

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



Expressed

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



Heard

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



Respected

- 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 Document 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 – treatment	C2 – ICU/Intu	C2 – ICU/Intu	C2 – ICU/Intu	C2 – ICU/Intu	C2 – ICU/Intu
Following Conversation With			Temporary Su	Representativ	Capabl	Capabl	Capabl	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, St	Chen DR, Dal	Culp DR, Gray	Patel		
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.

Document Viewer - Demo, Rachel ACP - 23684814

Result type: Goals of Care Narrative
Result date: Sunday, June 09, 2019 17:42 PDT
Result status: Auth (Verified)
Result title: Goals of Care Narrative
Performed by: Carson DR, Rachel Colleen on Sunday, June 09, 2019 17:42 PDT
Verified by: Carson DR, Rachel Colleen on Sunday, June 09, 2019 17:42 PDT
Encounter info: 92021355401, NRG, Day Care, 24-May-2019 - 24-May-2019

*** Final Report ***

Goals of Care Narrative

I took this opportunity to have a conversation about goals of care. I used the Harvard/Ariadne Labs "Serious Illness Conversation Guide" template. Summary of the conversation is as follows:

What do you understand about your illness? He understands that his health has deteriorated in the last several months. He was taken aback when palliative care was brought up but then in talking with various staff he is more understanding of the palliative care philosophy and understands that it is not just for the last days to weeks of life. He understands that he will never be a transplant candidate.

What prognostic info was given to pt? I told him that I did not think he would survive multiple years and that his life expectancy was more likely months to perhaps a year.

What are your goals if your health worsens? Regarding his goals, he would like to spend as much time as possible with his 1-year-old granddaughter. He spent some time describing how much he enjoys every minute with her and how he very much hopes to live long enough that she knows him and ultimately might remember him when she is older. He would like to spend as much time with his family as possible. Now that his vision is better, He has been hoping he could get his driver's license back and has ensured his car for the last 18 months just in case. He would like to be able to go on outings locally to see

Immunizations
Interactive View and I&O
Patient Information
MAR

DC No CK Location/Comments
Paper MOST Location/Comments
Goals of Care
Goals of Care Narrative
Potential TSDMs - Unranked
Potential TSDM A Name

scanned in at Dr Gray's clinic
scanned in at Dr Gray's office

Daffy Duck

Goals of C
Daffy Duck

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*)

1

2

3

Ad Hoc Charting - zyxTestPatient, VITALSLINK

- Physician ☒ Advance Care Planning/Goals of Care
- All Items ☐ PED Degree of Interventions
- ☐ Primary Adult Vitals Height Weight
- ☐ Risk of Violence Screening Tool

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

Chart Close

Goals of Care Narrative

Goals of Care Narrative

Segoe UI

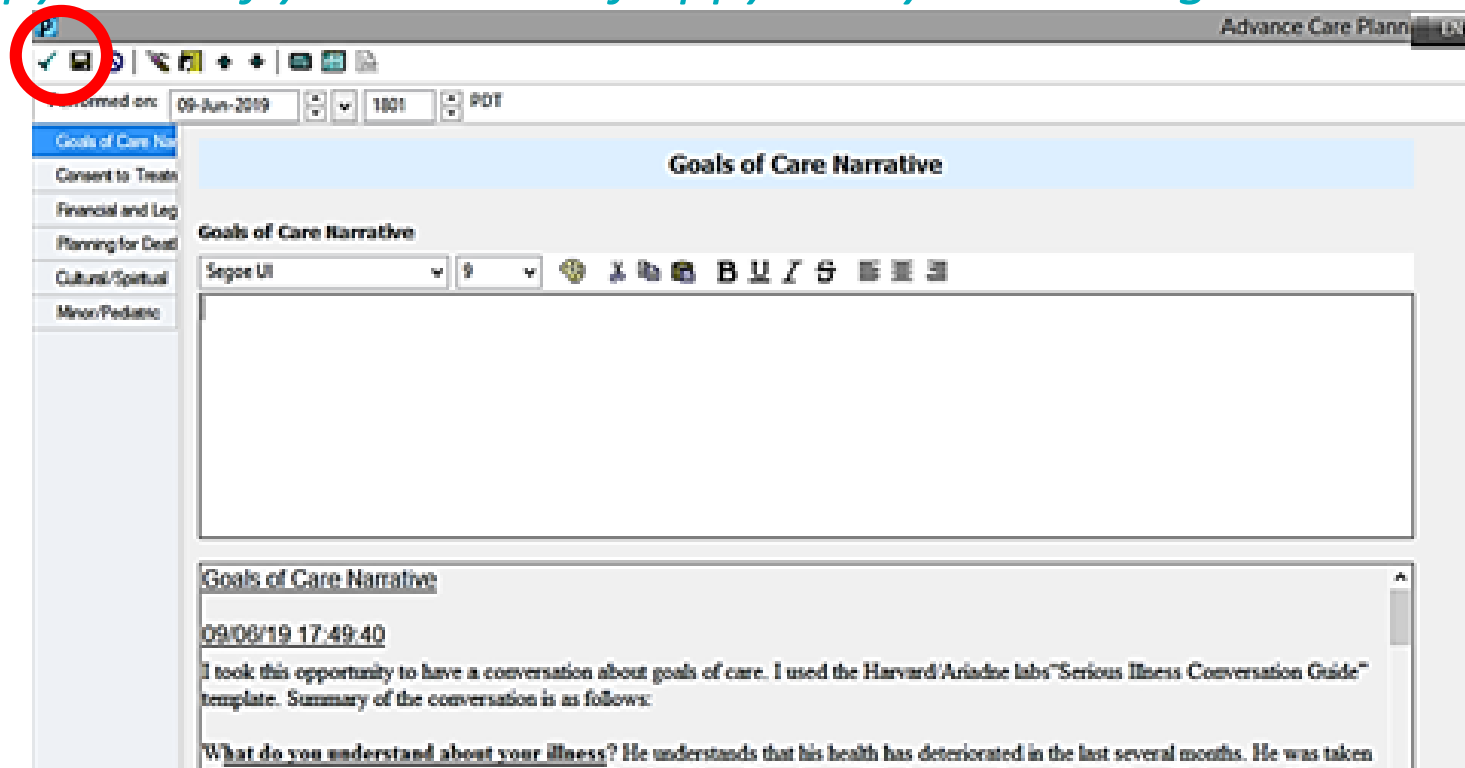
09/06/19 17:49:40

I took this opportunity to have a conversation about goals of care. I used the Harvard/Ariadne labs "Serious Illness Conversation Guide" template. Summary of the conversation is as follows:

What do you understand about your illness? He understands that his health has deteriorated in the last several months. He was taken

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!

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*)



Advance Care Planning

Completed on: 09-Jun-2019 1001 PDT

Goals of Care Narrative

Goals of Care Narrative

Sign off

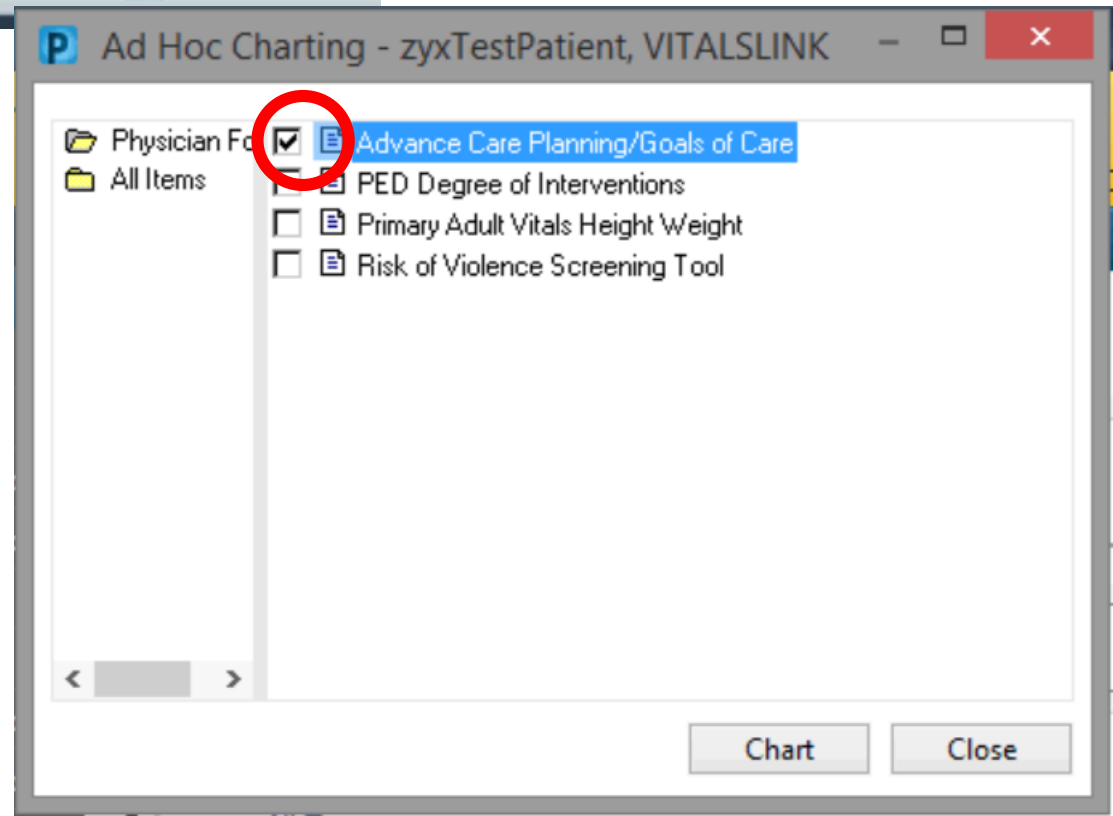
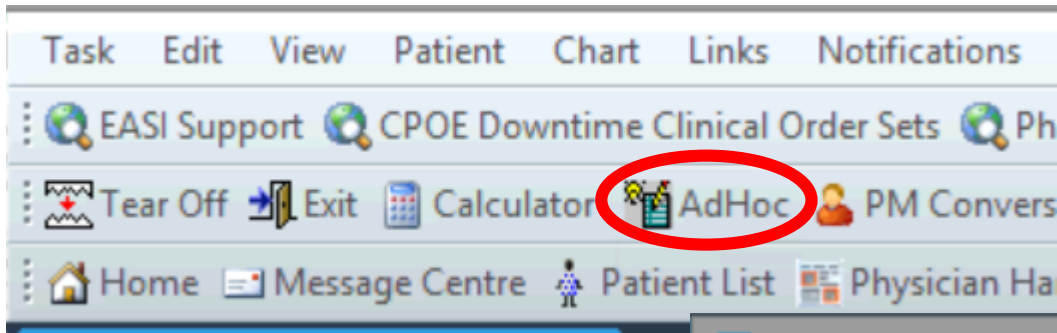
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Doctors/NPs can document a GOC conversation by creating a new ACP form from the “AdHoc” menu:



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”... spooooooky)
- encounter-specific (not patient-level like the allergy record)
- not editable by clinical staff (only NUAs/patient-placement staff have access)

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

Advance Care Planning/Goals of Care - zyxTestPatient, VITALSLINK

*Performed on: 24-Oct-2019 17:35 PDT By: Carson DR, Rachel Colleen

Consent to Treatment

Representatives - Health and Personal Care

Name of Appointee/ Representative	Telephone Number(s)	Address	Comments/Exact Location of Document
Jack Peralta			

Documents - Health

Document	Comments/Exact Location of Document
Advance Directive	
Written expression	
Religious, Cultural, or other wishes	
Provincial No CPR Form	
Paper MOST	
Support/Assistance Court Order	

Potential Temporary Substitute Decision Makers Potential TSDMs may be listed in any order and will be sorted based on the

Name	Relationship	Eligible?	Reason Ineligible	Additional Doc Location and Date/Time	Phone Number(s)
Potential TSDM A Jake Peralta	son	Eligible			250-555-2222
Potential TSDM B Roger Peralta	ex husband	Possibly eligible, verify	estranged		250-222-4444

Results Review

Flowsheet: Provider Advance Directive Informz Level: Provider Advance Directive Informz Table Group List

Showing results from (11-Jun-2019 - 24-Oct-2019) Show more results

Goals of Care

Potential TSDMs - Unranked

Potential TSDM A Name	Potential TSDM A Relationship	Potential TSDM A Eligible?	Potential TSDM A Phone Number	Potential TSDM B Name	Potential TSDM B Relationship	Potential TSDM B Eligible?	Potential TSDM B Reason Ineligible	Potential TSDM B Phone Number	Potential TSDM C Name	Potential TSDM C Relationship	Potential TSDM C Eligible?	Potential TSDM C Phone Number	Potential TSDM D Name	Potential TSDM D Relationship	Potential TSDM D Eligible?	Potential TSDM D Phone Number
Jake Peralta	son	Eligible	250-555-2222	Roger Peralta	ex husband	Possibly eligible, verify	estranged	250-222-4444	Amy Santiago	daughter in law	Eligible	250-111-1111	Raymond Holt	friend	Eligible	250-888-7777