

Electronic Documentation of Goals of Care Designation Discussions Among Alberta-based Geriatric Patients



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ABSTRACT

Background

Goals of Care Designations are important medical orders that are used to determine the appropriate level of medical intervention for individuals in the event of life limiting illness. Canada has an aging population and individuals are living with higher levels of chronic illness and comorbidity. As patient autonomy increases, it has become increasingly important to have accurate and up-to-date documentation of a patient's medical wishes for life sustaining care.

Methods

This was a retrospective chart review of 400 randomly selected patients 65 years of age and over, seen at the University of Alberta Hospital outpatient clinic for Comprehensive Geriatric Assessment from July 1, 2022 to June 30, 2023. We extracted the frequency of Goals of Care Designation (GCD) documentation determined by historical data available within selected patient charts, the setting of each discussion, and the specialty of each provider completing Goals of Care documentation.

Results

Only 49.3% (197/400) of patients had any documented GCD entered on their electronic medical record (EMR). Of the 356 completed GCD forms, 267 (75%) were completed in an inpatient setting; the majority of GCD forms were completed by a specialist in Internal Medicine (39.89%, n=142) or Family Medicine (37.64%, n=134).

Conclusions

Our study revealed that less than half of patients had any GCD documentation in the provincial EMR. As accurate Goals of Care documentation is vital to patient care and autonomy, every opportunity should be taken by health-care professionals to complete this essential documentation.

Key words: goals of care, care of the elderly, geriatric assessment

INTRODUCTION

Goals of Care Designations are medical orders that are used to guide the level of medical intervention and focus of care for individuals in the event of life limiting illness. These designations are generally determined by aligning a patient's personal wishes for care with expert health-care professional advice. Goals of Care Designations (GCD) or Physician Orders for Life-Sustaining Treatment are a relatively new concept in medicine that has been steadily evolving over several decades.⁽¹⁾ The concept was initially born out of the necessity for hospitals and physicians to create policies to communicate a patient's preferences for resuscitation. This practice began with the Do Not Resuscitate order that was first formally introduced in the 1970s.⁽²⁾

As patient life expectancy increased in developed countries,⁽³⁾ so did the availability of advanced medical and surgical interventions for life-sustaining measures. While these developments may have increased life expectancy, this has not always equated to a reduction in patient morbidity and improved quality of life.⁽³⁾ With a coinciding shift in the practice of medicine towards increased patient autonomy,⁽⁴⁾ it became clear that a patient's wishes could no longer be summed up in a simple binary (Do Not Resuscitate vs. Full Code) system.

Numerous documentation tools have been created and implemented across North America, including the Physician Orders for Life-Sustaining Treatment program in the United States and multiple versions of the Goals of Care Designation form across Canadian provinces and territories.⁽⁵⁻¹⁵⁾ These tools aimed to clarify patient preferences regarding a range of life-sustaining measures, extending far beyond cardiopulmonary resuscitation status. While the classification methods often differ, the main tenets typically include a focus on Resuscitation (R), Medical Management (M) or Comfort Measures (C).

Prior research has suggested that establishing Goals of Care with a patient provides higher quality health care and may avoid unnecessary medical interventions.⁽¹⁶⁾ However,

there are multiple barriers to initiating and engaging in Goals of Care conversations. These include lack of health-care provider time for a proper discussion, lack of training for health-care providers in conducting Goals of Care conversations, physician concern that a discussion may alter the physician–patient relationship, and a patient’s or families’ unreadiness or resistance to engage in Goals of Care discussions.^(16,17)

Alberta Health Services has been using their revised Goals of Care Designation form since 2014. It includes seven distinct designations that fit into the broad categories of resuscitative care, medical care with focus on cure or control of condition, and medical care with a focus on comfort.⁽⁷⁾ In Alberta, a Goal of Care Designation form is usually completed or amended by the individual who is the designated Most Responsible Health Practitioner for a patient in an inpatient, outpatient, or long-term care setting. In Alberta, Nurse Practitioners are also able to conduct Goals of Care discussions.⁽⁷⁾

On November 3, 2019, Alberta Health Services launched a new clinical information system or electronic medical record (EMR) referred to as Connect Care. The aim of this system was to connect hospitals and outpatient sites so as to seamlessly share medical information, support patient transitions, and provide increased continuity of care in Alberta.⁽¹⁸⁾ The Connect Care EMR has been gradually rolled out in a stepwise fashion, and the University of Alberta Hospital site was included in the first stage of the launch.⁽¹⁹⁾ Since the initial launch of Connect Care, health-care providers have been encouraged to review and document a patient’s Goals of Care wishes or document pre-existing hard-copy Goals of Care Designation forms into Connect Care. There has been limited research examining Goals of Care Designations in the context of new EMR systems and further study of this area could help inform implementation of electronic GCD uptake in the future.

Our objective was to determine the frequency and characteristics of completed Connect Care-documented GCD orders in an Alberta-based geriatric population who had undergone Comprehensive Geriatric Assessment at the University of Alberta Hospital outpatient clinic. We also determined the settings of health-care provider-completed GCD orders, and the specialty of health-care providers who documented GCD orders in the Connect Care EMR system.

METHODS

This study was approved by the University of Alberta’s Health Research Ethics Board (Study ID Number Pro00134131). The ethics approval included a waiver of consent for this study. Site approval was received from the University of Alberta Hospital (Operational Approval #66273).

Study Design

This was a retrospective chart review of patients 65 years of age or older, who had their initial Comprehensive Geriatric Assessment in the outpatient Senior’s Clinic at the University of Alberta Hospital from July 1, 2022 to June 30, 2023. This population was chosen as an entry point to collect GCD

information from a participant pool who were more likely to: be residents with a history of medical care in the area; have medical complexity and therefore be of particular priority for a GCD order; and have had higher exposure to medical professionals in the last five years and therefore more opportunities to complete an electronic GCD order. By accessing this patient population, we aimed to better understand how this aspect of Connect Care was being utilized, and to analyze as many GCD orders as possible through the carefully selected patient population. From the 439 eligible patients, we randomly selected 400 patients (using the Random Sequence Generator in Random.org).

Geriatric Assessment Referrals

The University of Alberta Hospital received referrals through a central intake system. These referrals may be sent by family physicians, emergency department physicians, hospital inpatient physicians, or Continuing Care staff in the community. The central intake receives all Edmonton-zone geriatric outpatient referrals and these are assigned to geriatric outpatient clinics or are marked for in-home assessment based on multiple factors including patient location, level of frailty, and urgency of assessment. The approximate wait time from geriatric referral receipt to appointment was six to 12 months.

Goals of Care Designations

Charts were reviewed for any GCD order entries that occurred prior to December 30, 2023. We excluded patients who died prior to June 30, 2023. Within each patient chart, there was an electronic GCD record that tracked any electronic uploads or changes to GCD since the inception of Connect Care in Alberta. These records included the date of GCD changes, the location of the change, and the health-care provider responsible for the change. The chart review focused on assessing the frequency of GCD order completion or amendment, determined by historical data available within selected patient charts, the setting of each GCD order change, and the specialty of each provider initiating the GCD change.

Outcomes

Data were extracted manually from patient electronic medical records. We extracted the following data: patient age at time of initial Comprehensive Geriatric Assessment; patient gender; patient setting of Connect-Care-documented GCD order completion or amendment (inpatient, outpatient or ER); date of Connect-Care-documented GCD amendment; Goals of Care designation; number of Goals of Care designation reviews or amendments completed per patient during the above-mentioned time frame; and the specialty or profession of the health-care provider initiating a GCD order completion or amendment.

Analysis

We used descriptive statistics (frequencies, percentages, means, standard deviations) to describe the sample and to characterize the data.

RESULTS

Demographics

In the 400-patient chart review, the mean age of our patient population was 80.5 years (SD \pm 7.1) with an age range of 65–98 years (Table 1). Our patient population was 57.3% female.

Goals of Care Documentation

In our 400-patient chart review, only 197 (49.3%) of the patients had any documented Goals of Care Designation order completed on their Connect Care electronic chart. The number of completed Goals of Care Designations in the Connect Care patient charts ranged from one to seven documented GCD encounters per patient (Table 2). In total, we reviewed 356 GCD orders. Of these, 40 (11.24%) were uploaded as paper documents and were not readily available for review in the Advanced Care Planning/Goals of Care Designation (ACP/GCD) tab. This affected 39 (19.80%) of the study participants. GCD orders reviewed dated back to January 2016 and included up to December 30, 2023. The majority of GCD orders reviewed were completed in 2023 (n=171, 48.03%).

Location

Of the 356 completed Goals of Care Designation orders, 267 (75%) were completed in an inpatient setting, 46 (12.92%) were completed in an outpatient setting, and 42 (11.8%) were completed in an Emergency Room (Table 3). Only one GCD order was documented as being completed in the patient's home.

Physician Specialty

The majority of Goals of Care Designation orders were completed by a specialist from the Internal Medicine service (39.89%; 142/356) or Family Medicine service (37.64%; 134/356) (see Table 4). Only 17 (4.78%) of the GCD orders were completed by physicians in the geriatric specialty, including those of the Care of the Elderly or Geriatric Internal Medicine designation.

DISCUSSION

In our retrospective chart review of 400 patients who underwent a Comprehensive Geriatric Assessment at the University of Alberta outpatient clinic, we attempted to evaluate the quantity and quality of Goals of Care Designation (GCD) documentation in the new Connect Care Electronic Medical Record (EMR) in the province of Alberta.

Our study revealed that only 49.3% of patients undergoing an outpatient geriatric assessment had any active GCD documentation in their Connect Care EMR. This represents a potentially significant and important deficiency in the medical record for over 50% of our patients. It is well known that a patient with no active GCD documentation may be defaulted to a “full resuscitation” status and this could lead to unnecessary invasive measures, potential harm for the patient, and increased healthcare costs.⁽²⁰⁾ Previous studies have demonstrated that physicians' orders for life-sustaining treatment, such as cardiopulmonary resuscitation, can be inconsistent with seriously ill hospitalized patients' wishes, particularly

TABLE 1.
Demographics of sample

| <i>Patient Characteristics</i> | <i>Total Sample</i> <i>n = 400</i> | <i>No. (%) of Patients</i> <i>With Any GCD</i> <i>n = 197 (49.3%)</i> | <i>No. (%) of Patients</i> <i>Without Any GCD on Connect Care</i> <i>n = 203 (50.7%)</i> |
|--------------------------------|---------------------------------------|---|--|
| Age, yr, mean \pm SD | 80.5 \pm 7.1 | 81.3 \pm 7.2 | 79.7 \pm 6.9 |
| Sex (female) | 229 (57.3) | 118 (59.9) | 111 (54.7) |

TABLE 2.
Number of documented Goals of Care Designations among those with GCD orders

| <i>Number of GOCs</i> | <i>Number of Patients^a</i> | <i>% of Patients</i> | <i># of GCDs</i> |
|-----------------------|---------------------------------------|----------------------|------------------|
| 1 | 107 | 54.31% | 107 |
| 2 | 46 | 23.35% | 92 |
| 3 | 27 | 13.71% | 81 |
| 4 | 12 | 6.09% | 48 |
| 5 | 3 | 1.52% | 15 |
| 6 | 1 | 0.51% | 6 |
| 7 | 1 | 0.51% | 7 |
| Grand Total | 197 | 100.00% | 356 |

^a203 patients did not have any documented Goals of Care Designations.

TABLE 3.
Patient settings among the 356 completed
Goals of Care Designation forms

| <i>Patient Setting</i> | <i>Number of Patients (n = 356)</i> | <i>%</i> |
|------------------------|---|----------|
| Inpatient | 267 | 75.00% |
| Outpatient | 46 | 12.92% |
| ER | 42 | 11.80% |
| Home | 1 | 0.28% |
| Total | 356 | 100% |

when receiving more invasive end-of-life interventions than what the patient would have preferred.⁽²¹⁾ With health care moving away from paper charts and toward electronic health records, it is important to ensure that a patients' Goals of Care status is accurately transferred and documented in their electronic medical record.

During the chart review, it was found that approximately one in five (19.8%) participants who had any GCD order had at least one paper GCD form uploaded into the "Advance Care Planning Documents" section of the Advance Care Planning/Goals of Care Designation (ACP/GCD) area of the chart. An unintended consequence of this method is that the ACP/GCD tab had to be opened to view this information and the current GCD order was not readily visible at the 'front' of the electronic patient chart. This meant that the GCD order on the chart could read "not on file", despite having a valid GCD order, or the listed GCD order could potentially not reflect the patient's most current order. We also found anecdotally that some patients with their GCD listed as "not on file" might have their GCD listed on an alternate electronic medical record (NetCare), but this had not been effectively transferred to the Connect Care chart. These complicating factors create opportunity for medical error, and highlight the need for more seamless communication between a patient's paper GCD form and electronic medical records.

In our review, the vast majority of GCD orders were completed in an inpatient setting (75%), and most orders were completed by health-care professionals in either the Internal Medicine (39.9%) or Family Medicine (37.6%) specialty. Goals of Care discussions can be complex and there are often barriers to their completion.^(16,17) It can be difficult to decide when is the best time—and who is best suited—to conduct these sensitive discussions. It has often been suggested that family physicians are in the best position due to their extensive knowledge of a patient's medical issues, values, and beliefs. However, this has been complicated by the fact that many Canadians do not have a family physician or their physician may not have the time or resources to initiate discussions.⁽²²⁾ In practice, Goals of Care discussions often occur when there is an acute change in a patient's health status and, therefore, may be completed in an inpatient setting by a specialist who is less familiar with a patient's unique circumstances.

TABLE 4.
Specialties or professions completing
Goals of Care Designation order

| <i>Specialty</i> | <i>Frequency</i> | <i>Specialty Total (n=356)</i> | <i>%</i> |
|--|------------------|--|----------|
| Surgery | | 34 | 9.55% |
| General Surgery | 7 | | |
| Cardiac Surgery | 6 | | |
| Cardiac Surgery – Nurse Practitioner | 1 | | |
| Obstetrics and Gynecology | 4 | | |
| Orthopedic Surgery | 9 | | |
| Urology | 6 | | |
| Neurosurgery | 1 | | |
| Emergency Medicine | | 41 | 11.52% |
| Emergency Medicine | 16 | | |
| Family Medicine (ER) | 25 | | |
| Family Medicine | | 134 | 37.64% |
| Family Medicine (Hospitalist) | 78 | | |
| Family Medicine – Nurse Practitioner (Hospitalist) | 7 | | |
| Family Medicine (Patient's General Practitioner) | 36 | | |
| Family Medicine (Sports Medicine) | 1 | | |
| Nurse Practitioner Primary Care | 1 | | |
| Family Medicine (Care of the Elderly) ^a | 11 | | |
| Internal Medicine | | 142 | 39.89% |
| General Internal Medicine | 70 | | |
| General Internal Medicine – Nurse Practitioner | 3 | | |
| Cardiology | 18 | | |
| Cardiology – Nurse Practitioner | 2 | | |
| Critical care | 5 | | |
| Endocrinology | 1 | | |
| Gastroenterology | 6 | | |
| Hematology | 1 | | |
| Infectious Disease | 1 | | |
| Nephrology | 1 | | |
| Neurology | 14 | | |
| Oncology | 2 | | |
| Respirology | 12 | | |
| Geriatrics ^a | 6 | | |
| Psychiatry | | 5 | 1.40% |
| Psychiatry | 1 | | |
| Geriatric Psychiatry | 4 | | |

^aCare of the Elderly (11) + Geriatrics (6) = 17 (4.78%).

While there may be no ideal time to conduct these discussions, GCD documentation is vital to patient care, and every opportunity should be taken by all health-care professionals to complete documentation.

It has become well-established that interprofessional health-care teams can improve the delivery of patient-centered care and health outcomes for patients.⁽²³⁻²⁵⁾ Over recent years, there has been growing interest in widening the roles of multidisciplinary health-care team members to be involved in Advance Care Planning with patients, including advance care directives and capacity assessments.^(26,27) An example of this includes the Decision-Making Capacity Assessment model that has had success training multidisciplinary team members (including Occupational Therapists, Social Workers, Registered Nurses or Psychiatric Nurses) to become more involved in the patient Capacity Assessment process.⁽²⁸⁾ Empowering other health-care team members to assist or conduct Goals of Care discussions may help improve the quality of patient care and allow for more collaboration in the shared decision-making process.

This chart review had several limitations. It must be noted that community-based family physicians may have limited or no direct access to Connect Care, therefore limiting their ability to update a patient's electronic GCD form. This potentially resulted in significant underreporting of family physicians who completed paper GCD orders. It should also be noted that this review took place during the first five years of a large-scale EMR launch and, during its initial implementation, staff may not yet have had the training or resources to transfer all patient health information into their electronic chart or may not have prioritized GCD documentation. It is also possible that patients could have had a physical GCD copy that had yet to be added to the electronic chart. Our study population was collected from one outpatient site (the University of Alberta Hospital Senior's Clinic) and this could impact general applicability. Additionally, EMRs can vary significantly both nationally and internationally, and this could limit the generalizability of our findings.

CONCLUSION

Our retrospective chart review analyzed electronic Goals of Care documentation for patients undergoing a Comprehensive Geriatric Assessment at a university outpatient clinic, and our study revealed that under one half (49.3%) of the reviewed patients had any GCD documentation in their Connect Care EMR. Of the completed Goals of Care documents, the majority of orders were completed in an inpatient setting and most were completed by a physician in Internal Medicine or Family Medicine. However, these results were likely limited by family physicians' often restricted access to amending patient electronic medical records and the highly selective patient population studied. Our study reflects some of the difficulties inherent in launching a large-scale EMR and the issues associated with completing Goals of Care documentation. As accurate Goals of Care documentation is vital to

quality patient care and autonomy, every opportunity should be taken by all eligible health-care practitioners to complete this documentation.

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CONFLICT OF INTEREST DISCLOSURES

We have read and understood the *Canadian Geriatrics Journal's* policy on conflicts of interest disclosure and declare that we have none.

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