### Guidelines for Use:

1. This form is for use by all members of the health care team (e.g., nurses, social workers, spiritual care, physicians) as a written communication tool to record information relevant to discussion about advance care planning. This could include conversations about the patient's values and previously documented advance care plans, current medical condition and goals of care including Medical Order for Scope of Treatment (MOST) / resuscitation status.

2. Discussions with patient, family, and/or substitute decision maker are documented along with the subsequent action taken (e.g., Physician notified, or ‘My Voice’ guide introduced). If input is provided by someone other than patient / SDM, indicate their name and relationship (e.g., Susan Smith (neighbour) advises “X, Y, Z”).

3. This form is placed in the green sleeve with other advance care planning documents and the MOST. All current documents remain in the green sleeve and are to be reviewed to confirm that the wishes are the most current capable wishes at each admission or with a change in health status. Prior documents are filed in the chart, with a single diagonal line struck through to indicate they are no longer current.

4. The MOST form, or other goals of care MUST be reviewed promptly at each admission, in discussion with the capable patient or a substitute decision maker.

### Conversations with patient if capable; if not, with family or substitute decision maker regarding future care

<table>
<thead>
<tr>
<th>Date</th>
<th>Brief summary of discussion/focus/action</th>
<th>Staff Name</th>
<th>Discipline</th>
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| 4/27/2018    | Review patient's chart and spoke with patient and son about pt's level of functioning prior to admission. Pt would benefit from a palliative approach to care based on the following SPIC criteria:  
- unplanned hosp admissions (admitted last year d/t fall)  
- significant weight loss (10 lbs in past 4 months)  
- increasing dependence for personal care in past 4 months  
- declining mobility, including 4 falls in past year and current # R hip  
- persistent delirium despite treatment  
Based on above, writer would not be surprised if pt were to die in next 6 to 12 mos. Pt would benefit from a Serious Illness Conversation to determine Goals of Care on current admission.  
Plan: follow up with Dr. Lee re: initiating Serious Illness Conversation.--------------------------------------------------------------- | Suzie Q.    | RN         |
| 4/27/2018    | Walked pt to bathroom. Pt expressed frustration at declining memory and decreased physical capacity. Says she is worried about now being independent enough to return home to live with son. Clearly states does not want to go to Residential Care facility as her sister lived in facility and had a negative experience there. Copy of What Matters Most handout provided to pt with suggestion that she consider discussing questions with son.  
Plan: follow up with pt. and son when he visits next. ------  | Sally A.    | LPN        |

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