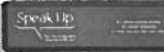


**Advance Care Planning
in relation to
Health Care Consent**

Public Information Session



**Advance Care Planning
in relation to
Health Care Consent**

Created by
The Ontario Health Care Consent and Advance Care Planning
Community of Practice October 2013

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Presentation Content

- Promote understanding of "Advance Care Planning" and Health Care Consent
- Review terms and concepts
- Review how to engage in process of "Advance Care Planning"
- To share resources

Why talk about "Advance Care Planning"

- Our population is aging
- While Canadians are living longer – 100% of us will die
- Most Canadians die of chronic illnesses – and they live with these illnesses for many years before death
- 8 out of 10 Canadians have never heard of "Advance Care Planning"

Case #1

Mrs. Anderson a widow who lives in a nursing home, falls and breaks her hip. After surgery, she has a heart attack, is resuscitated, and placed on a breathing machine in intensive care. She remains unresponsive, and her condition remains unchanged despite maximum medical treatment. Her family knows nothing of her health care wishes as she has never discussed these matters with them. Her physician of 30 years had not approached the subject either.

How would you feel if this was your mom, wife or aunt?

Case #2

Mr. Tang has been called to the emergency department as his wife was involved in a motor vehicle accident and is in critical condition. She has serious head and neck injuries, multiple organ trauma and is on life support. The physicians are looking for direction from Mr. Tang in regard to his wife's care. It is unlikely that she will recover.

What will Mr. Tang draw on to guide the decisions needing to be made?

Case #3

Mr. Singh is a 68 year old man with early stage Alzheimer disease. The doctor has explained to him what is likely to happen as the disease progresses. Mr. Singh is married with 4 adult children.

How does Mr. Singh begin to share information with his family for his future?

Why is this topic so important?

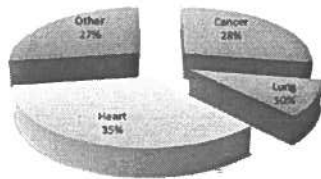
Research has shown that:

- If you have expressed your wishes in advance, you are much more likely to have your end-of-life wishes known and followed
- Your family members will have less stress and anxiety – because they know your wishes
- You will be more satisfied with your care as will your family and Substitute Decision Maker(s) [SDM(s)]
- You will have a better quality of life and death
- You may hope that you will be able to communicate until the very end but most deaths do not occur this way



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Most Canadians die of a chronic illness



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What is "Advance Care Planning"?

- A process of reflection and communication
- The communication of wishes (verbal, written, otherwise)
- A way to let others know your future health and personal care wishes
- The consideration of who will speak for you when you are no longer capable of directing your care

"Advance Care Planning"

- It is about communicating your wishes now, while you are capable, on how you wish to be cared for in the future if you become incapable of providing consent.
- It may also involve giving someone you trust the information and authority to act on those wishes for you. This person is called a Substitute Decision Maker (SDM).

Important Concepts and Terms

- You are "capable" if you are able to understand and appreciate.
- You must be able to understand information that is relevant to making a decision about your health care, nutrition, shelter, clothing, hygiene or safety, and you must be able to grasp the likely results of making the decision or not making it. (appreciate)

Important Concepts and Terms

Substitute Decision Maker (SDM)

A Substitute Decision-Maker(s) is a person(s) who makes care and treatment decisions on your behalf if and when you become incapable of making these decisions for yourself.

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Substitute Decision Maker(s) [SDM(s)]

- SDM(s) must follow your expressed wishes wherever possible.
- If unable to follow your wishes, or if your wishes are unknown, the SDM(s) must act in your best interest.
- Communication of your wishes helps the SDM(s) to make decisions on your behalf when you are no longer capable.
- In an emergency a Health Care Provider may not know your wishes and may have to act immediately in your best interest.

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Substitute Decision Maker(s) [SDM(s)]

Must be:

- Over the age of 16
- Willing and able to act as a SDM
- Not prohibited through court order
- Mentally capable of making decisions

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Substitute Decision Maker(s) [SDM(s)]

- You can appoint a Substitute Decision Maker(s) in a document called a **Power of Attorney for Personal Care**.
- You have a Substitute Decision Maker(s) even if you do not appoint one as determined by the hierarchy defined in the Health Care Consent Act.

Hierarchy (a ranked list) of Substitute Decision Makers

1. Guardian of Person
2. Attorney named in a POA/PC
3. Representative appointed by Consent and Capacity Board
4. Spouse or Partner
5. Child or Parent or CAS (Person with Right of Custody)
6. Parent with right of access
7. Brother or Sister
8. Any other relative
9. Public Guardian or Trustee

Health Care Consent Act 1996 (HCCA)

What is a Power of Attorney (POA)?

In Ontario there are 2 POA documents

1. Power of Attorney for Finances
2. Power of Attorney for Personal Care

POA for Personal Care

- A **Power of Attorney for Personal Care** is a written document in which you appoint a person(s) to be your **Substitute Decision Maker(s)**.
- The person(s) will act on your behalf should you become incapable.
- This document must be signed and dated by you, and witnessed by two people.

Substitute Decision Maker(s) [SDM(s)]

If a **Power of Attorney for Personal Care** document has not been completed, **Health Care Providers** must get consent for treatment (or refusal of consent for treatment) from the next highest ranked person from the hierarchy of **Substitute Decision Makers**.

Hierarchy (a ranked list) of Substitute Decision Makers

1. Guardian of Person
2. Attorney named in a POAPC
3. Representative appointed by Consent and Capacity Board
4. Spouse or Partner
5. Child or Parent or CAS (Person with Right of Custody)
6. Parent with right of access
7. Brother or Sister
8. Any other relative
9. Public Guardian or Trustee

Health Care Consent Act 1996 (HCCA)

How does all this fit together?

- Wishes in an "advance care plan" (or a conversation) guide your future SDM(s) to make health care decisions if you become incapable
- Your wishes are interpreted by your SDM(s) when you are incapable
- Health Care Providers are required to get informed consent from you (if capable) or your SDM(s) (if you are incapable) prior to initiating care or treatment of any kind in any situation

Health Care Consent

- Health Care Providers must get informed consent or refusal of consent in order to provide care and treatment
- Health Care Providers are obligated to provide:
 - an explanation of the treatment proposed
 - the risks, benefits, side effects of the treatment
 - alternative courses of action
 - what to expect if this treatment is not provided
 - answers to questions

Consent vs. Wishes

- Health Care Professionals must get informed consent (from you or your Substitute Decision Maker(s) if you are not capable). Consent is related to specific care or treatment(s) offered in relation to a current health condition.
- Wishes are not consent.

Wishes typically are:

- a) Based on "if" scenarios (speculations) – "If I have a terminal condition..." "If I am in pain..." "If I have dementia..." "If that happens to me..."
- b) Based on beliefs, values and goals
- c) May be based on a known condition (ALS, Alzheimer's, etc.)

**"Advance Care Planning"
in relation to
Health Care Consent**

What does all this information have to do with you?

The Process

1. Think about what is right for you (consider your values, beliefs, goals).
2. Learn about health care options and medical procedures.
3. Determine who will be your Substitute Decision Maker(s).
4. Have the conversation(s). Write down or record your wishes if you wish. (communicate)
5. Review your wishes/plan regularly.

Speak Up
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Step 1-Think about what is right for you

Reflect on your values and beliefs.

- **Values** are an individual's judgement of what is important in life; dignity, independence
- **Beliefs** are what an individual accepts as true or real; a firmly held opinion, a religious conviction

Speak Up
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Step 2 -Learn about health care options and medical procedures

- There are many different medical procedures that might be used during an illness or at the end of life. Some people want those procedures, but others do not. (examples - CPR, tube feeding, breathing machines etc.)
- What do you want considered; what would influence your wishes? (i.e. time left to live, level of impairment, quality of life)



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Step 3 -Determine your Substitute Decision Maker(s)

- Who do you feel would be most capable of honoring your wishes and making decisions on your behalf? (i.e. spouse, a trusted family member or a good friend)
- Remember – You can appoint through a document called Power of Attorney for Personal Care (POAPC)
- If no one appointed: Hierarchy of SDM(s) is set out by law



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Hierarchy (a ranked list) of Substitute Decision Makers

1. Guardian of Person
2. Attorney named in a POAPC
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6. Parent with right of access
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Health Care Consent Act 1996 (HCCA)

Step 4 - Have the Conversation



It is all about the conversation!

- Talk with your family, friends, and especially your Substitute Decision Maker(s)
- If your wishes/plan is written down, make sure you share a copy
- Talk to your Substitute Decision Maker(s) so they will understand, honour and feel comfortable making care or medical treatment decisions on your behalf.
- Talk with others about your wishes/plan (doctor, lawyer)

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Step 5 - Communicate Your Wishes

- You can make your wishes known through conversations, written or taped instructions or by any other means of communication
- You can complete a Power of Attorney for Personal Care to appoint your Substitute Decision Maker(s)
- You might see a lawyer and prepare a document that reflects your wishes



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**Step 6
Review Your Wishes/Plan Regularly**

- Our lives – and the people around us – change over time. Review your wishes/plan regularly to be sure it still reflects your wishes and that you are comfortable with your choice of SDM(s).
- Remember, it will only be used if you cannot speak for yourself.
- You cannot predict how and when you will die. You can change your plan as often as you like and as your life changes.
- Share your wishes with those important to you.



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In Summary : "Advance Care Planning" is:

- A process of reflection and communication about values, beliefs and goals of care
- A process of planning for a time when you cannot make care and treatment decisions (sharing wishes)
- A process that involves discussions with family, friends, and Health Care Professionals
- A process in which you may appoint a SDM(s)
- A process that results in the sharing of your wishes

**In Summary :
What "Advance Care Planning" is not:**

- One conversation only about treatment options with a physician or other Health Care Provider
- Consent to treatment
- Strictly a refusal of medical treatments
- A document / form / checklist to be completed
- Wishes that are not shared with your family or SDM(s)

Case #1

You fall and break your hip. After surgery, you have a heart attack, are resuscitated, and placed on a breathing machine in intensive care. You remain unresponsive, and your condition remains unchanged despite maximum medical treatment. Your family knows nothing of your health care wishes as you've never discussed these matters with them. Your physician of 30 years has not approached the subject either.

Would your SDM(s) know how you would want to be treated if you were in this situation?

Case #2

You have been called to the emergency department as your partner has been involved in a motor vehicle accident and is in critical condition. Your partner has serious head and neck injuries, multiple organ trauma and is on life support.

What do you know about your partner to guide the health care decisions required?

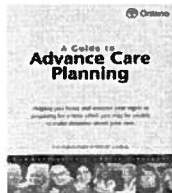
Case #3

You have early stage Alzheimer disease and the doctor has explained to you what is likely to happen as the disease progresses. You are married and have several adult children.

What is important for your family to know to ensure your life remains consistent with your values and beliefs?

Resources


A Guide to Advance Care Planning



<http://www.seniors.gov.on.ca/en/advancedcare/index.php>

Resources

Powers of Attorney



<http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf>

Resources

Speak Up Campaign

Web site and resources for:

- Patients and families
- Professionals
- Community organizations / agencies / programs
- Researchers



www.advancecareplanning.ca

Resources

- Your Health Care Provider (Physician, Case Managers, Nurses, Social Workers)
- Advocacy Centre for the Elderly (ACE)
www.ancelaw.ca
416-598-2656
- Support Organizations (Cancer Society, Alzheimer's, ALS etc.)

Research References --re: Slide 8

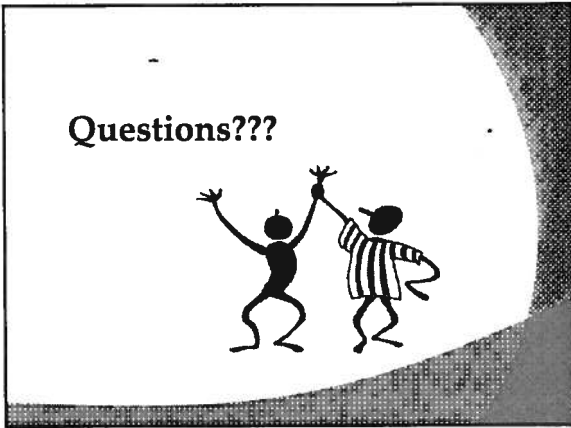
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Zhang, B., et al. (2009). Health care costs in the last week of life. *Arch Intern*; 169(3): 480-488



Resources

College of Nurses Ontario

This practice guideline on *Consent* provides an overview of the steps needed to obtain consent along with the *Guideline for Nurses Advocating for Clients Found Incapable of Making Certain Decisions*.

Available from:

http://www.cno.org/Global/docs/policy/41020_consent.pdf

Resources

Developed for social workers and social service workers who encounter dilemmas pertaining to consent and confidentiality with clients who are children and youth.
 Practice Guidelines: Consent and Confidentiality with Children and Youth
 Available from:
<http://www.ocswssw.org/docs/childrenyouthguidelines.pdf>

Code of Ethics and Standards of Practice (pgs. 43-45)
 Available from:
<http://www.ocswssw.org/docs/codeofethicsstandardsofpractice.pdf?LanguageID=EN-US>

Resources

College of Physicians and Surgeons - Consent to Medical Treatment policy #4-05

The document helps clarify when and how a physician can obtain a patient's consent to treatment and what constitutes consent.
 Available from:
<http://www.cpso.on.ca/uploadedFiles/policies/policies/policyitems/Consent.pdf>
