ADVANCED CARE PLANNING IN THE EHR
Provider Guide

INTRODUCTION

Advance Care Planning (ACP) is a process that a capable adult follows to ensure that their values, wishes, beliefs, and goals of care are known, in the event that they become incapable of providing direction or consent in their care. This process includes conversations with the adult's loved ones and health care providers. These conversations should be ongoing, as wishes and health status may change. Advance Care Planning may also include the adult recording their wishes, making a list of possible Temporary Substitute Decision Makers (TSDM), the legal appointment of a Substitute Decision Maker (SDM), and/or writing an Advance Directive.

What is my role in Advance Care Planning?

We all support ACP through:
- Ascertaining what beliefs, values, and wishes relating to health, capabilities, and care are important to the patient and working with the patient to identify goals of care.
- Ensuring that patients have information and, if needed, clarification about prognosis and treatment options.
- Ensuring patients have information about personal planning options (this may include a referral to Social Work and/or providing additional resources).

How can I learn more about Advance Care Planning?

There are numerous resources available regarding ACP:
- The BC Ministry of Health's My Voice booklet.
- HealthLink BC's Advance Care Planning site.
- BC Ministry of Health's Advance Care Planning site.
- NIDUS, a BC non-profit offering information and resources relating to personal planning options.
- Speak Up, a national website offering information and resources related to ACP.

For more information about Advance Care Planning, please contact the Advance Care Planning Coordinator at advancecareplanning@viha.ca.

What do I do with the Advance Care Planning information that I receive?

Like allergy information, ACP information needs to be readily available anywhere a patient receives care. The new ACP Powerform provides a way for this information to be recorded, so that all clinicians can find it with just two clicks, wherever the patient is within Island Health. It is important that the ACP information in the chart is regularly verified with the patient to ensure that the information is accurate and up to date. Patients' Advance Care Plans can change at any time.

What information can be recorded in the Powerform?

The ACP Powerform has several sections:

- Goals of Care Narrative: In this section, Health Care Providers (HCPs) can document information that they receive about a patient's values, wishes, beliefs, and goals related to their care. This is recorded in a free-text box. The page also includes a list of the key elements of the Serious Illness Conversation to help guide HCPs in their discussions.

- Consent to Treatment: This section allows HCPs to document any legal documents that are relevant to consent, such as a Representation Agreement, Advance Directive, or Committee of Person. This section also allows HCPs to record the names and contact information of potential TSDM and to indicate their eligibility (criteria are listed on the page). Information in this section should be reviewed regularly, as documents and relationships can change.

  The table below outlines the documents that may be completed:

	Advance Directive	Enduring POA	RA7 Financial	RA7 Personal and Health	RA9 Personal and Health	Committee of Estate	Committee of Person
Financial	NO	YES	Routine Management	NO	NO	YES	NO
Legal	NO	YES	Limited	NO	NO	YES	NO
Personal Care	NO	NO	NO	YES Limited	YES	NO	YES
Health Care	YES	NO	NO	YES Limited	YES	NO	YES

  HCPs must always seek consent using the standards set out in the *Health Care* (Consent) and *Care Facility* (Admission) *Act*.

- Financial and Legal**:** HCPs can use this page to document any financial or legal arrangements that a patient may have in place, such as a Committee of Estate or Power of Attorney. This page also allows HCPs to record whether a patient is receiving Palliative Benefits and when they were registered with the program.

- Planning for Death: Information about a patient's end of life wishes their funeral arrangements and executor can be included here. HCPs may document whether an Expected Death in the Home (EDITH) form has been completed. Conversation notes and information related to a patient's request for Medical Assistance in Dying may also be recorded on this page.

- Cultural/Spiritual: HCPs may record a patient's religious preference, information related to a religious community, and religious or cultural considerations relevant to their care.

- Minor/Pediatric: HCPs working with minors may use this section to document information about a minor's healthcare decision maker, degrees of intervention, and ACP conversations.

HOW TO: ADVANCE CARE PLANNING IN POWERCHART

This [two-minute video](#) provides an overview of ACP documentation in PowerChart.

## QUICK REFERENCE GUIDE FOR PHYSICIANS

APPLIES TO	All providers and clinicians who document Advance Care Planning (ACP), Serious Illness Conversations, and Goals of Care in the Electronic Health Record (EHR)
PURPOSE	To demonstrate the procedure for efficiently documenting and viewing ACP information in the EHR

Background

Documentation is integral to ACP to ensure a patient's wishes are expressed, heard, and respected. To facilitate communication of those wishes, the EHR has been configured to capture this specific information and display it within the workflow.

Accessing the Advance Care Planning/Goals of Care PowerForm

- From Adhoc documentation Admission/Transfer/Discharge folder:
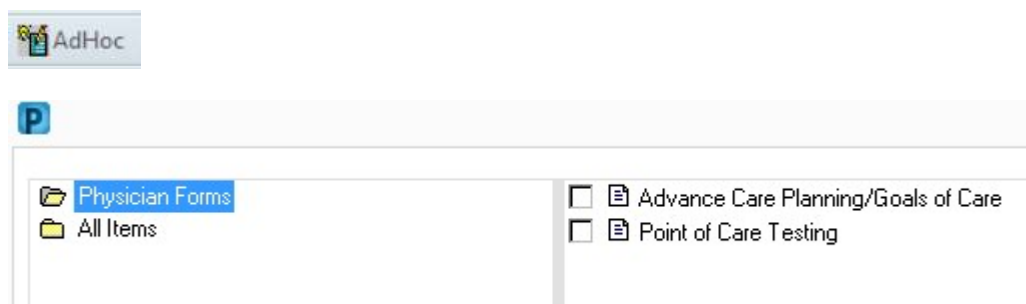
- From the Workflow pages ACP component:
  (Not all PowerChart users have this component)

Using the PowerForm

For detailed information on how to use PowerForms, refer to the PowerForm quick reference guide.

Use the check mark ✓ to sign a completed PowerForm, not the save 💾 button. Saved documents are only visible to the author and will not communicate ACP to the care team.

Viewing ACP Documentation within the Electronic Health Record

- From Results Review:

- From the Workflow pages:

Modifying a signed PowerForm

- Navigate to *Form Browser* from the Menu on the left hand side of the screen.
- Locate the form you wish to modify.
- Right click and select *Modify*.
- Update the PowerForm, and click *Sign*.

Marking a PowerForm "In Error"

- Navigate to *Form Browser* from the Menu on the left hand side of the screen.
- Locate the form you wish to mark In Error.
- Right click and select *Unchart*.
- Write a reason for marking the form In Error in the comment section, and click *Sign*.