Durham Hospice Services

April 2022 Educational Newsletter

Written By Brenda Derdaele RN, CHPCN(c)

"How people die lives in the memories of those who live on"
- DAME CICELY SAUNDERS

Upcoming Events

VON Advanced Care Planning Week

(click each link below to register. All education sessions held via Zoom)

Apr. 11/2022 - 12-1pm - What is ACP?

Apr. 12/2022 - 12-1pm - Financial and Legal Perspectives

Apr. 13/2022 - 12-1pm - Person Centred Decision Making

Apr. 13/2022 - 3-4pm - Person Centred Decision Making

Apr. 14/2022 - 12-1pm - Health Care Consent and Capacity

What is Person-Centred Care?

There is no one definition of person-centred care. Research has looked into what matters to patients and how to provide person-centred care to make sure people have a good experience. There are many different aspects of person-centred care, including:

-respecting people's values and putting people at the centre of care

- taking into account people's preferences and expressed needs

-coordinating and integrating care

-working together to make sure there is good communication, information and education

-making sure people are physically comfortable and safe

-emotional support

-involving family and/or whomever the person deems to be family

-making sure there is continuity between and within services

-making sure people have access to appropriate care when they need it

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Speak Up Ontario
Link to Resource

Clinician Guide to Advanced Care Planning Discussions
Link to Resource

Advanced Care Planning

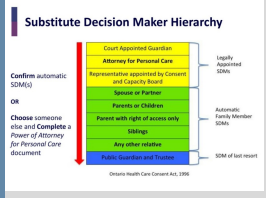
ACP in Ontario is:

Confirming your Substitute Decision Maker (s) (SDM)

and

Communicating your wishes, values and beliefs about care to help your SDM(s) make health and personal care decisions for you if you became mentally incapable of doing so for yourself

Advance Care Planning (ACP) - Outcome is to identify wishes, the SDM and prepare the SDM for future



decision-making. ACP is the process of talking about wishes, values and beliefs that would guide the future SDM when they would be called upon to make treatment decisions on a person's behalf.

Goals of Care Discussion (GoC) - Outcome is different every time – exploring patient's goals assesses readiness and prepares for decision-making. Goals of Care Conversations are generally a communication framework that assists in understanding and assessing the person's goals for care.(i.e. personal and clinical goals).

Health Care Consent (HCC) - Outcome is always care or treatment decision(s).Healthcare providers are required to get informed consent from a capable person prior to any care or treatment. HCC conversations are focused on a decision regarding a proposed treatment(s)or care plan based on a person's current condition

HealthCare Consent Advance Care Planning Community(HCC ACP CoP) of Practice (HCC ACP CoP)

Health Care Consent:

Ontario law requires healthcare providers to explain your illness and any treatments (pro's and con's) etc. The HCP must obtain informed consent or refusal of consent before providing treatment or care. Person has the right to agree or refuse any treatments or care offered.

It is a basic patient right to decide what health care to receive.

Only in emergencies, to save a life or to reduce suffering, can people be treated without informed consent.

Consent always comes from a person: either the mentally capable person or their substitute decision maker(s).

Resources on Health Care Consent - click here

Person-Centred Decision Making

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

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.

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.

- Include any cultural beliefs, rituals and values

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

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

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

But, my patients don't want to talk about this?

They actually do. Your patients look to you as the expert and want to get information about Advance Care Planning from you. As health care professionals your role is to simply plant the seed, clear up any misconceptions and get your patients on the right track.

You cannot predict when accidents or illness may occur that could affect your patients' ability to make their own health care decisions. And crisis is definitely not the place for these conversations. So, it's important to start these conversations early so that your patients know who their SDM(s) is, and are confident that their SDM(s) have the information they need to make healthcare decisions on their behalf.

https://www.speakupontario.ca/resource-guide/

Don't Delay Advance Care Planning Discussions

Consider this scenario experienced by many Canadians today. As a Health Care Provider, what would you advise this individual to do next?

> Mrs. Smith is 80 years old, recently widowed, and in generally good health. She tells you she had previously discussed her end-of-life preferences with her husband, but has not shared these wishes with anyone else, including her only son who lives in United States. Mrs. Smith has a close relationship with a friend who lives nearby. She would like this friend to be involved in decision-making when she no longer has capacity to consent to treatment.

Conversations about end-of-life care can be difficult. Only half of Canadians discuss their end-of-life wishes with family or friends, and even fewer communicate their end-of-life care preferences to their healthcare providers. However, a discussion between the patient and anyone in her health care team about care that is likely to be needed in the future may encourage a patient to verbalize and develop an advance care plan before it's too late. Remember to be compassionate and empathic when having these conversations.

Treatment decisions for end-of-life care can be very difficult and emotional, particularly when the patient is incapable of consenting and the patient's wishes are unknown or unclear. This can increase the likelihood of disagreements and conflict between family members and within healthcare teams. Advance care planning (ACP) can reduce these challenges and risks, and help to improve the overall end-of-life experience for patients and their families.

ACP and Person Centred Decision Making is a process that includes the patient choosing a substitute decision-maker (SDM) and communicating his or her wishes, values, and beliefs to others. The goal of such planning is to ensure others understand the individual's preferences for healthcare in the event he or she is unable to provide consent when needed. ACP and PCDM helps ensure the patient's wishes are respected and reduces the likelihood of conflicts between family members or with the healthcare team. It also allows healthcare providers to deliver care that more closely meets the patient's needs and wants.

ACP and PCDM is not a replacement for consent. While it can help guide decision-making, consent is still required for specific treatments. That consent may come from the patient if he or she is capable, or from an incapable patient's SDM. Remember the SDM is "the Person" and the POA PC is "a document".

Identifying substitute decision-makers

When a patient loses the capacity to consent, physicians need to turn to the appropriate person to obtain consent for end-of-life treatment. An

SDM is an individual who has the legal authority to make decisions on behalf of the patient. In Ontario we have an automatic hierarchy of SDM's, therefore everyone has an automatic SDM. A person also has the ability to name a SDM (s) of there choice through a Power of Attorney for Personal Care document.

Generally speaking, SDMs must comply with any wishes of the patient expressed orally or in writing when he or she was capable of making such decisions. The SDM should be guided by the patient's best interests, and ideally there will have been a prior conversation between the patient and SDM about the patient's wishes.

In the example, Mrs. Smith did not prepare a POA-PC document, naming a SDM. Without such a document, her son would be appointed as the SDM, in keeping with the legislation. However, Mrs. Smith may not want her son to act as her SDM, for reasons that may include that he lives too far away, is not aware or does not agree with her final wishes, and so on. In this case, the health care team needed to proactively discuss with her the importance of completing a POA-PC document specifies her wishes as to who would be making her decisions if unable to speak for herself. This may be naming her close friend—who she feels will best represent her treatment goals, and her values and beliefs.

Resources:

Person-Centred Decision-Making: Quick Reference Guide

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

Advance Care Planning Conversations: A Guide for You and Your Substitute Decision Maker

Advance Care Planning Conversation Guide (worksheet)

Health Care Consent ACP IN ONTARIO– SUMMARY OF KEY THEMES AND COMMON ERRORS (HPCO)

Dying with Dignity Canada

Speak Up - Health Care Consent and Advance Care Planning Webinars

Education and Resources

Palliative Care Educational Hub Website has be launched !! :)

Full of resources and more being added daily.

Webinars available!! After completion, please provide your information in Survey Monkey link, in order to receive a Certificate of Participation.

Palliative Education

Comprehensive Advanced Palliative Care Education (CAPCE) starting in May 2022. Click to see flyer.

Enhanced Fundamentals of Hospice Palliative Care (EFHPC). Click to see flyer.

VON Durham Hospice Services

Please help VON Durham Hospice Services support our Palliative Community, through Volunteer Support, Patient and Caregiver support groups, Hospice Nurse Navigation, Supportive Care Counselling, Grief and Bereavement one to one support and group support. Click below to access referral form.

Visit our website

Referral Form

OAK RIDGES HOSPICE OF DURHAM LTD.

Thanks to Oak Ridges Hospice for their ongoing support. If you are interested in a tour or a referral, please visit their website for more information.