Streamlined Goals of Care Designation decision-making for COVID-19

STEP 1 – Any health care professional

1. Ask your patient if they already have a Personal Directive, Goals of Care Designation Order ("R, M, C") or Green Sleeve – They may have the answers you need

YES – Read them

NO

PERSONAL DIRECTIVE
Tells you:
- AGENT (Alternate Decision Maker if patients loses capacity) - **Do you have current contact info?**
- HEALTHCARE WISHES - may provide guidance or highlight conflicts for discussion

GOALS OF CARE DESIGNATION ORDER
- **Does it align** with COVID 19 treatments that are clinically appropriate and available, based on current resources?

ACP GCD TRACKING RECORD
Tells you:
What has already been discussed -It may have decision-making guidance you need

STEP 2 – Any health care professional

2. Discuss goals of care based on information you have
Document on the ACP GCD Tracking Record – This helps next care provider

2. Discuss goals of care - See Reverse for Tips
Document on the ACP GCD Tracking Record –This helps next care provider

STEP 3 – MD or NP Only

3. Determine/Confirm Goals of Care Designation Order
Confirm or write new GCD order that is most aligned with person's values ***and*** what is clinically appropriate/available.
Put all documents in green sleeve.

Alberta Health Services

Goals of Care Discussion Tips for People Sick with Covid-19

Set up Conversation:
"I'd like to talk with you **about** how to best care for you with your illness. Is that OK?"
"First may I ask, what is your **understanding** of what is happening to you?"

Consider Prognosis (choose from below)
Ask permission to share prognosis: "May I tell you what I think is happening?"

Healthy Person
Expected to benefit from ICU/Ventilator:
e.g. **I hope** this is not the case but **I'm worried** that you may need intensive care and a breathing machine to help you survive your infection. I think it is important we prepare for that possibility.

Person with Comorbidities
Uncertain benefit from ICU/Ventilator:
e.g. It is **difficult to predict** what will happen with your illness. **I hope** that you will recover. But **I'm worried** that with your other health conditions, you could get sicker quickly and that you are at risk of dying. I think it is important for us to prepare for that possibility.

Person with Serious Illness
Unlikely to benefit from ICU/Ventilator
e.g. **I wish** this wasn't the case but **I'm worried** that with your other health conditions, you may get sicker quickly and that you are at risk of dying. I think it is important we prepare for that possibility.

Leave a moment of silence. Acknowledge emotions with empathy. Explore patient values e.g.
"Have you already thought about what's most important to you in this situation?"
"If you become very sick, how much are you willing to go through for the possibility of gaining more time?"

Consider, do the patients values and your opinion of best care match or not?
Make a recommendation: "I'd like to make a recommendation…"

Matches resuscitative goals (e.g. R1, R2)
"I want you to know that we will do all that we can to support you through this. If we think there is a reasonable chance that you will survive COVID-19 using all available treatments, including a breathing machine (or ventilator), then are you willing to try those things?
We call this **Resuscitative care."**

Matches Medical goals (e.g. M1/M2)
"I want you to know that we will do all that we can to support you through using medical treatments (such as oxygen and IV fluids), as well as ensuring you are comfortable as best we can. How does that plan sound to you? We call this **Medical Care"**

Matches Comfort goals (C1/C2)
"I want you to know that we will keep taking care of you the best we can. I'm hoping you won't get worse and we will always make sure you are comfortable, for as long as you are with us. How does that plan sound to you?
We call this **Comfort Care."**

If there is a mismatch between patient **preferences and what is likely to *benefit them consider:***
- **You do not have to offer treatments that are inappropriate or unavailable**
- **Share likely outcomes of treatments**

***e.g.* "I wish** things were different but **I'm worried** that if you get sicker, using a breathing machine (or ventilator) is unlikely to help you survive and get back to a quality of life that is important to you. I want you to know that we will do all that we can to support you through using medical treatments (such as oxygen and IV fluids), as well as ensuring you are comfortable as best we can. How does that plan sound to you?
We call this **Medical Care (M1)"**

"Thank you for talking with me. I know this is an uncertain time. We will do everything we can to help you through this."

More communication tips :Vital Talk or Planning Ahead with Vulnerable Patients During Covid-19