Advance Care Planning: What Does it Mean to YOU?

Annual Clinical Day

December 8, 2018

HUMBER RIVER HOSPITAL

Patient Care Reinvented.

Special thanks to Dr. Nadia Incardona, Frank Wagner, and Bob Parke

Community/Family Practice

Capable Patient

- Identify or confirm SDM
- Discuss
  - values, beliefs
  - a person's concept of a good life or quality of life
  - perceptions of benefits, burdens
  - acceptable trade-offs

Goals of Care Discussion

Capable Patient or their SDM

- What is most important to the person (goals)?
- Are there previous conversations (eg ACP) that help you define the person's goals for care now?
- How do these goals fit with available treatment options?

Treatment Decisions

- Look for prior capable wishes that apply to the decision to be made (e.g. from ACP or POA document)
- Informed consent process
- Incorporates patient values into the decision making process

(Dr. Nadia Incardona, 2017)

Case

- Mrs. M is an 85 year old woman
- Entered the hospital through ED due to a fall
- Right hip fracture
- Refuses surgery
- During her admission on a medical floor she starts to experience delirium and increased reason for medical concern
- Goals of Care conversations commence with her daughter
- Her daughter say, “She would want everything”

Disclosure(s)

- Rosanna Macri
  - HRH Ethicist

  - U of T Affiliations
  - Committees including the Advance Care Planning Community of Practice in Canada

"We've discussed honesty as a policy, but, so far, it hasn't gained any momentum."

Objectives

- To explore the complex nature of Advance Care Planning
- To validate the importance and moral weight placed on end of life decisions and caregivers:
  - Understanding and unpacking values and wishes for future healthcare
  - Identifying the right SDM
- To help develop comfort and language in practice
- To help understand and bridge the gap between community and hospitals

Advance Care Planning in Canada

Talking About End-of-Life Care

Presented by Speak Up

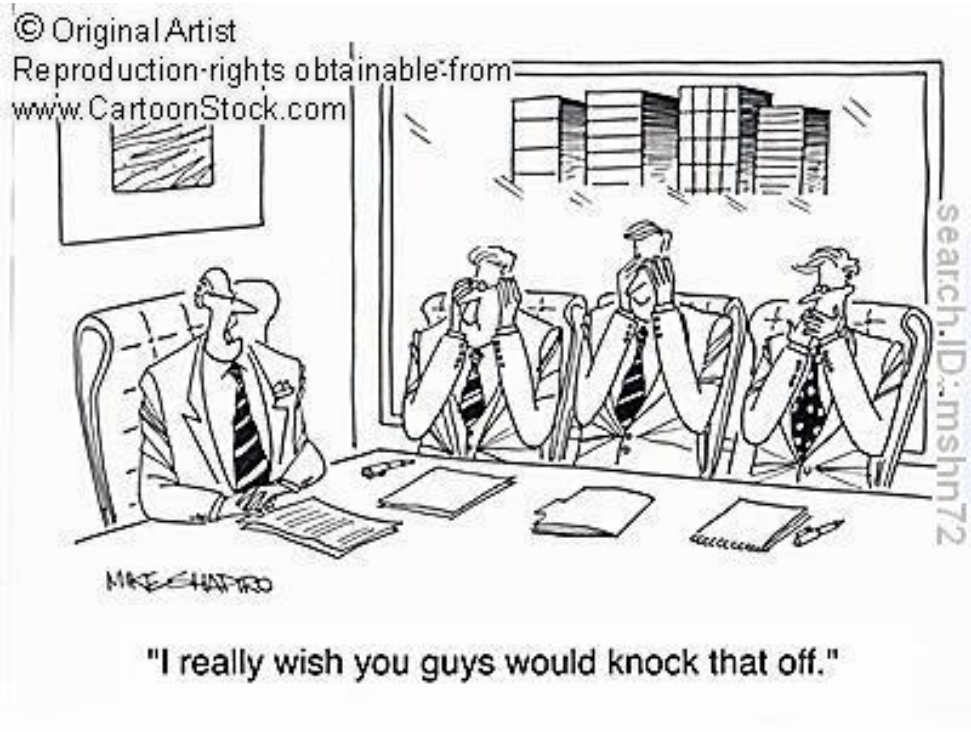
Start the conversation about end-of-life care

www.advancecareplanning.ca

What is Bioethics?

Bioethics involves critical reflection on moral/ethical issues arising in the areas of health care and research *toward:*

- deciding *what* we should do
  - What decisions are morally right or acceptable;
- explaining *why* we should do it
  - Justifying our decision in moral terms;
- describing *how* we should do it
  - The method or manner of our response

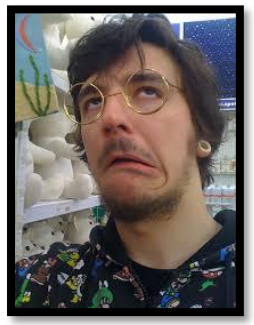


(Dr. Barb Secker)

So what does ethics have to do with ACP?

- Imagine

» Serious car accident



» Sudden hemorrhage

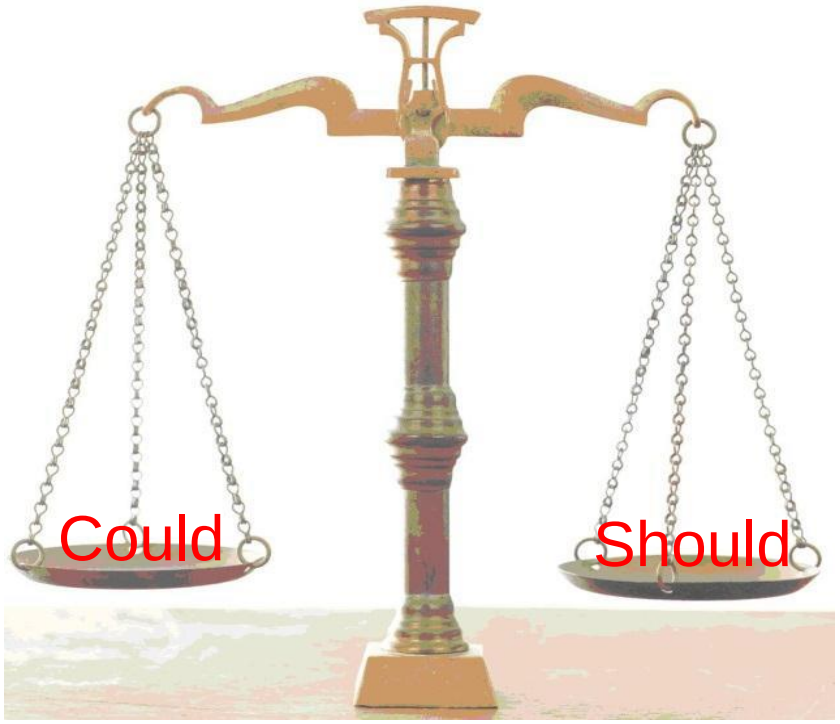
» Diagnosed with dementia

- How do you define living?
- How do you define quality of life?
- If you can imagine any of these happening to you, what do you think may be most important to you in those moments/situations?

Poll the Audience

- How many of you have completed a will?
- How many of you have completed an advance directive?

What is “the good” that you want to achieve?



- Provide quality end-of-life care
- Reduce suffering (as defined by the patient), respect their wishes, and lessen conflict and distress.
- Give people the space and opportunity to think about last wishes
- Help patients/families with the language to have these conversations

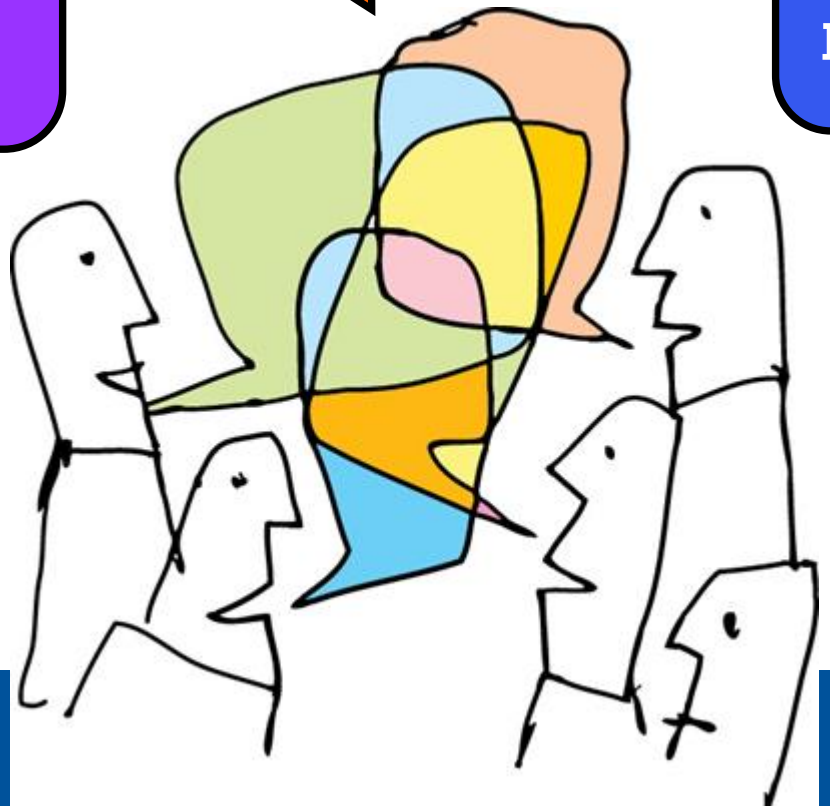
What is an Ethical Issue?

the Bioethicists say: any situation in which you…

Encounter conflicting values, beliefs, goals or difficult alternatives

Are unsure about what we should do or why we should do it

Are concerned that rights are being violated or persons not being respected



Have conflicting obligations or responsibilities

Are concerned with fairness or justice

Signs of an Ethical Issue:

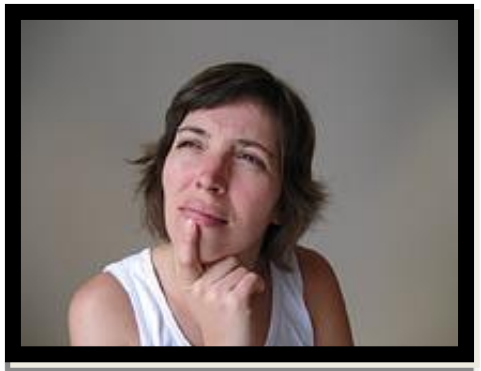
My gut tells me **something's wrong**

I **can't sleep** at night or I take my anxiety at work home with me

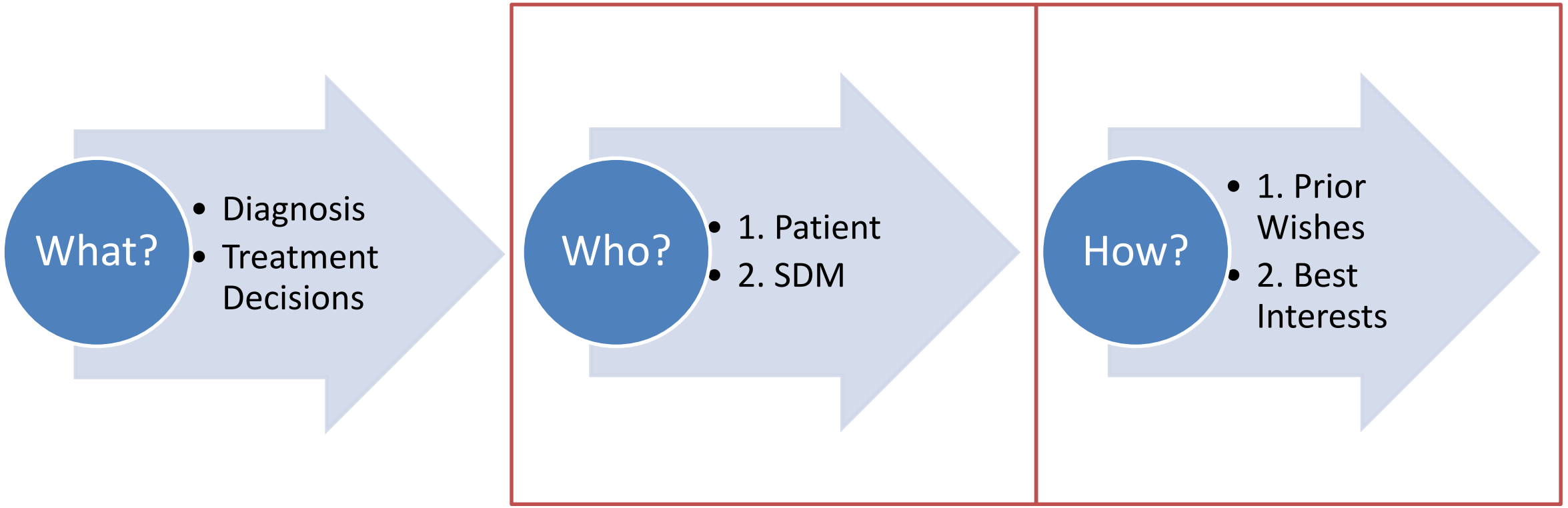
I start **questioning** my own or others' **basic beliefs** like religion, culture or 'up-bringing'

Conflict arises between co-workers

There are **no easy** or right **answers** to the problem



Ethical Decision Making 101



The Who: If Capable

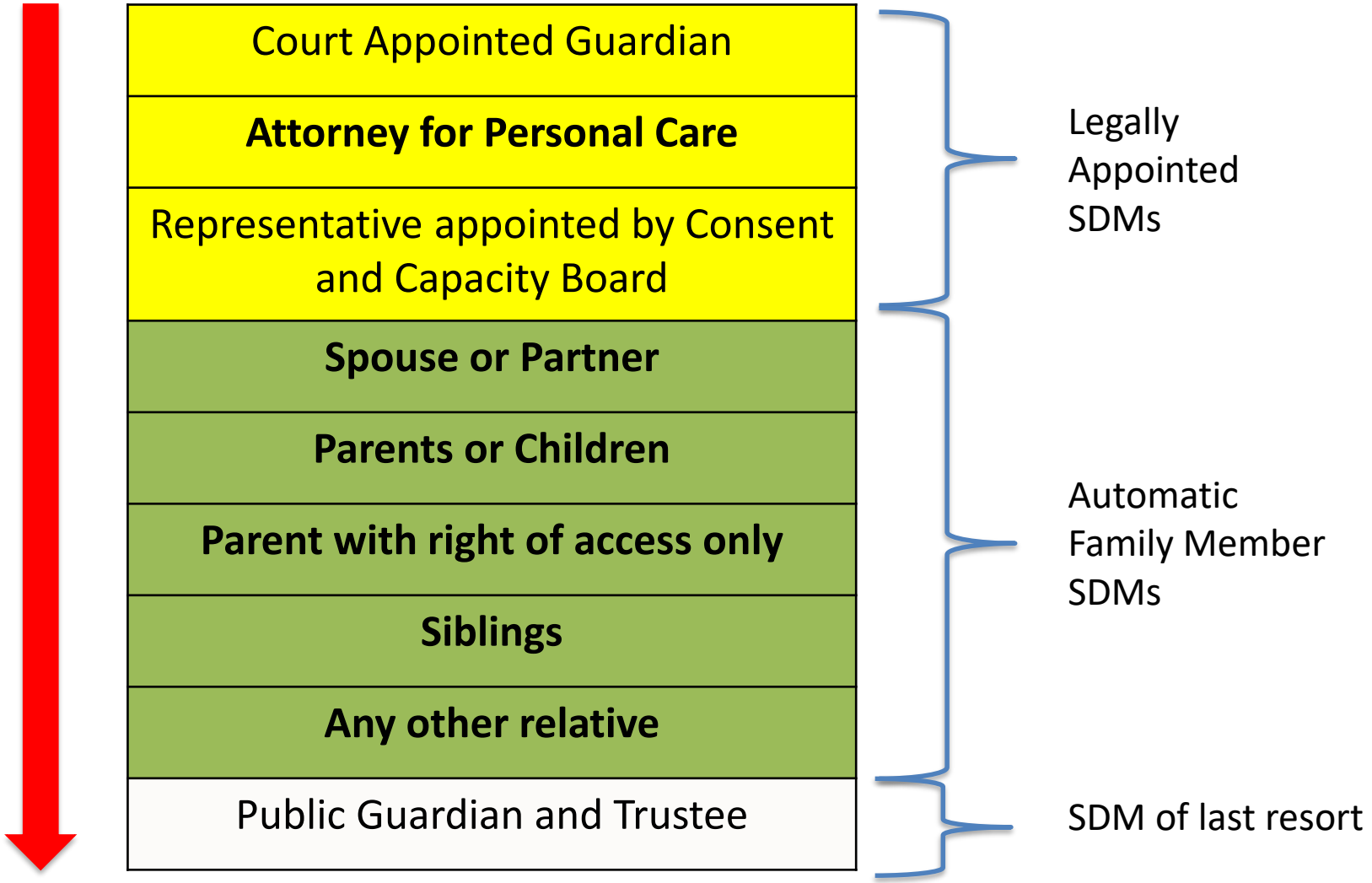
1. The patient/client
   - If capable … what does this mean legally

- Consent = Informed decision-making involves has 3 components:
  1. Disclosure – the provision of all relevant information and the comprehension of this information by the patient
  2. Capacity- the patient's ability to **understand** information and **appreciate** potential consequences of their decision
  3. Voluntariness- the patient's right to come to a decision freely (without force, coercion or manipulation)

The Who: If Incapable

2. The Substitute Decision Maker (SDM)
   - An SDM is a person at least 16 years of age who is available, capable and willing to make the incapable person's decision.
   - Well defined hierarchy in the Health Care Consent Act and Substitute Decisions Act
   - Legally assigned Attorney for Personal Care (POA) takes precedence
   - If no POA has been designated, the next of kin become decision makers (e.g. If there are 5 children ALL will share in decision making if they want)

Substitute Decision Maker Hierarchy



(Dr. Nadia Incardona, 2017)

Clarifying POA Documents

- Power of Attorney is a legal document that gives that gives someone else the right to make decisions on the patient's behalf
  - Property
  - Personal Care

- https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf

If SDM ranking is part of the HCCA why bother with a POA?

Answer:

- Because your patient wants the person who knows them best!

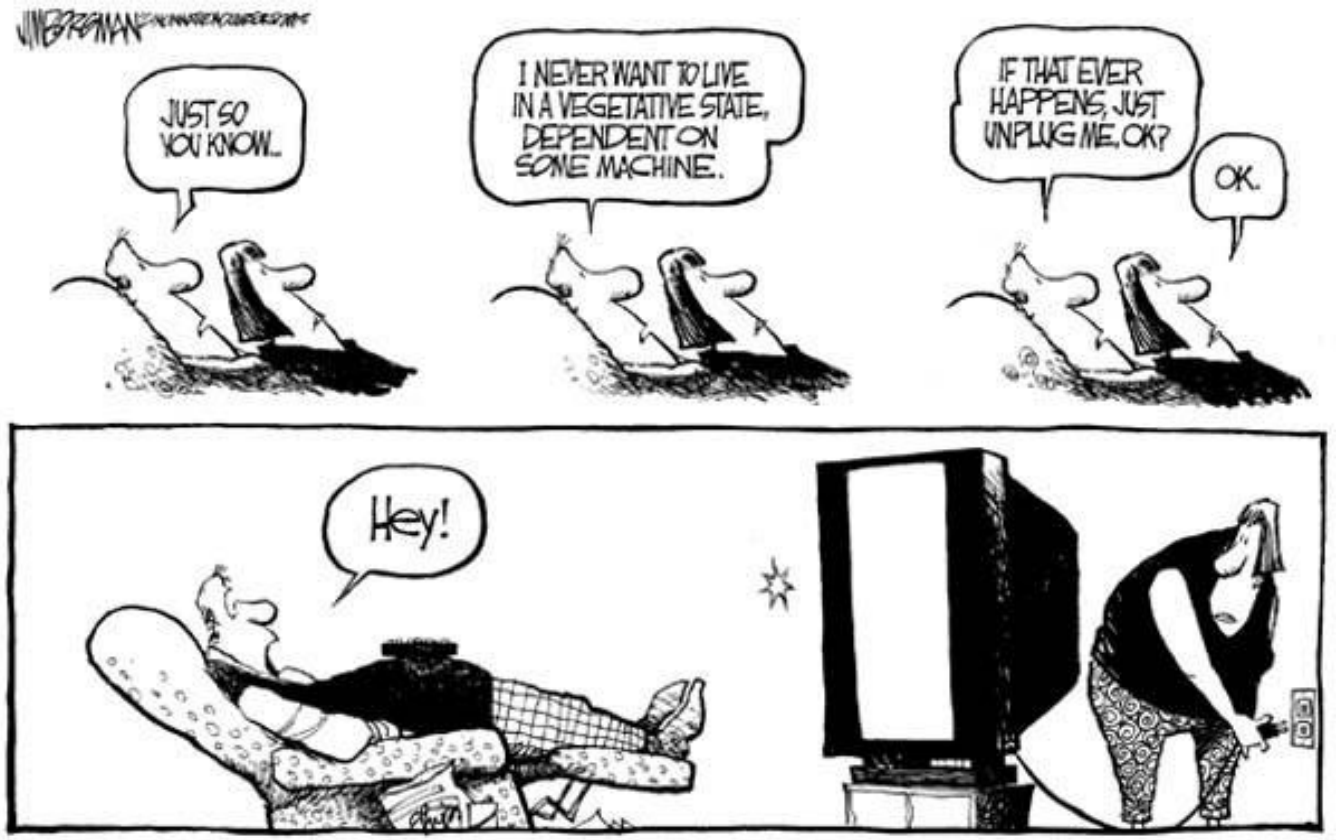
e.g. multiple children; best friend vs. husband; etc.

What if two or more persons of equal ranking disagree about whether to give or refuse consent?

How does your patient decide who will be their Attorney for care?

Answer:

- Values
- Religious Beliefs
- Age
- Trust
- Relationship



Poll the Audience

- How many of you have assigned Attorneys for Personal Care and Finances/Property?
- How many of you talk about advance directives with your patients?

Ethical Decision Making: the HOW

*The most ethical way is EARLY if possible

1. Prior expressed capable wishes applicable to the current decision
   - Advance care planning & Goals of care conversations
     - Advance directives/Living wills
     - Verbal communication/Conversations
     - Understanding patient/client values and beliefs

2. Best interests of the person

Goals of Care Discussion

Treatment Decisions

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How do we have these conversations?

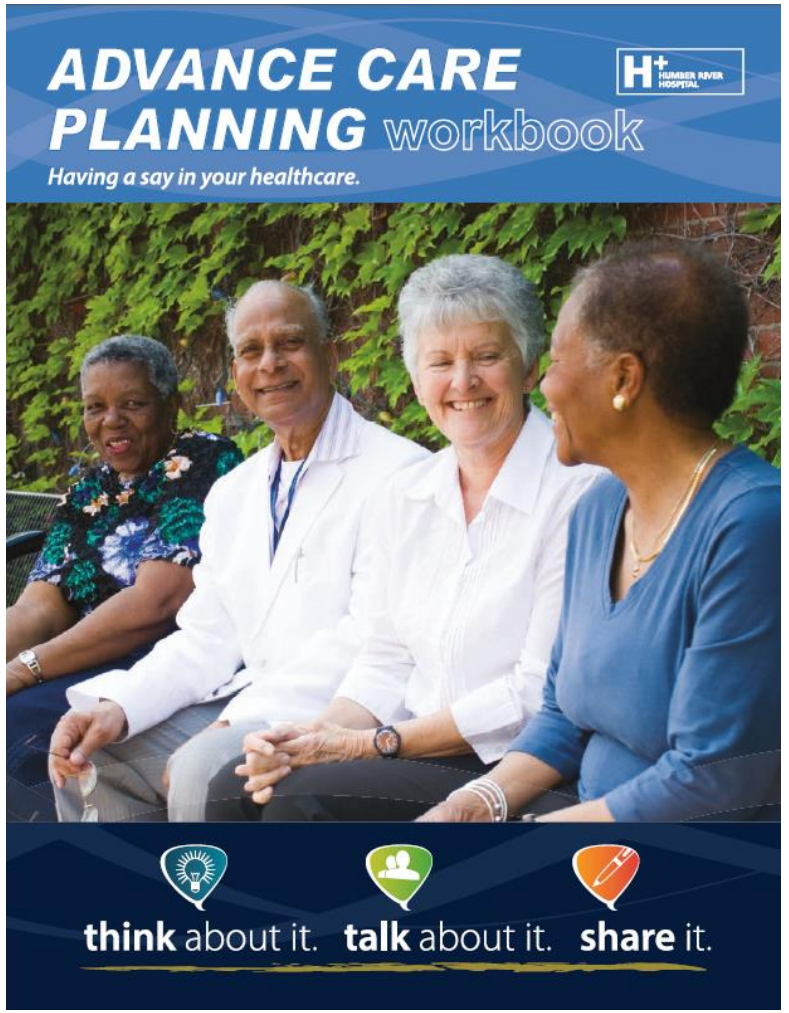
- Be mindful of manner and tone of conversation
- Start the conversations early and often
- Share information in a way that helps patient and/or SDMs understand
- Respond to all questions
- Content:
  - Importance and benefit of ACP
    - Exploring your values, wishes and beliefs
    - Choosing the right SDM
    - Preferences for the location of death (including manageable options)
    - Attitudes towards certain medical interventions (e.g., resuscitation, ventilation, organ donation, etc.)
  - Importance of documentation and dissemination
  - Importance of reviewing the ACP throughout the patient's life

Advance Care Planning: Values
The Really Difficult Questions

- What is most important to the person?
- How would the individual weigh benefits and burdens?
- What would suffering look like?
- Are we prolonging life or death?
- Is it time to shift from quality of life to quality of death?
- How would your loved one define life or quality of life?
- How we do things is sometimes more important than what we do

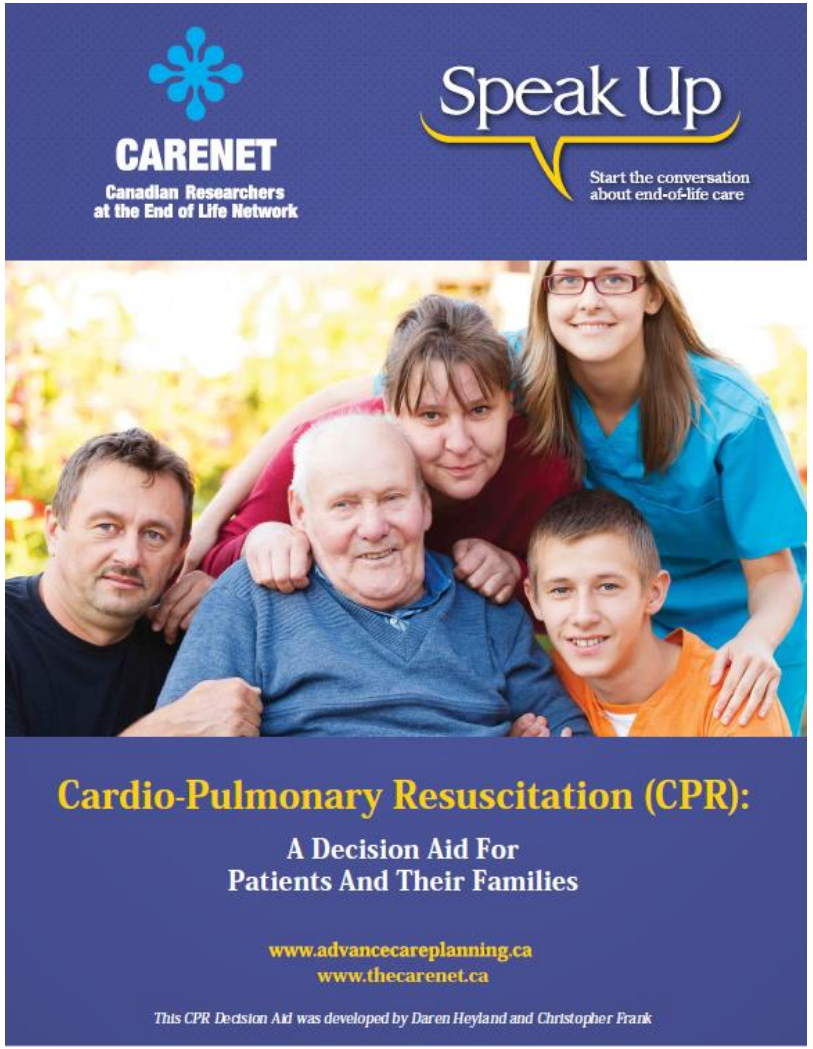
Importance of Advance Care Planning

- Patient/client suffers “traumatic transfer”
- Patient/client and family at odds with each other
- Patient/client and family lose trust with health care team
- Decrease quality of life



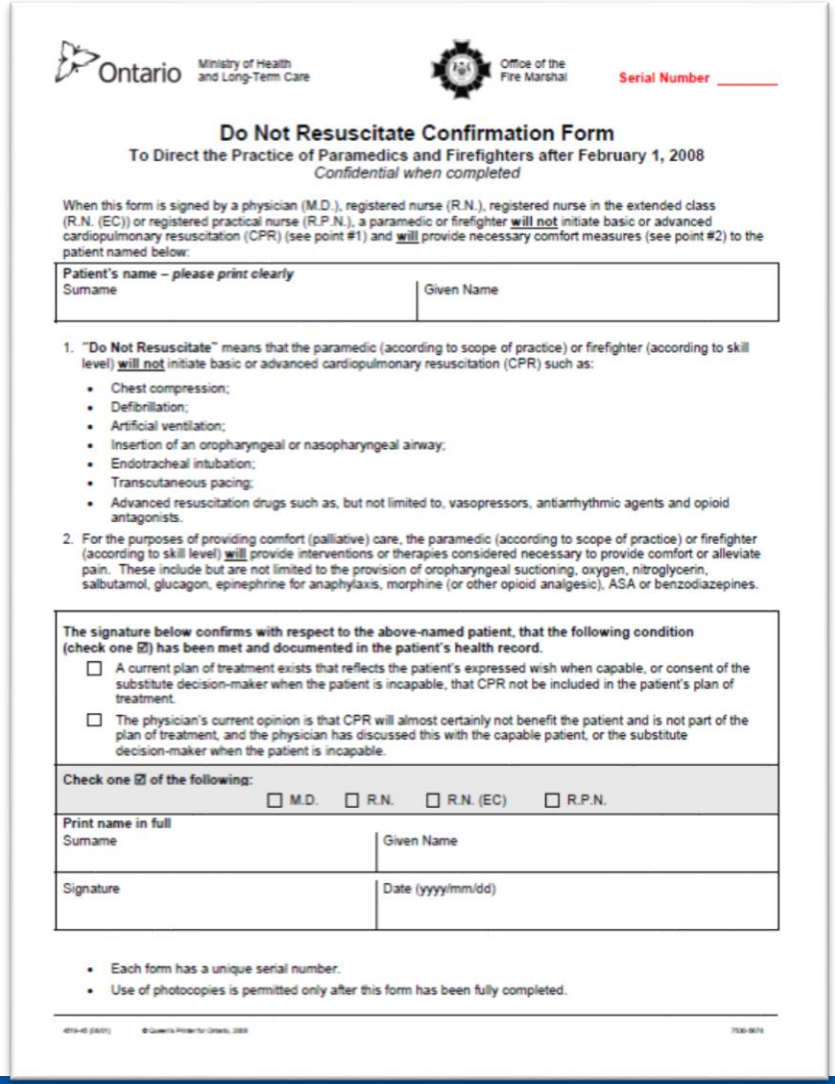
What are Goals of Care?

- Full Cardiopulmonary Resuscitation
  - Appropriate investigation/interventions including attempted resuscitation
- Specific Interventions
  - All appropriate investigations/interventions including admission to ICU for intubation/ventilation, vasopressors and BiPAP excluding attempt to resuscitate
- Medical Care
  - All appropriate investigations/interventions excluding attempt to resuscitate and ICU admission
- Comfort Care
  - All investigations/interventions which promote **maximal comfort and symptom control and maintenance of quality of life** excluding attempt to resuscitate ≠ NO CARE



Friendly Reminder

- To avoid traumatic transfers, if no resuscitation is decided upon, ensure a Ministry of Health and Long-Term Care “Do Not Resuscitate Confirmation Order” form is complete and patient/family knows to have it easily available



Ontario Ministry of Health and Long-Term Care

Office of the Fire Marshal

Serial Number _____

Do Not Resuscitate Confirmation Form

To Direct the Practice of Paramedics and Firefighters after February 1, 2008

Confidential when completed

When this form is signed by a physician (M.D.), registered nurse (R.N.), registered nurse in the extended class (R.N. (EC)) or registered practical nurse (R.P.N.), a paramedic or firefighter **will not** initiate basic or advanced cardiopulmonary resuscitation (CPR) (see point #1) and **will** provide necessary comfort measures (see point #2) to the patient named below:

Patient's name – *please print clearly*	
Surname	Given Name

1. "**Do Not Resuscitate**" means that the paramedic (according to scope of practice) or firefighter (according to skill level) **will not** initiate basic or advanced cardiopulmonary resuscitation (CPR) such as:
   - Chest compression;
   - Defibrillation;
   - Artificial ventilation;
   - Insertion of an oropharyngeal or nasopharyngeal airway;
   - Endotracheal intubation;
   - Transcutaneous pacing;
   - Advanced resuscitation drugs such as, but not limited to, vasopressors, antiarrhythmic agents and opioid antagonists.
2. For the purposes of providing comfort (palliative) care, the paramedic (according to scope of practice) or firefighter (according to skill level) **will** provide interventions or therapies considered necessary to provide comfort or alleviate pain. These include but are not limited to the provision of oropharyngeal suctioning, oxygen, nitroglycerin, salbutamol, glucagon, epinephrine for anaphylaxis, morphine (or other opioid analgesic), ASA or benzodiazepines.

The signature below confirms with respect to the above-named patient, that the following condition (check one ☑) has been met and documented in the patient's health record.

☐ A current plan of treatment exists that reflects the patient's expressed wish when capable, or consent of the substitute decision-maker when the patient is incapable, that CPR not be included in the patient's plan of treatment.

☐ The physician's current opinion is that CPR will almost certainly not benefit the patient and is not part of the plan of treatment, and the physician has discussed this with the capable patient, or the substitute decision-maker when the patient is incapable.

Check one ☑ of the following: ☐ M.D. ☐ R.N. ☐ R.N. (EC) ☐ R.P.N.

Print name in full	
Surname	Given Name
Signature	Date (yyyy/mm/dd)

- Each form has a unique serial number.
- Use of photocopies is permitted only after this form has been fully completed.

Considering someone's best interests

- Consistent with the persons' values and beliefs
- Most beneficial and least harmful solution
- Considers both quality and quantity of life
- Is there a less invasive option?

HRH Seniors Care Resources

Acute Care Inpatient Services

- Specialized Geriatric Units
- Geriatric Consultation Services
- Clinical Practice Leader for Geriatrics
- Geriatric Psychiatrist
- LOFT Behaviour Support Transition Resources (BSTR)
- Reactivation Care Centres (RCC)

Ambulatory Care Services

- Geriatric Emergency Management (GEM) Nurse
- Nurse Lead Outreach Team (NLOT)
- Geriatric Outreach Team (GOT)
- Healthy Living (Seniors) Clinic
- Falls Prevention Clinic
- Geriatric Mental Health Outreach Team

Community Service

- Health Links
- Central LHIN Home and Community
- Ontario Telehealth Network (OTN)

Ontario Resources

- Speak Up Campaign (Canada/Ontario)

http://www.advancecareplanning.ca/about-advance-care-planning/

https://www.makingmywishesknown.ca/

- Ministry of the Attorney General – POA documents

https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf

- Ministry of Health and Long-Term Care – Do Not Resuscitate Confirmation Order

http://www.health.gov.on.ca/en/pro/programs/emergency_health/docs/ehs_training_blltn108_en.pdf

- Community Legal Education Ontario

www.cleo.on.ca

- Advocacy Centre for the Elderly (ACE)

http://www.acelaw.ca/

Take Home Messages

- When possible plan early. Discuss these issues with your loved ones and your patients when everyone can participate
- Make sure everyone knows who the legal SDM is
- Don't wait for the crisis to occur to consider these important aspects of care for the first time
- Everyone involved (patients, loved ones, caregivers, healthcare providers) will experience a better outcome when these issues are discussed in a non-crisis situation, using an ethical decision-making lens

Questions/Comments