Green:conversation
Black: formally necessary- can choose from
Red: extra

1-GOC,
2-Advance Care Planning
3-CPR
4-MOST

Goals of Care

(http://www.coastalpalliativecare.ca/wp-content/uploads/2016/10/MOST-in-RC-final.pdf)

Many people find it hard to talk about nearing the end of life and end-of-life care. Talking to your care providers can help you better understand your health status. Ask about what you might experience in the future as a result of your medical condition. Learn about possible medical treatments (medicines, tests, and other therapies) and what you can expect from them. Once you understand your medical condition and what could be done to treat it, take time to think about what the future might look like as your health changes.
Ask yourself:

- What is important to you? What matters most?
- What does 'quality of life' mean to you?
- What are your goals in the time you have left?
- Do you have any fears about end of life?

-Discussion about COVID-19 and the course

"COVID - 19 is a viral illness that spreads like the flu. We know it is particularly serious in seniors, especially for those who have other medical conditions. We know now there is a chance that [she/he] will die from it, possibly quite quickly. While each person's situation is different, the safest and most comfortable place for most seniors to be cared for is in the care home. Doctors have learned that there is no benefit for most seniors with COVID-19 to go to the hospital and that they do not survive intensive care when they get that sick. And so far there is no treatment that can kill this virus. Your […] might recover with supportive care.

We are preparing to care for any of our residents who become sick with COVID-19 in our care home. We want you to know that our main priority is to ensure that your [relative] is comfortable and cared for throughout their illness if they become sick. Most symptoms are related to cough, fever and shortness of breath. There are medicines and treatments for all of these symptoms that will be provided in the home and they will be provided with all fluids and nourishment for their comfort." here at the care home, or they may die from this illness.

-Videos to watch about Goals of Care
www.youtube.com/watch?v=5BD9yJJdhIQ&feature=youtu.be
https://www.youtube.com/watch?v=Y0TyhWQOf_8

What is advance care planning
(www.gov.bc.ca/advancecare)

Advance care planning begins by thinking about your beliefs, values and wishes regarding future health care treatment. It is about having conversations with your close family, friends and health care provider(s) so that they know the health care treatment you would agree to, or refuse, if you become incapable of expressing your own decisions.
By planning ahead you:
• make your wishes and instructions for your future health care known;
• provide your health care team with information to guide them in your care; and
• ease the burden of your loved ones at a difficult time.

How to start advance care planning
Tell someone close to you, or your health care provider, that you want to talk about your future health care. Have as many conversations as you need. Use the provincial guide and workbook, **My Voice: Expressing My Wishes for Future Health Care to guide you and write down your options.**
https://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf
When you write down your wishes and instructions for future health care, you are making an advance care plan. A basic advance plan consists of the following:
• Conversations with close family or friends, and your health care provider(s).
• A written record of your beliefs, values and wishes for future health care treatment.

• The names and contact information of the people who qualify to be on your temporary substitute decision maker (TSDM) list. When a TSDM is needed, one person is chosen from this list in the order below (the order is set by B.C. law):

Your spouse (married, common-law, same sex)

Your son or daughter (age 19 or over, any birth order)

Your parent (either, includes adoptive)

Your brother or sister (any birth order)

A grandparent

A grandchild (any birth order)

Anyone else related to you by birth or adoption

Your close friend

A person immediately related by marriage

Advance care plan options

Your advance care plan can also include:

• A Representation Agreement (RA) where you write your instructions and name someone to make your health and personal care decisions if you become incapable. There are two types: A **Section 9** or 'enhanced' RA (allows decisions to refuse life-support), and a **Section 7** or 'standard' RA for individuals with lower levels of capability (does not allow decisions to refuse life-support).

• An Advance Directive with your instructions for health and personal care that are given to your health care provider, which he/she must follow directly when it speaks to the care you need at the time.

• Appointing someone to make decisions about your financial affairs, business and property in an Enduring Power of Attorney, which would take effect only when you become incapable.

WHAT IS CPR Cardiopulmonary Resuscitation

https://vch.eduhealth.ca/PDFs/EB/EB.270.L43.pdf

-Cardiopulmonary Resuscitation (CPR) is an attempt to restart the heart when the heart stops beating.

CPR can include:
• Pressing on the chest to pump blood through the heart to the body (chest compressions); and
• Forcing air into the lungs, using a mask with a bag attached to it.
Doing CPR can result in broken ribs and possible damage organs such as the heart and lungs. Being without oxygen, even for a short time, can result in damage to the brain.
Does CPR work for everyone?
No. CPR can work for people who are fairly healthy and suffer an event that stops their heart, and someone closeby starts CPR right away. Situations could include a heart attack or a severe electrical shock.
When is CPR not effective?
Unlike what you see on television, CPR is not usually effective. In particular, CPR will rarely restart the heart of people whose medical condition has already caused damage to their heart, lungs, kidneys, or brain.

Medical Orders for Scope of Treatment (MOST)

https://pathwaysbc-forms.s3.amazonaws.com/documents/1566/original/VCH_MOST_form.pdf?1578954146

These are the instructions that guide your healthcare team about the general focus of your care, and where you might want care. We will always ask you at the time when a decision is needed about treatment. However, in an emergency or should you not be able to speak for yourself, the goals of care and MOST will guide us.

Options for Treatment

*** Option One**

Supportive care, symptom management, and comfort measures. Allow natural death.
In this situation, we would:
• Offer medicine and other therapies to control symptoms such as pain and shortness of breath.

• Continue to give medicine to manage chronic illness (Example: If you have diabetes, we would continue with medicine to control high blood sugar.)
• Focus on quality of life and easing symptoms.
• Only use therapies that will improve comfort or quality of life.
• Allow death to happen naturally and not try to resuscitate with CPR.

***Option Two**

Option One plus therapeutic measures and medications to manage acute conditions within the current setting(in the facility)
In this situation, we would:
• Offer medicines and other therapies to control symptoms such as pain and shortness of breath, as well as manage chronic illness.
• Give medicines and therapies easily available in the Residential Care facility to try and fix the health problem.
• Only use therapies that will improve comfort or quality of life.

***Option Three**

Option Two PLUS admission to an acute care hospital for medical/surgical treatment as indicated. No referral to Critical Care.
In this situation, we would:
• Continue to offer medicines and other therapies to control symptoms such as pain and shortness of breath, as well as manage chronic illness.
• Try to fix or control any health problems.
• Transfer to a hospital if the health problem gets worse or basic treatment at the hospital might help.
• Do tests and treatments including surgery.
• If not getting better, allow death to happen naturally and not try to resuscitate with CPR or do any life-sustaining treatments.

***Option Four**

Maximum therapeutic effort as in Option Three including referral to Critical Care but not including intubation and ventilation.
In this situation, we would:
• Continue to offer medicines and other therapies to control symptoms such as pain and shortness of breath, as well as manage chronic illness.
• Try to fix or control any health problems.
• Transfer to a hospital if the health problem gets worse or special treatment at the hospital is

likely to be successful, such as in an Intensive Care Unit.
• Do tests and treatments including surgery.
• Allow death to happen naturally if health worsens or recovery is not likely. We would not try to resuscitate(CPR/Intubation)

***Option Five**
Maximum therapeutic effort as in Option Four including referral to Critical Care and including intubation and ventilation.
In this situation, we would:
• Continue to treat symptoms and try to fix or control any health problems.
• Transfer to a hospital when special treatment is needed, including transfer to the Intensive Care Unit.
• Do whatever tests and treatments are needed including life-sustaining treatments such as inserting a breathing tube or placing on a breathing machine.
• We would not try to resuscitate with CPR, and would allow death to happen naturally if your heart stops.