Health Care Consent & Advance Care Planning in Ontario

What You Need to Know

Health Care Consent Advance Care Planning Community of Practice
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Welcome

- Introductions
- Webinar Instructions
  - If you have a mute button on your phone, please use it
  - If you don’t, press *6
- Background

Learning Objectives

- At the end of this session, participants will have a better understanding of:
  - What Health Care Consent and Advance Care Planning means in Ontario
  - What all HSPs need to both know and understand about Health Care Consent and Advance Care Planning
  - What Long Term Care Homes must understand about Health Care Consent and Advance Care Planning to support their residents and their role

Poll #1

For a person who lacks the mental capacity to provide consent for treatment plans, ACP conversations can occur with substitute decision makers on behalf of the person.

True *or* False?

Poll #2

Wishes for treatments should be documented in either an advance directive or a living will.

True *or* False?

Poll #3

When a person appoints an Attorney for Personal Care only a lawyer has the authority to oversee the process.

True *or* False?

Poll #4

Wishes expressed verbally are less clinically relevant then wishes that are written, signed and witnessed.

True *or* False?

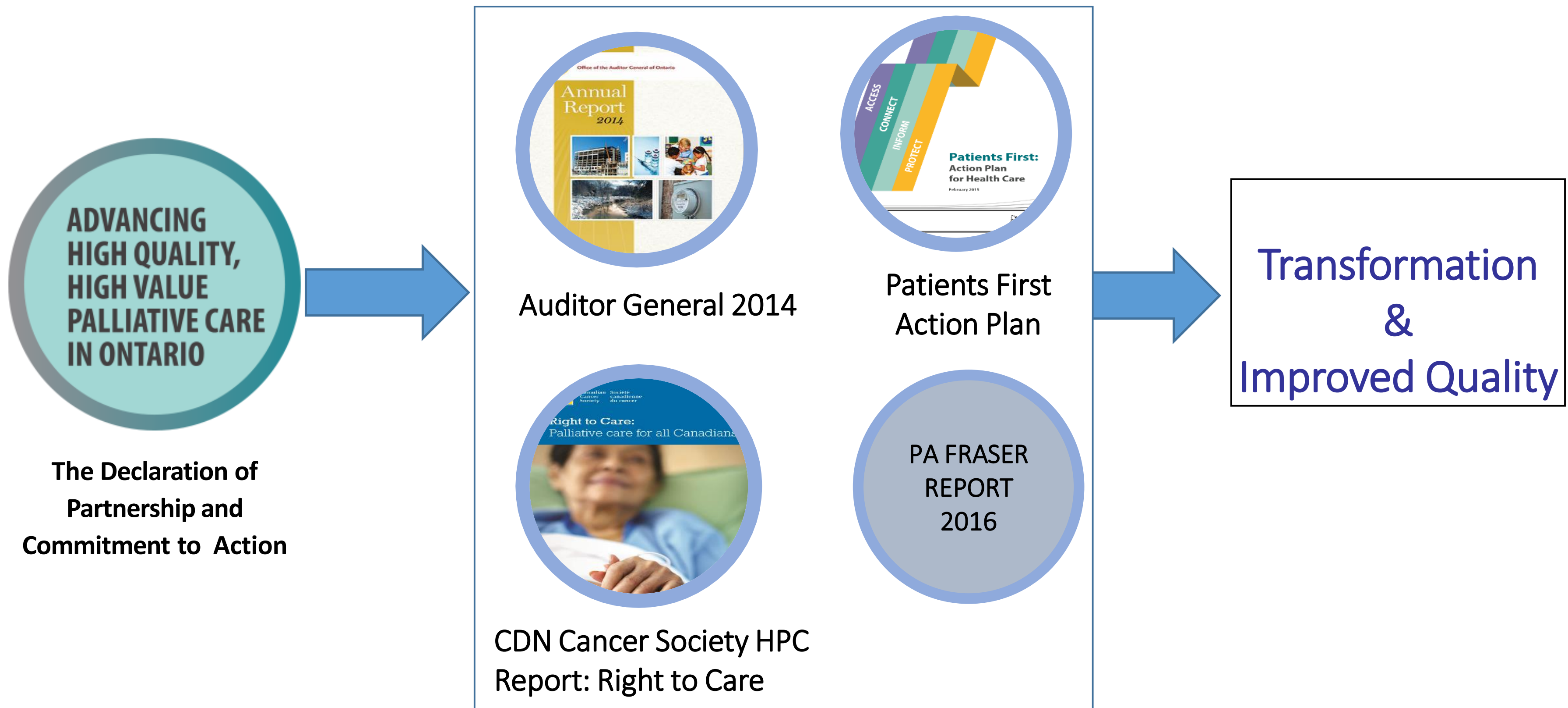
Why does it matter to GET THIS RIGHT?

Outcome evidence indicates that Consent and ACP:

- Improves patient & family satisfaction with EOL care[1]
- Decreases caregiver distress & trauma[2]
- Decreases unwanted investigations, interventions & treatments[3]
- Increases the likelihood of dying in preferred setting[3]
- Decreases hospitalizations & admissions to critical care[4]
- Decreases cost to the health care system[5]

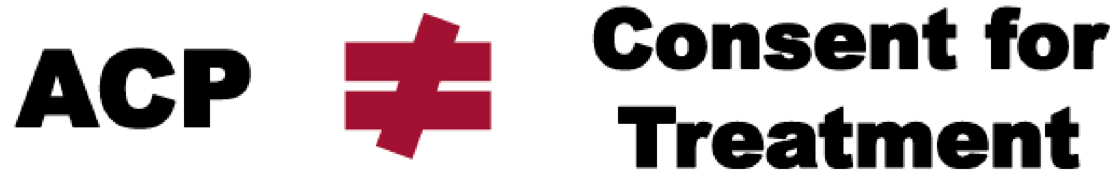
This was not always the case…what changed?

Why does it matter to GET THIS RIGHT?



Why does it matter to GET THIS RIGHT?

Under Ontario Law, Advance Care Planning is part of the Health Care Consent Act



Health care professionals must always obtain informed consent or refusal before treatment from either the mentally capable patient or their substitute decision maker (SDM)

Why does it matter to GET THIS RIGHT?

- The Law Commission of Ontario strongly recommends using terminology in the Health Care Consent Act (HCCA):

  > **"...terminology used in health care consent and advance care planning forms, tools, and policies track the language in the HCCA, and that these documents should expressly distinguish between consent and the recording of wishes, values, and beliefs**."

- There is tremendous confusion and incorrect practices about this distinction within Hospitals, LTC Homes and Community HSPs across Ontario
- **Many HSPs are currently noncompliant with the Ontario Legal Framework**

Who needs to worry about GETTING THIS RIGHT?

Hospitals

Patient's Care Wishes

☐ Patient has requested to discuss AD's

☐ Patient has a written directive and ☐ copy has been requested
☐ copy has been obtained and placed in record

☐ Patient has discussed care wishes with SDM(s)

Has the patient / SDM verbally expressed care wishes? ☐ Yes ☐ No
If "yes" summarize any information provided here, and notify physician:

Has the physician been informed? ☐ Yes ☐ No
(Note, if care wish information is provided physician must be notified.)

Name of Physician:______________________ Date:________________ Time:_____________

Name of Healthcare professional Completing this form:_________ Date:_____________

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These are either confusing or incorrect elements

Who needs to worry about GETTING THIS RIGHT?

Long Term Care

Advance Directive for Treatment
Resident's Name: ____
If the Resident is incapable, Substitute Decision-Maker (SDM): _______________________________
Health Practitioner recording consent: ______________________________
Date of consent discussion: _________________________________

Name and Description of Directive
After discussion, the Resident or SDM has decided that in the event of life threatening illness, the Resident is to receive treatment as follows:
☐ **COMFORT MEASURES ONLY**
☐ **COMFORT MEASURES WITH ADDITIONAL TREATMENT AVAILABLE AT THE HOME**
☐ **TRANSFER TO ACUTE CARE HOSPITAL WITHOUT CARDIOPULMONARY RESUSCITATION**
☐ **TRANSFER TO ACUTE CARE HOSPITAL WITH CARDIOPULMONARY RESUSCITATION**

Informed Consent
I have been provided the following information by the Home:
Nature of the directive ☐ Yes Expected benefits of the directive ☐ Yes
Material risks of the directive ☐ Yes Material side effects of the directive ☐ Yes
Alternative courses of action ☐ Yes Likely consequences of not having the directive ☐ Yes

Who needs to worry about GETTING THIS RIGHT?

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HealthLinks

<table>
<tr><th colspan="6">My plan for future situations</th></tr>
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Who needs to worry about GETTING THIS RIGHT?

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These are either confusing or incorrect elements

Advance Care Planning

Future health condition the implications for which may not be easily known to the person

Consent to a Treatment or Plan of Treatment

Current health condition, where the Implications are known

Credit Chris Sherwood

Why does it matter to GET THIS RIGHT?

Risk of **legal liability** and **unforeseen negative consequences**, which could include:

- Hospitals and LTC homes cited to their respective reporting and oversight bodies
- LHIN found negligent under the Ministry-LHIN Accountability Agreement
- Detrimental Media coverage locally and provincially
- Civil suits
- Physicians reported to the CPSO
- Nurses Reported to CNO
- Complaints lodged at the Law Society

Who will be accountable to GET THIS RIGHT?

- LTC Homes are required by the Long Term Care Homes Act to have all such forms / policies “certified” as compliant with the law by legal counsel who has expertise in HCCA or consent law

- It is a matter of “when” not “if” system performance indicators are implemented at regional level

- It is a matter of “when” not “if” this will be added to Accreditation Standards

What is required in all care settings to GET THIS RIGHT?

- Understanding of and proper implementation of the **CONSENT** process
- Consent comes from a **CAPABLE PERSON** not a document or any form of advance care planning
- Understanding that consent is required for **ALL** treatments or a Plan of Treatment based on the person's current health condition
- Understanding that consent must be informed - risks, benefits, side effects, alternatives, what happens if patient refuses treatment

What is required in all care settings to GET THIS RIGHT?

- There must be proper determination of a person's **CAPACITY** for treatment decision-making

Definition of Capacity:

- **Ability to understand** the information that is relevant to making a decision about the treatment, admission, or personal assistance service as the case may be, AND
- **Ability to appreciate** the reasonable foreseeable consequences of a decision or lack of decision

(HCCA s. 4)

What is required in all care settings to GET THIS RIGHT?

- Mental capacity:
  - Is **issue specific – for each type of decision and for each new decision**
  - Is **not a diagnosis**
  - Can fluctuate
  - Does include having INSIGHT
  - Is presumed **unless there is REASON to believe otherwise**
- If a person is mentally incapable for a particular treatment decision then the HCP must turn to the SDM(s)

What is required in all care settings to GET THIS RIGHT?

Who assesses mental capacity for treatment?

- Duty of **Health Practitioner** offering the treatment to determine if a resident/patient is capable or not and whether its necessary to turn to the patient's SDM(s) for consent
- This is NOT done by a "capacity assessor" as defined in the Substitute Decisions Act

What is required in all care settings to GET THIS RIGHT?

- Understanding of who is the treatment decision maker - Patient or incapable patient's SDM

- Understanding of WHO is the RIGHT SDM according to the hierarchy and recording name and contact information properly on forms

What is required in all care settings to GET THIS RIGHT?

Understanding that a patient, when capable, may engage in **ADVANCE CARE PLANNING** which is:

- Confirming that they want their AUTOMATIC SDM(s) OR Choosing an SDM(s) by preparing a POAPC

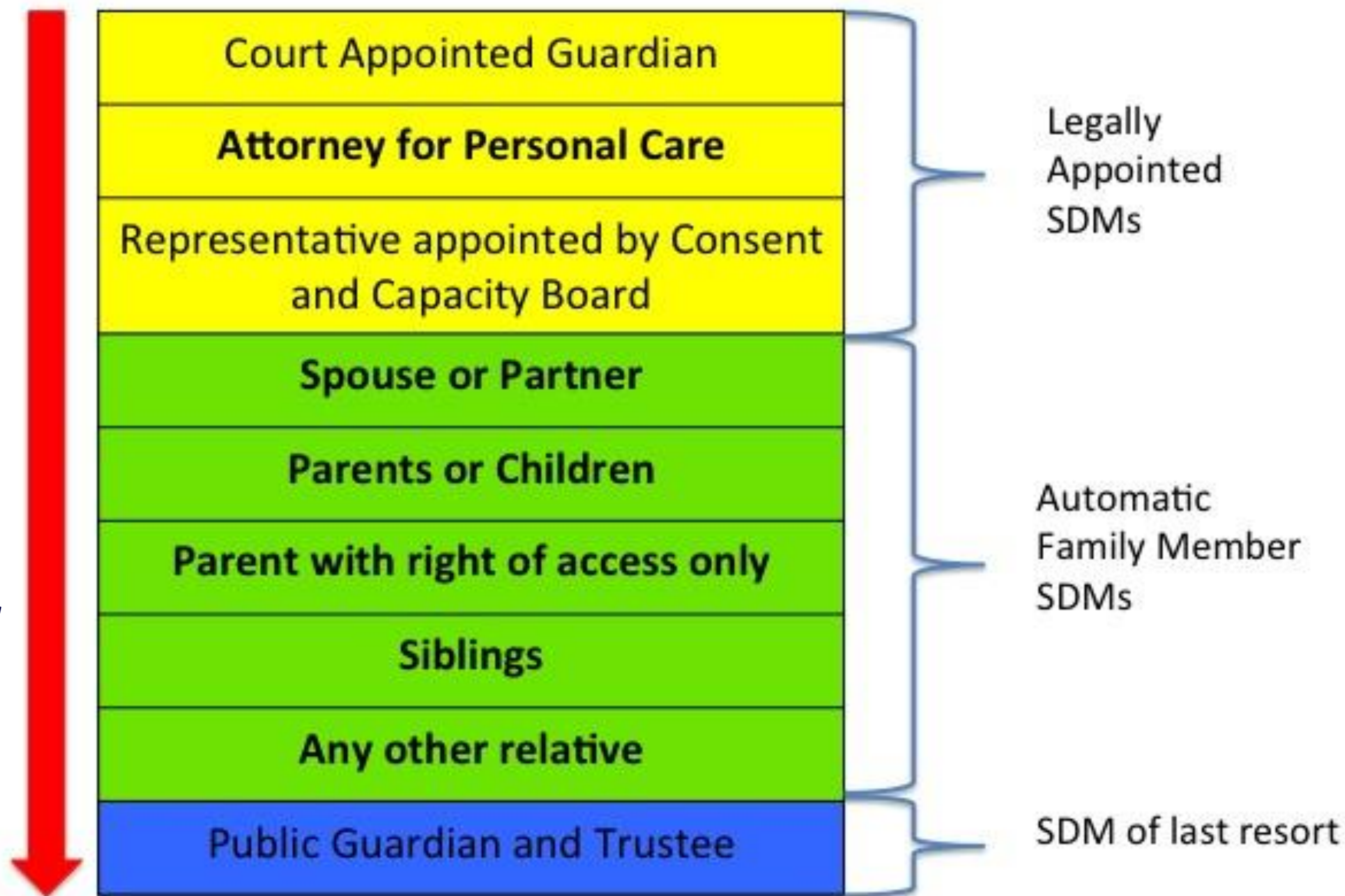
AND

- Communicating their Wishes, Values and Beliefs about care to help SDM(s) make healthcare decisions for them in the future when they are incapable

Substitute Decision Maker Hierarchy

Confirm automatic SDM(s)

Choose someone else and **Prepare** a *Power of Attorney for Personal Care* document



What is required in all care settings to GET THIS RIGHT?

- An understanding that **SDMs** cannot engage in advance care planning for a patient

- An understanding the relationship between and differences between advance care planning, goals of care and informed consent

What is required in all care settings to GET THIS RIGHT?

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

Info guides future decision-making

Info directly informs decision-making

Future Care

Current Care

Advance Care Planning Conversations

Goals of Care Discussion

Decision-Making or Consent Discussion

Treatment Decisions to be made

Figure: Relationship between three discussions that contribute to informed consent

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What is required in all care settings to GET THIS RIGHT?

The person's values, wishes, and goals for their care

PLANNING for FUTURE care

DECISION-MAKING for CURRENT care

Advance Care Planning → **Goals of Care Discussion**

Advance care planning
- a capable patient reflects on wishes and values about health and care
- information should guide substitute decision maker(s) if the patient becomes incapable in the future

Goals of care discussion
- ensuring a shared understanding of illness
- the goals a patient or substitute decision maker(s) has for care are identified and facilitate decision-making and consent

Goals of Care Discussion → **Decision-Making Discussions** → **Consent for treatment or care**

Components of person-centred decision-making in serious illness

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What is required in all care settings to GET THIS RIGHT?

	Clinical Context	Outcome is...	Outcome is NOT...	How goals are defined
Advance Care Planning	Future	Values & wishes prepare SDM(s) for future decision-making	Code Status, POLST, etc.	Patient is to define and describe
Goals of Care Discussion	Current	Patient understands illness Clinician understands patient's values & goals	Code Status, POLST, etc.	Patient is to define and describe
Decision-making Discussions	Current	Care or treatment decision(s) e.g. code status, POLST, etc.		Treatment oriented e.g. cure, resuscitation, comfort

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How a person makes healthcare decisions

Values

Evidence

Health Care Decisions

- Are the risks worth the possible benefits?
- Is this plan consistent with what is important to me?

- Facts
- Expected outcome
- Side effects and risks

Fulford KWM, Peile E, Carroll H. Essential values-based practice: Clinical stories linking science with people. New York: Cambridge University Press 2012. Adapted by Dr. Nadia Incardona

What’s the clinical approach to GET THIS RIGHT?

Not helpful Consent and ACP Conversations…

Commonly used	Think about it for a moment…
“No heroics and no machines”	Ever? Or when there is no chance of recovery? What about a 90% chance?
“No tubes”	What if the circumstances were short term and reversible… would a “tube” be acceptable?
“Do everything”	What does this mean? What “state of being” is to be achieved? How will the SDM know when everything has been done?

What's the clinical approach to GET THIS RIGHT?

Helpful Consent and ACP Conversations…

	Explore further
"No heroics and no machines"	What experiences have you had to bring you to this? What is it about "heroics and machines"?
"No tubes"	What is it about a tube that makes you not want one?
"Do everything"	What does it mean to not "do everything"? What worries or fears come to mind? How should we approach reconciling this?

What’s the clinical approach to GET THIS RIGHT?

Outcomes of an ideal Consent and ACP conversation

- SDM is aware of the person’s values and what he or she views as meaningful in life
- SDM begins to understand how the person makes decisions (i.e. how they view benefit and burdens)
- SDM has information that would guide decision making
- Avoids statements such as “no machines” or “no heroics” or “no feeding tubes” without modifiers that would make these situations bearable or unbearable for the person

What's the clinical approach to GET THIS RIGHT?

Outcome evidence of Consent and ACP conversations:

- Improves patient & family satisfaction with EOL care[1]
- Decreases caregiver distress & trauma[2]
- Decreases unwanted investigations, interventions & treatments[3]
- Increases the likelihood of dying in preferred setting[3]
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- Decreases cost to the health care system[5]

This was not always the case…what changed?

What's the clinical approach to GET THIS RIGHT?

- Promote understanding the role of the SDM in **INTERPRETING** and applying any form of the patient's advance care planning (if any)
- Promote understanding that HSPs **DO NOT** take direction from any form of advance care planning (whether written, oral or communicated by alternative means) except in an emergency
- Promote understanding that **code status (e.g. DNR)** is **NOT** an advance care planning wish **but requires an INFORMED CONSENT**

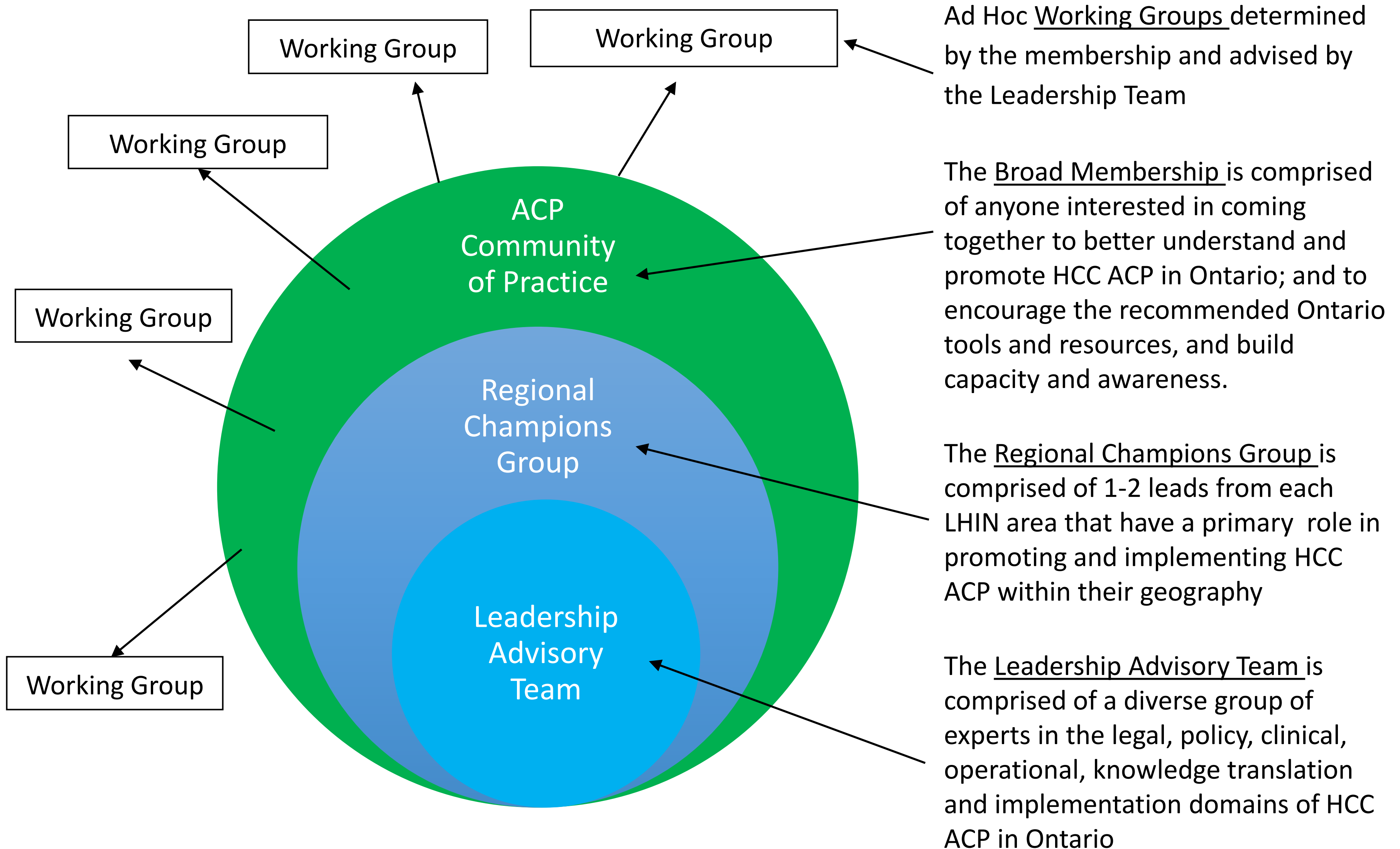
System Strategies to GET THIS RIGHT

- Clarify confusions, dispel misconceptions and correct incorrect information
- Provide accurate knowledge about the **Ontario** legal framework
- Encourage consistent practices
- Expect accurate language which promotes clear communication
- Discover and utilize Ontario specific tools, supports and resources (paper & people)

How we can help you to GET THIS RIGHT?

- In response to the need for provincial resources on HCC ACP that utilizes an Ontario legal framework, Hospice Palliative Care Ontario hosts a Health Care Consent Advance Care Planning Community of Practice (HCC ACP CoP)
- The CoP supports Ontario clinicians, administrators, caregivers, policymakers, researchers, educators and leaders who are committed to the promotion of HCC ACP in Ontario.

How we can help you to GET THIS RIGHT?



How we can help you to GET THIS RIGHT?

- To become a member of the CoP simply register at:
  http://fluidsurveys.com/s/hpco-hcc-acp-cop/
- Your participation would:
  - Provide you with direct access to all HCC ACP CoP Tools, Resources and Updates
  - Increase Sector Performance Compliance
  - Increase Patient Centred Care
  - Increase System Capacity & Consistency

Resource Review Process to GET THIS RIGHT

- Across the province considerable time and effort is spent by associations, organizations and projects to develop HCC ACP related documents and processes.
- In an effort to support this work, the HCC ACP CoP Leadership Advisory Team offers to review HCC ACP related resources (i.e. content, policies, procedures, materials, presentations etc.,) to ensure the language and intent complies with the Ontario Legal Framework.
- The Resource Review process emerged out a strong desire to support colleagues and address the specific nature of HCC ACP in Ontario.

HCC ACP CoP Tool Kit to GET THIS RIGHT?

1. Health Care Consent Advance Care Planning Common Themes and Errors Tool
2. Leadership in Advance Care Planning in Ontario Tool
3. Leadership Screening Tool
4. Health Care Consent and Advance Care Planning Glossary of Terms for Ontario
5. Physician Assisted Dying (PAD) and Advance Care Planning (ACP)
6. National Consent Legislation Summary Chart
7. ACE Tip Sheet #1: Health Care Consent and Advance Care Planning the Basics
8. ACE Tip Sheet #2: HIERARCHY of Substitute Decision Makers (SDMs) in the Health Care Consent Act
9. ACE: Advance Care Planning – ONTARIO – SUMMARY – Health Care Consent Act List of “approved” HCC and ACP resources

Benefits of GETTING THIS RIGHT

Along with ensuring the right information is given to the right person, at the right time, the resource review process can help:

- Ensure compliance
- Facilitate the use of information
- Enhance clarity and understanding
- Meet legislated professional obligations
- Honour the basic rights of patients
- Reduce the risk of legal liability

To schedule a resources review simply go to: http://www.speakupontario.ca/resource/ontario-guides/

Speak Up Ontario to GET THIS RIGHT

www.speakupontario.ca

Ontario Advance Care Planning Workbook

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WHO WILL SPEAK FOR YOU?

Learn About Making Your Plan >

Advance Care Planning is a process of thinking about and sharing your wishes for future health and personal care.
It can help you tell others what would be important if you were ill and unable to communicate. Learn more >

FIND INFORMATION FOR

3:18 PM
2016-06-02

Key Reference Sites to GET THIS RIGHT

- Key Reference Documents:
- Ontario Health Care Consent Act, 1996 - https://www.ontario.ca/laws/statute/96h02
- Ontario Substitute Decisions Act, 1992 - https://www.ontario.ca/laws/statute/92s30
- Consent and Capacity Board - http://www.ccboard.on.ca/scripts/english/aboutus/index.asp
- Public Guardian and Trustee Office - https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/
- ACE Advocacy Centre for the Elderly - http://www.acelaw.ca/advance_care_planning_-_publications.php
- Hospice Palliative Care Ontario - http://www.hpco.ca
- Speak Up Ontario – http://www.speakupontario.ca
- Community Legal Education Ontario (CLEO) - http://www.cleo.on.ca/en/publications/power http://www.cleo.on.ca/en/publications/continuing

Who is currently GETTING THIS RIGHT:

- ACP Conversation Guides – Produced by Dr. Nadia Incardona and Dr. Jeff Myers, 2016
- Clinical Primer - How to prepare for Advance Care Planning Conversations with patients and substitute decision-maker(s) or SDM(s)
- ACP Conversation Guide - This document serves to record wishes, values and beliefs for future healthcare. It is NOT consent for treatment but is as a representation of a person's capable thoughts and reflections.
- Advance Care Planning Conversations: A Guide for You and Your Substitute Decision Maker - How you can prepare for having Advance Care Planning Conversations

Who is currently GETTING THIS RIGHT:

- East Toronto Health Link developed an Ontario ACP toolkit for patients with chronic diseases and the healthcare providers who care for them.
  - Initiative funded by the Toronto Central LHIN
- Using the Ontario Speak Up campaign as a framework, tools were created to help patients with chronic progressive disease as part of a coordinated care plan, discuss their future care wishes with their family and members of their health team.
- An e-learning module was also created which is an ACP Primer and Practical Approaches for healthcare providers in Ontario

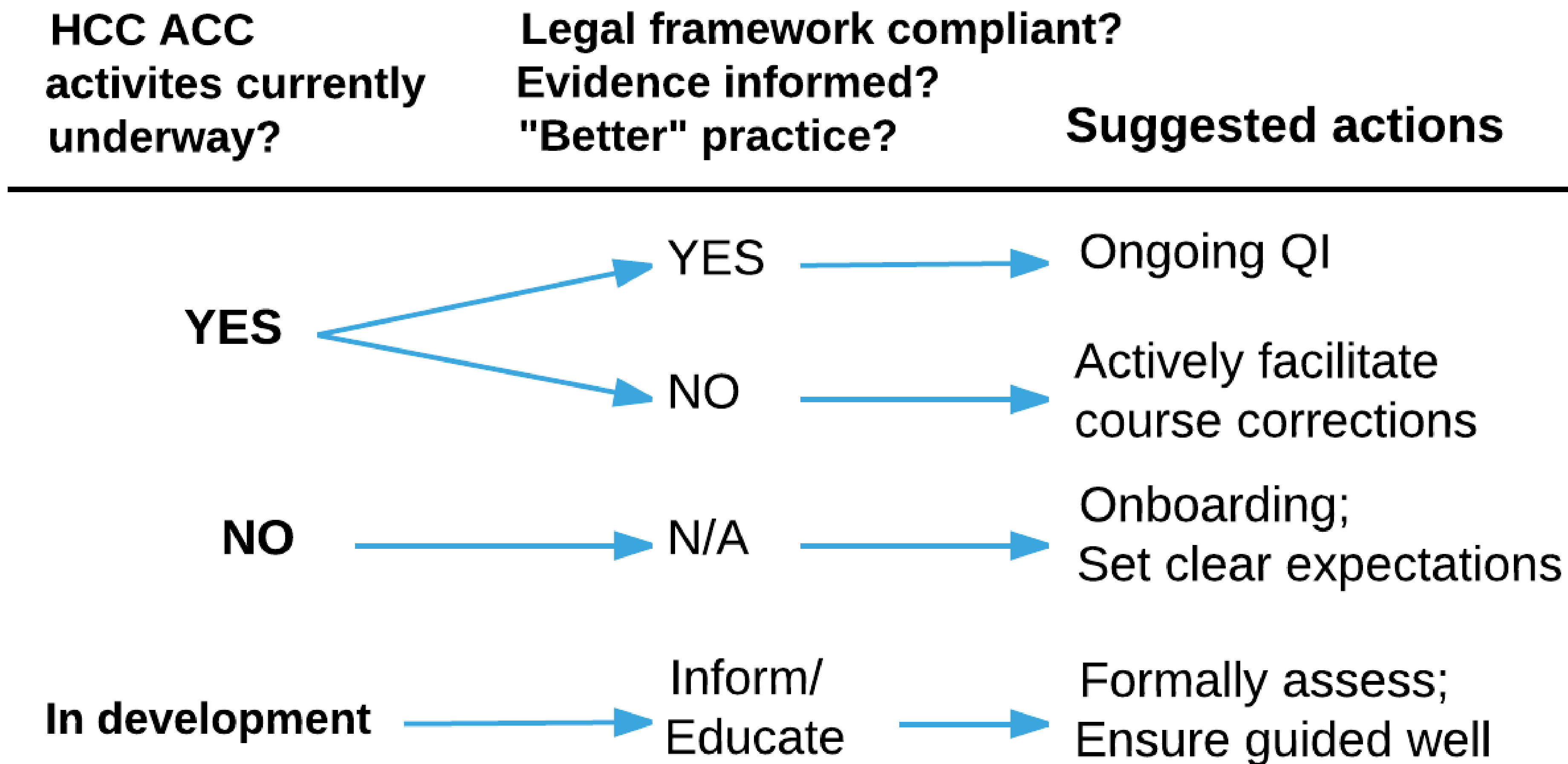
System Strategies to GET THIS RIGHT

To improve the quality and effectiveness of HCC ACP in Ontario, culture must be changed. Culture change requires:

1. **Education:**
   - People & SDMs:
     - Aware
     - Informed
     - Self management strategies
   - Clinician competence:
     - Attitudes/Aware
     - Knowledge/Information
       - Legal framework
       - Actual conversation
     - Skills
2. **Documentation/EMR**
   - Standardized
   - Accessible
3. **Quality improvement**
4. **System wide planning & coordination**

System Strategies to GET THIS RIGHT

Process for assessing organizations and institutions



Ontario needs to GET THIS RIGHT

- 100% of people in Ontario will die
- **CONSENT and ACP is relevant to 100% of Ontarians**
- It is **NOT** a matter of **IF** we get this right, it is now about **HOW** and **WHEN** we get this right
- Effectiveness requires a system wide approach
- Ideally a coordinated effort at provincial, regional and community levels is required for success

Contact:

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To join the HCC ACP CoP simply register at:

http://fluidsurveys.com/s/hpco-hcc-acp-cop/

Questions and Discussion