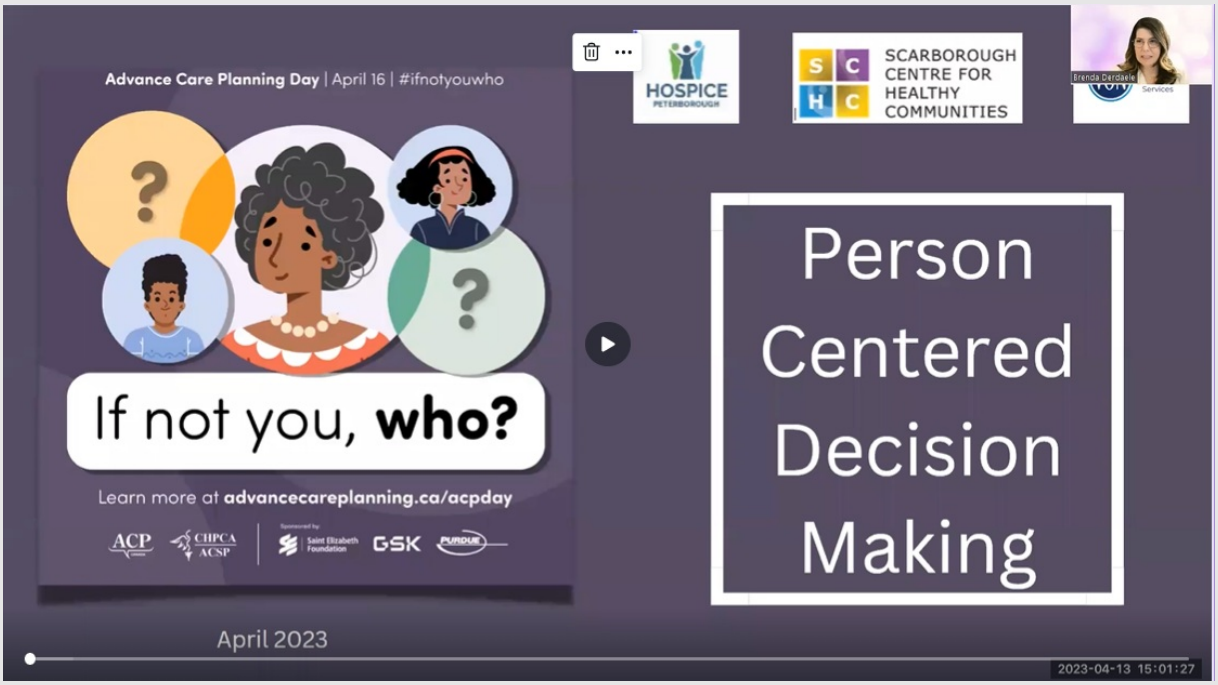
Click Here to view recording



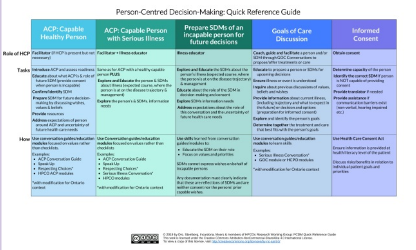
Click HERE for the online evaluation in order to receive your certificate of attendance.

Click HERE to download the slide deck used in this presentation.

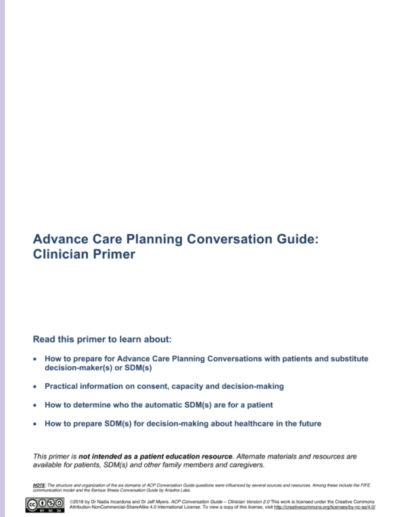
The information provided in this newsletter is for educational purposes only.

Resources

(click on pictures for PDF version)



Patient Centered Decision Making (PDF attached - 2 pages)

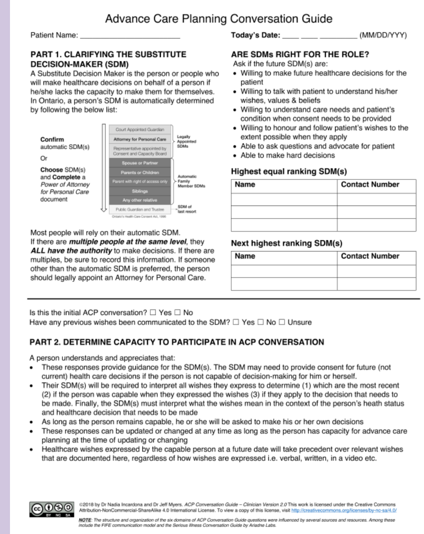

Advance Care Planning Conversation Guide: Clinician Primer

Read this primer to learn about:

- How to prepare for Advance Care Planning Conversations with patients and substitute decision-maker(s) or SDM(s)
- Practical information on consent, capacity and decision-making
- How to determine who the automatic SDM(s) are for a patient
- How to prepare SDM(s) for decision-making about healthcare in the future

This primer is **not intended as a patient education resource**. Alternate materials and resources are available for patients, SDM(s) and other family members and caregivers.

ACP Conversation Guide: Clinician Primer


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:

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

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.

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:

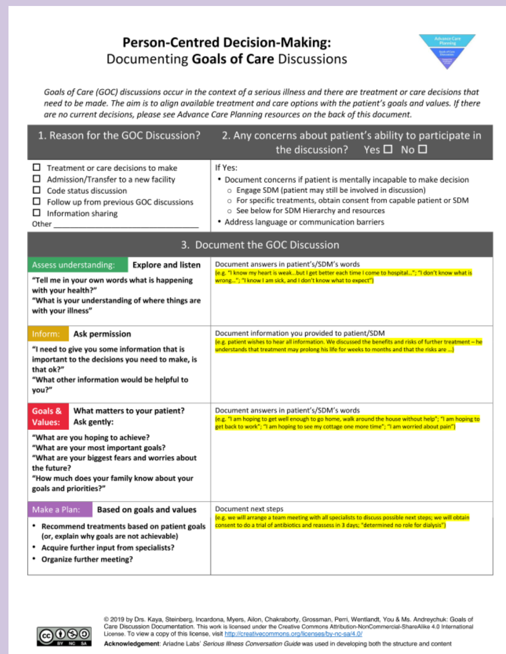
- These responses provide guidance for the SDM(s). The SDM may need to provide consent for future (not current) health care decisions if the person is not capable of decision-making for him or herself.
- Their SDM(s) will be required to interpret all wishes they express to determine (1) which are the 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 health 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.

ACP Conversation Guide

Advanced Care Planning Ontario
https://www.advancecareplanningontario.ca/ Hospice

Hospice Palliative Care Ontario - Online Learning

HPCO Resources
https://www.pcdm.ca/quick-links/resources

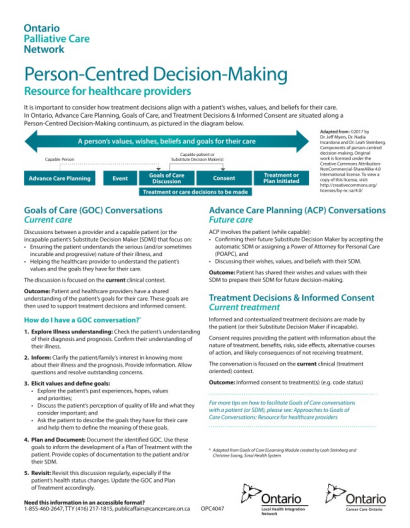

Person-Centred Decision-Making:
Documenting **Goals of Care** Discussions

Goals of Care (GOC) discussions occur in the context of a serious illness and there are treatment or care decisions that need to be made. The aim is to align available treatment and care options with the patient's goals and values. If there are no current decisions, please see Advance Care Planning resources on the back of this document.

1. Reason for the GOC Discussion?	2. Any concerns about patient's ability to participate in the discussion? Yes ☐ No ☐
☐ Treatment or care decisions to make ☐ Admission/Transfer to a new facility ☐ Code status discussion ☐ Follow up from previous GOC discussions ☐ Information sharing Other ______	If Yes: • Document concerns if patient is mentally incapable to make decision ○ Engage SDM (patient may still be involved in discussion) ○ For specific treatments, obtain consent from capable patient or SDM ○ See below for SDM Hierarchy and resources • Address language or communication barriers

3. Document the GOC Discussion	
Assess understanding: Explore and listen "Tell me in your own words what is happening with your health?" "What is your understanding of where things are with your illness?"	Document answers in patient's/SDM's words
Inform: Ask permission "I need to give you some information that is important to the decisions you need to make, is that ok?" "What other information would be helpful to you?"	Document information you provided to patient/SDM
Goals & Values: What matters to your patient? Ask gently: "What are you hoping to achieve? "What are your most important goals? "What are your biggest fears and worries about the future? "How much does your family know about your goals and priorities?"	Document answers in patient's/SDM's words
Make a Plan: Based on goals and values • Recommend treatments based on patient goals (or, explain why goals are not achievable) • Acquire further input from specialists? • Organize further meeting?	Document next steps

Documenting Goals of Care Discussions



Ontario Palliative Care Network

Person-Centred Decision-Making

Resource for healthcare providers

It is important to consider how treatment decisions align with a patient's wishes, values, and beliefs for their care. In Ontario, Advance Care Planning, Goals of Care, and Treatment Decisions & Informed Consent are situated along a Person-Centred Decision-Making continuum, as pictured in the diagram below.

A person's values, wishes, beliefs and goals for their care

Capable Person — Capable patient or Substitute Decision Maker(s) — or

Advance Care Planning | Event | Goals of Care Discussion | Consent | Treatment or Plan Initiated

Treatment or care decisions to be made

Adapted from: © 2017 by Dr. Jeff Myers, Dr. Nadia Incardona and Dr. Leah Steinberg. Adapted with permission for shared decision-making. Original work is licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License. To view a copy of this license, visit http://creativecommons.org/licenses/by-nc-sa/4.0/

Goals of Care (GOC) Conversations
Current care

Discussions between a provider and a capable patient (or the incapable patient's Substitute Decision Maker (SDM)) that focus on:
- Ensuring the patient understands the serious (and/or sometimes incurable and progressive) nature of their illness, and
- Helping the healthcare provider to understand the patient's values and the goals they have for their care.

The discussion is focused on the **current** clinical context.

Outcome: Patient and healthcare providers have a shared understanding of the patient's goals for their care. These goals are then used to support treatment decisions and informed consent.

How do I have a GOC conversation?

1. **Explore illness understanding:** Check the patient's understanding of their diagnosis and prognosis. Confirm their understanding of their illness.
2. **Inform:** Clarify the patient/family's interest in knowing more about their illness and the prognosis. Provide information. Allow questions and resolve outstanding concerns.
3. **Elicit values and define goals:**
   - Explore the patient's past experiences, hopes, values and priorities;
   - Discuss the patient's perception of quality of life and what they consider important; and
   - Ask the patient to describe the goals they have for their care and help them to define the meaning of these goals.
4. **Plan and Document:** Document the identified GOC. Use these goals to inform the development of a Plan of Treatment with the patient. Provide copies of documentation to the patient and/or their SDM.
5. **Revisit:** Revisit this discussion regularly, especially if the patient's health status changes. Update the GOC and Plan of Treatment accordingly.

Need this information in an accessible format?
1-855-460-2647, TTY (416) 217-1815, publicaffairs@cancercare.on.ca

Advance Care Planning (ACP) Conversations
Future care

ACP involves the patient (while capable):
- Confirming their future Substitute Decision Maker by accepting the automatic SDM or assigning a Power of Attorney for Personal Care (POAPC), and
- Discussing their wishes, values, and beliefs with their SDM.

Outcome: Patient has shared their wishes and values with their SDM to prepare their SDM for future decision-making.

Treatment Decisions & Informed Consent
Current treatment

Informed and contextualized treatment decisions are made by the patient (or their Substitute Decision Maker if incapable).

Consent requires providing the patient with information about the nature of treatment, benefits, risks, side effects, alternative courses of action, and likely consequences of not receiving treatment.

The conversation is focused on the **current** clinical (treatment oriented) context.

Outcome: Informed consent to treatment(s) (e.g. code status)

For more tips on how to facilitate Goals of Care conversations with a patient (or SDM), please see: Approaches to Goals of Care Conversations: Resource for healthcare providers

* Adapted from Goals of Care (Learning Module created by Leah Steinberg and Christine Soong, Sinai Health System

Ontario Local Health Integration Network | Ontario Cancer Care Ontario

OPC4047

Palliative Pain and Symptom Management Consultants

For consultation support or education requests:

Brenda Derdaele, RN, CHPCN (C)
Palliative Pain & Symptom Management Consultant
Durham Region

brenda.derdaele@von.ca

Erin Newman-Waller, RN, BScN, CHPCN(C)
Palliative Pain & Symptom Management Consultant
Peterborough Hospice

enewmanwaller@hospicepeterborough.org

Gwen Cleveland, RN, BScN, MEd, CHPCN(C)
Palliative Pain & Symptom Management Consultant Scarborough

gcleveland@schcontario.ca

May Educational Opportunities:

Topic: Exploring What's New & Different in Palliative Care

Lunch and Learn
- Wednesday May 10/2023
- 12-1pm

Lunch & Learn Registration

Coffee and Palliative Care
- Thursday, May 11/2023
- 3-4pm

Coffee & Palliative Care Registration

Durham Region PPSMC Educational Hub

PDF Version of Newsletter

Central East Palliative Care Educational Opportunities

- Fundamentals in Hospice Palliative Care
- Enhanced Fundamentals in Hospice Palliative Care
- Advanced Palliative Practice Skills (APPS)
- Comprehensive Advanced Palliative Care Education

Click Photo's for PDF Version

Durham Hospice Services

SCARBOROUGH CENTRE FOR HEALTHY COMMUNITIES

HOSPICE PETERBOROUGH

For information about Palliative Education offered by SCHC, go to

https://schcontario.ca/programs/health-services/palliative-education/

FUNDAMENTALS 2023

Fundamentals Core education is a certificate program for ALL health care providers and volunteers who wish to enhance knowledge and develop capacity related to hospice palliative care.

Fundamentals ENHANCED education is intended for Nurse Practitioners (NPs), Registered Nurses (RNs), and Registered Practical Nurses (RPNs) with an interest in developing his/her/their capacity related to hospice palliative care in a clinical setting. NPs, RNs and RPNs must take the core Fundamentals program prior to taking the Enhanced Fundamentals program. Both the Fundamentals CORE and ENHANCED session are a prerequisite for the CAPCE program.

Fundamentals eligibility:
- Health care provider or volunteer caring for people with a progressive, life-limiting illness
- Access to an internet-enabled computer
- Knowledge of basic computer programs

Included in the core curriculum:
- An 11 chapter program guide
- 8 e-learning modules
- 2 peer-to-peer exchanges (learning debriefs)
- 1 reflective activity
- 3 group learning sessions*
- 1 (one) additional online group learning session for the ENHANCED program that is mandatory for all RPNs, RNs, NPs wishing to go one to take CAPCE in the future.

Cost:$50

**learning may be conducted in-person, virtual or a blended delivery depending COVID guidelines and/or restrictions*

Winter session
January 12, February 2, February 16, **Enhanced** March 2 from 6-9pm

Spring sessions
Session 1: April 20, May 11, May 25, **Enhanced** June 8 from 6-9pm
Session 2: April 25, May 16, May 30, **Enhanced** June 13 from 9am-12pm

Fall sessions
Session 1: September 14, October 5, October 19, **Enhanced** November 2 from 6-9pm
Session 2: September 19, October 10, October 24, **Enhanced** November 7 from 9-12pm

Registration now open for all sessions at
http://www.hospicepeterborough.org/registration/

For more information please contact
Erin Newman-Waller at 705-868-8126 or
email: enewmanwaller@hospicepeterborough.org

CAPCE dates to come.....

Durham Hospice Services

Please help VON Durham Hospice Services support our Palliative Community.

We offer:
- Hospice Volunteer supports
- Patient & Caregiver support groups
- Care Navigation
- Supportive Care Counselling
- Grief & Bereavement support
- Community Education

Visit our Website | vondurham.org

VON Durham Referral Form

Hospice Peterborough offers:

- Hospice Volunteer supports
- Patient & Caregiver support groups
- Nurse Navigation
- Supportive Care Counselling
- Grief & Bereavement support
- Community Education
- Hospice Residence

HOSPICE PETERBOROUGH

hospicepeterborough.org

Referral Form

SCARBOROUGH CENTRE FOR HEALTHY COMMUNITIES

SCHC provides comprehensive, focused health programs and services to improve the holistic overall health and well-being for our community.

Through the operation of 42 distinct and integrated services across 10 sites that work together to improve the health of the Scarborough community, SCHC provides medical assistance through clinics, has a growing youth program, and offers many social support programs, including a food bank.

Go to https://https://schcontario.ca// to learn more about SCHC.

Thanks to Oak Ridges Hospice for their ongoing support and exemplary end-of-life care. If you are interested in a tour or making a referral, please visit their website for more information.

Visit their Website / Oak Ridges Hospice

OAK RIDGES HOSPICE OF DURHAM LTD.

HONOURING THE JOURNEY

ED'S HOUSE NORTHUMBERLAND HOSPICE CARE CENTRE

Thank you to Ed's House for their continued support of our Palliative Education Program.

For more information and how they can help support you or your loved one in the community or through the End of Life journey, please visit their website.

Visit their Website / Ed's House