LCC Session 36

CanMEDS Competency: Communication, Professional

Sandra Andreychuk

What will happen in this session?

Review of Quality End of Life Care Protocol and POST

This will be a large group session in Room MDCL 3023

Suggested Time 60 minutes.

Readings: see attached in addition to this video

http://www.vimeo.com/hamiltonhealthsciences/eol1

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ADDRESSOGRAPH

Patient's Name:

Physician Ordered Scope of Treatment (POST)

***** This POST replaces any previous POST*****

*****Our goal for all patients, regardless of resuscitation status, is to ensure their dignity and comfort. *****

Patient capable of participating in care planning: ☐ Yes ☐ No

Name of Substitute Decision Maker (SDM) if applicable: _____ Relationship: _____

Patient has written Advance Directive: ☐ Yes ☐ No Reviewed by MRP/delegate and SDM ☐ Yes ☐ No

1. Summary of goals of care (e.g. focus on comfort, focus on prolonging life, etc.)

Discussed with ☐ Patient ☐ SDM ☐ Both

_____

_____

_____

2. Code status in the event of respiratory or cardiac arrest (please check one then complete Section 3):

☐ Provide cardiopulmonary resuscitation (CPR) as clinically indicated

☐ Allow Natural Death (AND). Do not attempt cardiopulmonary resuscitation (no CPR)

Specific resuscitation details: _____

_____

3. Scope of treatment:

☐ Active treatment including critical care. Intubation ☐ Yes ☐ No

☐ Active treatment excluding critical care

☐ Treatment to focus on palliation

4. Summary of plan: ☐ I have reviewed and discontinued previous POST

_____

_____

_____

_____

_____

This POST must remain in a Greensleeve at the front of the Patient Chart

*****Complete all areas in signature box. Orders will not be processed without a written signature and bradma on each page*****

Signature: _____ Pager # _____ Date _____ Time _____
Signature/Printed Name/Designation (YYYY/MM/DD)

Co-Signature: _____ Pager # _____ Date _____ Time _____
Signature/Printed Name/Designation (YYYY/MM/DD)

Transcribed By: _____ Date _____ Time _____
Signature/Printed Name/Designation (YYYY/MM/DD)

Checked By: _____ Date _____ Time _____
Signature/Printed Name/Designation (YYYY/MM/DD)

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ADDRESSOGRAPH
Baby Jacob Smith

Patient's Name:
Jacob Smith.

Physician Ordered Scope of Treatment (POST)

***** This POST replaces any previous POST*****

*****Our goal for all patients, regardless of resuscitation status, is to ensure their dignity and comfort. *****

Patient capable of participating in care planning: ☐ Yes ☑ No

Name of Substitute Decision Maker (SDM) if applicable: Joe + Ann Smith Relationship: Parents

Patient has written Advance Directive: ☐ Yes ☑ No Reviewed by MRP/delegate and SDM ☑ Yes ☐ No

1. Summary of goals of care (e.g. focus on comfort, focus on prolonging life, etc.)

Discussed with ☐ Patient ☑ SDM ☐ Both

To be provided with All live sustaining Measures Ĉ an end goal for Joe and Ann TO take Jacob home.

2. Code status in the event of respiratory or cardiac arrest (please check one then complete Section 3):

☑ Provide cardiopulmonary resuscitation (CPR) as clinically indicated

☐ Allow Natural Death (AND). Do not attempt cardiopulmonary resuscitation (no CPR) ☐

Specific resuscitation details: _____

3. Scope of treatment:

☑ Active treatment including critical care. Intubation ☑ Yes ☐ No

☐ Active treatment excluding critical care

☐ Treatment to focus on palliation

4. Summary of plan: ☐ I have reviewed and discontinued previous POST

- Provide Ventilation support attempting TO wean TO Low flow for DIC Home
- Con't working TOward establishing full feeds with a comsination of gavage + oral
- Bld work limited TO once Weekly
- Plan TO Revisit plan of care with Parents in 2wks

This POST must remain in a Greensleeve at the front of the Patient Chart

*****Complete all areas in signature box. Orders will not be processed without a written signature and bradma on each page*****

Signature: _____ Signature/Printed Name/Designation Pager # 1000 Date 20 14/05/25 (YYYY/MM/DD) Time 1430

Co-Signature: _____ Signature/Printed Name/Designation Pager # 127 Date 20 14/05/25 (YYYY/MM/DD) Time 1445

Transcribed By: _____ Signature/Printed Name/Designation Date _____ (YYYY/MM/DD) Time _____

Checked By: _____ Signature/Printed Name/Designation Date _____ (YYYY/MM/DD) Time _____

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POST User Guide

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Step/Description	Tips & Scripts
1. Pre-Meeting Preparation • Learn as much about the patient as possible: medical history, previously expressed wishes and goals of care and end of life conversations • Conduct team huddle to share information, establish plan for conversation, include interprofessional perspectives	• Review medical record, Advance Directive and previous end of life discussions with patient/SDM • Review previous POST. Review/gather relevant resources (see below)
2. Introductions and Establish Goals for Conversation • Sit down for the conversation, if possible • Ensure people know each other • Establish supportive, caring ethos • Establish purpose of discussion	• *We are here because we are involved in your/your loved one's care…* • *We are meeting to discuss...* • *We hope to accomplish...* • *Our goal for this conversation is to ensure we all understand the current medical condition and the patient's wishes and values to establish goals of care.*
3. Patient/SDM Understandings • Involve patient/SDM in the discussion • Assess patient/SDM perceptions of medical condition • Invite sharing of concerns	• *What do you understand about your/your loved one's medical situation?* • *How do you think you/they are doing?* • *What questions do you have?* • *Is there anything you are worried about?*
4. Medical Update • Do not make treatment discussions at this point (see step 7) • Describe current status, prognosis (short-term and long-term) • Educate, clarify re: reasonable and appropriate treatment options • Allow opportunities for questions	• Use medical language appropriate to the patient's/SDM's level of understanding • Respond appropriately to any emotions (convey empathy and compassion)
5. Values History • Understand patient's values and priorities as related to current situation • *For incapable patients:* Engage family in focusing on patient's previously expressed wishes and values, and their applicability to this circumstance • Refer to patient's written Advance Directive, if one exists • Review the role of the Substitute Decision Maker and definition of best interests	• *For patient: What are you hoping for? What is most important to you at this time in your life? What does quality of life mean to you?* • *For SDM - Did the patient ever talk about what they would want if they became very ill? What does quality of life mean to the patient? What gives their life meaning and purpose?*
6. Develop a Plan • Together with patient/SDM, develop realistic treatment goals and plans (short-term and long-term) • Identify treatment options that align with patient's wishes, goals, values and best interests • Reminder: Only treatment options that are clinically indicated* (beneficial to patient and not unduly harmful) should be offered (see definition below) • Avoid putting onus of decision-making on one individual	• *Based on what I know of your medical situation and what is important to you/the patient, appropriate clinical options include…* • *My recommendation is...* • *If family/patient requests treatments that are not clinically indicated: "I am not offering other treatments because…"* • *What we will do next is...* • *How else can we support you at this time? (psychosocial, spiritual supports)*
7. Review and Document Outcome of Conversation • Complete POST as appropriate; review with Patient/SDM/team to ensure accuracy • Chart discussion in progress notes or dictation, including any decisions made; include date, persons present at meeting, current status of illness/prognosis, options discussed, patient/family wishes, goals of care, discharge plans, etc.	• Offer copy of POST to patient/SDM • Place POST in Greensleeve • In case of disagreement about goals of care or treatment plans, refer to the Quality End of Life Care Protocol or the Conflict Resolution Protocol (see resource list below)

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Resource List:

Quality End of Life Care Protocol: click here to view

Protocol for Resolving Conflicts Regarding Treatment and/or Discharge Plans: click here to view (pending publication on Policy Library)

Quality End of Life Intranet Site: Includes links to the Quality End of Life Care Protocol and educational resources: http://sharepoint/depts/QEoLC (right click to open hyperlink)

Ethics at HHS Intranet Site: Includes educational resources and information about the ethics consultation service : http://corpweb.hhsc.ca/body.cfm?id=376 (right click to open hyperlink)

Make your wishes known: A patient education pamphlet about advance care planning; Click here view the pamphlet (right click to open hyperlink)

Making Decisions for Others: A patient/family educational pamphlet about the role of Substitute Decision Makers: Click here to view the pamphlet (right click to open hyperlink)

***Clinically Indicated:** In accordance with the College of Physicians and Surgeons of Ontario as defined in the Policy Statement # 1-06. Decision Making for the End-of-Life, Section 3.2: "Physicians are not obliged to provide treatment that will almost certainly not be of benefit to the patient." This means CPR and other treatments need not be offered when: "There is almost certainly no chance that the person will benefit from CPR and other life support, either because the underlying illness or disease makes recovery or improvement virtually unprecedented, or because the person will be unable to experience any permanent benefit." A clinical judgment about the appropriateness of a treatment option should NOT be based on the clinician's personal judgment of the patient's quality of life, moral character, lifestyle or other social factors.

In addition to CPR / AND the following interventions to support quality of life may be considered when discussing the plan of care with the patient/SDM:

- Antibiotic treatment
- Feeding tube (artificial nutrition)
- Deep suctioning
- Hydration (intravenous or subcutaneous)
- Vital signs
- Medical Imaging (e.g. – X-rays, scans, etc.)
- Blood / blood products
- Venipuncture (blood sampling)
- ICU / CCU admission

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Quality End of Life Care Protocol – FAQ

What is the purpose of the Quality End of Life Care Protocol?

The QEoL Care protocol emphasizes the following:

- **pro-active planning**: discussing end-of-life care with a patient/family *before* a crisis occurs
- **collaboration**: including the interprofessional team, patient and family in care plan discussions and aligning decisions with applicable wishes/values/best interests of the patient
- **standardized documentation** of a patient's care plan that is clear, concise and easy to access in the chart and through Meditech

What is the POST?

POST stands for Physician Orders for Scope of Treatment. It provides a clear and concise snapshot of a patient's care plan including specific life-sustaining treatments. The POST replaces DNR orders.

What is new about the revised of the Quality End of Life Care Protocol (introduced in 2014)?

- Definition of **"Clinically Indicated"** has been included in the Protocol and POST order set to support clinical judgment regarding treatment options offered
- **maintaining continuity of care by** using the discharge summary, verbal communication and Meditech dashboard to convey EoL care planning and patients wishes when patient transfers between units, facilities or is readmitted to hospital
- Protocol clearly defines process for voiding previous POST forms
- Target population for POST more clearly defined
- Protocol clearly identifies default resuscitation status where no POST exists
- Supporting definitions and references added
- **Use of previous POST upon readmission** to hospital in the event that the patients is incapable to make medical decisions and in the absence of a SDM.

The new QEoLC Protocol replaces the old QEoLC policy and the previous DNR policy. It is available in the HHS Policy Library.

What is new about the revised of the POST form (introduced in 2014)?

- Introduces consistent location for POST placement in a "Greensleeve" at the front of the patient chart
- Begins with a philosophical statement: "Our goal for all patients, regardless of resuscitation status, is to ensure their dignity and comfort."
- Provides more space for narrative comments
- Indication of patient capacity at time of POST completion
- POST now has four sections:

1. Summary of goals of care (narrative)
2. Code status in event of respiratory or cardiac arrest (CPR or Allow Natural Death-AND)
3. Scope of Treatment: three options are provided: Active treatment including critical care; Active treatment excluding critical care; Treatment to focus on palliation
4. Summary of plan (narrative)

- Checkbox to indicate that previous POST has been discontinued

Where is the POST located?

The POST is to be located at the front of the patient's chart in a Greensleeve. All previous POSTs should be discontinued once an updated POST is completed, but remain in the Greensleeve along with other end of life documents.

What is a Greensleeve?

A clear plastic sleeve that is outlined in green and placed in the front of the patient's chart. The Greensleeve will contain: the current POST (on top); previous discontinued POST forms; any other end of life care documents, such as a written Advance Directive or out-of-hospital DNR Confirmation form. This ensures the POST is easy to find in an emergency.

Is the POST necessary if a patient already has an Advance Directive?

Yes. An Advance Directive is a directive to the patient's SDM, not to the health care team. If a patient is not capable, the Advance Directive can provide a helpful starting point for a discussion with the SDM to clarify the patient's values and wishes, but a POST must still be completed if limits on treatment are appropriate.

How should I use the POST when discussing end-of-life care with a patient/SDM?

The POST is **not** meant to be a conversation guide for discussions about end-of-life care. Rather, it is a documentation tool that should reflect the outcome of that dialogue. To assist HCPs in facilitating these discussions, a User Guide is linked to the POST order set and available on the QEoLC intranet site.

Who is responsible for completing the POST?

While other members of the health care team may lead the process of developing a care plan for the patient, it is up to the MRP or delegate to sign-off on the plan, including completing the POST in accordance with the plan of care that is developed to meet the patient's goals, wishes and best interests. After completing and signing the POST, the MRP should also complete specific orders aligned with the patient's treatment plan and a dictation or progress note describing their conversation with the patient/family/SDM in more detail.

Does a POST need to be filled out for every patient?

No. For many patients discussing end-of-life care would not be appropriate. If, however, the health care team would not be surprised if the patient dies within the next year, even with optimal treatment, then a pro-active discussion about end-of-life care should be initiated.

What resources are available to HCPs to support the implementation of the new QEoLC protocol?

The following educational materials are available on the Quality End of Life Intranet Site: http://sharepoint/depatients/QEoLC (right click to open hyperlink)

- **Team Planning Guide** may be used to develop a team strategy before engaging in end-of-life planning with the patient/SDM
- **"Make your wishes known"** patient/family pamphlet to help patients/families make decisions about their goals of care: Click here view the pamphlet (right click to open hyperlink)
- **Making Decisions for Others:** patient/family pamphlet describing the role of the SDM; Click here to view the pamphlet (right click to open hyperlink)
- **Conflict Resolution Guide** to provide guidance around dealing with conflict regarding end-of-life care
- **Reflective Practice Module "To Know Thyself"** to enable HCPs to examine their own attitudes, values, and behaviors related to their care of people near end-of-life
- **Identification of Adult Patients At Risk of Dying** a tool that uses clinical indicators to identify patients appropriate for engagement in end of life planning

Ethics at HHS Intranet Site: contains general ethics resources and information about the ethics consultation service: http://corpweb.hhsc.ca/body.cfm?id=376 (right click to open hyperlink)

Posting Date:
Posting History Dates: 2009-07-24

Title: MAC - Quality End-of-Life Care Protocol

Applies to: All HHS staff, hospital affiliates and members of the Medical, Dental and Midwifery staff.

1.0 Guiding Values and Principles

1.1 Quality end-of-life care (QEoLC) is:

- Holistic
- Provided in a manner that is sensitive to the patient's and family's particular experience with illness (including their personal, cultural and religious values, beliefs and practices, their developmental state and preparedness to deal with the dying process)
- Caring
- Compassionate
- Respectful of human dignity

1.2 HHS is committed to patient and family centred care. At every stage of a patient's illness, health professionals are expected to:

- Communicate clearly, transparently and honestly with patients/families
- Collaborate in decision-making
- Respond to patients'/families' unique needs

1.3 Informed and capable patients have the moral and legal right to refuse, or withdraw consent to, any or all medical interventions--including life-saving treatments--no matter how beneficial. If a patient is not capable, decisions should be made by the appropriate Substitute Decision Maker (SDM) in alignment with the patient's previously expressed wishes, or in the event the patient has not previously expressed wishes applicable to the circumstances, the patient's values and beliefs, and best interests (values and beliefs are part of the best interests definition in the Health Care Consent Act (HCCA). (See MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy). The SDM may choose to consult other family/friends when making decisions for the patient.

- Where there is conflict between the incapable patient's previously expressed wishes or best interests and the wishes of the patient's SDM/family, the patient's previously expressed wishes or best interests are paramount (as per the Health Care Consent Act of Ontario [1996]). Not Offering Non-Beneficial Treatments College of Physicians and Surgeons of Ontario (CPSO) End of Life Policy.

1.4 Quality end-of-life care is a collaborative process that includes the patient, SDM and family, and the entire interprofessional care team. Ideally end-of-life treatment decisions are made by consensus, achieved through respectful and timely communication amongst all parties.

1.5 Proactive end-of-life care planning helps to ensure the safety and dignity of patients and the quality of care. End-of-life (EoL) Care Treatment Plans should be aligned with:

- Applicable wishes (values/goals/beliefs) of the capable patient
- Best interests of patients
- Best practice guidelines, safe practices, and best available evidence

1.6 Proactive end-of-life care planning (including early involvement of Palliative Care) and good documentation of end-of-life treatment plans support seamless transitions between care settings and amongst care providers for patients.

1.7 Discussions about the dying process and end-of-life care ideally happen with patients and families before a crisis occurs. Referral to Palliative Care and opportunities for end-of-life care planning should be made available to patients and families at any time along their illness trajectory.

2.0 Purpose & Goals

2.1 To achieve excellent patient and family centered care for all patients with a life-threatening or life-limiting condition through collaborative and proactive end-of-life care planning and treatment decisions and to provide a framework for decision making and goal setting with patients, SDMs and families (as appropriate).

2.2 To have a clearly documented end-of-life care treatment plan ("Physician Ordered Scope of Treatment for End of Life Care [(POST]" for inpatients) and resuscitation status for targeted patients that is aligned with the wishes (where applicable), and/or best interests of the patient, and supports the needs of the patient's family.

3.0 Policy

3.1 Target Patient Population:

3.1.1 When negotiating treatment plans with patients/families, health care professionals should ask themselves: "*Would I be surprised if this patient died within the next year?*" If the answer is "No, I would not be surprised if the patient died", it is appropriate to begin proactive end-of-life planning.

3.1.2 Targeted patient population may also include patients meeting *any* of the following criteria:

- Terminal, life-threatening, life-limiting illness(es)
- Chronic illness with declining functional ability, quality of life, and/or disease progression and/or acute exacerbation
- Indications of imminent death
- Patient/SDM initiates discussion of end-of-life care plans
- Patients with advance care directives that indicates refusal of any life-sustaining treatments under certain circumstances (includes directions in a POA for Personal Care, a written "living will" and oral instructions to staff or family to withdraw/withhold life-sustaining treatments)
- Any patient whose death is expected within one year is appropriate for this protocol.

3.2 Interprofessional Team Responsibilities:

3.2.1 **All health care professionals (HCP)s** having a therapeutic relationship with a patient:

- Provide leadership by encouraging proactive, collaborative and values-based end-of-life care planning, consulting with spiritual care, social work and palliative care as appropriate.
- Notify the MRP if the patient/SDM/family initiate an end-of-life discussion, and specific patient/SDM/family wishes.
- Proactively and sensitively engage in end-of-life care planning. Ideally this is done through interprofessional collaboration, such as a team huddle, *before* approaching the patient/SDM/family to initiate an end-of-life discussion. A team huddle will ensure consistent and accurate communication with the patient/SDM/family, and avoid team conflict.
- Participate in EoL care planning discussions with patient/SDM/family, as appropriate.
- Document all EoL discussions on the End-of-Life Care Flowsheet in Meditech or if unavailable, in progress notes. Ensuring orders arising from the POST are transcribed (transcribe as "See POST order").
- Notify other HCPs of the patient's/SDM'S/family's wishes as appropriate, and included in transfer of accountability.
- Review the POST as appropriate and notifying the MRP if patient/SDM/family wishes to change any aspect of it.
- Be involved in team debrief after conversations have occurred.
- Review the End-of-Life Care Flowsheet in Meditech (where available).
- Engage in collaborative conflict resolution processes in the event of conflict between team members or between the team and the patient/SDM/family regarding end-of-life treatment plans or wishes.

3.2.2 **The MRP is responsible to:**

- Identify and offer treatment options that serve the patient's best interests.

  Note: MRPs are not obligated to offer treatments that are not medically indicated (*not beneficial to patient and not unduly harmful)* **or** medically indicated but contrary to patient's previously expressed wishes,
- Make every effort to have another interprofessional team member present for the end-of-life discussion to support all parties.
- Verify the patient's/SDM's/family's current goals and wishes and review the patient's advance directive (if there is a directive).
- **Note:** In the ED, emergency physicians take the responsibility of initiating an interim discussion with patients/SDMs/families regarding goals and wishes around the end-of-life care to assist them in dealing with the crisis and should chart this on the Emergency record. A more complete discussion regarding goals and wishes around the end-of-life care and completion of POST is the responsibility of the admitting MRP.
- Complete and sign the POST Form in accordance with the goals/wishes/best interests of the patient.

  Note: In some situations, such as acute events, when the MRP is not immediately available, the responsibility of discussing patient's/SDM's/family's goals and wishes around end-of-life care and completing and signing the POST can be performed by a delegate (resident, RN (EC), or clinical fellow) or consulting physician (e.g. ICU, PCCU, Palliative Care, RACE Team, PACE Team), in communication and collaboration with the MRP.

Document all EoL discussions on the End-of-Life Care Flowsheet in Meditech (where available) and/or progress notes.

- Offer a copy of the POST to the patient/SDM
- Review the POST as appropriate (see Step 7: Maintain Continuity of Care below)
- Engage in collaborative conflict resolution processes in the event of conflict between team members or between the team and the patient/SDM/family regarding end-of-life treatment plans or wishes.

3.3 Default Resuscitation Status

Ideally, all patients meeting target criteria will have a POST on the chart. If any patient does not have a completed POST, appropriate resuscitation and care will be provided, based on the physician / RN (EC)s' clinical judgment in accordance with relevant college standards.

4.0 Procedure

This is an overview of the process for quality end-of-life care planning for patients at HHS. (See Quality End-of-Life Care Flowmap)

Note: Each clinical program or unit is expected to develop its own specific procedures or guidelines to tailor the implementation of this policy to the needs of their unique patient populations.

Step 1: Assess for Appropriateness of End-of-life Care Planning

1. The Health Care Professional with a therapeutic relationship with the patient assesses the appropriateness of initiating end-of-life care planning, using one or both of the following triggers:

A. ***Would I be surprised if this patient died within the next year?*** If the answer is *no*, proceed to Step 2: Meet as an Interprofessional Team.

B. ***Does the patient meet the inclusion criteria above*** (see Target Patient Population

above)? If the answer is *yes*, proceed to Step 2: Meet as an Interprofessional Team.

2. **Assessment of Urgency**
If the patient is at imminent risk of dying or requiring resuscitation within 24 hours, this represents an urgent need for end-of-life care planning, and the health care professional may proceed to Step 3: Initiate End-of-Life Care Discussion(s).

If the patient is *not* at imminent risk of dying or requiring resuscitation within 24 hours, the health care professional should continue to Step 2: Meet as an Interprofessional Team**.**

Step 2: Meet as an Interprofessional Team

1. In non-urgent situations, the interprofessional team (including MRP and and/or delegates/consultants) meets to gather facts and identify strategies for engaging in end-of-life care planning with a patient/SDM/family. In this meeting the team assesses/reviews:
- Patient's prognosis
- Whether the patient is capable of EoL care planning"? (see MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy)
- What treatment options are aligned with patient's best interests?
- Who is the patient's SDM (if incapable), according to s.20 of the Health Care Consent Act, Addendum B.1 SDM ranking)
- (See MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy,
- Patient/SDM readiness for end-of-life planning
- Known relevant patient wishes expressed when the patient was capable. **Note:** Previously expressed wishes can be oral (in previous conversations/meetings), or in writing (in a Living Will or Advance Directive or included in a Power of Attorney for Personal Care); or expressed by alternative means (i.e. symbol/word communication board).
  Note: It is up to the SDM of the incapable patient to interpret a Living Will or Advance Directive - the team can assist if requested by SDM or challenge interpretation if decision-making does not appear to be aligned with the Living Will or Advanced Medical Directive and/or in patient's best interests as per the HCCA (via the Consent and Capacity Board or other mechanism. Consult Risk Management and Ethics Consultation Service in such instances.)
- Best context, timing & strategies to engage patient/SDM in end-of-life care planning
- Essential team members to engage in the EoL conversation with patient/SDM/family

2. The interprofessional team notifies the MRP of intention to engage patient/SDM in End-of-Life discussion (if not present for team meeting).
3. If significant conflict arises during process, proceed to Step 5: Attempt to Resolve Conflict and Disagreement**.**

Step 3: Initiate End-of-Life Care Discussion

End-of-life care discussions are always conducted in a sensitive, respectful, compassionate manner, with attention to the holistic needs of the patient/family. Ideally both patient and SDM/family will be present for these discussions to ensure consistent and transparent communication.
- When a patient or SDM indicates that the patient has a written Advance Care Directive, this document may provide a helpful starting point for the discussion to help clarify the relevant values and the wishes of the patient and the clinical implications of the Advance Directive.
  Note: An Advance Care Directive does **not** constitute a medical order. A POST must be completed to support the patient's wishes after conversation with the patient/SDM.
- At all times, decisions regarding CPR and other potentially life-sustaining treatments should be made according to the likelihood of benefit to the patient and should take into

account the patient's goals of care, values and beliefs.

- End-of-life care planning is a process that evolves over time. Health care professionals should reassure patients/SDMs/families that they have the right to review and change their decisions as circumstances change in the context of the treatments that are being offered.
- As with any informed consent conversation, when addressing specific treatment options, the following information is provided:
  - The expected benefits
  - Risks
  - Alternative courses of action
  - Likely consequences of not having the treatment (see MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy).
- HCP informs patient/SDM/family that in most cases, without a specific order restricting resuscitation **and if deemed clinically appropriate**, the default is to resuscitate the patient.

Step 4: **Document End-of-Life Planning**

1. Documenting End-of-Life Care Wishes and Discussions:

- When a patient or SDM indicates that there is a written Advance Directive, Living Will or instructions in a Power of Attorney for Personal Care, the HCP requests a copy for placement in the patient's record.
- All HCPs document the salient points from EoL discussions in the health record.
- All end-of-life related documentation should be under the End-of-Life Care Flowsheet in Meditech, or if unavailable, written in the Progress Notes.

2. Using the POST:

- The MRP/delegate/consultant (if appropriate) completes a POST and places it into the Green Sleeve at the front of the patient's chart.
  Note: If delegate or consultant completes POST, notify MRP.
- Appropriate orders are written and transcribed.
- Transcribe the POST to the KARDEX (if used) as "See POST order."
- Place the current POST, any previous POST, Advanced directives, living will and any other documents pertaining to the goals of care and end of life wishes of the patient into the Green sleeve at the front of the patient's chart.
- To void, previous POST strike through the document and signing MRP or delegates name and date. Ensure #4. Summary of plan, of the current POST is completed, indicating that "I have reviewed and discontinued previous POST".
- Offer copy of POST to patient/SDM.
- When a POST is completed, dictate or write a note in the physician progress notes
  Note: All end-of-life related documentation should be recorded in the End-of-Life Care Flowsheet in Meditech, and include:
  - Persons present for conversation
  - Who is the SDM (if patient is incapable)
  - Date of the conversation
  - Current status of illness
  - Prognosis
  - Treatment options discussed
  - Patient/family wishes
  - Goals of care during the illness
  - Discharge planning
  - End-of-life care plan
- Once completed, enact POST regardless of change in MRP unless further discussion and

decision with patients, families and health care team warrant a revision of the POST orders.

3. Preparing for Discharge:
   - Forward POST and dictation/note with reference to end of life care plan to the patient's family physician and other appropriate community care providers, to ensure continuity of care.
   - Complete DNR Confirmation Form (if appropriate)
   - Provide information to prepare patient and family for future trajectory of illness, e.g. home death.

Step 5: Attempt to Resolve Disagreement and Conflict

If there is disagreement regarding end-of-life care plans/goals/wishes between:
- Health care team and patient/SDM/family
- Patient and family (or between family members of an incapable patient)
- Health care team members

Then:
1. Attempt resolution through a team/family meeting and by accessing local resources, such as Social Work or Spiritual and Religious Care or Patient Relations.
2. Seek appropriate clinical consultations (e.g. Palliative Care) or a second medical opinion to clarify the patient's prognosis and appropriate treatment options.
3. Call Clinical Ethics Consultation Service for support and mediation if conflict persists (73661 or through Paging or Order Entry on Meditech).
   Note: Any member of the health care team, including the patient/SDM/ family, is welcome to contact the Clinical Ethics Consultation Service at any point in the patient's care.
4. In accordance with the Health Care Consent Act and CPSO guidelines for End of Life Care only clinically indicated treatment is offered including CPR or Allow Natural Death (AND), even if the SDM/family disagrees.

Step 6: Review POST

Duration of validity: A POST is valid for the patient's hospital admission until:
- The patient dies
  or
- The patient is transferred out of HHS care
  or
- The POST is voided by the MRP or the patient/SDM. Refer to Step 4: Document End-of-Life Planning - Using the POST

If any aspect of the plan for life-sustaining treatment changes, the old POST form should be voided and a new POST completed and signed by the MRP/delegate and placed in a green sleeve at front of the chart.

1. Review the POST with the patient/SDM in the following circumstances:
   - At the request of the patient/SDM:
     - If a patient/SDM indicates to any HCP a wish to change their resuscitation status and End-of-Life care plan, the HCP should void the form, contact the MRP immediately and document their conversation with the patient/SDM in the health record (where available, all end-of-life related documentation should be placed in the End-of-Life Care Flowsheet in Meditech).
   - When there is a significant change in the patient's condition/prognosis
     - In order to promote continuity and quality of care at end-of-life, HCPs should initiate review of the patient's POST only when there is a significant change in the

patient's status or new evidence to warrant change in the treatment plan.

- When the patient is transferred from one facility or unit to another (e.g. from inpatient to outpatient, from ICU to medicine ward).
    - The POST should be reviewed and confirmed by the receiving MRP.
- Before a patient undergoes surgery or an invasive procedure (see below).

If no changes are made to the POST upon review, the MRP/delegate indicates in the progress notes that it has been reviewed and remains unchanged.

2. **Surgery/Procedures:** Surgery or other invasive procedures may be appropriate for palliative patients or patients who have a POST indicating "Allow Natural Death."

- Before the surgery/procedure the physician and anesthesiologist will discuss with the patient/SDM the possible necessity of resuscitative measures to reverse the effects of anesthesia and agree on the time interval in which application of such measures might be reasonable.
- A summary of the above discussion as well as any changes to the POST for the duration of the Perioperative period are documented in the progress notes.

Note: This does not void or change the POST or care plan outside of the surgical procedure resuscitative measures.

If the patient/SDM makes an informed decision to refuse resuscitation during the surgery/procedure, this decision should be respected and documented. Both the anesthesiologist and the surgeon document this discussion in the progress notes indicating that the POST remains in effect.

Step 7: Maintain Continuity of Care

Discharge: If the patient is discharged home or to another facility, communicate the wishes and goals of the patient/SDM regarding end-of-life care and the content of the POST to both transferring personnel (ambulance) and the receiving facility and the family physician (if discharged home). This information should be communicated in the discharge summary as well as verbally to the transferring personnel. In addition to the discharge summary and verbal communication, the patient should be offered a copy of the current POST If the patient/SDM has selected "Allow Natural Death" as indicated on their POST, staff should complete the DNR Confirmation Form in preparation for transfer.

Refer to discharge summary guidelines.

Readmission to hospital: When a patient is readmitted to hospital, the HCP can identify the presence of a previous POST through the End-of-Life Care on Meditech (where available). If a POST from a previous admission is identified through the patient record, or the patient/SDM presents a copy of the previous POST or a current DNR Confirmation Form, the MRP/delegate should review the patient's/SDM's current end-of-life care wishes and complete a new POST form.

Note: If a POST from a previous admission is identified through the patient record, and the patient is incapable of participating in decisions **and** the SDM is unavailable, the health care team may act on the basis of the previous POST until such time as new document can be completed with the appropriate decision-maker. The MRP should endeavor to do this within 24 hours.

5.0 Documentation

- Physician Ordered Scope of Treatment (POST) for End of Life Care Order Set and Conversation Guide
- DNR Confirmation Form (if patient is discharged) DNR-C Form ordered through Service Ontario.

- End-of-Life Care Flowsheet (Meditech)

6.0 Definitions

Advance Care Directive/Living Will: A written form/document that states the patient's wishes about their health and personal care. The patient does this while capable, instructing their Substitute Decision Maker (SDM)/Power of Attorney (POA)on the level of care and treatments they would or would not want under certain circumstances. Advance care directives still require deliberation and interpretation to ensure they are applicable to the current circumstances. Also see **'Previously Expressed Wishes**'.

Allow Natural Death (AND): When this choice is made, it means that the health care team will not prolong or interrupt the dying process in the event of cardiorespiratory arrest. **This replaces the phrase, "Do not resuscitate" (DNR) or "No cardiopulmonary resuscitation" (No CPR).**

Best Interests: Defined in s.21(2) of the Health Care Consent Act (HCCA), Ontario 1996. In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the treatment is likely to,

   i. improve the incapable person's condition or well-being,

   ii. prevent the incapable person's condition or well-being from deteriorating, or

   iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.

2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.

4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

Capacity: A patient/client/resident is capable with respect to consenting to a treatment if she/he is able to understand the information that is relevant to making a decision concerning the treatment, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. For a more comprehensive definition of capacity, see the MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy.

Cardiopulmonary Resuscitation (CPR): Measures such as chest compressions, cardiac defibrillation (applying shocks to the chest over the heart), endotracheal intubation (insertion of a breathing tube down the throat), and inotrope/vasopressor administration (emergency drugs to stimulate the heart and clamp down on blood vessels). Other modalities of life support may also be attempted.

Clinically Indicated: In accordance with the College of Physicians and Surgeons of Ontario as defined in the Policy Statement # 1-06. Decision Making for the End-of-Life, Section 3.2, , "Physicians are not obliged to provide treatment that will almost certainly not be of benefit to

the patient."

Patients almost certainly will not benefit is defined as: "There is almost certainly no chance that the person will benefit from CPR and other life support, either because the underlying illness or disease makes recovery or improvement virtually unprecedented, or because the person will be unable to experience any permanent benefit."

"A clinical judgment about the appropriateness of a treatment option should NOT be based on the clinician's personal judgment of the patient's quality of life, moral character, lifestyle or other social factors." Or SDM/family demands for treatment(s) that are not being offered.

Family
Family is defined as those closest to the patient in knowledge, care and affection. Family may include the biological family, the family of acquisition related by marriage or contract and the family of choice and friends.
Note: Family involvement/the sharing of the patient's personal health information can only happen if the capable patient consents to the involvement or in the event the patient is incapable, the patient's SDM consents to it.

Green sleeve: A green coloured plastic sleeve kept at the front of the patient's chart and will be the repository of all documents pertaining to goals of care and EoL: current and previous voided POST, Advanced Care Directive and individualized patient documents.

Interprofessional Team: A team of health care providers who work together with the patient and family to develop and implement a plan of care. Members of this team reflect the expertise required to address the varied needs of the individual patient and family being cared for and may include physicians, nurses, social workers, chaplains, dieticians, therapists, volunteers, and other disciplines as indicated.

Holistic Care: Care that recognizes the intrinsic value of each person as an autonomous and unique individual and that is provided in a manner that is sensitive to the patient's and family's personal, cultural, and spiritual/religious values, beliefs, and practices, their developmental state, and their preparedness to deal with the dying process.

Most Responsible Physician (MRP):
A member of the Professional Staff with admitting privileges, who will have overall responsibility for the care of the patient.

Health Care Professional (HCP):
A person who by education, training, certification, or licensure is qualified to and is engaged in providing health care.

Registered Nurse Extended Class [RN(EC)]
The Extended Class is for RNs who have obtained additional education and experience. Members in this class have an expanded scope of practice with legislated authority to diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform procedures.

Palliative Care: Care aimed at relieving suffering and improving the quality of living and dying for those who are living with or dying from a life-threatening or life-limiting illness. This care strives to address physical, psychological, social, spiritual, and practical issues for patients and families, regardless of where patients fall in the disease trajectory.

POST (Physician Ordered Scope of Treatment for End of Life Care): An HHS-approved form that documents the patient/SDM's wishes regarding end-of-life care, specifically life-sustaining treatments and resuscitation. **The POST replaces the DNR order.**

Previously Expressed Wishes: A patient's wishes regarding future treatment that were

expressed at a time when the patient was capable. Previously expressed wishes can be oral (expressed in previous conversations/meetings with SDM, family or Healthcare Team), **or** in writing in a Living Will or Advance Care Directive or included in a Power of Attorney; **or** expressed by alternative means (i.e. symbol/word communication board).
Note: Previously expressed wishes may not always be applicable to the patient's current clinical situation. Also see "**Advanced Care Directives**".

Substitute Decision Maker (SDM): A person who is authorized under the *Health Care Consent Act, 1996* (HCCA) to give or refuse consent to a treatment on behalf of a person who is incapable. The SDM must be capable, willing and available. The SDM should make a decision that is consistent with the patient's previously expressed capable wishes applicable to the circumstances and the patient's values/beliefs. In the absence of prior capable and applicable wishes, SDMs should follow the principles of best interests as set out in s.21(2) of the HCCA in making decisions for patients.

7.0 Cross References

MAC - Organ and Tissue Donation Referral Protocol
MAC - Consent, Withdrawal or Refusal of Consent for Treatment Policy
MAC - Physician Documentation of Patient Care in the Health Record Policy

Note: This policy replaces the following previously published policies:

- Do Not Resuscitate Orders Policy
- Advance Directives Policy
- Patient in a Persistent Vegetative State Policy
- PERI – Do Not Resuscitate Orders – Operating Room
- JCC/RAD "Procedure for the Documentation of No CPR/Do Not Resuscitate Orders"

8.0 Other HHS References

HHS Order Set site:

- Physician Ordered Scope of Treatment (POST) for End of Life Care (POST) Order Set
- Conversation Guide for POST Order Set

Quality End of Life site:

- A Practical Guide To Conflict Resolution
- End-of-Life Discussion Team Planning Guide
- Identification of Adult Patient at Risk of Dying Tool
- Reflective Practice Tool for HCP Involved in End-of-Life Care
- QEoLC Protocol FAQ's
- Making Your Wishes Known, Patient Education booklet, PD#6911
- QEoL video on EOL Conversations

9.0 External References

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http://www.albertahealthservices.ca/ps-1023351-103547-acp-gcd-order.pdf

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10.0 Developed By
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11.0 In Consultation With
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Hospital Legal Counsel
Council of Chiefs
Family Advisory Committee (MCH)
Director Health Records

12.0 Approved By
Professional Advisory Committee
Medical Advisory Committee

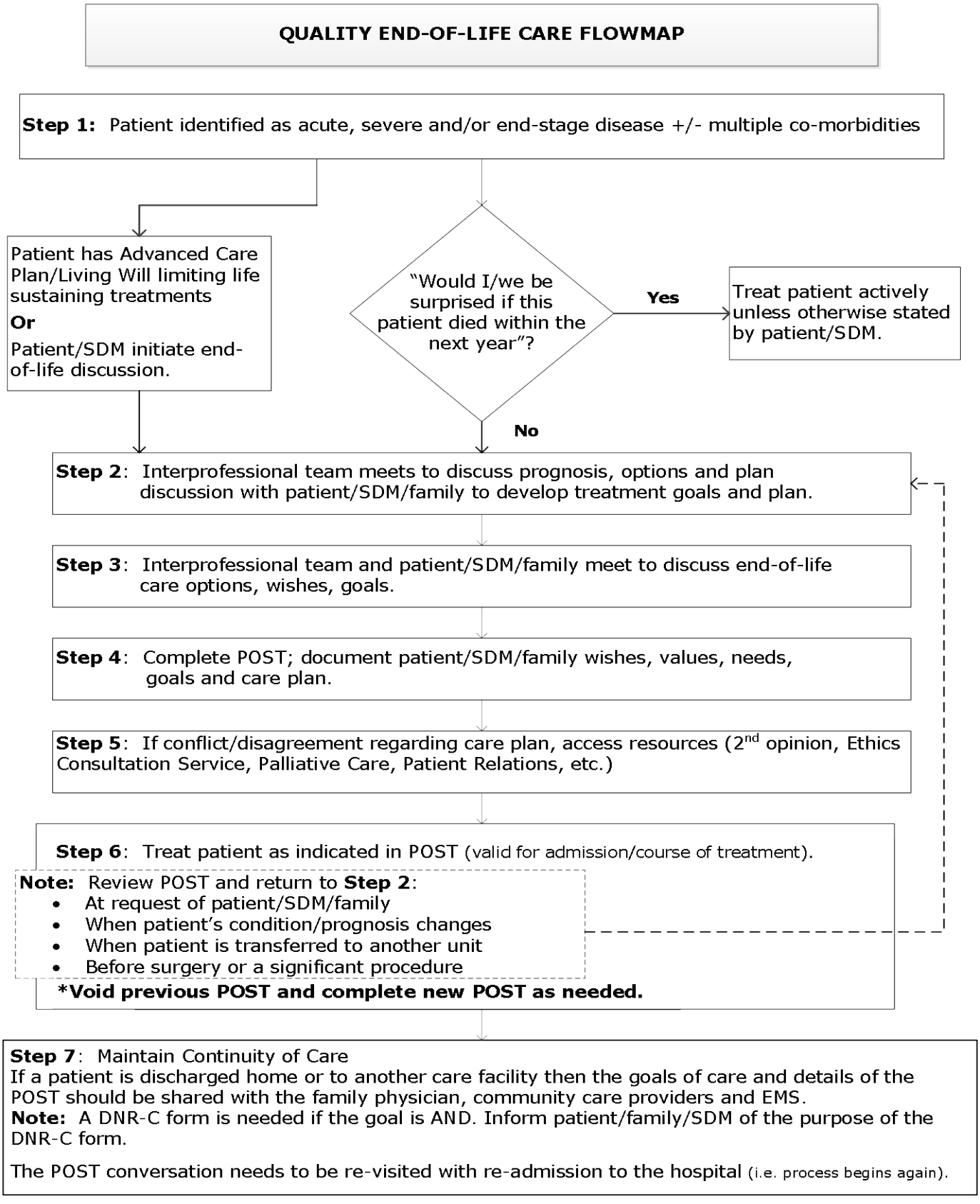
13.0 2013 Review / Approval
Quality End-of-Life Care Taskforce
Clinical Ethics Committee
Hospital Legal Counsel
Interprofessional Advisory Committee (IPAC)
Medical Advisory Committee (MAC)

14.0 Appendix
Quality End-of-Life Care Flowmap

Keyword Assignment	Death, DNR, Do not resuscitate,

END OF DOCUMENT

Appendix:


QUALITY END-OF-LIFE CARE FLOWMAP
Step 1: Patient identified as acute, severe and/or end-stage disease +/- multiple co-morbidities
Patient has Advanced Care Plan/Living Will limiting life sustaining treatments
Or
Patient/SDM initiate end-of-life discussion.
"Would I/we be surprised if this patient died within the next year"?
Yes
Treat patient actively unless otherwise stated by patient/SDM.
No
Step 2: Interprofessional team meets to discuss prognosis, options and plan discussion with patient/SDM/family to develop treatment goals and plan.
Step 3: Interprofessional team and patient/SDM/family meet to discuss end-of-life care options, wishes, goals.
Step 4: Complete POST; document patient/SDM/family wishes, values, needs, goals and care plan.
Step 5: If conflict/disagreement regarding care plan, access resources (2nd opinion, Ethics Consultation Service, Palliative Care, Patient Relations, etc.)
Step 6: Treat patient as indicated in POST (valid for admission/course of treatment).
Note: Review POST and return to Step 2:
At request of patient/SDM/family
When patient's condition/prognosis changes
When patient is transferred to another unit
Before surgery or a significant procedure
*Void previous POST and complete new POST as needed.
Step 7: Maintain Continuity of Care
If a patient is discharged home or to another care facility then the goals of care and details of the POST should be shared with the family physician, community care providers and EMS.
Note: A DNR-C form is needed if the goal is AND. Inform patient/family/SDM of the purpose of the DNR-C form.
The POST conversation needs to be re-visited with re-admission to the hospital (i.e. process begins again).