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Advance Care Planning

Conversations Worth Having

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- Imagine: You’re in the hospital, too ill or hurt to speak for yourself…
- Think: Do you know who would make health care decisions for you?

- Imagine: Your husband/wife has had a stroke and is unable to communicate with doctors

- Think: Would you know what health care he/she would want or not want?

Advance Care Planning
Conversations Worth Having

Advance Care Planning
&
Health Care Consent

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Conversations Worth Having

Collaboration between:

- Hospice of Waterloo Region
- Hospice Wellington

Working With:

- General Public
- Community Professionals
- Health Care Providers
    - Increased understanding of ACP & HCC
    - Common language, common practices
    - Reflect Ontario law

Three year funding from Waterloo Wellington Local Health Integration Network

Putting into Context

- Before providing **any treatment** health care providers must obtain **informed consent** from:
  1. **Patient**
  2. **Substitute Decision Maker** (if the patient is mentally incapable)

- Consent **ALWAYS** comes from a person, not a piece of paper

- Adapted from Judith Wahl with permission

What is Advance Care Planning in Ontario?

1. Identifying your future **Substitute Decision Maker**
2. Having **conversations** about what is important to you

Step 1: Identifying your Substitute Decision Maker

There are two ways to identify your SDM in Ontario:

1. Complete a **Power of Attorney for Personal Care**

2. Confirm the automatic person on the **hierarchy**

Hierarchy of SDMs HCCA s. 20

1. Guardian of person
2. Attorney in **Power of Attorney for Personal Care**
3. Representative appointed by the Consent & 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. Office of the Public Guardian and Trustee

What do SDMs do?

- Make **health care and personal care decisions** for you

- Only make decisions if you **DO NOT HAVE CAPACITY**

- Have to make the decisions the way **YOU** would have made them
  - Must use previously expressed **wishes**
  - Act in your **best interest**

Requirements to act as SDM

1. Capable with respect to treatment proposed
2. 16 years old
3. There is no court order or separation agreement prohibiting access to the incapable person or giving or refusing consent on his or her behalf
4. Is available
5. Is willing to assume the responsibility of giving or refusing consent

Types of Decisions

1. **Long-term care** placement
2. **Health care** decisions
   - Consent or refuse tests, procedures, surgery
   - Begin or withdraw life-prolonging measures
   - Who will provide medical care
   - Speaking with health care professionals
   - Admit or discharge from medical facility
   - Looking at medical information
3. **Personal care** decisions (only Attorney in POAPC)

How SDMs make decisions

1. **Wishes**
   - Must follow any wishes you expressed while capable
   - Even if they do not agree with the decision
   - That's why conversations are so important
2. **Best Interests**
   - If wishes are not known, SDM must act in best interest
   - Think about person's values and beliefs, wishes while incapable
   - Is treatment likely to improve condition, prevent deterioration, etc.

Advance Care Planning in Ontario

- Does **not** need to be in **writing**

- **Later** wishes, however communicated, expressed while capable **prevail over earlier wishes**

- This is true even if the previous wishes were in **writing** and the later wishes are **oral**

- **Not** only about **End-of-Life**

- **Not** about **Living Wills** or **Advance Directives**

Step 2

Conversations with Substitute Decision Maker and other loved ones

Examples

- Letting SDM, loved ones and physician know your wishes, values and beliefs
- What do they need to know about you in order to make decisions the way you would?
- What brings quality to your life?
- What brings you pleasure and joy?
- What fears do you have about your health?

Benefits of ACP

- Improves patient & family satisfaction with care
- **Decreased caregiver distress & trauma**
- Decreased unwanted investigations, interventions & treatments
- Pts more likely to die in preferred setting, with earlier palliative care involvement
- Less likely to be hospitalized & admitted to critical care
- Decreased cost

Dr. Jeff Myers

What's next – Individual Level

1. Identify your **Substitute Decision Maker** by either:
   I. **Confirming person on hierarchy**
   II. **Doing Power of Attorney for Personal Care**

2. Complete the **SDM** card and keep in your **wallet**

3. Have the **conversations** with **your SDM and your other loved ones** about what is important to you

We need your help

- Working across the Waterloo Wellington area
  - About 750,000 people
  - We can’t do this alone!

- Do you have **connections** with other **groups** who would be interested in this?
  - Church/Faith groups
  - Workplaces
  - Etc

Evaluations & Contact Sheet!

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Thank you!