Vancouver Coastal Health Authority

ADVANCE CARE PLANNING & GOALS OF CARE DISCUSSION RECORD

For use by all members of the health care team

PCIS LABEL

Guidelines for Use:

1. This form is for use by all members of the health care team (e.g. nurses, social workers, spiritualcare, 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 Orders for Scope of Treatment (MOST) or 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 the patient/SDM, indicate their name and relationship (e.g. Susan Smith, neighbour).
3. This form is placed directly before the green sleeve. The green sleeve should contain all other Advance Care Planning documents and the MOST form. **All relevant documents are to be reviewed upon admission and with a change in the patient's health status** to confirm that they reflect their most current wishes.

Conversations with patients if capable. If not, follow the hierarchy of Substitute Decision-Makers.

Date/Time & Discussed with _____:	**Brief summary of discussion/focus/action** *Outline the information provided to the patient/family and what was shared by patient/other (goals, understanding, fears, trade-offs, prognosis). Staff are to sign their entry, print their name & discipline.		
Date:	**Clinical Frailty Scale:**	**Name**:	**Discipline**:
Date:	**Number of SPICT Indicators:**	**Name**:	**Discipline**:
Date:	**Surprise Question:** ☐ **Yes** ☐ **No** **(Would you be suprised if this patient died in the next 6-12 months?)**	**Name**:	**Discipline**:

**When patient discharged, place form in green sleeve.

Date/Time & Discussed with _____:	**Brief summary of discussion/focus/action** *Outline the information provided to the patient/family and what was shared by patient/other (goals, understanding, fears, trade-offs, prognosis). Staff are to sign their entry, print their name & discipline.

**When patient discharged, place form in green sleeve.