Provincial Health Services Authority

ADVANCE CARE PLANNING PROCEDURE

Summary of Changes

	NEW	Previous
BC Cancer	October 11, 2019	October 2018

1. Introduction

1.1. Focus

The purpose of this procedure is to provide instructions on the advance care planning (ACP) procedures to ensure that all patients diagnosed with cancer are offered ACP conversations and that Goals of Care order/code status is completed when necessary.

A particular focus is on patients that are nearing end of life.

1.2. Site Applicability

This practice applies to all BC Cancer ('BCC') centres.

1.3. Practice Level

This procedure is intended to apply to all BCC physicians/nurse practitioners, and other health care providers.

1.4. Definitions

1. **Adult:** The term "adult" is defined by the B.C. Health Care (Consent and Care Facility (Admission) Act (HCCFAA) as anyone 19 years of age or older.

2. **Advance Care Planning Green Sleeve:** refers to a green coloured plastic page protector that is used to store Advance Care Planning Documents.

3. **Advance Care Planning (ACP):** is the process of a capable adult talking over their beliefs, values, and wishes about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions.

At BCC ACP includes:

- Participation in serious illness conversations with the patient/substitute decision maker using the serious illness conversation guide;
- Completion of goals of care orders/code status in collaboration with the patient/substitute decision maker; and
- Documentation of ACP discussions.

4. **Advance Care Plan**: is a written summary of the capable adults advance care planning conversations and wishes to guide their substitute decision-maker if called to make a healthcare decision in the event the adult is incapable of making decisions. This may include Advance Directive and/or Representative Agreement.

5. **Advance Directive:** The term "Advance Directive" is defined by the HCCFAA to mean a written legal document made by a capable adult that:
Gives or refuses consent to healthcare for the adult in the event that the adult is not capable of giving the instruction at the time the health care is required, and complies with the requirements of part 2:1 of the HCCFAA. A document made before September 1st, 2011, which complies with the legislative requirements prescribed on September 1st, 2011, is deemed to be an Advance Directive.

6. **Committee of Person:** Appointed by the court under the Patients Property Act to be the Personal Guardian of an Adult. The power of the Committee, thought extensive, can be limited to restrictions imposed in the order issued by the court appointing the Committee.

7. **Goals of Care (GOC)**: The intended purposes of health care interventions and support as recognized by both a Patient and Substitute Decision Maker, and Health Care provider.

8. **Goals of Care Order:** Orders documented based on an adults Advance Care Planning conversations that details a variety of medical interventions that will or will not be initiated. Also known as code status.

9. **Most Responsible Physician:** This includes the most responsible physician who initiates treatment and is best able to provide information that will allow the Patient to understand fully all the aspects of the treatment decision. This individual is accountable for coordinating and overseeing the care of the Patient for a specific procedure or course of treatment.

10. **Patient:** Any adult (19 years of age or older) who is receiving healthcare in the BCC facilities as an inpatient or outpatient.

11. **Personal Guardian:** A Personal Guardian is the name used in the HCCFAA to describe a Committee of Person for an adult who is declared under the Patients Property Act to be:

    i. Incapable of managing himself or herself; or
    ii. Incapable of managing himself or herself and his or her financial affairs

12. **PRISM form:** A form completed by patients to gather information about distress and symptoms which becomes part of the health care record.

13. **Public Guardian or Trustee:** If there is no one willing or able to act as a Substitute Decision Maker, the Health Care Provider can refer the matter to the B. C Public Guardian and Trustee. Call the Health Care Decision Line at (604) 775- 1101 or (604) 775-1007.

14. **Representative Agreement:** A Representation Agreement is the key legal document in British Columbia for personal planning/advance care planning. It is a legally enforceable document and used in case of incapacity, for end-of-life, and other support needs.

15. **Representative:** An individual appointed in a Representation Agreement to make decisions on behalf of another and includes an alternate Representative. There are two types of Representation Agreements:
    i. Standard Agreements (S.7 Representation Agreements): Standard Agreements generally cover daily living and most health care decisions. Representatives under Standard Agreements are not authorized to make or

help make decisions to refuse health care necessary to preserve life of to physically retrain the Adult.

ii. Enhanced Agreements (S.9 Representation Agreements): The authority of a Representative is expanded. It is important to review all Representation Agreements with the Agency Risk Manager before accepting consent for the Representative.

16. **Substitute Decision Maker (SDM):** An individual who acts on behalf of the Patient who is incapable of giving or refusing consent to healthcare, There are three categories of Substitute Decision- Makers:
    i. Personal Guardians;
    ii. Representatives;
    iii. Temporary Substitute Decision Makers

    See Appendix F: Determining Who Can Provide Substitute Consent for an Incapable Adult 19 years of age or older for a Treatment Proposal.

17. **Temporary Substitute Decision Maker (TSDM):** A Temporary Substitute Decision Maker (TSDM) is appointed when an adult is incapable of making specific major or minor health care consent decisions and there is no Personal Guardian or Representative appointed nor an Advance Directive dealing with the situation. A TSDM is chosen by the Most Responsible Provider in accordance with the list set out in the *Health Care (Consent) and Care Facility (Admission) Act*. A health care provider must choose the first, in the listed order, of the following who is available and qualifies:
    1. The adult's spouse;
    2. The adult's child;
    3. The adult's parent;
    4. The adult's brother or sister;
    5. The adult's grandparents;
    6. The adult's grandchild
    7. Anyone else related by birth or adoption to the adult;
    8. A close friend of the adult (see Glossary for a definition);
    9. A person immediately related to the adult by marriage;
    10. The Public Guardian and Trustee.

To qualify the person must:

- Be at least 19 years of age;
- Have been in contact with the adult during the preceding 12 months;
- Have no dispute with the adult;
- Be capable of giving, refusing or revoking substitute consent; and
- Be willing to comply with the duties of a Temporary Substitute Decision Maker

2. Procedure (Appendix A: Workflow)

2.1. Steps and Rationale

1. Patients

a. Every adult patient completes a "PRISM" form.

b. If the patient indicates on the PRISM that they would like more information on ACP, a staff member will provide ACP information such as the BCC Patient Booklet "So you've been diagnosed with cancer—Now what?" and/or "My Voice" booklet.

- ACP information can also be accessed in the centre Guidebook for Patients (Appendix B).

c. The physician/nurse practitioner will ask themselves the SURPRISE question: "Would I be surprised if this patient died in the next 12 months".

- If the answer is **NO**:
  - Consider a referral to Palliative Care, if required:
    - Community referral: when no acute symptom control issues, patient is eligible for palliative care benefits, and/or Palliative Performance Scale (PPS) score 50% or less; or,
    - BCC PSMPC (Pain and Symptom Management/Palliative Care): symptom management interventions have failed, uncontrolled symptoms, complex GOC/decision making, multiple comorbidities, substance use disorder not

already managed, and/or no access to community programs.

- Refer to MAID, if requested.
- Consider a referral to another health care provider (e.g. nurse, PFC: patient and family counselling) to help with the serious illness conversations.
    - Consider a referral to patient and family counselling when there are perceived high levels of anxiety, suicidal ideation, patient asks for more support, patient has practical (e.g. financial) questions, or a complex family situation.
- Check the medical record for a Goals of Care (GOC) Order (See Appendix C) / Code Status.
    - If no documentation exists, the physician/nurse practitioner completes the GOC order/code status in discussion with the patient (if capable) or substitute decision maker ('SDM') if not capable.
        - The health care professional must discuss current medical conditions, prognosis and treatment options including life sustaining treatments.
        - The patient/SDM are given the opportunity to think through and discuss options including life-sustaining treatments.
        - The patient/SDM communicate personal preferences regarding life sustaining treatment.
        - Discuss other patient documents such as Medical Orders Scope of Treatment ('MOST'), Advance Directive if provided.
- If a GOC order/code status is already on the medical record, it is reviewed with the patient/SDM:
    - Whenever treatment intent changes;
    - Whenever there is a significant health status change:
    - At request of patient or SDM; and,

- At minimum annually.

- If the answer is **YES**:
  - ACP conversations may still occur. Consider reviewing ACP resources with the patient/SDM.
  - Consider referrals to PSMPC and/or PFC, if necessary.

h. In the absence of a completed GOC order/code status the patient will receive care as follows:

- As communicated by a capable patient;
- As communicated by an incapable patient's SDM;
- As expressed by the patient in another document such as an Advance Directive/MOST if relevant to the healthcare decision required;
- As determined by the patient's healthcare team. If cardiopulmonary resuscitation (CPR) and/or other treatment is considered to be medically futile (of no value and not in the patient's best interest) there is no legal obligation to provide the treatment regardless of whether the patient requests the treatment and/or CPR.

k. A copy of the GOC Order/code status is given to the patient/SDM and general practitioner/MRP:

- When initially completed;
- Anytime the GOC/code status is updated; and,
- At transfer/discharge.

Patients are instructed to keep the documentation, inform health care providers of any changes in documentation, and provide it upon future presentation to any health care facility or service.

l. At transition (transfer/discharge), the referral facility, community or service are provided with information on the GOC order/code status.

m. If a conflict/dispute results please refer to:

- Appendix E: Decision Support and Dispute Resolution

- Appendix F: Resolution of disputes about expectations for care not considered beneficial.

2.2. Site Specific Practices

None

2.3. Documentation

The documentation required includes:

a. CAIS process (prior to Cerner).
   - Each new patient will be provided with a plastic green sleeve to hold copies of all ACP documentation.
     - In the event that the individual is a VCC inpatient, the green sleeve is placed at the front of the chart.
   - All BCC and non-BCC ACP documents (e.g. MOST) are faxed to HIM for upload to CAIS alerts section and added to the physician/nurse practitioner action list to be signed off..
   - HIM uploads document to CAIS alert section.
   - Additional ACP conversations are documented on the ACP Record (see Appendix D).
   - Physicians/nurse practitioners to use FESR ACP template.

b. Cerner process:
   - Complete the Goals of Care/code status selection.
   - Complete ACP form/Goals of Care Discussion form.

2.4. Patient Education

Patient Education includes the following resources:

- My Voice. Expressing My Wishes for Future Health Care Treatment Advance Care Planning Guide. Ministry of Health
- Cancer and Advance Care Planning. You've been diagnosed with cancer Now what?

2.5. Health Care Provider Education

- Serious illness Conversation Guide.
- BCC - Introduction to Advance Care Planning (Learning Hub)

3. Related Documents and References

3.1. Related Documents

See Radiation Therapy process – "ACP document discovered in treatment and patient discovery".

3.2. References

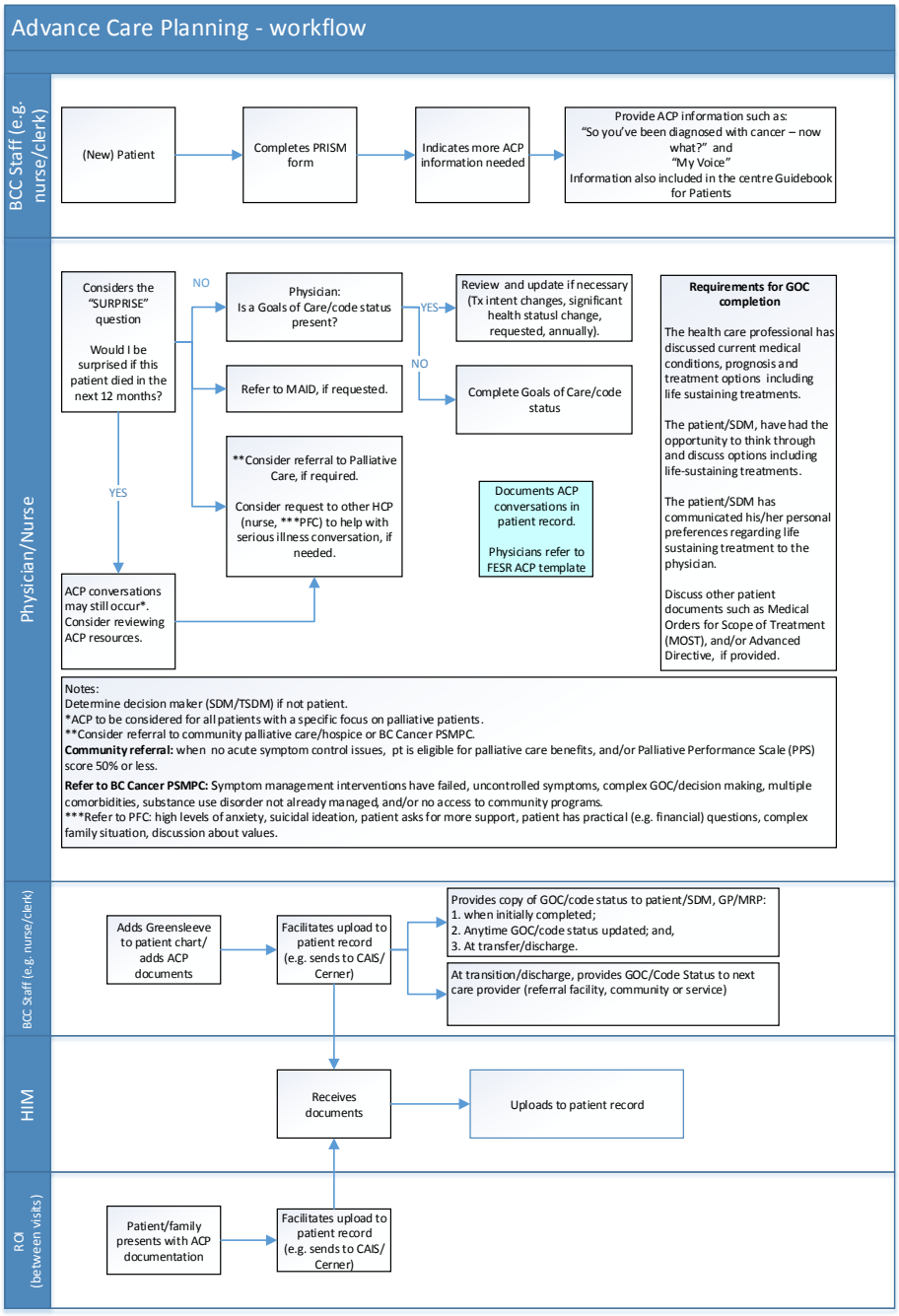
a. Freedom of Information and Privacy Act (B.C)
b. Health Care (Consent) and Care facility (Admission) Act (B.C.) Hospital Act and Regulations BC
c. Alberta Health Services. (2008). Advance Care Planning: Goals of Care Designation.
d. Regional Policy Manual. Retrieved from: http://www.albertahealthservices.ca/3917.asp
e. BC Ministry of Health http://www.health.gov.bc.ca/hcc/advance-care-planning.html Cancer Care Manitoba, (2011). Advance Care Planning, Cancercare Manitoba Patient Care Policy and Procedure Manual.

f. Fraser Health Authority. (2011). Advance Care Planning and Medical Orders for Scope of Treatment. Fraser Health Authority Policy Health Care Providers Guide to Consent, Victoria, BC. Author
g. London Health Science Centre. (2011) End of Life Decision Making. Policy Administration Console.
h. Vancouver Coastal Health Authority (2014). Medical Orders for Scope of Treatment and Advance Care Planning: Development and Treatment Policies.
i. PHSA MAiD Guideline – provides an overview of MAiD, general guidance for all staff and physicians, and process steps for responding to request for MAiD.
j. PHSA MAiD information sheet for patients – a simple Q&A document on MAiD that can be provided to patients.
k. PHSA MAiD Care Coordination Office – a resource run by Risk Management to provide support to PHSA patients and health care providers with the MAiD process.

4. Appendices

- Appendix A: Procedure workflow
- Appendix B: Advance Care Planning – Patient Resources
- Appendix C: Goals of Care (GOC) Orders From
- Appendix D: Advance Care Planning Record
- Appendix E: Decision Support and Dispute Resolution
- Appendix F: Resolution of disputes about expectations for care not considered beneficial.
- Appendix G: Determining Who Can Provide Substitute Consent for an Incapable Adult 19 years of age or older for a Treatment Proposal

Appendix A: Procedure workflow



Appendix A: Advance Care Planning – Patient Resources

BC CANCER
Provincial Health Services Authority

Advance Care Planning – Patient Resources

1. **BC Cancer website (www.bccancer.bc.ca):**

   Search the term "advance care planning" is the search box for access to:

   1. Advance Care Planning Expressing your wishes and instructions for future health care treatment
   2. You've been diagnosed with cancer Now what?

   The BC Cancer Patient & Family Counselling program offers counselling services to cancer patients and family members. Visit www.bccancer.bc.ca for contact information.

   The BC Cancer Pain & Symptom Management program offers support you and your family with emotional and social concerns that come with living with cancer and can assist with care planning and decision-making, especially around transitions.

2. **BC Centre for Palliative Care**

   The BC Centre for Palliative Care provides leadership for best practices, research and education in advance care planning, serious illness conversations, integration of a palliative approach to care, and building compassionate communities.

   To learn more about advanced care planning, including information, further resources and events around the province visit: www.bc-cpc.ca/acp.

   Email: office@bc-cpc.ca
   Website: http://www.bc-cpc.ca/cpc/
   Telephone: 604-553-4866

3. **Nidus Personal Planning Resource Centre and Registry**

   Nidus is a non-profit charity, personal planning center and registry.

   Email: info@nidus.ca
   Website: http://www.nidus.ca/
   Telephone: 604.408.7414

Appendix B: Goals of Care Orders

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GOALS OF CARE (GOC) ORDERS

To be completed by physician

SECTION ONE: CODE STATUS: IF ADULT HAS NO PULSE AND IS NOT BREATHING

☐ **Attempt CPR** (Cardiopulmonary Resuscitation), **Full Code.**

☐ **Do Not Attempt** Cardiopulmonary Resuscitation **(DNACPR: no check compressions or other direct means of restarting the heart). Please initial below.**

SECTION TWO: GOALS OF CARE ORDER BASED ON DOCUMENTED CONVERSATIONS (initial appropriate level)

1	**No CPR, No Intubation, Supportive Care**	No CPR, supportive care, symptom management, continued management of chronic conditions, and comfort measures. Allow natural death.
2	**No CPR, No Intubation, Therapeutic Care**	No CPR. Option 1 plus therapeutic measures and medications to manage acute conditions within the current setting.
3	**No CPR, No Intubation, Acute Transfer,**	No CPR. Option 2 plus admission to an acute care hospital (if not already admitted) for medical/surgical treatment as indicated. No referral to Critical Care.
4	**No CPR, No intubation, Critical care**	No CPR. Maximum therapeutic effort as in Option 3 including referral to Critical Care but not intubation and ventilation.
5	**No CPR, May intubate, Critical care**	No CPR. Maximum therapeutic effort as in Option 4 including referral to Critical Care and including intubation and ventilation.

SECTION THREE: DURING CHEMOTHERAPY

IF DURING CHEMOTHERAPY ADULT HAS NO PULSE AND IS NOT BREATHING:

☐ Waive DNR for duration of chemotherapy infusions, attempt *CPR*

☐ Do Not Attempt Cardiopulmonary Resuscitation *DNR*

SECTION FOUR: GOALS OF CARE ORDER WRITTEN AS A RESULT OF: (check all that apply)

☐ Conversations/Consensus

- ☐ Capable adult
- ☐ Representative Name:_____Date:_____
- ☐ Temporary Substitute Decision Maker (TSDM) Name_____Date:_____

☐ Physician Assessment

☐ Supporting Documentation:

- ☐ Representation Agreement (see over) Provide copy to Name:_____Date:___
- ☐ Advance Directive: (see over) Date:_____
- ☐ Other Goals of Care Order eg. Fraser Health MOST
- ☐ Provincial No Cardiopulmonary Resuscitation Form Date:_____

☐ copy to patient ☐ copy to GP

Date (dd/mm/yr): Physician Signature: Print name:

August 2018 Everyone:/Advance Care Planning/1 – ACP Chart Documentation Forms/Goals of Care Oder Form

Appendix C: Advance Care Planning Record

BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

Identifying Information:

ADVANCE CARE PLANNING (ACP) RECORD

For use by all members of the health care team

Patient Name: _____

Physician(s): _____

☐ Advance Care Planning conversation initiated: _____ _____
Date Signature

Guidelines for Use: (continued on back of form)

1. This form is for use by all members of the health care team (e.g. nurses, counsellors, physicians) as a written communication tool to record information relevant to advance care planning. This could include: conversations about the patient's health status, goals, values, wishes, withholding / withdrawing support, comfort care, etc.
2. Discussions with patient, family and/or substitute decision maker are documented, along with the subsequent action taken (e.g. Physician notified, or *'So You've Been Diagnosed with Cancer' and/or 'My Voice'* Guide introduced).
3. This form is placed in the green sleeve (green page protector) behind the ORDERS and with other advance care planning documents. All Advance Care Planning records are to remain in the green sleeve, and are to be reviewed at each visit/admission with changes in health status, or more frequently as determined by the program/team.

Advance care planning conversations with patient, family or substitute decision maker

Date	Brief summary of ACP discussion/focus	Action	Staff Name

March 2015 Everyone: /Advance Care Planning/1-ACP Chart Documentation Forms/ACP Record Form

Appendix D: Decision Support and Dispute Resolution

In some cases conflict or difficulties may arise in the decision-making process due to various factors and patients/families/SDM or the health care team may require additional support.

The role of the health care professionals providing decision support or dispute resolution is to assist patients, families, physicians and staff with further information and discussion as required to reach consensus on treatment options and advance care planning in accordance with the legislation.

The following services can be accessed using the current referral process:

- **Interprofessional Health Care Teams**: in most situations the staff and physicians providing care to a patient have the required knowledge and experience with Advance Care Planning and with additional time and attention the issues may be resolved.
- **Second Opinion- MRP or designate** also has the option to seek a second opinion from a physician/health care team provider, ethics committee, or public trustee with knowledge and skills relevant to the circumstances of the patient's condition.
- **Second Opinion-Patients/families/SDM** also have an option to seek a second opinion from a physician/healthcare team provider, ethics committee, or public trustee with knowledge and skills relevant to the circumstances of the patient's condition.
- **BC Cancer Services**:
    - **Patient and Family Counselling** can provide information and support regarding patients and family's social, emotional, economic and environment issues.
    - **Pain and Symptom Management and Palliative Care**- provide support and information regarding symptom management during terminal illness, care planning/ACP issues, and preparation for end of life.
    - **Nurses:** Can provide support and information to patients about advance care planning and provide patient education resources.
    - **Nursing Support Clinics** - provide support and information regarding symptom management during terminal illness and preparation for end of life.

In the event that a dispute or disagreement regarding a Patient's treatment plan remains after avenues of decision support have been pursued, the MRP will consult with the designated medical professional practice leader. It is not the role of the designated medical professional practice leader to direct the

determination of the treatment plan but rather to lend guidance and support for due process in making decisions that are clinically and ethically sound.

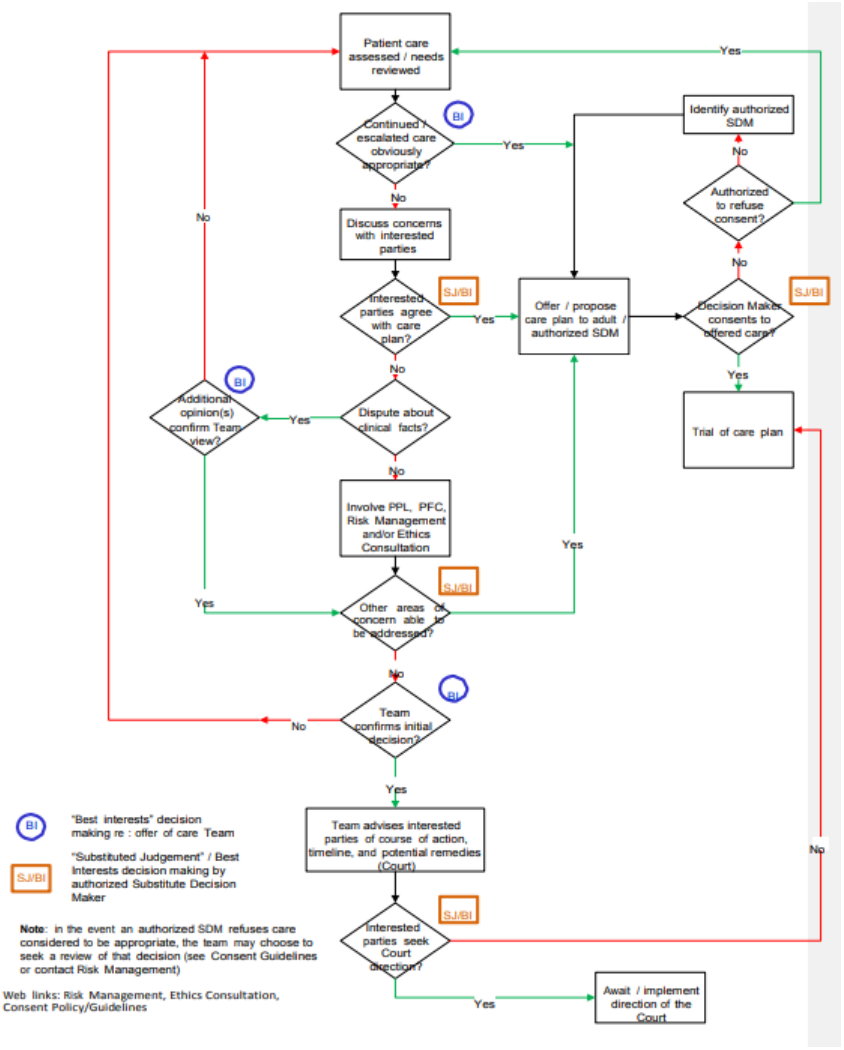
If appropriate avenues of decision support and dispute resolution have been explored, including consultation with the designated professional practice leader, and the disagreement remains:

The MRP may issue based on his/her professional judgment a clinically relevant Goals of Care Order.

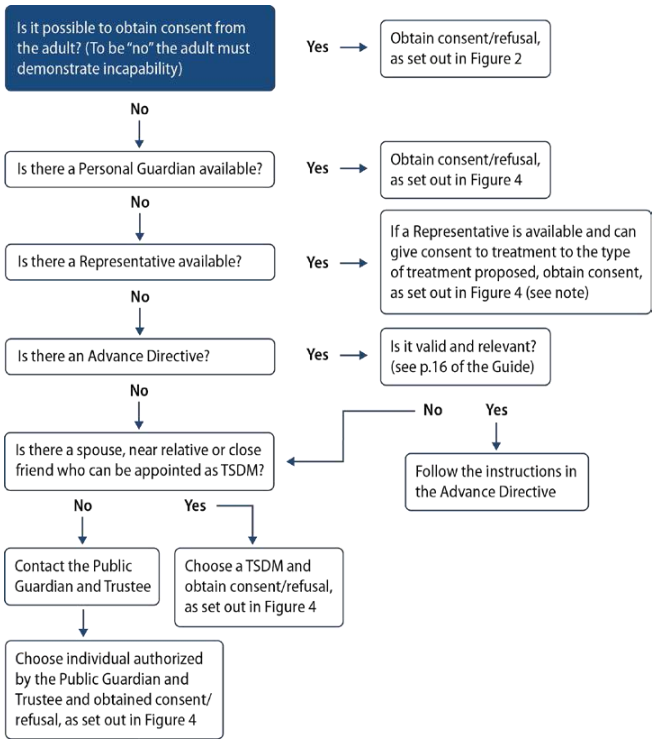
- The BCC support for this will be noted via the designated medical administrator and on the patients chart. The MRP or designated medical professional practice leader will notify risk management and;
- The MRP (or designate) or the designated medical professional practice leader shall advise the patient that he/she may pursue avenues such as the PHSA Patient Care Quality Office and/or obtain legal advice/options as desired.
- Risk management should be consulted related to all unresolved disputes.

When there is no Personal Guardian or Representative appointed nor an Advance Directive dealing with the situation, a TSDM is chosen by the MRP (see definitions).

Appendix E: Resolution of disputes about expectations for care not considered beneficial



Appendix F: Determining Who Can Provide Substitute Consent for an Incapable Adult 19 years of age or older for a Treatment Proposal



Note: Health care providers must stop or withdraw treatment if consent is subsequently withdrawn or refused**.**

If the adult has an Advance Directive as well as a Representative, the Advance Directive may override the need for consent from the Representative if the Representation Agreement expressly states that the consent of the Representative is not required. In addition, if an adult has provided instructions in an Advance Directive with respect to any matter over which the Representative does not have decision-making authority, a health care provider should follow the instructions in the Advance Directive.

****Last page of document****

First Issued:	19-02-2015		
Approving Body:	BC Cancer Quality Council		
Final Sign Off:	**Name**	**Title**	**Date Signed**
	Michael McKenzie	BC Cancer VP, Quality	11-10-2019
Developed By:	**Name**	**Dept.**	**HO**
	Advance Care Planning Advisory Committee	n/a	PHSA
Owner(s):	Advance Care Planning Advisory Committee	n/a	PHSA
Posted Date:	11-10-2019		
Version:	3		
Revision:	**Name of Reviser**	**Description**	**Date**
	Sara Camano	Add nurse practitioners to document	11-10-2019
	Sara Camano		01-09-2018