Helping our patients' Values and Wishes for End of Life Care to be:

- Public Awareness and Education
- Community Engagement
- Clinician Training to have ACP conversations

- Standardized documentation of ACP conversations and MOST that is accessible
- Clinician training to enter MOST
- Information-sharing between Care Providers and Health Record Systems

- Operational Procedures to seek Advance Care planning information, use it to inform decisions and ensure care provided is congruent to patient wishes

It's finally here!

The Advance Care Planning/MOST tab in Results Review

All the historical info available in one place to make decisions/run a family meeting

Results Review | Full screen | Print | 0 minutes ago

Safety Risk

Last 48 Hours | Lab - Recent | Lab - Extended | Microbiology | Diagnostics | Vitals - Recent | Vitals - Extended | Clinical Information | Documents | **MOST/ACP** | Medicine Summary

Flowsheet: Provider Advance Directive Informa ... Level: Provider Advance Directive Informa (Table / Group / List)

Last 100 Results in the Past 3 Years

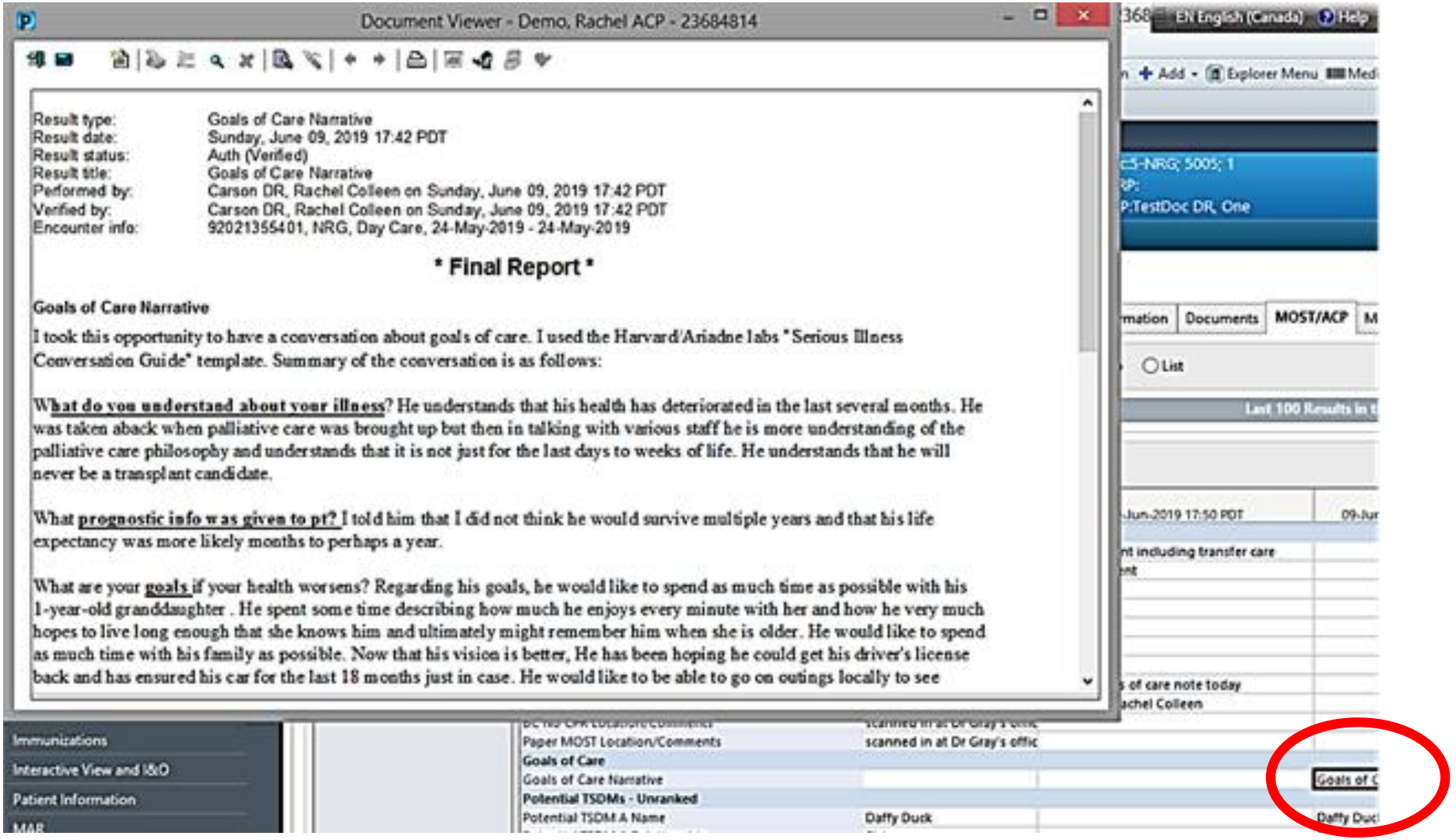
Navigator
- Resuscitation Status Details
- Goals of Care

Showing results from (08-Jul-2017 - 07-Oct-2019) Show more results

Provider Advance Directive Information	07-Oct-2019 22:42 PDT	12-Aug-2019 18:13 PDT	12-Aug-2019 15:38 PDT	01-Jul-2019 21:56 PDT	14-Jun-2019 22:21 PDT	20-May-2019 17:39 PDT	22-Jul-2017 22:32 PDT	08-Jul-2017 14:38 PDT
Resuscitation Status Details								
Intervention Level			M3 – treatmer	C2 – ICU/Intu	C2 – ICU/Intu			
Following Conversation With			Temporary Su	Representativ	Capabl	Patie	Capabl	
Names of People Interviewed				Spouse				
Conversation Documented In								
Supporting Documentation Reviewed								
Other Supporting Documentation Reviewed								
Additional Directions								
Special Instructions			common law					
MOST Ordered By			Takeda DR, S	Chen DR, Dal	Culp DR, Gre			
Documentation Site								
Goals of Care								
Goals of Care Narrative	Goals of Care		Goals of Care					

The MOST is the cherry on top, but the Goals of Care Documentation is where the "good stuff" is

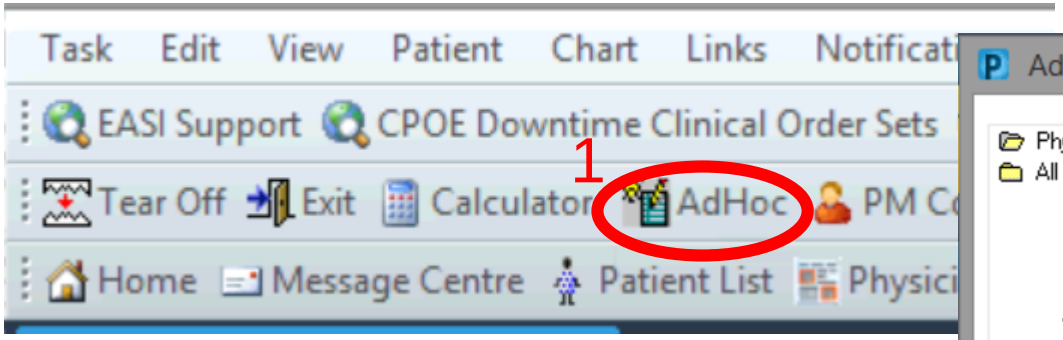
To read previous notes on Goals of Care discussions, Double click on the "Goals of Care Narrative" cell and it opens the document for that date.

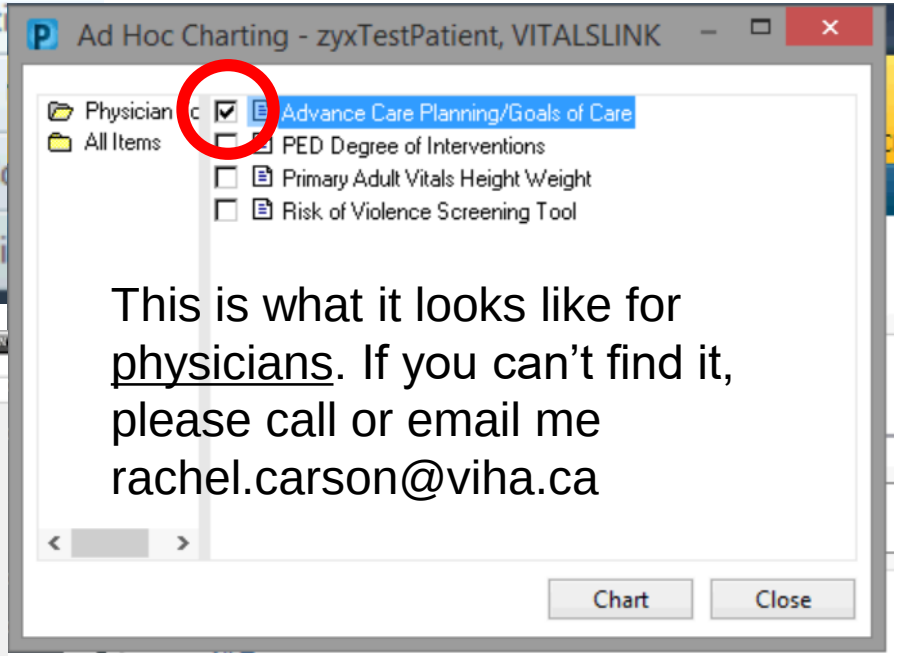


Doctors/NPs can document a GOC conversation by creating a new ACP form from the "AdHoc" menu:

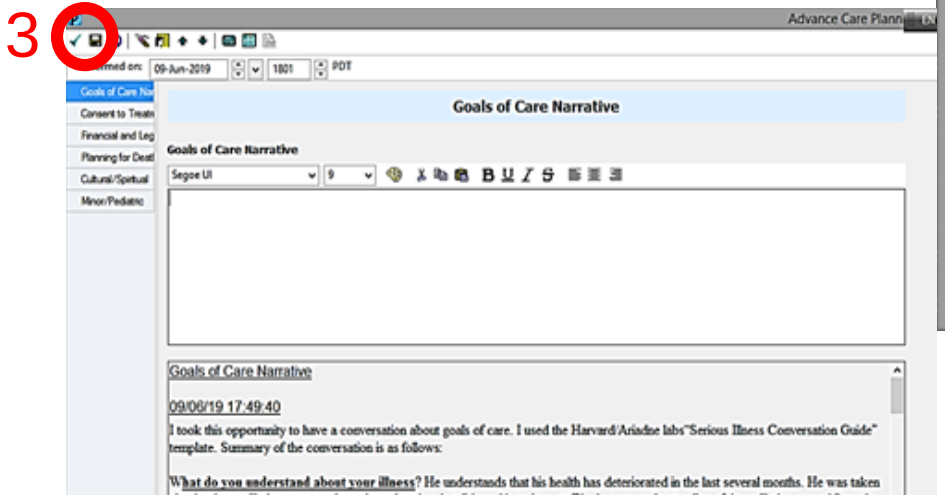
It's 3 clicks to open it

The most recent note is visible underneath for reference, with cues for the components of the "Serious Illness Conversation" template underneath that. Sign it by clicking the checkmark (*NOT the floppy disc! If you click the floppy disc your work gets hidden*)





This is what it looks like for physicians. If you can't find it, please call or email me rachel.carson@viha.ca



ANYONE (nurse, social worker, MD, NP, dietitian, PT etc) can use this form to enter information about a Goals of Care conversation they have with the patient, because **Advance Care Planning is a team sport**!

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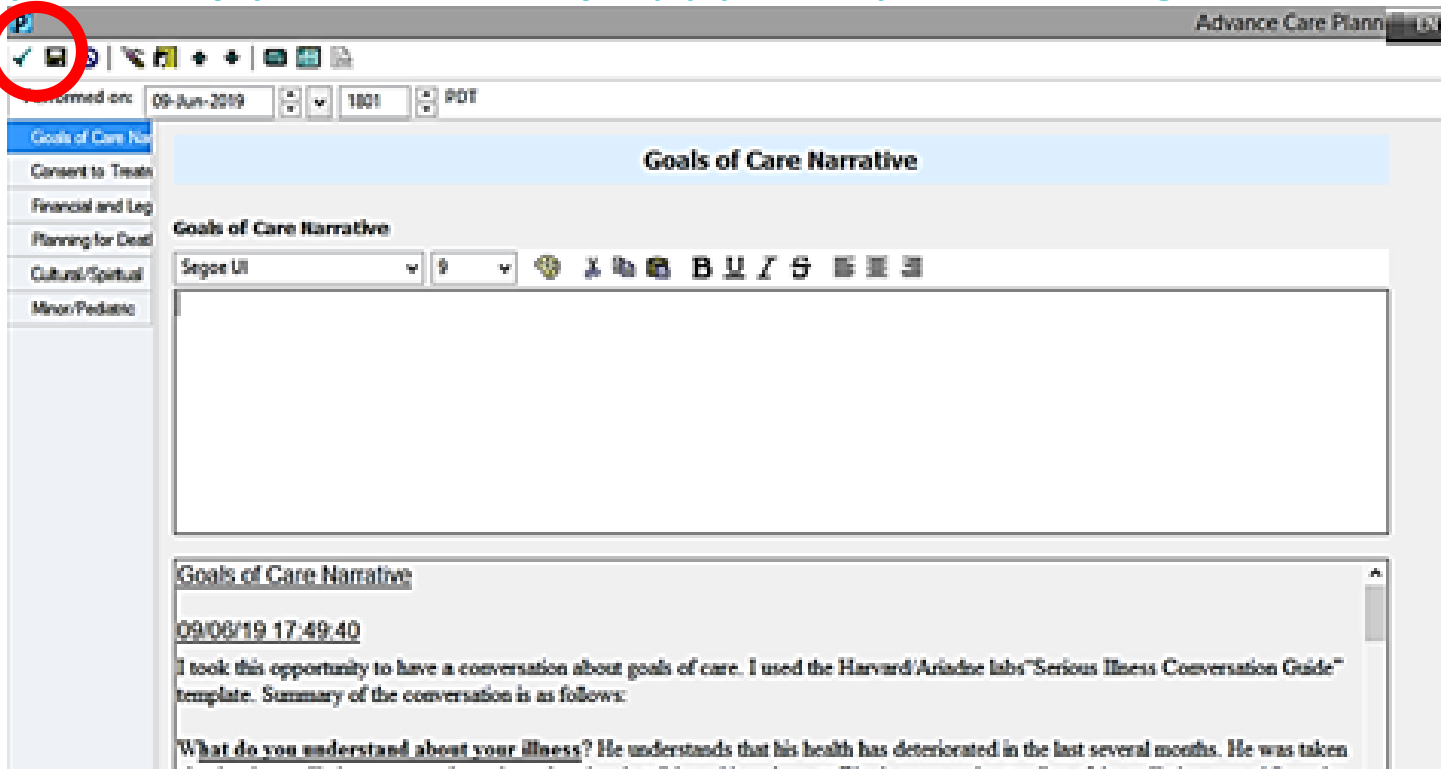

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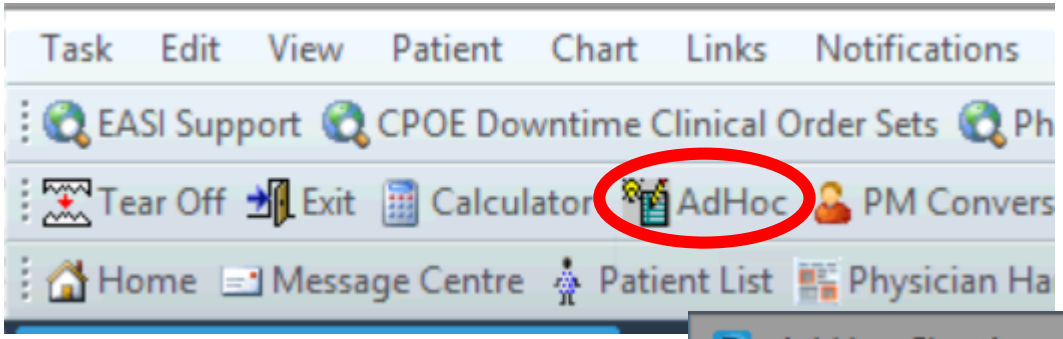

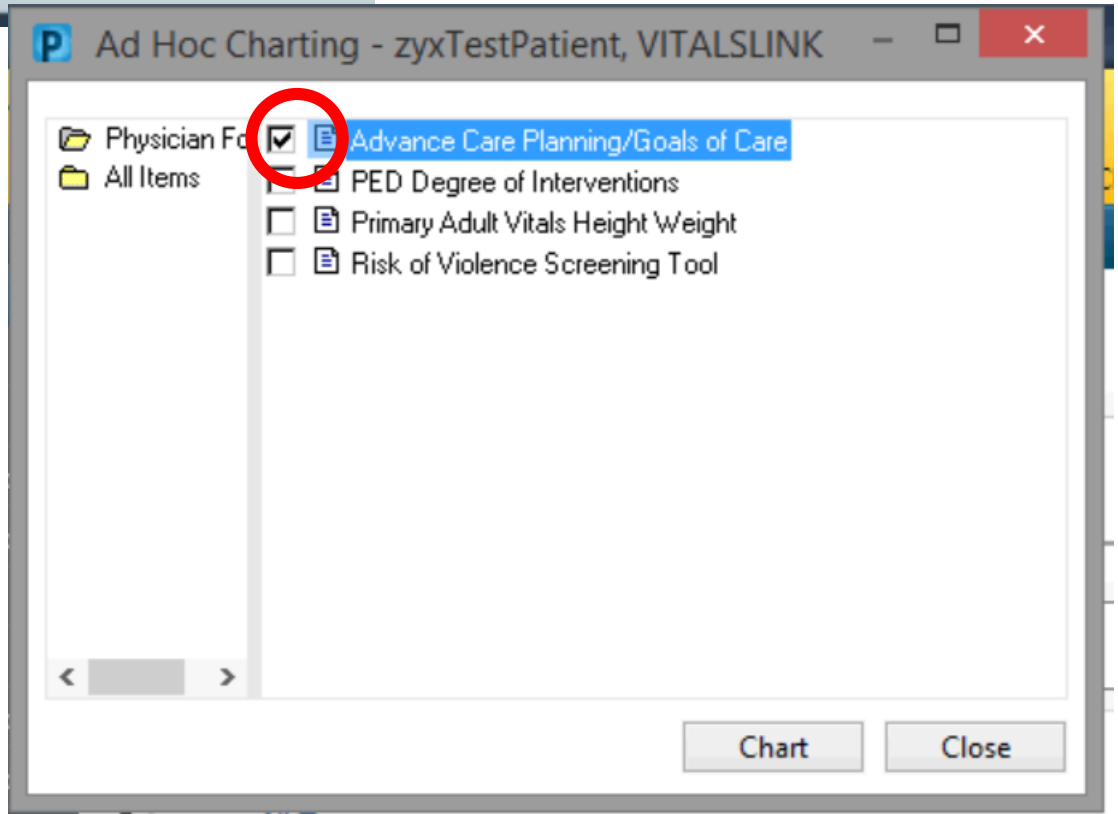

This is what it looks like for some physicians – 3 clicks to open

Doctors/NPs may also want to put the Goals of Care Discussion as part of their main consult / progress note then copy (CTRL-C) and paste it into the ACP/Goals of Care form box

Why? Because the ACP/Goals of Care form can't be copied to someone outside of iHealth (e.g. to family physician office office) the way a physician consult can.

Only an MD/NP document (not a form) can be sent out electronically to physician offices, so if you want to send a summary of the discussion to the GP, the MD/NP has to put it in a note, and copy that to GP then cut and paste it into the ACP form

Nursing or allied health documentation can only be sent out to physician offices by printing and faxing

Who are you going to call?

Emergency Contacts in Cerner are:

- Different from substitute decision makers (neighbour vs relative in Toronto)
- unreliable ("ghost contacts"… spoooooky)
- encounter-specific (not patient-level like the allergy record)
- not editable by clinical staff (only NUAs/patient-placement staff have access)

Record <u>potential</u> temporary substitute decision makers (TSDMs) and their contact info in the ACP form (Consent to Treatment section)