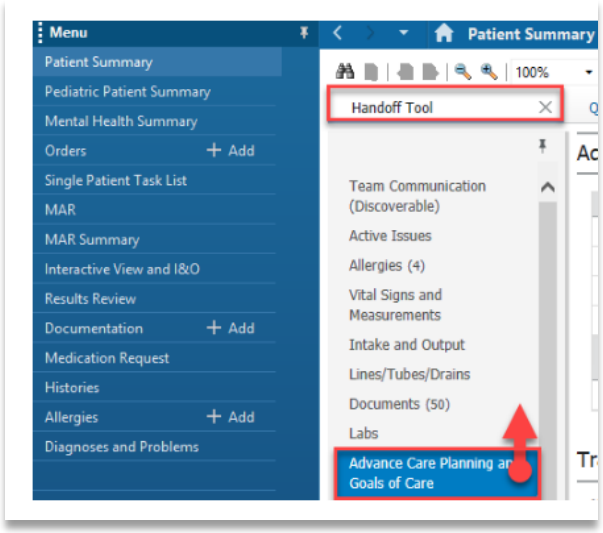
CST: Documenting ACP or Goals of Care

ACP PowerForm	Goals of Care PowerForm
Discussions/documents prior to this encounter, or updates to ACP documents on this encounter: • Advance Care Plans (formal or informal discussions/records of health wishes) • Advance Directives • Rep Agreements • Palliative Care Benefits • Provincial No CPR form	Discussions (during this encounter) regarding: • Illness understanding, goals/values, fears, trade-offs, preferences • Code status • Prognosis shared by team (time-based, functional, level of dependency)

Steps in PowerChart

1. Select appropriate patient & encounter
2. From the blue menu, select either *Patient Summary* or *Mental Health Summary* → and then *Handoff Tool*
3. Select "Advance Care Planning and Goals of Care" from menu



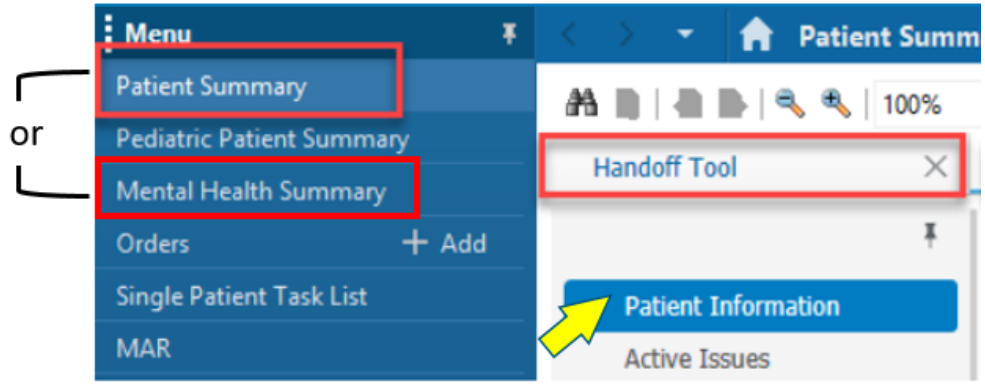
4. Click on ⊞ sign and select either Advance Care Planning <u>or</u> Goals of Care Discussion (see below).
5. Complete appropriate PowerForm

CST: Documenting in an SDM/TSDM PowerForm

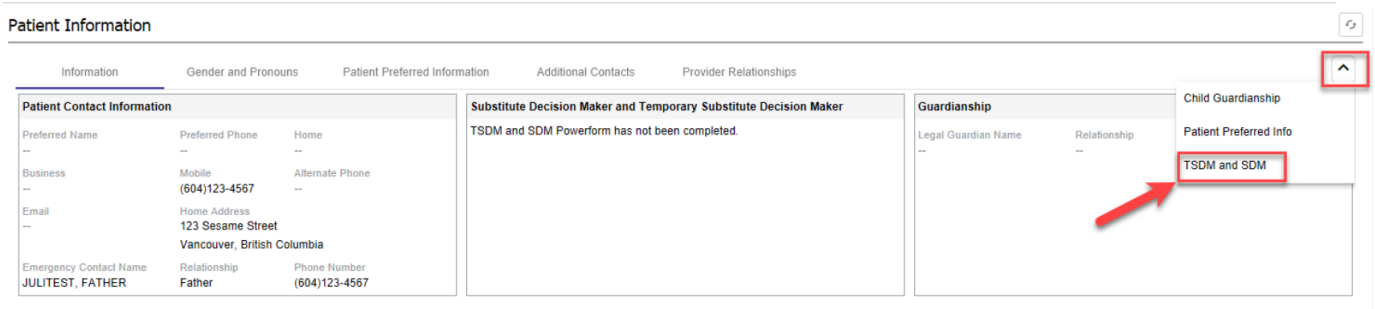
Use: Entering information on Representation Agreements or details around a TSDM for this patient encounter

Steps in PowerChart

1. Select appropriate patient & encounter
2. From the blue menu, select *Patient Summary* or *Mental Health Summary* → then *Handoff Tool*
3. Select "*Patient Information*" from the Handoff Tool menu



4. Click the [^] sign on the far right of the *Patient Information* folder, and select *TSDM and SDM.*



5. Complete the appropriate PowerForm, sign & save the document.
   *Note: If you indicate Representation 7 or Representation 9 in the TSDM form, it will automatically switch you over to the SDM PowerForm which contains more specific fields.

6. To view the information you've entered, refresh your screen and it will appear under *Patient Information.*