# HEALTH CARE DIRECTIVE
# GOALS OF CARE

Health PEI

# Health Care Directive (HCD)

- Legal binding document.
- Identifies the treatments you would accept or refuse if you are no longer able to make decisions for yourself.
- Identifies a proxy to make decisions for them in the event they are not able to make decisions for themselves.
- Available in French and English

# Health PEI

One Island Health System

**GOALS OF CARE**

It is a requirement to ask and document.

Is there an existing Health Care Directive on file? ☐ No ☐ Yes

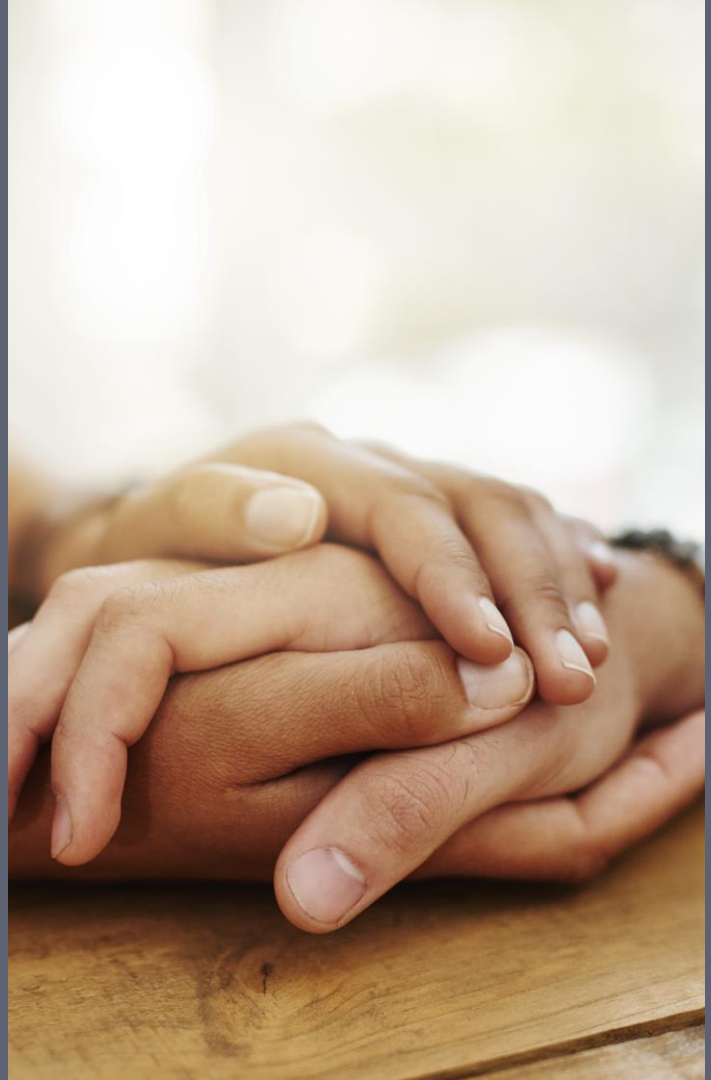
(If yes, it shall guide further discussions as an indication of the Patient/Client/Resident's wishes at time of writing)

| GOALS OF CARE | Initials of Health Care Provider | |
|---|---|---|
| R<br>Medical Care and | | Goals of care and interventions are for care and control of the Patient/Resident/Client condition. The |

- Not all residents will move in with completed Health Care Directives (HCD),  we are to encourage residents to complete HCD and delegate a proxy on move in.
- HCD give the residents control over end-of-life decisions if they reach a point when they cannot make their own decisions about their health care.

# Goals of Care

- A Health PEI Goals of Care form is required for all move ins to Long-Term Care
- Identifies the level of care the resident wants to receive while in our long-term care homes.
- Available in French and English.



| GOALS OF CARE | Initials of Health Care Provider | |
|---|---|---|
| **R**<br>**Medical Care and Interventions, including Resuscitation** | | Goals of care and interventions are for care and control of the Patient/Resident/Client condition. The Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered ***including resuscitation.*** |
| **M**<br>**Medical Care and Interventions, excluding Resuscitation** | | Goals of care and interventions are for care and control of the Patient/Resident/Client condition. The Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered ***excluding resuscitation.*** |
| **C**<br>**Care and Interventions focused on comfort, excluding Resuscitation** | | Goals of care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life, ***excluding resuscitation.*** |

If the Goals of Care indicated above include resuscitation, indicate below which interventions the Patient/Resident/Client is accepting of:

(a) defibrillation ☐ (b) chest compressions ☐ (c) intubation ☐ (d) ICU/CCU care ☐

(e) ICU/CCU care for noninvasive ventilation and treatment ☐

Don't forget checking these.

# Risks of CPR for Older Adults

The nurse will attempt to keep blood flowing to the heart with chest compressions which may cause damage to the ribs and lungs.

The nurse will use a device to provide electric shock to the heart to attempt to restart the rhythm of the heart.

Even with quality CPR - 82% will die

- This rate of death increases to 90 to 92% with aging and chronic illnesses.

# Survival Rates of CPR

- CPR that is performed correctly may cause lung bruising, airway damage, internal bleeding and broken ribs, increasing risk of death.
- Average 30-day survival in nursing homes after was CPR is less than 2% (Pape et al.)
- If bystanders witnessed the arrest, performed CPR, and pre-hospital defibrillation was performed, 30-day survival increased 7.7% (Pape et al.)

## Medical

Investigations and Treatments provided in an acute care setting.

- IV therapy
- Antibiotic therapy via Intravenous route

## Comfort

Treatments provided at the nursing home.

- The same hydration therapy using subcutaneous route
- Antibiotic therapy (oral or intermuscular route)

- Comfort Care and End-of-Life care are not the same thing. In comfort care, we continue to monitor and treat chronic illnesses using a person-centered focus.
- When a resident reaches a point in their life when end-of-life palliative care is needed, we provide appropriate palliative care within comfort care with discussions with the resident and/or substitute decision maker.

Indicate all individuals who participated in Goals of Care discussion(s) by checking appropriate box(es).

- ☐ Patient/Resident/Client Print Name: _____
- ☐ Family Member(s) Print Name: _____
- ☐ Substitute Decision Maker Print Name: _____
- ☐ Health Care Provider(s) Print Name: _____

Check all that participated in discussion

Document details of the Patient/Resident/Client specific instructions or wishes and/or details of discussions with the individuals indicated above on back of page.

**I confirm that I have discussed my Goals of Care with a Health Care Team member and that this form accurately reflects the choice(s) that I have made respecting the type of care I want to receive. I understand that this document is a record of my conversation with the Health Care Team and not a health care directive as defined under the *Consent to Treatment and Health Care Directives Act*.**

_____ _____
Signature of patient/resident/client/substitute decision maker **yyyy/mm/dd**

_____ _____ _____
**Name and Designation of RN, NP or MD** **Signature of RN, NP or MD** **yyyy/mm/dd**

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The Goals of Care were reviewed with the Patient/Resident/Client and/or Substitute Decision Maker and no change to the form is required.

_____ _____ _____
**Name and Designation of RN, NP or MD** **Signature of RN, NP or MD** **yyyy/mm/dd**

**If review results in any changes to the Patient/Resident/Client Goals of Care, a new form must be completed.**

# What to capture on the back

- Resident's capacity to make health care decisions – ask the resident their understanding of their illness? Ask the resident their values, worries or fears?
- The name of the Proxy or Substitute Decision Maker (if applicable and available)
- Specifics around their goals of care: what are they willing to accept or not accept (ie bloodwork, antibiotics etc).
- Ensure the resident is aware they can change their mind at anytime

If review results in any changes to the Patient/Resident/Client Goals of Care, a new form must be completed.
Refer to date/time of Progress Note entry if more space is required.

December 18, 2024 – Met with resident to review Goals of Care, resident has a diagnosis of moderate cognitive impairment and previously signed a Health Care Directive naming her daughter Jennie Miller as her proxy. Resident does not have any forms signed indicating any lack of capacity to make health care decisions, however when I was asking her questions about her wishes, she became teary eyed and struggled to answer the questions. I had concerns with her cognitive ability to make the decision. I asked her if she would feel more comfortable with Jennie present and she said yes.

December 19, 2024, met with resident and her daughter Jennie who is her proxy. Together they decided that she would like to be comfort but still wanted to have some treatments to manage her Diabetes. They did not want her to go the hospital for treatment if we could provide care in the home. Advised her and Jennie that we could provide treatments to manager her diabetes and could provide antibiotics if she got an infection as well as subcutaneous fluid replacement but could not provide IV therapy. Both agreed they would like that. I explained that they could change their mind at any time and we could review the decision if her health status changed.

---------- ----------Samantha Clow, RN

In this example, we addressed our cognitive concerns in a person centered approach by involving her proxy. We documented what she wanted for her care and that she can change her mind.

# References:


- A Guide to Advance Care Planning – Retrieved from www.healthpei.ca/advancecareplanning
- CPR – A Decision Care Guide – Retrieved form www.healthpei.ca/advancecareplanning
- Pape, M., Rajan, S., Hansen, S.M., & Mortensen, R.M., (2018). Survival After Out-of-Hospital Cardiac Arrest in Nursing Homes A Nationwide Study. DOI:10.1016/j.resuscitation.2018.02.004.


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# Question?