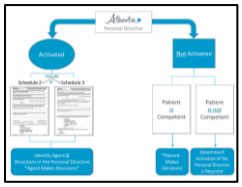
Alberta Health Services

Advance Care Planning/Goals of Care Conversation Toolkit

This toolkit includes 3 resources you can use in practice to help navigate the critical steps in Advance Care Planning/Goals of Care conversations.

Step 1) **Who** Do I Talk To?

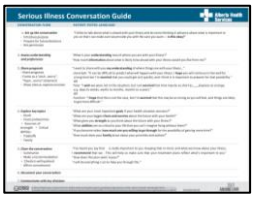
If your patient doesn't have capacity, knowing who to have these discussions with is important. The AB Personal Directive Algorithm included in this kit can be helpful in figuring out who should speak on behalf of your patient.



(Full size version on pg.2)

Step 2) What Could I Say?

This toolkit includes the Serious Illness Conversation Guide developed by Ariadne Labs. It is a scripted tool with evidence-based and extensively tested language you can use to guide these conversations.



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Step 3) Where Do I Document it?

This toolkit includes AHS's Advance Care Planning Goals of Care Tracking Record where these conversations should be documented. The Tracking Record goes in the patient's Green Sleeve.

(Full size version on pg.4&5)

For questions/information e-mail CalgaryConversations.Matter@ahs.ca
or visit www.conversationsmatter.ca

ADVANCE CARE PLANNING
CONVERSATIONS MATTER
GOALS OF CARE DESIGNATIONS

Alberta

Personal Directive

Activated

Include

Schedule 2 or Schedule 3

Identify Agent & Directions in the Personal Directive
Agent Makes Decisions

Not Activated

Patient *is* Competent

*Patient Makes Decisions

Patient *is not* Competent

Determine if Activation of the Personal Directive is Required

Serious Illness Conversation Guide

Alberta Health Services

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. ***Set up the conversation*** - Introduce purpose - Prepare for future decisions - Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"
2. ***Assess understanding and preferences***	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. ***Share prognosis*** - Share prognosis - Frame as a "wish...worry", "hope...worry" statement - Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness..." *Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as____*(express as a range, e.g. days to weeks, weeks to months, months to a year).*" OR *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. ***Explore key topics*** - Goals - Fears and worries - Sources of strength - Critical abilities - Tradeoffs - Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. ***Close the conversation*** - Summarize - Make a recommendation - Check in with patient - Affirm commitment	"I've heard you say that is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we . This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. ***Document your conversation***	
7. ***Communicate with key clinicians***	

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Advance Care Planning/Goals of Care Designation Tracking Record

- Purpose: to document the content of Advance Care Planning (ACP)/Goals of Care Designation (GCD) conversations and/or decisions.

  Benefits:
  - Assists healthcare providers in being aware of previous conversations and to understand the reasons underlying the current GCD order.
  - Gives clues about where to pick up the conversation if decisions need to be reviewed or confirmed.
- The ACP GCD Tracking Record is a continuous record that goes in the Green Sleeve. Documenting on both Tracking Record and progress note may be necessary to ensure transfer of critical information.
- The original form is kept in the patient's Green Sleeve. When the patient moves to a new care setting, including home, a copy remains with the sending facility.

Date *(yyyy-Mon-dd)*	**Site/ Attendees**	**Conversation Summary Notes**	**Required Documentation**
			Any member of the healthcare team can record conversations on this form.
			Include who was involved in today's discussions *(i.e. patient, family, healthcare provider Include name and relationship/discipline)*
			Summarize conversation and/or key decisions from today's discussion
			It helps to document responses to the following speaking prompts.
			■ Have you completed a Personal Directive?
			■ Have you selected an alternative decision maker? If so do they know your wishes?
			■ What is your understanding now of where you are with your illness?
			■ If your health situation worsens what are your important goals?
			■ Do you know if you have a Green Sleeve?
			■ Do you know if you have a Goals of Care Designation (GCD) order?

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