

Frequently Asked Questions (FAQ's)
Advance Care Planning: Goals of Care Designation (Adult) policy

Question 1. What is the difference between an M2 and C1 Designation?

A simple way of looking at this is to ask – What is the goal of care? Are we initiating an intervention in order to cure or control an illness or to relieve a symptom and get someone better so that they can live longer (M2)? Or are we intervening solely to relieve a symptom, with no expectation that treatment would meaningfully increase the duration of their life (C1)?

Patients with an M designation have a goal of care aimed at cure or control of their health conditions. They will not be resuscitated for cardiac or respiratory arrest, and will not receive care in an ICU.

After discussion about their health condition and the medical appropriateness of potential care and interventions, patients with an M2 designation seek interventions and care treatment options available where they currently live. They do not wish to be transferred to acute care. They say “care for me as well as you can within the limitations of where I live, attempting to cure or control my health conditions. But I don’t want to be in hospital, or leave this place where I live.”

NOTE: There are circumstances - such as a broken hip or other unexpected trauma when an M2 designated patient may have a goal directed transfer to Acute Care. In such an instance there is an expectation of timely return to the person’s living environment once the unexpected illness has been addressed. Such a person’s Designation would remain M2 in Acute Care with the particular circumstances noted in the Medical Orders, progress notes and Tracking Record.

Patients with a C designation have a goal of care aimed at comfort and symptom control, without cure or control of underlying, life-limiting illness. The location of care is determined by the needs of the patient and where the optimum symptom control can be provided.

After discussion about their health condition and the medical appropriateness of potential care and interventions, patients with a C1 designation seek interventions and care that address symptom management for comfort and maintenance of function so that they can live as well as possible until death. They say –“I know I have an illness that will cause me to die soon. Keep me as comfortable as you can so I don’t suffer and keep me as functional as you can so that I can accomplish limited goals in my remaining weeks or months. New illnesses that occur should be treated only if that can help reduce suffering.”

By way of example, a person with an M2 designation who develops a new pneumonia would receive treatment aimed at cure of the pneumonia, but only in the current location of care. A person with a C1 designation who develops pneumonia might seek treatment that would relieve potential pain, dyspnea and distress, whether or not the treatment could fully resolve the

pneumonia. Sometimes antibiotics would be contemplated for such a patient, with the sole intent of relieving symptoms.

Question 2. What is the purpose of the Green Sleeve?

The Green Sleeve is a plastic pocket that is meant to house important documents that outline a person's goals for healthcare. It is given to people cared for in Alberta Health Services – Calgary and Area who have had discussions or completed documents that refer to decision-making about their current or future care.

The information is intended to ensure that all healthcare providers in any setting have access to important decisions related to the patient's goals of care and guidelines for direction of interventions that have been discussed with the patient.

The Green Sleeve is to accompany the person as they transfer between care providers and sites.

Question 3. What may the Green Sleeve contain?

1. Goals of Care Designation (GCD) order when one exists

The GCD order paper format will be in the Green Sleeve except in areas that use electronic order entry. In areas using SCM the order will be entered and viewed in electronic format.

2. Advance Care Planning Tracking Record

The original of this document is kept in the Green Sleeve to allow care providers at each site access to the full record of conversations that have occurred over time.

3. Personal Directive and/or "My Voice" workbook copies if they exist.

Question 4. What should a care provider do with a Green Sleeve?

- **Review** Green Sleeve contents on admission
- **Ensure** current care and orders are congruent with information in Green Sleeve
- **Send** Green Sleeve with patient when they transfer to another site or care provider
- **Remind** the patient to take the Green Sleeve when they go to hospital or attend a clinic appointment

Question 5. What is the main differentiating point for the three R sub-categories?

The differentiation of the subcategories is based on the intensity of interventions appropriate for the patient.

For instance, an R3 designated patient would not request, nor be expected to benefit from intubation and chest compression. Example: A person in a monitored CCU setting, with a correctable rhythm disturbance, and a serious chronic illness, but who wishes to live longer to accomplish some important goals, might have this Designation so that the symptomatic rhythm disturbance could be treated. Treatment could include cardioversion or medication. Treatment would not include chest compression or intubation if the patient suffered cardiopulmonary arrest.

In the old Code Level system, this differentiation could not be easily incorporated.

Question 6. What is the main difference between C1 and C2?

The main differentiating point is proximity to death.

C1 patients may have weeks to live, or even many months.

Several circumstances could be contemplated:

- a) They might have a terminal illness from which they are expected to die soon. Some would still want simple treatments such as antibiotics for a new pneumonia, if that intervention would allow them to accomplish some final goals. But some of these C1 designated patients would request that new illnesses should not be cured, with the focus being on comfort until death.
- b) Some people with a slowly progressive terminal illness could potentially live for many months or several years. Such a person might still carry a C1 Designation. They would be seeking maximal function and symptom control. Some of these patients would not wish to receive life prolonging interventions in the event of intercurrent illness, and some would. Those important decisions are made through continued dialogue as the person progresses through their disease trajectory.

C2 designated patients are expected to die within hours or perhaps a few days, and seek maximal symptom relief and withdrawal of any life prolonging measures, in preparation for imminent death.

Designation decisions are not only about the intervention itself, but are primarily about the intention or goal of the intervention. So for instance, a previously well hypovolemic 60 year old person with an acute illness might be given life saving iv fluids with the intention of supporting the patient until he returns to health. The intention of iv fluid administration is very different for the 60 year old person with metastatic cancer treated with opioids. In the latter case, i.v. fluids may be necessary in some circumstances to retain adequate renal function in order to clear opioid metabolites and prevent delirium if that person is seeking to accomplish important preparations for eventual death. Similar intervention, but with an entirely different goal of care.

Question7. How are M sub-categories differentiated?

The subcategories of M are based on decisions about location of care. An M1 designated person – often someone in chronic Home Care or in Supported Living such as Long Term Care – might

seek and would be appropriate for interventions in a more acute setting, but not including resuscitation and ICU interventions.

However, an M2 designated person residing at home or in LTC would not be transferred to acute care, should their condition deteriorate. They would be treated with the interventions that are available in their current setting with the goal of control of underlying illness, cure of intercurrent illness and symptom relief.

Hospitalized patient with M1 designation:

An M1 patient currently in hospital is someone who would not be appropriate for resuscitative measures followed by ICU should they have a cardiorespiratory arrest. They would still be offered other interventions that are appropriate to cure or control their underlying illness and to treat intercurrent illnesses.

M1

Here is an example of decision-making for a person with an M1 designation. Mr. Jones, a 70 year old man at home, living with diabetes and heart failure, develops pneumonia. He and his physician have agreed about an M1 Goal of Care Designation. He is treated with oral antibiotics, but deteriorates. He would next be appropriately sent to acute care for investigation and potential treatment with IV antibiotics.

M2

Mrs. Smith, a 70 year old woman in LTC with COPD, diabetes and debilitating arthritis indicates that she never wants to see the inside of a hospital again. She has an M2 Designation. She develops pneumonia and is appropriately started on oral antibiotics. However she deteriorates and only hospital care and iv antibiotics could potentially help her recover. With an M2 designation, she would not be transferred to hospital and would be treated with palliative intent. If there is time, she should have her designation changed to C1 or if very close to death, C2. Even in the M2 category, as with all categories, comfort and symptom control measures are still important, and should be employed.

Question 8. Do all patients require a Goal of Care Designation?

It is preferred that all patients will have a Goal of Care Designation (GCD) for their health encounter.

It is most necessary in Acute care settings and in Long Term Care and Designated Assisted Living environments. Many Home Care patients, palliative care patients and some people cared for from community offices would be best served by having a GCD.

Question 9. Are there default Goals of Care Designations?

In general we are discouraging use of Default GCD Orders within Order Sets.

However, we are working on establishing criteria for justifiable use of default GCDs for selected patients.

For instance, young otherwise healthy elective surgery patients can be expected to have an R1 GCD. Similarly, it would be rare for a labouring woman to have other than an R1 designation.

Further work is being undertaken to determine if any Order Sets in the electronic ordering environment should include default GCD Orders.

Question 10. Who should I have a Goals of Care conversation with prior to issuing a GCD Order?

Anyone for whom it is clinically appropriate to have a conversation with, in order to determine a GCD.

If you have any clinical or personal information about a patient that would make you question that a GCD other than R1 is to be considered, you should have a conversation with the patient (or proxy decision-maker) leading to a conjointly determined GCD.

If it is obvious to you that an R1 designation is most appropriate, it can still be worthwhile to confirm this with many patients.

For labouring women, and for some other very healthy individuals who are having an episodic health encounter in the system, the conversation could be viewed as intrusive and inappropriate. Wise clinical judgement will be the best guide.

Question 11. Should patients be aware of their GCD?

It is ideal that patients both participate in the discussion leading to a GCD, and be aware of the GCD.

When an R1 designation is assumed, there is less motivation to deliberately raise awareness about the details of this designation.

Our initiative is working on engagement of the public and of patients in particular so that people will generally be more aware of GCDs and their implications for health care decision-making. A number of brochures and education initiatives are being provided for patients and the public so that they can be full participants in GCD determinations and in Advance Care Planning activities.

Question 12. Can the Code 66 Team be called for patients with designations that are not in the R grouping?

YES

- o Code 66 teams request that clinicians utilize the Code 66 criteria to determine whether it is appropriate to call a Code 66.

- o The Code 66 team will see any patient that staff is concerned about as per the criteria, and will respond to multiple calls for the same patient as necessary.
- o Contact should always be initiated with the patient's attending physician before or at the time of the Code 66 call.
- o The Code 66 outreach teams do see both C and M designated patients because there may be ways that they can help to assess and manage the patient's immediate deterioration, but it is possible that the Code 66 team may not be able to suggest any further intervention.

Question 13. When is a Code 66 call inappropriate?

A Code 66 would not be called if the unit staff and attending are present and can manage the situation.

A Code 66 would not be called if the patient was quickly approaching an expected death (C2) and other resources such as palliative consult staff were available to address symptoms.

A Code 66 would not be called if the patient were already pulseless.

Question 14. Can you clarify the differences between the policy definitions of Resuscitation, Life Support Interventions and Life Sustaining Measures?

The distinctions between Resuscitation, Life Support Interventions and Life Sustaining Measures can be understood related to:

- o time frames under which the interventions are usually employed
- o goals or anticipated results of the interventions

Interventions may be applicable in more than one of the categories depending on the anticipated results.

Resuscitation: To revive.

Time frame: Immediate

Anticipated Results: Restore/stabilize acute deterioration in a patient's vital signs

Resuscitation means the initial effort undertaken to reverse and stabilize an acute deterioration in a patient's vital signs. The patient's R designation determines whether any or all of the following interventions are appropriate:

- chest compressions
- mechanical ventilation,
- external electrical stimulation of the heart (defibrillation, external pacemakers, cardioversion)
- certain medications

Life Support Interventions: Interventions used in maintenance of critical organ physiology.

These measures are usually provided in ICU.

Time Frame: Short Term

Anticipated Results: Supports critical organ function until the healing process has taken place and life support is no longer required.

Life Support Interventions refer to that attempt to support critical organ function, restore normal physiology and allow healing to occur. These interventions directed at providing

physiological support are typically undertaken in ICU but EMS, ED, Code teams, and particular cardiac units may also utilize life support interventions according to their specific protocols.

Life Sustaining Measures: Therapies that maintain life without supporting unstable physiology.

Time Frame: Usually longer term

Anticipated Results: Maintain life by assisting bodily functions. Underlying illnesses may continue to progress.

Life sustaining measures mean therapies that sustain life without supporting unstable physiology. Such therapies can be used in many other clinical circumstances. Examples include enteral tube feeding and intravenous hydration, and dialysis. When viewed as life sustaining measures, they are offered in the terminal stages of an illness in order to provide comfort or prolong life. These measures should be clinically useful towards the intended goals and in agreement with the patient's goals.

ARCHIVED QUESTIONS

Question: Are any of the three R Designations equivalent to the current Level 1?

R1 is equivalent to current Level 1.

The new general R Designation has more subcategories to refine directions of treatment for patients who may require ICU care.

Question: Is Designation C1 or C2 equivalent to current Level 3?

No. Although many palliative patients are designated C, and would previously have been Level 3, the intentions of care are now more easily defined.

In the old system, for many, a Code Level 3 assignment meant that potentially aggressive symptom management or life saving interventions were not to be offered. This inappropriate limitation has been corrected in the new designations.

The intention of a C1 Designation is the alleviation of symptoms and maintenance of function at any time through the trajectory of a life limiting illness. There is no intention to cure the underlying illness from which the person is expected to die. Examples of acceptable interventions for some C1 patients could include palliative chemo, major symptom relieving surgery, and PEG tube feeding, if their increasingly limited health goals can still be met reasonably by way of these interventions.

Question: Is Designation M equivalent to current Level 2?

There is not a one to one relationship between current Level 2 and the new M Designation. The M designation has a somewhat more narrow focus. Some Level 2 patients under the old system would now be in the R2, R3, M1, M2 or C 1 Designation category. Level 2 was the most challenging Code Level, not providing clear enough direction for many patients' care.