Carewest
INNOVATIVE HEALTH CARE

ADVANCE CARE PLANNING FOR FUTURE MEDICAL DECISIONS

What is Advance Care Planning?

Advance Care Planning is a way to help people think about and document wishes for their care. Advance Care Planning considers individual's cultural traditions, personal preferences and values, and family situation and lifestyles. It communicates the person's wishes when they are not able to do that and helps the healthcare providers and family understand those. Because a person's wishes and values may change over time or with changes in their health; it is important to keep the conversation open and to discuss these changes.

Advance Care Planning therefore is basically a 5 step process which starts with the person THINKING about their own values and wishes, followed by LEARNING about their own health, then CHOOSING someone to make decisions and acting on their behalf, followed by COMMNICATING the wishes and values about health care to the designated agent, loved ones and healthcare team, and then finally DOCUMENTING this in a Personal Directive.

In a Personal Directive, a person names and alternate decision maker, an 'agent' who can speak on the person's behalf when the person themselves is unable to do so. It only becomes into effect it the person is unable to make decisions about their health care.

Advance Care Planning conversations and Personal Directive don't necessarily result in Goals of Care Designations (GCD). Goals of Care Designations are medical orders that describe and communicate the general focus of care whether it be resuscitative, medical or comfort care and where this care will be provided. These conversations can take place at any time during the person's life and daily routines.

Any conversation you have with your client that relates to their wishes, (e.g. "I don't even want a tube feed in me".) should be documented on the "Advance Care Planning Tracking Record". Any member of the interdisciplinary team can initiate or participate in conversations about any client's wishes, however, the GCD Order can only be written by the most responsible heath care practitioner (a physician or a nurse practitioner). If a person has not begun Advance Care Planning before an admission/move in, it can be started at any time.

The Advance Care Planning documents (Advance Care Planning Tracking Record, Personal Directive, and current Goals or Care Designation Order), are kept in a **Green Sleeve**, a plastic holder that belongs to the person. People are asked to keep this in or close by their fridge when at home. When the person moves throughout the health care system, the Green Sleeve accompanies the person regardless of care

or living environment so that health care providers always know about the previous discussions and the person's current Goals of Care Designation.

Goals of Care Designations

There are three main categories of Goals of Care Designations. Each of them have subcategories. The three main categories are described below.

Medical Care

Medical care is an appropriate approach when resuscitative care therapies are unlikely to work. Person is expected to benefit from and is accepting of any appropriate medical tests and/or interventions that can be offered, excluding ICU and resuscitative care. Additionally, locations for care (home, hospital, and care facility) are considered depending on what is medically appropriate and in keeping with the person's wishes and values.

Resuscitative Care

Person is expected to benefit from and is accepting of any appropriate medical tests and/or interventions that can be offered and may include intensive care (ICU) and resuscitation.

Comfort Care

The aim of medical tests and interventions are for optimal symptom control and maintenance of function when cure or control of an underlying condition is no longer possible or desired. Transfer to a hospital may occur in order to better understand or control symptoms.

Continuing Care Health Service Standards require that all regulated nurses and health care aides receive training in Personal Directives (Advance Care Planning). As a result, in addition to the above, you also need to view the appropriate AHS module. There is a shorter module for Unit Clerks also.

Please follow these steps:

- Copy and paste the following on your browser bar

  h**ttps://www.albertahealthservices.ca/info/Page12585.aspx**

- Click on ‘HEALTH PROFESSIONALS’ (green button) on the right side. This takes you to a pages where
- E LEARNING MODULES are listed on the right side
- Choose either
  - NON AHS Clinicians (regulated nurses) or
  - NON AHS Unit Clerks
- Click on ‘Access Module’
- Print the certificate and submit a copy to your Site Reception for data entry in the Education Database