to the Patient's/ SDM's discretion.

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 **ARIA®:** The electronic record system used to manage Patients' medical information at CancerCare Manitoba.

4.0 **POLICY:**

4.1 Advance Care Planning (ACP) is primarily a process of communication between the Patient/ SDM(s) and Health Care Team members. Such discussions shall be completed in advance of anticipated treatment, or change in treatment intent based on clinical status.

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

4.1.2 When an ACP conversation is initiated between a Patient/ SDM 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.

4.1.3 It remains the responsibility of the MRHP to undertake a full ACP conversation with the Patient/ Family/ SDM.

4.1.4 Standards of practice* indicate that ACP conversations shall take place at these key points in the Patient's cancer journey:

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/ Family/ SDM(s);

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

**ASCO and ESMO Clinical Practice Guidelines. See References 7.8 and 7.9, respectively.*

4.2 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.

4.3 The MRHP shall ensure that the Patient/ SDM(s) 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.

4.3.1 The MRHP shall ensure the Patient/ SDM(s) have opportunity to discuss questions and concerns regarding the information received.

4.3.2 The MRHP shall ensure these discussions precede completion or revision of the GOC Form. *See Appendix C, Degree of Clinical Benefit.*

4.4 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.[3]

[3] *Accreditation Canada. See References, 7.10.*

4.5 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 No. 01.017. *See References, 7.11.*

4.6 The MRHP shall provide the Patient/ SDM(s) with information describing resources within the health care system (e.g. Ethics, 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.

4.7 The goal of the process is to achieve Consensus amongst the Health Care Team and Patient/ SDM(s). If Consensus cannot be reached, the GOC Form shall be completed indicating **NC** - No Consensus. If the Patient declines a conversation about ACP/ GOC, the GOC Form shall be completed indicating **PD** - Patient Declined.

4.7.1 Should the Health Care Team and the Patient/ SDM(s) be unable to achieve Consensus as outlined in this policy, resources shall be made available to the Patient/ SDM or to Health Care Team members, as appropriate for the circumstances.

4.7.2 Resources for the Patient/ SDM may include, but are not limited to: Spiritual Care, Psychosocial Oncology, Patient Representatives, Clinical Experts, or representatives from CCMB Administration/ Management. The MRHP shall ensure that the necessary referrals take place.

4.7.3 In addition to any/ all resources listed in 4.7.2 above, members of the Health Care Team may wish to consult with the CCMB Clinical Ethics Committee. (*Refer to CCMB Policy No. 01.300. See References, 7.12).* The MHRP *or* the supervisor from the same discipline as the individual Health Care Team member seeking referral/ consultation shall ensure these take place.

4.8 If the Goals of Care Designation is No Consensus (**NC**) or Patient Declines (**PD**)**,** resuscitation efforts should be undertaken in circumstances where warranted. *See Definitions, 3.7, Resuscitation.*

4.9 Details of all ACP discussions must be documented on the GOC Form and recorded in ARIA®, saved under Advance Directive note type.

4.10 Audit of ACP documentation in ARIA® shall be conducted for quality assurance purposes at intervals determined by CCMB Senior Leadership.

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

(*See 4.1.4 a, b, and c above*):

- Before initiating a treatment plan
- With significant change in Patient's clinical status requiring treatment modification
- When requested by Patient/ Family/ SDM(s).

5.0 **EQUIPMENT AND SUPPLIES:**

5.1 CCMB Health Care Provider ACP Booklet

5.2 CCMB Health Care Provider Conversation Guides (3)

5.3 CCMB Patient ACP Workbook

5.4 CCMB Patient ACP Bookmark

5.5 Quick Tips for Physician for Goals of Care Integration into ARIA®

5.6 Quick Tips for Nurses and Clerks for Goals of Care Integration into ARIA®

5.7 ACP Goals of Care Initiative Flyer 2.0

5.8 Patient Video - CancerCare Manitoba - Advance Care Planning

5.9 Websites:
Health Care Professionals - www.advancecareplanninginoncologypractice.ca
Patients - www.advancecareplanningincancer.ca

6.0 **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.

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

i. Obtained to guide further discussion as an indication of the Patient's wishes at the time of writing, *and*

ii. Scanned into ARIA® using the appropriate note type of Advance Directive.

6.2 Questions to assess ACP need are included on the COMPASS tool *(Appendix D)* and ARIA® questionnaire. Patient resources should be provided to any Patient who indicates a need for more information.

6.3 When a Patient indicates desire for an ACP conversation, discussion should be

arranged in a timely fashion. The Patient should be provided with resource material to review before the appointment where the discussion will take place.

6.4 ACP discussions shall occur in consultation with:

i. The Patient, if the Patient has Capacity;

ii. Proxy if a proxy has been named in an ACP and/ or HCD;

iii. The SDM(s) as defined in 3.9 if the Patient lacks Capacity.

6.5 The Health Care Team shall engage the Patient and others, as outlined above or as appropriate, in discussion regarding Goals of Care. This process 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 and their Family/ SDM(s), availability of all parties for discussion, and location where the conversation will take place.

6.6 The ACP procedure will be entered into ARIA® so that all information regarding ACP communication with the Patient/ SDM(s) is accessible to all Health Care Team members.

6.7 Should the Health Care Team and the Patient/ SDM(s) be unable to achieve Consensus as outlined in this policy, the resources made available to the Health Care Team members and to the Patient/ SDM(s) may include, as appropriate: Ethics, Spiritual Care, Psychosocial Oncology, Patient Representatives, Clinical Experts and Administration/Management representatives.

6.8 Initiating the Goals of Care/ Advance Care Planning Discussion:

6.8.1 Physician (MRHP) introduces topic as per 6.3, above, and ensures the conversation includes:

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

ii. Identification of the SDM, and the roles/responsibilities involved;

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

iv. The role of life support interventions and/ or life sustaining measures and their expected degree of benefit. *See Appendix C*;

v. Information regarding comfort measures; and if appropriate, an offer for involvement of resources such as, but not limited to, Palliative Care, Social Work, Clinical Ethics consultation, or Spiritual Care to provide support and guidance to the Patient (or SDM).

See 5.0, Equipment and Supplies, and Appendix A for resources to guide ACP conversations.

6.9 Documenting the Goals of Care/ Advance Care Planning Discussion:

6.9.1 Once a Goals of Care Designation conversation has occurred, the level of care should be documented in the GOC tab located in the Physician Orders section of ARIA®. NOTE: All conversations regarding Goals of Care are to be documented in ARIA® even if a decision has not yet been made.

6.9.1.1 When a Goals of Care discussion has taken place and a Patient is undecided and needs time to reflect, use No Consensus (**NC**) when documenting the discussion in ARIA® via the Physician Order Panel.

6.9.1.2 When a Goals of Care discussion is initiated, and a Patient declines, use Patient Declined (**PD**) when documenting the discussion in ARIA® via the Physician Order Panel.

6.9.2 The nurse or the unit clerk must indicate the Goals of Care Designation by selecting the corresponding Goals of Care icon in ARIA®. The icon is a quick reference tool for the HealthCare Team to view the Patient's Goals of Care Designation. NOTE: There is no icon option for circumstances when there is No Consensus (**NC**) or the Patient Declines (**PD**).

6.9.3 If the Goals of Care Designation is No Consensus (**NC**) or Patient Declines (**PD),** resuscitation efforts should be undertaken in circumstances where warranted. *See 3.7 and 4.6, Resuscitation.*

6.9.4 Once the GOC Form has been completed by the MRHP, the unit clerk will print the Form and provide it to the clinic nurse to review with the Patient. The Patient may opt to sign or initial the Form if they so choose, but this is not a requirement. 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. If the GOC designation is **PD** (Patient Declined) or **NC** (No Consensus) it is not necessary to give the Patient a copy. In addition to the Form, the clinic nurse may provide the Patient with ACP resources available on the CCMB website at: www.advancecareplanninginoncologypractice.ca

6.9.5 If the SDM does not auto-populate on the GOC Form, a green sheet will be completed by the unit clerk and sent to CCMB Information Services (i.e. Medical Records) so that the Patient's contact profile can be updated accordingly.

6.9.6 The nurse provides the Patient with a copy of the GOC Form and the original is scanned by the unit clerk into ARIA® under the Advance Directives note tab using the appropriate Goals of Care scanning

description. Scanning should be completed prior to signing off the physician order as transcribed.

6.9.7 If the GOC order is a revision from the prior GOC, the Patient should be instructed to keep the most recent copy of the Form, and also to make it available to their Family/ SDM, and Health Care Providers.

6.9.8 If the GOC order is unchanged from the prior GOC Form, a new Form should be completed to demonstrate that a GOC discussion has been revisited. The most current GOC Form should be given to the Patient with instructions to keep the most recent copy and also to make it available to their Family/ SDM, and Health Care Providers.

6.10 When a Patient is to undergo a procedure that requires general or regional anesthesia (i.e., block/ spinal) or procedural sedation, and 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), the Health Care Team shall ensure that a discussion takes place with the Patient/ SDM(s) regarding the response to potential life-threatening problems that may occur during the perioperative period. The results of such discussions shall be documented in ARIA®.

6.11 If the Patient/ SDM(s) requests a review of existing Goals of Care, the Health Care Team's response to the request shall be as timely as possible, e.g. GOC should be reviewed within 72 hours of the Patient/ SDM(s) request. The Patient should be provided with resource material to review before the appointment where the discussion will take place.

6.11.1 When a review of Goals of Care *does not* result in a revision, the fact that a review occurred shall be noted on a new GOC Form. Similarly, if the review *does* result in a revision to Goals of Care, the revision is noted on a new Form.

6.11.2 After the review, the new GOC Form shall be scanned into ARIA® as in section 6.9.6.

7.0 **REFERENCES:**

7.1 Advance Care Planning-Goals of Care. WRHA Level 1, Regional Policy May 2015 Accessed online 14 March 2018 at: http://home.wrha.mb.ca/corp/policy/files/110.000.200.pdf

7.2 American College of Surgeons, ST-19. Statement on Advance Directives by Patients: "Do Not Resuscitate" in the Operating Room. Revised, October 2013. Accessed online 14 March 2018 at: http://www.facs.org/fellows_info/statements/st-19.html

7.3 Canadian Anesthesiologists' Society Committee on Ethics. (2002). Peri-Operative Status of "Do Not Resuscitate (DNR)* Orders and other Directives Regarding

Treatment. Accessed online 14 March 2018 at: http://www.cas.ca/English/Guidelines

7.4 Alberta Health Services (August 2014), Advance Care Planning Policy Accessed online 14 March 2018 at: https://extranet.ahsnet.ca/teams/policydocuments/1/clp-advance-care-planning-hcs-38-01-procedure.pdf

7.5 The Mental Health Act of Manitoba, C.C.S.M. c. M110. Accessed online 14 March 2018 at: http://web2.gov.mb.ca/laws/statutes/ccsm/m110e.php

7.6 The Health Care Directives Act of Manitoba, C.C.S.M. c. H27 Accessed online 14 March 2018 at: http://web2.gov.mb.ca/laws/statutes/ccsm/h027e.php

7.7 The Vulnerable Persons Living with a Mental Disability Act of Manitoba, C.C.S.M. c. V90. Accessed online 12 March 2018 at: http://web2.gov.mb.ca/laws/statutes/ccsm/v090e.php

7.8 Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update Accessed online 14 March 2018 at: https://www.ncbi.nlm.nih.gov/pubmed/?term=28034065

7.9 Schrijvers D., Cherny N.I., et al. ESMO Clinical Practice Guidelines on palliative care: advanced care planning. *Annals Oncol* 2014; 25(3): iii138 – iii142.

7.10 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.

7.11 CCMB Policy No. 01.017, *Language Access—Interpreter Services.* Available in CancerCare Manitoba's Governing Documents Library, Clinical Administration Folder.

7.12 CCMB Policy No. 01.300, *Clinical Ethical Issues*. Available in CancerCare Manitoba's Governing Documents Library, Clinical Administration Folder.

7.13 WRHA Collaborative Care Guiding Principles. Accessed online May 10, 2018 at: http://www.wrha.mb.ca/professionals/collaborativecare/about.php

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

Name:	Tara Carpenter-Kellett
Title/Position:	Manager, Continuity of Care, Community Oncology
Phone:	(204)-784-0210
E-mail:	tcarpenterkellett2@cancercare.mb.ca
Address:	

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
3.	

Revision History:				
Date	**Version**	**Status**	**Author**	**Summary of Changes**
dd/mm/yyyy		Initial, Draft Final Minor/Major revision		
Feb 2005	1	Initial		
Jul 18 2011	2	Revision		
Apr 4 2018	3	Revision	ACP Wkg Grp	Approved by CPMT pending final revisions.
01/06/2018	3	Final	T Carpenter-Kellet, Z Poole	Final revisions made by ACP working group

Approvals Record: This Policy requires approval by:		
Approval		
Date	**Name / Title**	**Signature**
	Not required.	

FINAL APPROVAL:		
Date	**Name / Title**	**Signature**
17 June 2018	Dr. P. Czaykowski Chief Medical Officer, CancerCare Manitoba	*Original signed by* *Dr. P. Czaykowski*

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.advancecareplanning.ca

APPENDIX B - ACP Goals of Care Form

CancerCare Manitoba
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ADVANCE CARE PLANNING- GOALS OF CARE

Refer to CCMB Advance Care Planning Policy #03.10.185 prior to completing this form

Label Info:
Last Name
First Name
DOB
PHIN
CR#
Address

History/Current Status of GOC Order

This is the first GOC Order I am aware of for this patient ☐

This GOC Order is a revision from the most recent prior GOC Order ☐

This GOC order is unchanged from the most recent prior GOC Order ☐

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. See back of form for definitions of terms used on this form, as well as ideas to guide a meaningful discussion about ACP and Goals of Care)

☐	**C**	**Symptom and Comfort Care –** Focus of care and interventions are for the active palliative treatment for a terminal illness, and support for those close to the patient. This includes medical care for symptom control and psychosocial and spiritual support in advance of death. Care can be provided in any location best suited for symptom based care. • Resuscitation is **not** undertaken • Measures are only used for goal directed symptom management
☐	**M**	**Medical care and Interventions, Excluding Resuscitation –** Focus of care and interventions are for cure or control of the condition. The patient either chooses not to receive or would not be expected to benefit from attempted resuscitation followed by life sustaining care in an ICU. • Resuscitation is **not** undertaken for cardio respiratory arrest • Life Sustaining Measures are used when appropriate
☐	**R**	**Medical Care and Interventions, Including Resuscitation –** Focus of care and interventions are for cure or control of the condition. The patient would desire, and is expected to benefit from attempted resuscitation and ICU care if required. • Resuscitation is undertaken for acute deterioration • Life Sustaining Measures are used when appropriate
☐	**PD**	**Patient Declined Discussion on Goals of Care**
☐	**NC**	**No Consensus –** unable to reach consensus (see details of discussion below)

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

☐ Patient/Resident/Client Print Name: _____

☐ Family Member(s) Print Name(s): _____

☐ Substitute Decision Maker(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 and ensure patient gets a copy**):

_____

_____

_____

_____

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

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 (August 2014), Advance Care Planning 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: *s 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