Flexing Your Core – Domain 5: Care Planning & Collaborative Practice
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Link to BCCPC's Advance Care Planning resources page: **https://www.bc-cpc.ca/acp/**

Sample of BC MOST(Medical Orders for Scope of Treatment. Each health authority has their own forms: **most-form.pdf (islandhealth.ca)**

In Alberta form is Goals of Care Designation Orders: Goals of Care Designation (GCD) Order (albertahealthservices.ca) – **note:** code level meanings are the reserve between the BC and Alberta versions

Case Study for anticipatory planning

> *You are caring for Alex, an 80-year-old man with heart disease that lives with his daughter and her husband, who both work full time, and 3 young grandchildren.*
>
> *Alex currently receives home support for a shower once a week. The home care nurse visits once a month. He has a family physician who he last saw 6 months ago.*
>
> *He is tired and recently noticed he gets short of breath walking up the stairs but otherwise feels "OK"*
>
> *His daughter approaches the home care nurse privately and shares that she has seen his energy and stability decline significantly in the last few weeks. She has suggested he use his walker, but Alex has declined. His daughter is concerned how she will support him as he declines*

Things to ensure are part of a care plan

- ✓ Dynamic
- ✓ Person-centred
- ✓ Proactive
- ✓ Shared

To create an anticipatory care plan:

1. **What questions do you want to ask Alex?**
   - First place to start is with patient. Even if patient has some cognitive challenges good to speak with them. Better buy-in to the care plan if patient is the driving force
   - Ask what is most important to him at this time
   - Where would he like to receive care? Balancing in-home care if the daughter has supports and balancing her and her family's needs and want Alex wants

- What is his understanding of what's happening? Physically, emotionally, spiritually? And then asking what are his thoughts on future of his health? Start here before I impose and ask questions about specific things I need to know for his care
- Does he recognize changes are happening? To get buy-in he needs to acknowledge
- When it gets harder what do you think will be helpful then? Person may not be on board or in a place to acknowledge so a question like this helps
- What makes you smile in a day? Reflects their immediate priorities right now. Directs patient-centered focus
    - Answer may be 'nothing' and gives good idea of client's state of emotional well-being
- Have there been any medication changes that may be contributing to his decrease in energy and/or stability changes?
    - Or maybe something has happened that he is not currently compliant with his current meds?

2. **Which members of the health care team would you want to bring into the care planning discussion?**
    - Social worker, nurse, doctor (can be challenging to get them at times) or NP
    - Occupational therapist
    - Alex; Caregiver; Social Worker; Home Care; Palliative Care Nurse; Primary Care Practitioner (physician/NP)/PA; OT/PT; Spiritual Care Practitioner; Community Paramedics
    - Bringing in those who can provide options to Alex and his family
    - Depends on who Alex wants involved
    - In acute care settings family conference generally happens
    - Sometimes patient doesn't want to talk about it so asking them if there is someone they would be more comfortable talking to (don't always want to talk to us) such as spiritual care provider or their pastor, maybe their primary care provider.
        - Or asking if there is someone you would like us to have this conversation with (TSDM).
        - Or asking is there a better time we can talk about this?
    - Alex & his family may feel overwhelmed when all HCPs enter the conversation space at once & how various professions coordinate the sequence of conversations. Can present to Alex here are the people that can come in to help the process of who comes in and when
        - Good to tag team with other HCPs if possible and clarify who will be focusing on which pieces of the conversation
3. **What issues do you anticipate could happen for Alex?**

- Gradually become more sedentary, risk of respiratory infection, mobility levels, loss of energy for daily activities, risk of falls, later stages could develop lower leg edema with discomfort and pain, lower limb infections
- Thinking of equipment, stability, home support that may be helpful
- Optimize respiratory and heart medication
- Maybe home oxygen, OTs maybe brought in to the home
- Fall alert system
- Continually having those ACP conversations, he and his family faced with a number of decisions
- Empowering him with knowledge of anticipated changes to come – MOST (Medically Orders for Scope of Treatment) or similar form for other provinces will be very helpful for these conversations