Advance Care Planning Conversation Guide

Patient Name: _____ **Today's Date:** ____ ____ _____ (MM/DD/YYY)

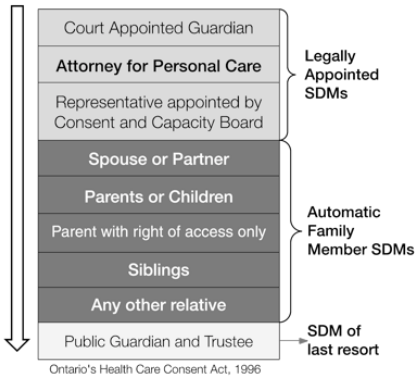
PART 1. CLARIFYING THE SUBSTITUTE DECISION-MAKER (SDM)

A Substitute Decision Maker is the person or people who will make healthcare decisions on behalf of a person if he/she lacks the capacity to make them for themselves. In Ontario, a person's SDM is automatically determined by following the below list:

Confirm automatic SDM(s)

Or

Choose SDM(s) and **Complete** a *Power of Attorney for Personal Care* document



Most people will rely on their automatic SDM.
If there are ***multiple people at the same level***, they ***ALL have the authority*** to make decisions. If there are multiples, be sure to record this information. If someone other than the automatic SDM is preferred, the person should legally appoint an Attorney for Personal Care.

ARE SDMs RIGHT FOR THE ROLE?

Ask if the future SDM(s) are:

- Willing to make future healthcare decisions for the patient
- Willing to talk with patient to understand his/her wishes, values & beliefs
- Willing to understand care needs and patient's condition when consent needs to be provided
- Willing to honour and follow patient's wishes to the extent possible when they apply
- Able to ask questions and advocate for patient
- Able to make hard decisions

Highest equal ranking SDM(s)

Name	Contact Number

Next highest ranking SDM(s)

Name	Contact Number

Is this the initial ACP conversation? ☐ Yes ☐ No
Have any previous wishes been communicated to the SDM? ☐ Yes ☐ No ☐ Unsure

PART 2. DETERMINE CAPACITY TO PARTICIPATE IN ACP CONVERSATION

A person understands and appreciates that:

- These responses provide guidance for the SDM(s). The SDM may need to provide consent for future (not current) health care decisions if the person is not capable of decision-making for him or herself.
- Their SDM(s) will be required to interpret all wishes they express to determine (1) which are the most recent (2) if the person was capable when they expressed the wishes (3) if they apply to the decision that needs to be made. Finally, the SDM(s) must interpret what the wishes mean in the context of the person's heath status and healthcare decision that needs to be made
- As long as the person remains capable, he or she will be asked to make his or her own decisions
- These responses can be updated or changed at any time as long as the person has capacity for advance care planning at the time of updating or changing
- Healthcare wishes expressed by the capable person at a future date will take precedent over relevant wishes that are documented here, regardless of how wishes are expressed i.e. verbal, written, in a video etc.

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***NOTE**: The structure and organization of the six domains of ACP Conversation Guide questions were influenced by several sources and resources. Among these include the FIFE communication model and the Serious Illness Conversation Guide by Ariadne Labs.*

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Patient Name: _____ Today's Date: ____ ____ _____
MM DD YYYY

PART 3: This document serves to record wishes, values and beliefs for *future* healthcare. It is **NOT** consent for treatment. It will be viewed as a representation of a person's capable thoughts and reflections therefore please use their own words.

Understanding

What do you understand about your current health or if you have any illnesses what have you been told by your healthcare providers? What do you expect to happen over time?
(E.g. Do you expect to get better, be cured, or is your illness expected to get worse over time? Do you think you may develop difficulty with memory, swallowing, walking or other things that are important to you?)

Information

If you have illnesses and are unsure about what might happen over time, what information about the illness and treatments would be helpful to you? Is there information that you don't want to know?

Values, Beliefs & Quality of life

What brings quality to your life? What is important to you and gives your life meaning?
(E.g. being able to live independently, being able to recognize important people in your life, being able to communicate, being able to enjoy food, spending time with friends & family etc.)

For clinicians: *How might this influence the person's healthcare decision making? How would an SDM use this information to make healthcare decisions in the future?*

The remainder of the questions require the person to consider future hypothetical situations. They are meant for the person to consider what might be important in the event of a sudden critical illness (e.g. accident) or as they are nearing the end of their life from a serious illness. This is a chance for the person to tell SDMs what is important and how the person would like SDMs to make decisions.

Worries & Fears

Think about the care you might need if you have a critical illness or if you are near the end of your life. What might you worry about or what fears come to mind?
(E.g. struggling to breathe, being in pain, being alone, losing your dignity, depending entirely on others, being a burden to your family/friends, being given up on too soon etc.)

Trade - offs

If you became critically ill, life support or life extending treatments might be offered. Describe for your SDM the state you consider unacceptable to keep living in.

For clinicians:

- *What would the person be willing to tolerate? To possibly gain more time? (E.g. would you trade the ability to communicate, the ability to interact with others, the ability to control of your bodily functions)*
- *Does this change for the person if the condition is permanent or if there is little or no chance of recovery?*

Near the end

If you were near the end of your life, what would be important you? (E.g. family and friends nearby, dying at home, having spiritual rituals performed, listening to music etc.)

For clinicians: *What might make the end more meaningful or peaceful for the person?*

Note to Healthcare Providers:
If this patient lacks capacity to make healthcare decisions in the future, this conversation may be used to guide SDM(s) in providing informed consent. It may outline information about prior capable wishes and best interests of the patient. Therefore, **this form must not include healthcare provider interpretations.**

The patient to whom this applies has reviewed this document and is in agreement with its contents. I have provided copies to the patient and their SDM(s). ☐ **I agree with this statement**

Health Care Provider Name: _____Health Care Provider Signature: _____

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