# Advance Care Planning, Goals of Care and Health Care Consent in Palliative Care

Project ECHO
Palliative Care - Canada
BY Pallium Canada

**Host:** Diana Vincze
**Presenters:**
Sunil Rocci, O.T. Reg. (Ont)
Tanya McAdams, NP-PHC, MScN Aging and Health, BScN
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# Territorial Honouring

# The Palliative Care ECHO Project

The Palliative Care ECHO Project is a 5-year national initiative to cultivate communities of practice and establish continuous professional development among health care providers across Canada who care for patients with life-limiting illness.

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The Palliative Care ECHO Project is supported by a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

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# LEAP Core

- Interprofessional course that focuses on the essential competencies to provide a palliative care approach.
- Taught by local experts who are experienced palliative care clinicians and educators.
- Delivered online or in-person.
- Ideal for any health care professional (e.g., physician, nurse, pharmacist, social worker, etc.) who provides care for patients with life-threatening and progressive life-limiting illnesses.
- Accredited by CFPC and Royal College.

Pallium Canada LEAP CORE

Learn more about the course and topics covered by visiting

**www.pallium.ca/course/leap-core**

# Introductions

## Host

**Diana Vincze**
Palliative Care ECHO Project Manager
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## ECHO Support

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## Presenters

**Tanya McAdams**, NP-PHC, MScN Aging and Health, BScN
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Designated Capacity Assessor
c/o Not Just Therapy Inc.

# Conflict of Interest

## Pallium Canada

- Non-profit
- Partially funded through a contribution by Health Canada
- Generates funds to support operations and R&D from course registration fees and sales of the Pallium Pocketbook

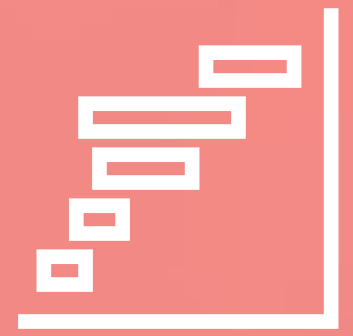
## Host/Presenter

- Diana Vincze: Nothing to disclose.
- Tanya McAdams: Nothing to disclose.
- Sunil Rocci: Nothing to disclose.

# Welcome and Reminders

- For comments, please use the chat function.
- For questions, please use the Q&A function, these questions will be addressed at the end of the session.
- This session is being recorded—this recording and slide deck will be emailed to registrants within the next week.

# Advance Care Planning, Goals of Care and Health Care Consent in Palliative Care



# What is an Advance Care Plan?

**It is a process that involves the mentally capable patient**

# How is Advance Care Planning Done?

A person may communicate his/her wishes orally, in writing, or by whatever means he/she uses to communicate A **VOLUNTARY** process Health facilities/practitioners **CANNOT REQUIRE** a patient to do advance care planning OR to use any particular form or method of advance care planning (i.e. levels of care forms.

# What are the Important Details to Explore in Advance Care Planning?

1. IDENTIFYING the future Substitute Decision-Maker (SDM), by either

a) confirming his/her satisfaction with their default/ automatic Substitute Decision-Maker in the SDM hierarchy list in the Health Care Consent Act **OR**
b) choosing someone else to act as SDM by preparing a Power of Attorney for Personal Care (a formal written document).

2. SHARING WISHES, VALUES, AND BELIEFS – through conversations with the SDM and others that clarify his/her wishes, values and beliefs, and more generally how he/she would like to be cared for in the event of incapacity to give or refuse consent

(i.e. What is quality of life to that patient? What is important to that patient in respect to his or her health?)

# Who Can Take Direction from an Advance Care Plan?

Advance care planning wishes are a **GUIDE** or directions for the Patient's SDM that prepares the SDM to make future health or personal care decisions on behalf of the incapable Patient. **Health Practitioners must get informed consent** from the Patient or incapable Patient's SDM even if the patient has done advance care planning in any way – written, oral or by alternative means.

*Advanced Care Planning is not a one-time conversation*. Wishes and values may change over time as a person's health and life status change. It is important to have continued conversations about wishes in the event of incapacity and to document these wishes accordingly.

An **Advance Care Plan, Living Will, or Advance Directive** these terms are **not legally defined in Ontario law**. While heard in common language, these terms have been borrowed from other jurisdictions, countries or provinces. Use of this terminology may cause confusion and misrepresentation of Health Care Consent or ACP. **Ontario law requires health care providers to obtain consent even where a patient has engaged in the process of ACP or has documented wishes.**

# ACP Resources for Healthcare Professionals and Patients

https://www.advancecareplanning.ca/
https://www.chpca.ca/projects/advance-care-planning/

First Nations:
https://www.fnha.ca/what-we-do/healthy-living/advance-care-planning

Healthcare Professionals:
https://www.cfpc.ca/CFPC/media/Resources/Education/ACP_GIFT_1pager_ENG_FINAL_RevMay18_Web.pdf

https://ltctoolkit.rnao.ca/resources/websites/advance-care-planning-canada-national-framework-november-2010

# What are Goals of Care (GoC) Conversations?

**GoC conversations are focused on the context of a current illness in relation to the expressed values and wishes which lead to a treatment choice or decision.**

Example:

An 89-year-old male patient of a Long-Term Care Home, has expressed wishes prior to his incapability that he did not want to be transferred to hospital in the event of any illness. He requested that he be provided comfort measures only. During his time at the LTCH he was diagnosed with Pneumonia and began to show signs and symptoms of Sepsis. A GoC conversation was held with the SDM, and a treatment plan was created to support the expressed wishes of the patient.

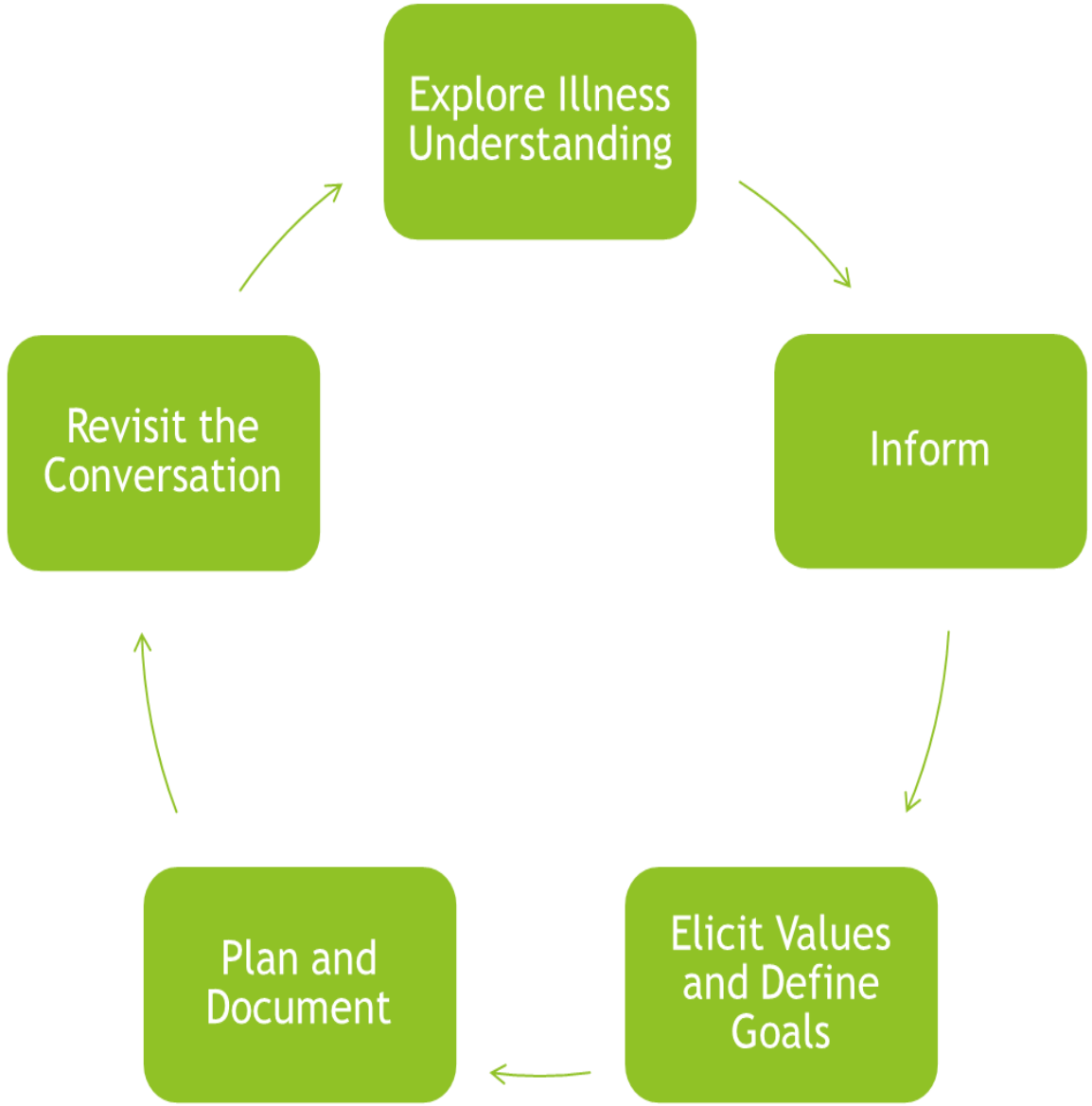
Goals of Care conversations should happen in a private and comfortable space, and therefore may need to be scheduled in advance.

**PREPARE** and become an “expert” where the patient/clinical context is concerned.

**CONFIRM** the patient’s preference when it comes to including family or friends in the conversation.

If the patient is **capable**, explore if they have confirmed an SDM. If the patient is not comfortable with their automatic SDM, discuss preparing a Power of Attorney (POA) for Personal Care.

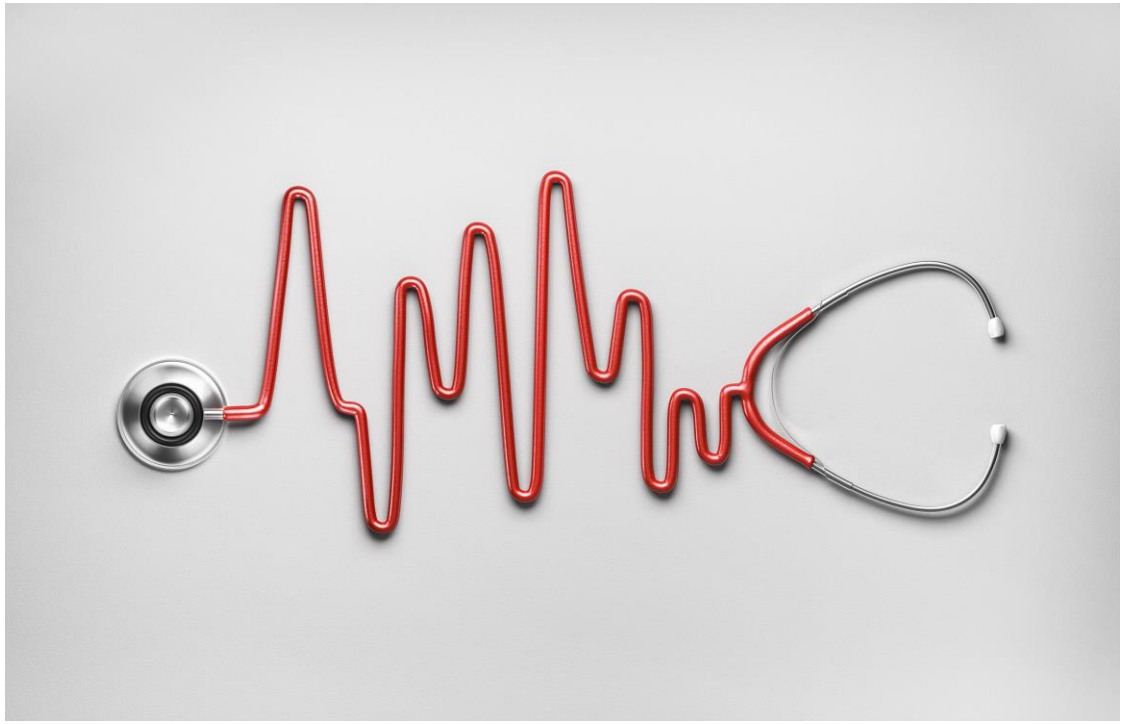
If the patient is **incapable**, the conversation must occur with the patient’s SDM, as the SDM holds responsibility for interpreting the patient’s previously expressed wishes, values and beliefs. In the event of a POA – conversations should occur with the POA(s).



# Health Care Consent

"Nothing about me, without me"

# Health Care Consent for Treatment



**No treatment without consent**

10 (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) They are of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) They are of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1)

https://www.ontario.ca/laws/statute/96h02#BK14

# Case Study #1

Ms. Bronson (Mary) is 85 years old and lives on her own, a widow of 5 years. Up until this point she has managed independently with some support from her daughter (who lives 50 miles away) and her neighbours. A recent fall has resulted in a marked reduction in Mary's mobility and currently she is requiring full support with her IADL's and some personal care needs. At times she also appears confused.  Mary has been assessed by a physiotherapist who feels that the best option would be for her to move into a nursing home.  Her daughter supports this recommendation as she feels that she is not able to offer her mother the support she needs and worries about the new onset confusion. Mary has stated that she does not want to go into a nursing home.

# Case Study #1

What are the issues to consider?

- Clinical concerns/needs, social supports, housing and living situations, IADL and ADL needs, etc.

Who else should be involved?

- Social work, Primary Care MRP..?
- Is the Daughter the only SDM?

What other elements of Mary's case might you explore?

# Case Study #1

Other professionals were also involved: Primary Care, Nursing, and Social Work

- Confusion – A clinical work-up including a urine for C&S, as well as standard laboratory testing was completed. Mary was diagnosed with a UTI. Upon further review of her cognition after treatment Mary was not reported to have any signs and symptoms of ongoing confusion.

Mary's daughter was involved in the conversations and planning, however given her mother had capacity, she could not dictate the circumstances of her Mothers living arrangements. Mary UNDERSTOOD and APPRECIATED the choice and risk to live and remain at home.

# Case Study # 2

Mr. Cavanaugh is a 73 year-old Gentlemen who lives in Long Term Care.

Med Hx: Moderate Cognitive Impairment, COPD, Hx of CVA, Afib, 3.5cm AAA, Hypertension.

ADL – assistance of 1 with dressing, eating and toileting.

Mobility – 2 wheeled walker and 1 assist.

DNR

POA: Daughter Angela

At 3am on a night shift Mr. Cavanaugh's Nurse notices that he has become febrile. Upon further examination she discovers:

HR: 124/min – irregular

02 saturation: 88% room air

RESP: Crackles and decreased breath sounds at the right middle and lower lobes.

The Nurse notes that Mr.Cavanaugh is not answering her questions appropriately and appears confused.

# Case Study # 2

What is the Nurses next steps?

What are your obligations as a healthcare provider in this situation?

# Q & A

# Session Wrap Up

- Thank you for joining us!
- Please fill out the feedback survey following the session—a link has been added into the chat.

# Thank You

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