Advanced Care Planning

IT'S ABOUT CONVERSATIONS

Speak Up

February, 2014

Learning Objectives

At the End of this presentation, participants will be able to:

- Identify the patients that need to start advanced care planning
- Recognize own feelings about advanced care planning
- Identify who an individuals substitute decision maker or power of attorney for personal care would be
- Identify three questions or statements that would assist in leading to conversations about advanced care planning

100 % OF CANADIANS WILL DIE

EVERYONES JOURNEY WILL BE DIFFERENT

Statistics

According to a 2012 Ipsos Reid Poll:

- 86% of Canadians have not heard of advanced care planning
- Less than half, have had a discussion with a family member or friend about wishes for healthcare treatments if they were too ill and unable to communicate
- Only 9% of Canadians have ever spoken to a healthcare provider about their future wishes for care

Ontario Law

In Ontario a person's wishes can be expressed orally, in a written form, or by any alternative means that you choose to communicate such as through a picture board or computer

Ontario law does not recognize a living will

Ontario law does recognize Power of Attorney for Personal Care and Substitute Decision Maker

Other Provincial Laws

- British Columbia has legislation in place that an Advanced Directive must be followed by your health care provider
- P.E.I. does not have a Consent and Capacity Board. Cases are brought before the court
- In Saskatchewan, the proxy (Substitute Decision Maker-Ontario) must be at least 18 years of age
- In the Yukon, an Enduring Power of Attorney must be signed by a lawyer.
- Laws governing Advanced Care Planning are different from province to province

Hierarchy of Substitute Decision Maker

1) Guardian of the person-usually court appointed
2) Attorney named in power of attorney for personal care
3) Representative appointed by the Ontario Consent and Capacity Board
4) Spouse or partner- legally married or cohabitate for one year includes same sex in Ontario
5) Child or custodial parent or Children's Aid Society
6) A parent who has only right of access-non custodial
7) Brother or sister (Note siblings are at the same level)
8) Any other relative
9) Public Guardian and Trustee (Last Resort)

Substitute Decision Makers

- Substitute decision makers in Ontario must be capable
- Greater than 16 years of age, unless he/she is the parent of the incapable person
- Not prohibited by court order or separation agreement to have access to you (the incapable person) or to give or refuse consent on your behalf
- Willing to assume responsibility
- Available

Personal Reflection

Imagine that in 5 minutes you are mentally incapable of making any personal care decisions.

What does quality of life mean to you?

Who will speak on your behalf if you are no longer able to?

Does this person know about your thoughts/values/wishes/for the future?

Does this person know what you would want ?

Does this person now what your treatment/care plan would include or not include?

What is Advanced Care Planning?

- Advanced Care Planning is a process designed to help capable people think about and express choices about their future care

- The capable person understands and can appreciate the consequences of their choices

Benefits of Advanced Care Planning

- Personal wishes are more likely to be respected and acted upon when decisions are made in advance
- Provides comfort and a sense of control at end of life
- Reduces stress and anxiety for those making difficult decisions
- Decreases potential for conflict among family members and friends
- Higher quality of life and death

Decision Making and Advanced Care Planning

Steps

1.Help patients/family identify/determine who will be their Substitute Decision Maker/Power of Attorney for Personal Care if they are incapable of making their own health care decisions

2.Help the patient/family to reflect on their values, beliefs, wishes and fears. Encourage them learn about care options

3.Schedule reviews with the patient/family, SDM and friends (as required).

4.Planning for funerals

5.Advanced care planning- its about **CONVERSATIONS**

Who should we initiate these conversations with?

- Absolutely:

  Capable adults with advanced stage disease

- Imperative With:

  Capable adults with chronic diseases along the illness trajectory or prior to a procedure with any associated risk

- Ideally:

  Healthy capable adults to create awareness

Begin the culture change!!! Speak up!!

Initiating Discussions

Our first priority is providing you with the best possible care…

It is difficult to predict when your health will change

It is important to learn about some future healthcare options and reflect on your thoughts. This will assist you when difficult decisions need to be made

Triggers for Evaluation of Advance Care Plans

The Five D's

- Death
- Decade
- Divorce
- Decision
- Decline in Health

Guiding Patients- Where To Begin

Think about what is right for you

Reflect on your values, beliefs, understanding about end of life care, specific medical procedures, drug therapy, CPR, dialysis, mechanical ventilation, and feeding tubes.

Guiding Patients-Where to Begin

Ask Yourself

If possible, where would I want to die: at home, in a hospice or in a hospital?

Do I want to die alone?

Do I want family or friends at my bedside?

Do I want certain medical interventions?

In what circumstances might I want certain medical interventions?

Is it important to me that certain religious customs be followed?

What would be meaningful at the time of my death?

What are my greatest fears about dying?

Where I Want To Die

Patient Room

Allow Natural Death

Allow Natural Death VS DNR- Positive language (Allow) VS Negative language (Do Not)

The focus of care is to keep you comfortable and to enhance your quality of life

Your treatment may include medication to control pain or to manage other symptoms such as shortness of breath or anxiety

Treatment may include other medical interventions such as antibiotics and hydration

However, cardiopulmonary resuscitation would not be given if your heart were to stop or if your breathing were to stop. You would be provided comfort care and allowed to die naturally.

Have The Conversations

- Discuss what types of care your patients would want or would not want

- Remember that a Substitute Decision Maker and Power of Attorney for Personal Care only come into effect when you are incapable of making your own personal care choices

- Re-visit these conversations with your SDM/ family/ friends. Over time our wishes may change. Do not hesitate to SPEAK UP.

Take Home Messages

- Wishes/Advance Care Plans are directions to future Substitute Decision Makers /Power of Attorney for Personal Care and Health Practitioners

- Wishes are interpreted by people. Forms are unable to provide consent to health care

- Health Care Providers always need to get consent from capable patient or Power of Attorney for personal Care/ Substitute Decision Maker

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Questions?

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