Advance Care Planning (ACP): respecting patients' wishes, providing appropriate care

Health Care Providers have an ethical and professional obligation to consider patient's wishes in determining what care to offer to the patient for a consent decision or, in the event a patient is not capable, an authorized Substitute Decision Maker;

Substitute Decision Makers have a legal obligation to make consent decisions based on to what the patient would have wanted[1];

Health Care Providers may on occasion need to remind Substitute Decision Makers of this requirement to fulfill their role, in respecting the patient's wishes.

Advance Care Planning (ACP) is the process of for capable adults to make their wishes known so as to guide decision making on their behalf should they be incapable or otherwise unable to communicate.

Legislative changes in 2011 and the publication of *My Voice* by the Ministry of Health made it more accessible - and therefore likely - that health care wishes can be formally documented in a section 7 or section 9 Representation Agreement (s7 RA, s9 RA) or Advance Directive (AD).

As patients or their families are more likely to present for care with ACP documents, Health Care Teams must be aware of the application of each of these documents.

The VCH **ASK** strategy for Advance Care Planning highlights the importance of conversations with patients and clients, and the receipt and management of documentation:

Ask patients if they have thought about future health care decisions or have any written wishes

Share and Store the information with the health care team (Greensleeve for visibility/ PARIS Clinical Summary

Know your patient's wishes in care planning, and where to find ACP resources should the patient seek more information, or for yourself, should you have any questions

Everyone on the health care team has a role in Advance Care Planning (ACP)

All health care providers should know what ACP is, the use of the Advance Care Planning Record in documenting the conversations related to ACP, and know how to share and store ACP documents.
It is recommended that each unit or program team team consider having at least one identified 'goto' resource person who is knowledgeable on ACP resources. (search "advance care planning" on VCHConnect, www.vcha.ca)

ACP documents can inform care planning, and must guide substitute consent decision making

Basic Advance Care Plan: Beliefs, values, and wishes to guide decision making of Temporary Substitute Decision Maker (TSDM); may be documented, or verbal.

TSDM: Temporary Substitute Decision Maker, a person appointed by the health care provider seeking the consent decision, from a hierarchical list when s/he determines that the adult is not capable to make the decision. The hierarchy is set by legislation and requires that TSDMs are 19 or older, capable, in contact with the adult in the last 12 months, and committed to making decisions according to the patient's prior capable wishes (such as in an advance care plan). The TSDM is legally required to make decisions that respect the patient's wishes, or may not be appointed / continue as TSDM.

Standard Representation Agreement 7 (RA 7): allows an adult, even one with lower level of capability, to name a Representative to make their routine financial management decisions, personal care decisions, and some health care decisions. A "Rep 7" is not authorized to refuse life support or life prolonging medical interventions, if these are offered by the Team.

Enhanced Representation Agreement 9 (RA 9): allows an adult to name a Representative to make personal care decisions and health care decisions, including decisions to accept or refuse life support or life prolonging medical interventions. A Rep 9 is not able to make financial or legal decisions.

Advance Directive (AD): conveys an adult's instructions about accepting or refusing health care directly to a health care provider. In order to be a valid AD, the document must indicate that the adult was aware no SDM would be asked to make a decision, and that any care refused in the document would not be provided.

a) If **AD only**, it provides instruction directly to Provider.
b) If **AD and Rep Agreement**, AD generally guides Rep's decisions (akin to Basic Advance Care Plan guiding TSDM), however
c) If **AD and Rep Agreement which explicitly states AD stands on own without Rep**, AD instructs health care provider directly

Concerning the Mental Health Act:

For persons certified under the Mental Health Act, the Mental Health Act guides psychiatric care decisions, however for health care interventions unrelated to psychiatric care, the health care provider must make every reasonable effort to obtain a consent from the adult, or Substitute Decision Maker.

1 Health Care (Consent) and Care Facility (Admission) Act - HCCCFA

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Hierarchy of decision making - from the Health Care (Consent) and Care Facility (Admission) Act
First, propose the care to the Adult
If the adult is not capable[2] of making that consent decision and/or cannot speak for himself/herself:

- Personal Guardian appointed by the Court (formerly known as Committee of Person)
- Advance Directive, if no Representation Agreement
- Representative (guided by Advance Directive if in place)
- Temporary Substitute Decision Maker (TSDM) : ranked list: spouse (ie marriage like relationship, including people of the same gender), child, parent, sibling, grandparent, grandchild, anyone else related by birth or adoption, close friend, someone related by marriage, Public Guardian and Trustee)

Frequently Asked Questions

Why do we need to know about ACP now?
Legislative changes have made having an advance care plan more accessible as it can be done at home with two witnesses, no lawyer/notary needed. Chronic disease is changing the trajectory of patient's care needs, and we need to adapt our processes.

Is an advance care plan the same as a No CPR order?
No. Individuals can write down their wishes about resuscitation but it is not a No CPR order or a DNACPR order. If people want a No CPR order, they can ask their doctor at their hospital or their residential care home. If the individuals are at home, they can ask their doctor to sign a provincial No CPR form. However, if someone has an apparently valid Advance Directive that states 'under no circumstances do I consent to CPR', the patient's wishes must be respected.

Does a Power of Attorney cover a client's health care decisions?
No. In British Columbia, a client's Power of Attorney only authorizes someone to make legal and financial decisions; there is no application in health care decision making. They cannot make decisions about health care.

A TSDM must honour the patient's wishes or convince the HCP that wishes have changed, if not:
Contact Client Relations & Risk Management for support and guidance.
The HCP may need to appoint a new TSDM who will honour the resident's wishes.

What happens if the Advance Directive does not deal with the health situation at hand?
If unsure about the AD's instructions, carry out emergency medical treatment until the instructions in the AD can be confirmed/clarified/validated with someone close to the adult, and the Health Care Team.
If the AD does not address the health care decision required, the HCP must seek consent from either a Personal Guardian, Representative, or a TSDM (unless Urgent / Emergency, in which case the care may be provided on determination by the physician).
If the AD is not appropriate, you are not obligated to follow it.

What if I am uncomfortable with the Advance Directive?
Contact Client Relations & Risk Management for support and guidance. (contact Switchboard at your site, or riskmanagement@vch.ca)

What happens if medical treatment has started then an AD identifies refusal of consent to care?
The treatment should be discontinued if wishes or instructions become known after treatment commenced.
HCPs (now includes Paramedics) are legally obligated to follow Advance Directives.

What about the Greensleeve?
In acute and residential care, these green transparent folders are located at the front of the chart.
They quickly identify Goals of Care / DNACPR Physician Orders / Level of Intervention, Advance Care Planning documents and the Advance Care Planning Record documenting ACP conversations.

Where can I find copies of a patient's ACP?
If possible, ask the patient or family for a copy. If ACP documents have been previously provided, they may have been placed in a greensleeve in the chart. This should be transferred to the patient's new chart and validated with the patient as current. If the patient is followed in the community, a summary of ACP discussions and documentation may be found under the "Clinical Summary Grid - Instructions for Health Care."

Where can I find more information?

email: advancecareplanning@vch.ca

VCH intranet: http://vcha.ca/acp

My Voice Workbook

[2] Adults are presumed to be capable, but a valid informed consent is one in which the adult demonstrates that he or she understands the information given by the health care provider, and that the information applies to the situation of the adult for whom the health care is proposed. (HCCCFA)