ACCEPT Study

1	0			-				
Site Number					Enrollment Number			

Audit of Communication, CarE Planning, and DocumenTation: A multicenter, prospective study

The ACCEPT Study

CASE REPORT FORM (CRF) Worksheets

CRF/REDCap Worksheets
Table of Contents

General Instructions

Please refer to the specific instructions for each type of form.

1. We recommend labeling the worksheets using both the site number & the patient enrollment number .

1	0			-				
Site Number					Enrollment Number			

2. All data requested via these worksheets will be entered into the ecrf (REDCAP). Data should taken from original source documents (e.g. the patient's hospital chart).
3. The date format will be day-month-year, entered as YYYY-MM-DD. For example: *2010 - 11 - 28*.
4. All times should be recorded using the 24 hour (military) clock. Midnight will be 00:00 hrs.
5. Anywhere in the CRF worksheet that "Other, specify" is indicated and/or has been selected, there must be an entry on the line provided further describing what "other" means.

Co-morbidities Instructions

General Instructions	Check off all comorbidities present **at the time of the current hospital admission** using the taxonomy list found on the next form. Newly diagnosed conditions during the current hospitalization should **not** be recorded. **Only those comorbidities found on the taxonomy listing should be recorded. (If a comorbidity is listed in the medical chart but there is no option found on the CRF, do not collect it.)** If comorbidities are absent, check the "No Comorbidities" box.
Myocardial	Record all comorbidities of cardiac nature: Angina, Arrhythmia, Valvular, Myocardial infarction, Congestive Heart Failure (or heart disease). Atrial fibrillation (A-fib) should be recorded as "Arrhythmia."
Vascular	Record all comorbidities of a vascular nature: Hypertension, peripheral vascular disease or claudication and cerebrovascular disease (Stroke or TIA).
Pulmonary	Record all comorbidities of a pulmonary nature: chronic pulmonary obstructive disorder (emphysema or COPD), asthma.
Neurologic	Record all comorbidities that are neurological in nature: dementia, hemiplegia (paraplegia), neurological illnesses (such as Multiple Sclerosis or Parkinson's).
Endocrine	Record all comorbidities that are related to the endocrine system: Type I Diabetes, Type II Diabetes, Diabetes with end-organ damage, obesity and/or BMI > 30. Thyroid disorders do not need to be recorded.
Renal	Record all comorbidities that are renal in nature: Moderate or severe renal disease. Moderate renal disease can be defined as a moderate reduction in GFR (30-59 mL/min/1.73 m^2). Severe renal disease can be defined as a severe reduction in GFR (15-29 mL/min/1.73 m^2).
Gastrointestinal	Record all comorbidities related to the gastrointestinal tract: mild liver disease, moderate or severe liver disease, GI bleeding, inflammatory bowel, peptic ulcer disease, gastrointestinal disease (hernia, reflux).
Cancer/Immune	Record all comorbidities related to the immune system or cancer: any tumor, lymphoma, leukemia, AIDS, metastatic solid tumor.
Psychological	Record the presence of any anxiety, panic or depression disorders. To meet the definition of a cormorbidity, patients with anxiety and panic disorders must be receiving treatment. Depression is defined as clinical depression.
Musculoskeletal	Record all comorbidities related to the musculoskeletal system: arthritis (rheumatoid, osteoarthritis), Degenerative Disc disease (back disease, spinal stenosis or severe chronic back pain), osteoporosis, connective tissue disease. Connective Tissue Disease includes: lupus, scleroderma, Sjogren's syndrome, Ehlers-Danlos syndrome, dermatomyosis, Marfan's syndrome.
Miscellaneous	Visual impairment (cataracts, glaucoma, macular degeneration). Hearing impairment (very hard of hearing even with hearing aids)

Co-morbidities

Were any comorbidities present during the current hospital admission? ☐ Yes (specify below, all that apply) ☐ No

MYOCARDIAL

- ☐ Angina
- ☐ Arrhythmia
- ☐ Valvular
- ☐ Myocardial infarction
- ☐ Congestive heart failure (or heart disease)

VASCULAR

- ☐ Hypertension
- ☐ Peripheral vascular disease or claudication
- ☐ Cerebrovascular disease (Stroke or TIA)

PULMONARY

- ☐ Chronic obstructive pulmonary disease (COPD, emphysema)
- ☐ Asthma

NEUROLOGIC

- ☐ Dementia
- ☐ Hemiplegia (paraplegia)
- ☐ Neurologic illnesses (such as Multiple sclerosis or Parkinsons)

ENDOCRINE

- ☐ Diabetes Type I or II
- ☐ Diabetes with end organ damage
- ☐ Obesity and/or BMI > 30 (weight in kg/(ht in meters)^2

RENAL

- ☐ Moderate or severe renal disease (on dialysis)

GASTROINTESTINAL

- ☐ Mild liver disease
- ☐ Moderate or severe liver disease
- ☐ GI Bleeding
- ☐ Inflammatory bowel
- ☐ Peptic ulcer disease
- ☐ Gastrointestinal Disease (hernia, reflux)

CANCER/IMMUNE

- ☐ Any Tumor
- ☐ Lymphoma
- ☐ Leukemia
- ☐ AIDS
- ☐ Metastatic solid tumor

PSYCHOLOGICAL

- ☐ Anxiety or Panic Disorders
- ☐ Depression

MUSKOSKELETAL

- ☐ Arthritis (Rheumatoid or Osteoarthritis)
- ☐ Degenerative Disc disease (back disease, spinal stenosis or severe chronic back pain)
- ☐ Osteoporosis
- ☐ Connective Tissue disease

MISCELLANEOUS

- ☐ Visual Impairment (cataracts, glaucoma, macular degeneration
- ☐ Hearing Impairment (very hard of hearing even with hearing aids)

Vasopressors/Inotropes Instructions

General Instructions	Collect Vasopressor/Inotrope infusions from the current hospitalization (this includes those administered in the ICU, step–down units and, if applicable, the ward.) • Dopamine • Dobutamine • Epinephrine (adrenaline) • Norepinephrine (levophed) • Vasopressin • Phenylephrine • Milrinone Record all vasopressor/inotropes given for > 30 minutes. We are **not** collecting vasopressors/inotrope dose. Do **not** capture boluses.
Did patient receive Vasopressors/ Inotropes infusions during this hospital admission?	Place a √ in the "No" box if the patient did not receive any of the above vasopressors/ inotropes at any point during the hospital stay. Place a √ in the "Yes" box if the patient did receive any of the above vasopressors/inotropes at any point during the hospital stay. Each individual vasopressor/inotrope administered to the patient over the course of their hospital stay should be documented as a separate entry.
Vasopressor/Inotrope (1) **Start Date & Discontinue Date**	**Start Date:** Enter the date when vasopressor/inotrope infusion(s) was first started. **Discontinue Date:** Enter the date when the vasopressor/inotrope was stopped. The vasopressor/inotrope is considered permanently stopped when it has been off for > 48 hours. Defining a new episode If the vasopressor/inotrope was stopped for ≤ 48 hours, then restarted, this is considered a continuation of the current episode, continue to follow it until it is permanently stopped. **Example:** Dopamine is started on 1-Mar-2012 @ 0800 hrs, the infusion is stopped on 5-Mar-2012 @ 1200 hrs. The infusion is restarted on 7-Mar-2012 @ 0600 hrs and continues until it is permanently stopped on 9-Mar-2012 @ 1700 hrs. The following should be recorded in the CRF. Start Date: 5-Mar-2012 Discontinue Date: 9-Mar-2012 (permanently stopped, > 48 hrs) If the vasopressor/inotrope was stopped for > 48 hours, then started again, this is considered a new episode and should be recorded as a separate entry. **Example:** Dopamine is started on 1-Mar-2012 @ 0800 hrs, the infusion continues until 4-Mar-2012 @ 1700 hrs. Dopamine is started again on 7-Mar-2012 @ 0500 hrs and continued until 9 -Mar-2012 @ 1700 hrs. Episode 1—Start date: 1-Mar-2012; Discontinue date: 4-Mar-2012 Episode 2—Start date: 7-Mar-2012; Discontinue date: 9-Mar-2012
Vasopressor/Inotrope (2, 3, 4, etc) **Start Date & Discontinue Date**	Enter the start date and discontinue dates for vasopressor/inotropes (2, 3, 4, etc). **Start Date:** Enter the date when vasopressor/inotrope infusion(s) was first started. **Discontinue Date:** Enter the date when the vasopressor/inotrope was stopped. The vasopressor/inotrope is considered permanently stopped when it has been off for > 48 hours. If the vasopressor/inotrope was stopped for ≤ 48 hours, then restarted, continue to follow it until it is permanently stopped. Continue for as many interruptions/restarts that take place during this hospital admission.

Vasopressors/Inotropes

Did the patient receive any Vasopressor or Inotrope infusions during this hospital admission?

☐ Yes (specify all below)

☐ No

Vasopressor/Inotrope(1)

Start Date	Discontinue Date
D D M M M 2 0 Y Y	D D M M M 2 0 Y Y

Vasopressor/Inotrope (2)

Start Date	Discontinue Date
D D M M M 2 0 Y Y	D D M M M 2 0 Y Y

Vasopressor/Inotrope (3)

Start Date	Discontinue Date
D D M M M 2 0 Y Y	D D M M M 2 0 Y Y

Vasopressor/Inotrope (4)

Start Date	Discontinue Date
D D M M M 2 0 Y Y	D D M M M 2 0 Y Y

Vasopressor/Inotrope (5)

Start Date	Discontinue Date
D D M M M 2 0 Y Y	D D M M M 2 0 Y Y

Vasopressor/Inotrope (6)

Start Date	Discontinue Date
D D M M M 2 0 Y Y	D D M M M 2 0 Y Y

Consultation Instructions

General Instructions	Indicate whether the patient was seen by any of the listed services were during their hospital stay. Check **all** that apply: • RACE (Rapid Assessment of Critical Event) Team or Code 66 or Code Blue • Critical Care or Critical Care Outreach • Home Care/Transition Services This should be checked if the consult is dated but no notes are written. • Social Work • Spiritual Care • Palliative Team • Palliative Home Care • Geriatrics Team

Consultations

Was the patient seen by any of the following services during their hospital stay? Check 'yes' or 'no' for each service listed below.

RACE Team or Code 66 or Code Blue	☐ Yes	☐ No
Critical Care or Critical Care Outreach	☐ Yes	☐ No
Home Care/Transition Services	☐ Yes	☐ No
Social Work	☐ Yes	☐ No
Spiritual Care	☐ Yes	☐ No
Palliative Team	☐ Yes	☐ No
Palliative Home Care	☐ Yes	☐ No
Geriatrics Team	☐ Yes	☐ No

During this hospital admission was there a new onset of acute renal failure requiring any form of dialysis?	If a "**new**" episode of acute renal failure was experienced by the patient during this hospitalization and requiring any form of dialysis, please document it on this page. Place a √ in the **No** box if the patient is in chronic renal failure requiring ongoing dialysis or has not had a new onset of renal failure during this hospitalization requiring any form of dialysis. Continue to the next question below. Place a √ in the **Yes** box if the patient received any form of dialysis or continuous renal placement throughout the patient's hospital stay for a new onset of renal failure. For example: A patient who has been in renal failure not requiring dialysis has an acute episode during this hospital admission that required dialysis. Another example: A patient with no history of renal failure suddenly during this hospital admission required dialysis for an acute episode. Dialysis is defined as intermittent hemodialysis (dialysis that starts and stops) or continuous renal replacement therapy that was initiated at any time during this hospital admission. Enter the start date that dialysis was first received in hospital. Enter the stop date that dialysis was last received in hospital. If the patient was receiving dialysis past hospital discharge, place a √ **in the Continued at the time of hospital discharge box and leave the discontinued date field blank.**
Did the patient arrive at the hospital with an existing PEG in place?	Percutaneous feeding tubes are those inserted through the skin and into the stomach or intestine. **NOTE:** nasoenteric or nasogastric feeding tubes (feeding tubes inserted nasally) should **not** be recorded here. Place a √ in the **Yes or No** box. If the patient arrived at the hospital with a PEG in place, indicate if it was still present at hospital discharge by placing a √ **in the Continued at time of hospital discharge box and leave the removal date field blank**. If the PEG was removed before the patient left the hospital indicate the date of PEG removal.
During this hospital admission did the patient ever have a percutaneous feeding tube inserted?	If at any time a percutaneous feeding tube (PEG) was inserted to the patient during this hospitalization then, please document it on this page. **NOTE:** nasoenteric or nasogastric feeding tubes (feeding tubes inserted nasally) should **not** be recorded here. Place a √ in the **Yes or No** box. Continue to the next question below. If yes, enter the date that the percutaneous feeding tube was inserted during this hospitalization. Enter the date the percutaneous feeding tube was removed. If the patient is discharged home with the percutaneous feeding tube in place a √ **in the Continued at time of hospital discharge box and leave the removal date field blank.** If a patient has multiple PEG insertions during the current hospitalization, only document the first PEG insertion.

Dialysis

During this hospital admission was there a <u>new</u> onset of acute renal failure requiring any form of dialysis?

☐ Yes (specify) → Start Date D D M M M 2 0 Y Y
☐ No

Was dialysis continuing at the time of hospital discharge?

☐ Yes
☐ No (specify discontinuation date) →

D D M M M 2 0 Y Y

Percutaneous Feeding Tube

Did the patient arrive at the hospital with an existing percutaneous feeding tube in place?

☐ Yes →
☐ No

Was the percutaneous feeding tube still inserted at the time of hospital discharge?

☐ Yes
☐ No (specify removal date) →

D D M M M 2 0 Y Y

During this hospital admission did the patient ever have a percutaneous feeding tube inserted?

☐ Yes (specify) → Start Date D D M M M 2 0 Y Y
☐ No

Was the percutaneous feeding tube still inserted at the time of hospital discharge?

☐ Yes
☐ No (specify removal date) →

D D M M M 2 0 Y Y

Non-Invasive/Invasive Ventilation Instructions

Did the patient receive non invasive/ invasive ventilation?	Place a √ in the No box if the patient did not receive non-invasive nor invasive support throughout the entire hospital admission. Skip the rest of this page and continue to the Index Hospitalization Overview page. Place a √ in the Yes box if the patient received any non-invasive and/or invasive support throughout the entire hospital admission and document all the start and stop dates in the spaces provided.
General Instructions	Document all dates in chronological order. Do <u>not</u> collect treatments for sleep apnea, only technologies started in hospital. **Non-Invasive ventilation refers to all modalities of ventilation that assist with breathing without the use of an endotracheal tube.** Non-invasive ventilation includes BI-PAP, nasal or mask ventilation. Mask CPAP is considered non-invasive. **Note:** nasal prongs, facemask or supplementation O2 are not considered ventilation since the patient still breathes spontaneously. These should not be recorded here. **Invasive mechanical ventilation refers to any mode of intermittent positive pressure delivered via an oral/nasal tracheal tube or tracheostomy with or without positive end expiratory pressure and high frequency jet ventilation or oscillation.** If non-invasive or invasive ventilation is re-started > 48 hrs after it was last stopped, then record the subsequent start and stop date as a new episode (in a new row).
Non Invasive OR Invasive	Place a √ in the box that applies to the type of support given.
Start Date and time	Enter the actual start date(s) and time(s) regardless of where it started (OR, ER etc), for the supports initiated at your institution over this entire hospital admission (including step-down and ICU admissions). For the patient who is mechanically ventilated prior to admission to your hospital: the mechanical start date and time is the same as the hospital admission date and time. *<u>This date and time cannot be before hospital admit.</u>* If the patient was mechanically ventilated in the OR, and then came to the ICU, the start date for mechanical ventilation would be the date and time it started in the OR. If the patient does not come into the ICU, DO NOT collect this episode of mechanical ventilation.
Stop date and time	Enter the stop date(s) and time(s) the ventilation is discontinued. Patients will be considered breathing without mechanical ventilation if they are: • extubated and on face mask (nasal prong) OR • intubated or breathing through a t-tube OR • tracheostomy mask breathing OR • continuous positive airway pressure (CPAP) ≤ 5cmH2O without pressure support or intermittent mandatory ventilation assistance. Patient is considered ventilator free if successfully extubated for > 48 continuous hours. (The stop date/time is the beginning of the 48 hour period). If the stop date and/or time is unknown, please check the appropriate box. If patient is transferred out of ICU to another institution and still receiving mechanical ventilation, enter the transfer date and time as the mechanical ventilation discontinuation date and time.

Non-Invasive/ Invasive Ventilation

Did the patient receive Non-Invasive/Invasive ventilation this hospital admission? ☐ Yes ☐ No

	Start Date	Start Time	Stop Date	Stop Time
☐ Non-Invasive ☐ Invasive	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y ☐ Stop date unknown	(24 hour clock) H H M M ☐ Stop time unknown
Was ventilation reinstituted > 48 hours after the stop date listed above?			☐ YES, proceed to make a new entry below ☐ No	
☐ Non-Invasive ☐ Invasive	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y ☐ Stop date unknown	(24 hour clock) H H M M ☐ Stop time unknown
Was ventilation reinstituted > 48 hours after the stop date listed above?			☐ YES, proceed to make a new entry below ☐ No	
☐ Non-Invasive ☐ Invasive	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y ☐ Stop date unknown	(24 hour clock) H H M M ☐ Stop time unknown
Was ventilation reinstituted > 48 hours after the stop date listed above?			☐ YES, proceed to make a new entry below ☐ No	
☐ Non-Invasive ☐ Invasive	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y ☐ Stop date unknown	(24 hour clock) H H M M ☐ Stop time unknown
Was ventilation reinstituted > 48 hours after the stop date listed above?			☐ YES, proceed to make a new entry below ☐ No	
☐ Non-Invasive ☐ Invasive	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y ☐ Stop date unknown	(24 hour clock) H H M M ☐ Stop time unknown

CPR Use in hospital

During this hospital admission was CPR ever used?	Place a √ in the No box if the patient did **not** receive CPR throughout the entire hospital admission. Skip the rest of this page and continue to the Goals of Care page. Place a √ in the Yes box if the patient received CPR at least once during the current hospital admission.
General Instructions	Document all dates in chronological order starting in the Episode 1 row. Document subsequent dates CPR used in the subsequent Episode 2 rows and so on. CPR is defined as any of the following had occurred; chest compressions, defibrillation; intubation (or not if the patient is already intubated). If CPR was used multiple times on a single day, please document it only once. Record the first instance of CPR on a single day. Example: CPR was performed on 1-Mar-2012 @ 2300 hrs, then again on 2-Mar-2012 @ 0015 hrs. This should be documented at two episodes: Episode 1—1-Mar-2012 Episode 2—2-Mar-2012
Episode 1	Enter the date CPR was first used. If there was another CPR episode place a √ in the Yes box and proceed to the Episode 2 row. If no further CPR usage place a √ in the No box.
Episode 2, 3, 4	Enter the subsequent date CPR was used. If there was another CPR episode place a √ in the Yes box and proceed to the Episode 2 row. If no further CPR usage place a √ in the No box. Repeat these steps for every further episode of CPR usage.

CPR Use in hospital

During this hospital visit was CPR ever used?

☐ **No**

☐ **Yes** (Indicate the date(s) CPR was used)

Episode #	Date CPR received	Another Episode?
1	D D M M M 2 0 Y Y	☐ Yes ☐ No
2	D D M M M 2 0 Y Y	☐ Yes ☐ No
3	D D M M M 2 0 Y Y	☐ Yes ☐ No
4	D D M M M 2 0 Y Y	☐ Yes ☐ No

Goals of Care

General Instructions	Document all instances of Goals of Care discussions and/or Goals of Care decisions documented in the medical chart. Record these instances in chronological order starting in row #1. Document subsequent Goals of Care discussions/decisions in the subsequent rows. If multiple discussions/decisions occurred in a single day, only record the results of the last discussion of the day. DNR includes "no CPR" or "no defibrillations".
Upon admission to the hospital, did the patient have a GoC designation noted in the medical chart?	If the patient was admitted to you institution previously, there may already be a documented GoC designation specified in the medical chart. Or if the patient has an advance directive, the physician may refer directly that that document. If so, record this existing GoC designation. If the patient transferred from another hospital that already conducted a GoC discussion, and this designation was also transferred, record that here. If a GoC discussion occurred with EMS prior to arrival at the hospital, for the purposes of the study consider this a discussion occurring in hospital.
During <u>this</u> hospital admission, was there ever a discussion or decision concerning a new GoC designation? **Or was an existing GoC designation changed?**	Indicate whether a new GoC discussion occurred during the current hospitalization. If the patient had an existing GoC specified in the medical chart at admission, indicate whether a <u>new</u> GoC designation was noted during the current hospitalization.
Documentation & Discussions **Goals of Care Decision**	There can be instances when a discussion with a patient has been documented, including the outcome of the discussion (i.e. GoC descision). There are also instances when an order may be written designating the GoC decision in the absence of any documented discussions. **Is there documentation of a GoC discussion in the medical chart?** If yes, enter the corresponding date. Discussions concerning GoC can be found in the progress notes, consultations and orders. **Was an order written concerning a GoC decision? If yes, indicate the corresponding date.** There are instances when a GoC discussion may have occurred though no decision is made. Conversely, there may be instances when a GoC decision is documented in the absence of any noted discussions. Indicate whether a GoC Decision was made or not. If a decision was made, select the option that best describes the decision. <u>Goals of Care designation</u> **Alberta:** R1 R2 R3 M1 M2 C1 C2 Refer to the Alberta Health Services Goals of Care Designation Order for a description of each designation. **British Columbia:** <u>DNAR</u> DNAR 1 DNAR 2 DNAR 3 DNAR 4 Full Code Refer to Providence Healthcare DNAR orders for a description of each designation. <u>MOST</u> DNR M1 DNR M2 DNR M3 DNR C1 DNR C2 CPR C2 Refer to Fraser Health Medical Orders for Scope of Treatment form for a description of each designation. **All other regions:** 1 2 3 4 5 6 7 8 1. Use machines and all possible measures including resuscitation (CPR) with a focus on keeping me alive at all costs. 2. Use machines and all possible measures with a focus on keeping me alive but if my heart stops, no resuscitation. 3. Use machines only in the short term to see if I will get better but if my illness is prolonged, change focus to comfort measures only. If my heart stops, no resuscitation (CPR). 4. Use full medical care to prolong my life but if my heart or my breathing stops, no resuscitation (CPR) or breathing machines. 5. Use comfort measures only with a focus on improving my quality of life and comfort. Allow natural death and no artificial prolongation of life and no resuscitation. 6. Unsure, documentation unclear 7. No documentation 8. Other, specify: _____

Goals of Care

Upon admission to the hospital, did the patient have an existing goals of care (GoC) designation noted in the medical chart?

☐ **No**

☐ **Yes** →

Specify the existing GoC designation:

Alberta: R1 R2 R3 M1 M2 C1 C2

British Columbia - DNAR: DNAR1 DNAR2 DNAR3 DNAR4

British Columbia - MOST: DNR M1 DNR M2 DNR M3 DNR C1 DNR C2 CPR C2

All other regions: 1 2 3 4 5 6 7 8-Other:specify_____

During this hospital admission, was there ever a discussion or decision concerning a new GoC designation? Or was an existing GoC designation changed?

☐ **No**

☐ **Yes, specify all below.**

Instance	Documentation & Discussions	Goals of Care Decision
1	**Is there documentation of a GoC discussion in the medical chart? If yes, enter the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No **Where did this occur?** ☐ EMT ☐ CTU ☐ Other ☐ ER ☐ ICU **Was an order written concerning a GoC decision? If yes, indicate the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No	☐ **No decision made** ☐ **Decision made** (specify below) ☐ No change from previous decision ☐ Change from previous decision, specify below Goals of Care Decision: *AB:* R1 R2 R3 M1 M2 C1 C2 *BC - DNAR:* DNAR1 DNAR2 DNAR3 DNAR4 Full Code *BC - MOST:* DNR M1 DNR M2 DNR M3 DNR C1 DNR C2 CPR C2 *All other regions:* 1 2 3 4 5 6 7 8 - Other (i.e. level of care):specify_____
	Another discussion	☐ Yes, enter discussions/decisions below ☐ No
2	**Is there documentation of a GoC discussion in the medical chart? If yes, enter the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No **Where did this occur?** ☐ EMT ☐ CTU ☐ Other ☐ ER ☐ ICU **Was an order written concerning a GoC decision? If yes, indicate the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No	☐ **No decision made** ☐ **Decision made** (specify below) ☐ No change from previous decision ☐ Change from previous decision, specify below Goals of Care Decision: *AB:* R1 R2 R3 M1 M2 C1 C2 *BC - DNAR:* DNAR1 DNAR2 DNAR3 DNAR4 Full Code *BC - MOST:* DNR M1 DNR M2 DNR M3 DNR C1 DNR C2 CPR C2 *All other regions:* 1 2 3 4 5 6 7 8 - Other (i.e. level of care):specify_____
	Another discussion	☐ Yes, enter discussions/decisions below ☐ No

Goals of Care (Continued)

Instance	Documentation & Discussions	Goals of Care Decision
3	**Is there documentation of a GoC discussion in the medical chart? If yes, enter the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No **Where did this occur?** ☐ EMT ☐ CTU ☐ Other ☐ ER ☐ ICU **Was an order written concerning a GoC decision? If yes, indicate the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No	☐ **No decision made** ☐ **Decision made** (specify below) ☐ No change from previous decision ☐ Change from previous decision, specify below Goals of Care Decision: *AB:* R1 R2 R3 M1 M2 C1 C2 *BC - DNAR:* DNAR1 DNAR2 DNAR3 DNAR4 Full Code *BC - MOST:* DNR M1 DNR M2 DNR M3 DNR C1 DNR C2 CPR C2 *All other regions:* 1 2 3 4 5 6 7 8 - Other (i.e. level of care):specify_____
	Another discussion	☐ Yes, enter discussions/decisions below ☐ No
4	**Is there documentation of a GoC discussion in the medical chart? If yes, enter the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No **Where did this occur?** ☐ EMT ☐ CTU ☐ Other ☐ ER ☐ ICU **Was an order written concerning a GoC decision? If yes, indicate the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No	☐ **No decision made** ☐ **Decision made** (specify below) ☐ No change from previous decision ☐ Change from previous decision, specify below Goals of Care Decision: *AB:* R1 R2 R3 M1 M2 C1 C2 *BC - DNAR:* DNAR1 DNAR2 DNAR3 DNAR4 Full Code *BC - MOST:* DNR M1 DNR M2 DNR M3 DNR C1 DNR C2 CPR C2 *All other regions:* 1 2 3 4 5 6 7 8 - Other (i.e. level of care):specify_____
	Another discussion	☐ Yes, enter discussions/decisions below ☐ No

Goals of Care (Continued)

Instance	Documentation & Discussions	Goals of Care Decision
5	**Is there documentation of a GoC discussion in the medical chart? If yes, enter the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No **Where did this occur?** ☐ EMT ☐ CTU ☐ Other ☐ ER ☐ ICU **Was an order written concerning a GoC decision? If yes, indicate the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No	☐ **No decision made** ☐ **Decision made** (specify below) ☐ No change from previous decision ☐ Change from previous decision, specify below Goals of Care Decision: *AB:* R1 R2 R3 M1 M2 C1 C2 *BC - DNAR:* DNAR1 DNAR2 DNAR3 DNAR4 Full Code *BC - MOST:* DNR M1 DNR M2 DNR M3 DNR C1 DNR C2 CPR C2 *All other regions:* 1 2 3 4 5 6 7 8 - Other (i.e. level of care):specify_____
	Another discussion	☐ Yes, enter discussions/decisions below ☐ No
6	**Is there documentation of a GoC discussion in the medical chart? If yes, enter the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No **Where did this occur?** ☐ EMT ☐ CTU ☐ Other ☐ ER ☐ ICU **Was an order written concerning a GoC decision? If yes, indicate the corresponding date.** ☐ Yes → D D M M M 2 0 Y Y ☐ No	☐ **No decision made** ☐ **Decision made** (specify below) ☐ No change from previous decision ☐ Change from previous decision, specify below Goals of Care Decision: *AB:* R1 R2 R3 M1 M2 C1 C2 *BC - DNAR:* DNAR1 DNAR2 DNAR3 DNAR4 Full Code *BC - MOST:* DNR M1 DNR M2 DNR M3 DNR C1 DNR C2 CPR C2 *All other regions:* 1 2 3 4 5 6 7 8 - Other (i.e. level of care):specify_____
	Another discussion	☐ Yes, enter discussions/decisions below ☐ No

Processes of Care Instructions: Upon hospital admission

Timeframe: Upon hospital admission = hospital admission ± 24 hours.
Were any of the following life sustaining therapies **WITHHELD**?

Indicate by checking Yes or No change from before hospital admit for each of the listed treatments if an order was written to withhold (not provide) any of the following life sustaining therapies:

- Vasopressors
- Ventilation
- Dialysis
- CPR includes (DNR, chest compressions, No Code or any component of CPR).

NOTE: These questions apply to any orders written to withhold life-sustaining treatment for patients whose outcome is not favourable (i.e. end of life scenario).

WITHHOLDING life sustaining therapies is defined as the patient is NOT currently receiving the applicable life sustaining therapy(ies) and then an order is written to never start the therapy or re-start it.

Remember, if your site uses coded Goals of Care designations (e.g. M1, M2, etc..), ensure you are familiar with which therapies are withheld (e.g. M1 = withholding vasopressors and ventilation) and record them here.

What to do when "NO ESCALATION OF CARE ORDERS" are written:

Scenario 1: If the patient is on any of the applicable therapies and then an order is written for no escalation of care, then it is WITHHOLDING therapy (as you are withholding giving any more than the dose they are currently receiving). If the patient is still on the applicable therapy and later the same day or later in the hospital stay an order for comfort measure only is written then you are WITHDRAWING therapy. Please document in the explanation of change column all no escalation of care orders.

Scenario 2: IF the patient is not on any therapies and no escalation of care order written then it is considered WITHHOLDING therapy.

Enter the date the order was written. If there are instances where multiple changes of process of care orders are documented regarding withholding care please collect the first order date written to withhold therapy.

Withholding dialysis may not be written in the doctor's orders, it might be captured in the progress notes. If this is the case then please use the date the note was written.

Provide brief comments as applicable. If more space is needed, go to the Comments Page at the end of the package.

Timeframe: Upon hospital admission ± a day: Were any of the following life sustaining therapies **WITHDRAWN**?

Indicate by checking Yes or No if an order was written to withdraw (stop a previously provided treatment) any of the following life sustaining therapies:

- Vasopressors
- Ventilation
- Dialysis

NOTE: These questions apply to any orders written to withdraw life-sustaining treatment for patients whose outcome is not favourable (i.e. end of life scenario). This does not apply for orders written for stopping normal every day treatment when no longer needed.

WITHDRAWING life sustaining therapies is defined as currently receiving any life sustaining therapy(ies) and then an order is written to stop it for patients whose outcome is not favourable.

Remember, if your site uses coded Goals of Care designations (e.g. M1, M2, etc..), ensure you are familiar with which therapies are withdrawn and record them here.

Enter the date the order was written to withdraw therapy.

Provide brief comments as applicable. If more space is needed, go to the Comments Page at the end of the package.

Processes of Care
Upon hospital admission

Upon hospital admission:
Were any of the following life sustaining therapies **WITHHELD?** ☐ No ☐ Yes
(Check all that apply)

Therapy	Yes/No	Date	Explanation of change
Vasopressors	☐ Yes ☐ No	D D M M M 2 0 Y Y	
Ventilation	☐ Yes ☐ No	D D M M M 2 0 Y Y	
Dialysis	☐ Yes ☐ No	D D M M M 2 0 Y Y	
CPR	☐ Yes ☐ No	D D M M M 2 0 Y Y	

Upon hospital admission:
Were any of the following life sustaining therapies **WITHDRAWN?** ☐ No ☐ Yes
(Check all that apply)

Therapy	Yes/No	Date	Explanation of change
Vasopressors	☐ Yes ☐ No	D D M M M 2 0 Y Y	
Ventilation	☐ Yes ☐ No	D D M M M 2 0 Y Y	
Dialysis	☐ Yes ☐ No	D D M M M 2 0 Y Y	

Processes of Care Instructions: During hospital admission to before hospital discharge or death

Timeframe: From 24 hours after hospital admission until before hospital discharge or death:
Were any of the following life sustaining therapies **WITHHELD**?

Indicate by checking Yes or No change from upon hospital admission for each of the listed treatments if an order was written to withhold (not provide) any of the following life sustaining therapies:

- Vasopressors
- Ventilation
- Dialysis
- CPR (includes DNR, chest compressions, No Code or any component of CPR).

NOTE: These questions apply to any orders written to withhold life-sustaining treatment for patients whose outcome is not favourable (i.e. end of life scenario).

WITHHOLDING life sustaining therapies is defined as the patient is NOT currently receiving the applicable life sustaining therapy(ies) and then an order is written to never start the therapy or re-start it.

Remember, if your site uses coded Goals of Care designations (e.g. M1, M2, etc..), ensure you are familiar with which therapies are withheld (e.g. M1 = withholding vasopressors and ventilation) and record them here.

Enter the date the order was written.

Withholding dialysis may not be written in the doctor's orders, it might be captured in the progress notes. If this is the case then please use the date the note was written.

Provide brief comments as applicable. If more space is needed, go to the Comments Page at the end of the package.

From after the time of hospital admission orders to before hospital discharge or death: Were any of the following life sustaining therapies **WITHDRAWN?**

Indicate by checking Yes or No change from upon hospital admission if an order was written to withdraw any of the following life sustaining therapies;

- Vasopressors
- Ventilation
- Dialysis

NOTE: These questions apply to any orders written to withdraw life-sustaining treatment for patients whose outcome is not favourable (i.e. end of life scenario). This does not apply for orders written for stopping normal every day treatment when no longer needed.

WITHDRAWING life sustaining therapies is defined as currently receiving any life sustaining therapy(ies) and then an order is written to stop it for patients whose outcome is not favourable.

Remember, if your site uses coded Goals of Care designations (e.g. M1, M2, etc..), ensure you are familiar with which therapies are withdrawn and record them here.

Enter the date the order was written.

Provide brief comments as applicable. If more space is needed, go to the Comments Page at the end of the package.

Processes of Care

During hospital admission to before hospital discharge or death

From after the time of hospital admission to before hospital discharge or death:
Were any of the life sustaining therapies **WITHHELD?** ☐ No ☐ Yes
(Check all that apply)

Therapy	Yes/No	Date	Explanation of change
Vasopressors	☐ Yes ☐ No change from upon hospital admission	D D M M M 2 0 Y Y	
Ventilation	☐ Yes ☐ No change from upon hospital admission	D D M M M 2 0 Y Y	
Dialysis	☐ Yes ☐ No change from upon hospital admission	D D M M M 2 0 Y Y	
CPR	☐ Yes ☐ No change from upon hospital admission	D D M M M 2 0 Y Y	

From after the time of hospital admission to before hospital discharge or death:
Were any of the life sustaining therapies **WITHDRAWN?** ☐ No ☐ Yes
(Check all that apply)

Therapy	Yes/No	Date	Explanation of change
Vasopressors	☐ Yes ☐ No change from upon hospital admission	D D M M M 2 0 Y Y	
Ventilation	☐ Yes ☐ No change from upon hospital admission	D D M M M 2 0 Y Y	
Dialysis	☐ Yes ☐ No change from upon hospital admission	D D M M M 2 0 Y Y	

Index Hospitalization Overview Instructions

General Instructions	Document all dates in chronological order, starting with the patient's index hospital admission date and time. The "index" hospital admission or "current" hospitalization is the admission pertinent to this study.
Hospital Admission	Enter the date and time the patient was admitted to hospital. The time of hospitalization is the time of initial presentation to the emergency department or hospital ward, whichever is the earliest.
ICU or Step Down	Document all ICU and Step Down admission and discharge dates and times chronologically for this hospitalization in each of the rows. Check either ICU or Step Down. A step down admission is defined as anything above a ward level, e.g. CCU, NCCU. Enter the actual admission date and time to ICU or Step Down. Enter the actual discharge date and time from ICU or Step Down. If the patient is transferred to another institution from your ICU then the ICU discharge date and time becomes the hospital discharge date and time. Death: Did the patient die while in ICU or Step-Down? IF YES: Check the Yes box. Enter the actual date and time of death that is documented on the death certificate as the ICU discharge date and time. In the event this information is not provided, take the date and time from the physician note. If that also is not provided, use the date and time documented in the nurse's charting.
Hospital Discharge	Enter the actual date and time discharged from the hospital. *It is not necessary to complete this field if the patient died in an ICU or step down unit.* For patients who are discharged to a Rehabilitation ward within the institution, the date and time the patient is discharged from the hospital to the Rehabilitation ward is the hospital discharge date and time. If the patient is still in hospital 90 days after admission, use day 90 as the Hospital Discharge date. Check the appropriate box. Death: Did the patient die after ICU or Step-Down discharge but before hospital discharge. IF YES: Check the Yes box. Enter the actual date and time of death that is documented on the death certificate as the hospital discharge date and time. In the event this information is not provided, take the date and time from the physician note. If that also is not provided, use the date and time documented in the nurse's charting.
Discharged to	Place a √ in the box that applies to the location of the patient at hospital discharge.

Index Hospitalization Overview

	Admission Date	Admission Time	Discharge Date	Discharge Time	Death
Hospital Admission	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)			
☐ ICU ☐ Step-Down	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	☐ Yes ☐ No
☐ ICU ☐ Step-Down	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	☐ Yes ☐ No
☐ ICU ☐ Step-Down	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	☐ Yes ☐ No
☐ ICU ☐ Step-Down	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	☐ Yes ☐ No
☐ ICU ☐ Step-Down	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	☐ Yes ☐ No
☐ ICU ☐ Step-Down	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	D D / M M M / 2 0 Y Y	H H M M (24 hour clock)	☐ Yes ☐ No
Hospital Discharge			D D / M M M / 2 0 Y Y ☐ Still in hospital at Day 90	H H M M (24 hour clock)	☐ Yes ☐ No
Discharged to	☐ Home ☐ Retirement Residence	☐ Long Term Care or Nursing Home ☐ Rehabilitation Facility	☐ Ward in another hospital ☐ Other (specify): ____________		