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• A fast, wired internet connection is best – slow connections might cause poor reception and gaps in audio or video

• Please use the background music to adjust the volume of your audio. If you cannot hear sound, try the following:

  1) Check the “Hardware and Sound” folder in your computer’s “Control Panel” – check if you are muted, if the volume is set at a good level, and if your playback device is set to be the system’s “default”

  2) Close and restart the webinar

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RGP of Toronto Network Webinar

Health Care Consent and Advance Care Planning in Ontario: What you Need to Know

February 22 2017

Health Care Consent Advance Care Planning Community of Practice

Judith Wahl, BA, LLB
Dr. Jeff Myers, MD, MSEd, CCFP(FC)
Julie Darnay, MEd
Health Care Consent &
Advance Care Planning in Ontario

What You Need to Know

Health Care Consent Advance Care Planning Community of Practice
Judith Wahl, B.A., LL.B.
Jeff Myers MD, MSEd, CCFP(PC)
Julie Darnay, MEd
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 Hospitals must understand about Health Care Consent and Advance Care Planning to support Patients and their Families
Key messages in the Hospital Setting

• Health Care Consent and Advance Care Planning must be implemented in ONTARIO in accordance with ONTARIO LAW

• Hospitals should NOT use forms and policies from other provinces or other jurisdictions without changing them to fit ONTARIO

• CONSENT must be obtained before treatment. ACP is not consent to treatment

• Obtaining advance care “plans” of patients on admission to hospital is not of much value and not much help when decisions about treatment in hospital need to be made.
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?
FALSE

• SDMs cannot advance care plan for another person. SDMs ONLY give or refuse consent to treatment on behalf of an incapable person.

• Only Patients when capable may do ACP for themselves.
Wishes for treatments should be documented in either an advance directive or a living will.

True or False?
FALSE

• There are no such documents called “Advance Directives” or “Living Wills” in Ontario law and this terminology should not be used as its confusing.

• In Ontario the only part of advance care planning that must be done in writing is when a person wants to name someone as their SDM that is not their automatic SDM. That must be done in writing by preparing a POA Personal care.

• Advance Care planning about communication of wishes, values and beliefs to guide the SDM may be done ORALLY, in WRITING, or be communicated by alternative means.
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\(^5\)

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

ACP ≠ Consent for Treatment

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

• Advance care planning wishes have been inappropriately used as consents when the health practitioners don’t have a good understanding of how Informed consent and ACP are related
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.”

i.e. Asking patients for their “Next of KIN” – BUT hospital should want to know should would be the patient's SDM

i.e. “Advance directives/ Living wills are NOT in Ontario legislation yet that terminology appears on many forms
### Hospitals

<table>
<thead>
<tr>
<th>Patient’s Care Wishes</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Patient has requested to discuss AD’s</td>
</tr>
<tr>
<td>□ Patient has a written directive and □ copy has been requested</td>
</tr>
<tr>
<td>□ copy has been obtained and placed in record</td>
</tr>
<tr>
<td>□ Patient has discussed care wishes with SDM(s)</td>
</tr>
</tbody>
</table>

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:_____________
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:

[Blank space]

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: _______________

These are either confusing or incorrect elements
Health Care Consent and Advance Care Planning

1. My Substitute Decision Maker (SDM) is/are: *(May require additional space for multiple SDMs)*
   - Name:
   - Contact Information:
   - Relationship:

   *(Note 1: Confirm that the above noted SDM is the highest ranked in the SDM hierarchy list)*

   **The Hierarchy List (Create as a drop down menu)**
   
   The following is the Hierarchy of SDMs in the Health Care Consent Act, s.21:
   
   1. Guardian of the Person with authority for Health Decisions
   2. Attorney for personal care with authority for Health Decisions *(See Note 2)*
   3. Representative appointed by the Consent and Capacity Board
   4. Spouse or partner
   5. Child or Parent or CAS *(person with right of custody)*
   6. Parent with right of access
   7. Brother or sister
   8. Any other relative
   9. Office of the Public Guardian and Trustee

   *(Note 2: if the above noted SDM is #2 in the hierarchy list: Attorney for personal care with authority for Health Decisions - confirm this information in the person’s POA for Personal Care document)*

2. I have shared my wishes, values and beliefs with my future Substitute Decision Maker as they relate to my future healthcare?
   - Yes
   - No

   *(Note 3: If No, provide ACP provincially approved resources i.e., Speak-Up Ontario ACP Workbook or website information, etc.)*
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 patients must be informed of their health condition and 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 **BY A HEALTH PRACTITIONER** not a **CAPACITY ASSESSOR**

**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 patient’s SDM(s)
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

• Understanding that the SDM must meet the requirements of being WILLING, AVAILABLE, MENTALLY CAPABLE, at least 16, and not prohibited by court order or separation agreement in order to act as SDM.
**Substitute Decision Maker Hierarchy**

- **Confirm** automatic SDM(s)
- **Choose** someone else and
- **Prepare** a *Power of Attorney for Personal Care* document

**Diagram:**

- **Court Appointed Guardian**
- **Attorney for Personal Care**
  - Representative appointed by Consent and Capacity Board
- **Spouse or Partner**
- **Parents or Children**
  - Parent with right of access only
- **Siblings**
- **Any other relative**
- **Public Guardian and Trustee**

**Legally Appointed SDMs**

- Automatic Family Member SDMs
- SDM of last resort

*Ontario Health Care Consent Act, 1996*
Understanding that a resident, 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
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 that SDMs may ONLY give or refuse consent – They may consent to a DNR or other end of life care taking place in the near future IF this is relevant to the resident’s PRESENT health condition

• An understanding of the relationship between and differences between advance care planning, goals of care and informed consent
How a person makes healthcare decisions

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

Values

Evidence

Health Care Decisions

- Facts
- Expected outcome
- Side effects and risks


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

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

Future Care

Advance Care Planning Conversations

Info guides future decision-making

Goals of Care Discussion

Decision-Making or Consent Discussion

Info directly informs decision-making

Current Care

Treatment Decisions to be made

Figure: Relationship between three discussions that contribute to informed consent

© 2016 by Dr Nadia Incardona and Dr Jeff Myers. Advance Care Planning Conversation Guide
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What is required in all care settings to GET THIS RIGHT?

<table>
<thead>
<tr>
<th>Clinical Context</th>
<th>Outcome is...</th>
<th>Outcome is NOT...</th>
<th>How goals are defined</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Future</strong></td>
<td>Values &amp; wishes prepare SDM(s) for future decision-making</td>
<td>Code Status, POLST, etc.</td>
<td>Patient is to define and describe</td>
</tr>
<tr>
<td><strong>Current</strong></td>
<td>Patient understands illness Clinician understands patient's values &amp; goals</td>
<td>Code Status, POLST, etc.</td>
<td>Patient is to define and describe</td>
</tr>
<tr>
<td><strong>Current</strong></td>
<td>Care or treatment decision(s) e.g. code status, POLST, etc.</td>
<td></td>
<td>Treatment oriented e.g. cure, resuscitation, comfort</td>
</tr>
</tbody>
</table>

Advance Care Planning

Goals of Care Discussion

Decision-making Discussions
What’s the clinical approach to GET THIS RIGHT?

Not helpful Consent and ACP Conversations...

<table>
<thead>
<tr>
<th>Commonly used</th>
<th>Think about it for a moment...</th>
</tr>
</thead>
<tbody>
<tr>
<td>“No heroics and no machines”</td>
<td>Ever? Or when there is no chance of recovery? What about a 90% chance?</td>
</tr>
<tr>
<td>“No tubes”</td>
<td>What if the circumstances were short term and reversible... would a “tube” be acceptable?</td>
</tr>
<tr>
<td>“Do everything”</td>
<td>What does this mean? What “state of being” is to be achieved? How will the SDM know when everything has been done?</td>
</tr>
<tr>
<td>Explore further</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>“No heroics and no machines”</td>
<td></td>
</tr>
<tr>
<td>What experiences have you had to bring you to this? What is it about “heroics and machines”?</td>
<td></td>
</tr>
<tr>
<td>“No tubes”</td>
<td></td>
</tr>
<tr>
<td>What is it about a tube that makes you not want one?</td>
<td></td>
</tr>
<tr>
<td>“Do everything”</td>
<td></td>
</tr>
<tr>
<td>What does it mean to not “do everything”? What worries or fears come to mind? How should we approach reconciling this?</td>
<td></td>
</tr>
</tbody>
</table>
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
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\(^3\)
- Decreases hospitalizations & admissions to critical care\(^4\)
- Decreases cost to the health care system\(^5\)

This was not always the case...what changed?
Important points to remember about ACP

• Ensure staff and SDMs understand the role of the SDM in **INTERPRETING** and applying any form of the patient's advance care planning (if any)

• Promote understanding that staff **DO NOT** take direction from any form of advance care planning (whether written, oral or communicated by alternative means) **except** in an emergency

• **DNRC forms are NOT** the same as consent to a DNR status in hospital
  - must confirm through discussion with a capable patient (or their SDM(s) if the patient is no longer capable)
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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>YES</td>
<td>Ongoing QI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td>Actively facilitate course corrections</td>
<td></td>
</tr>
<tr>
<td>NO</td>
<td>N/A</td>
<td>Onboarding; Set clear expectations</td>
<td></td>
</tr>
<tr>
<td>In development</td>
<td>Inform/Educate</td>
<td>Formally assess; Ensure guided well</td>
<td></td>
</tr>
</tbody>
</table>
• Creation of CoP’s to respond to the need for a resource for HCC and ACP utilizing an Ontario legal framework.

• The CoP supports Ontario clinicians, administrators, caregivers, policymakers, researchers, educators and leaders who are committed to the promotion of HCC ACP in Ontario.

• Goal of the CoP are to reinforce the link between HCC and ACP to health care providers.

• Hospice Palliative Care Ontario (HPCO) hosts and supports the work of the CoP
Ad Hoc **Working Groups** determined by the membership and advised by the Leadership Team.

The **Broad Membership** is comprised of anyone interested in coming together to better understand and promote HCC ACP in Ontario; and to encourage the recommended Ontario tools and resources, and build capacity and awareness.

The **Organizational Champions Group** is comprised of individuals, who want to expand into a lead role for promoting and/or implementing HCC ACP within their organization/facility/sector etc. Broad representation from all disciplines and sectors are sought (clinical, legal, social, financial etc.).

The **Regional Champions Group** is comprised of 1-2 leads from each LHIN area that have a lead role for promoting and/or implementing HCC ACP ideally across their regional geography.

The **Leadership Advisory Team** is comprised of a diverse group of experts in the legal, policy, clinical, operational, knowledge translation and implementation domains of HCC ACP in Ontario.
Hospital Working Group

• Scope:
  • To develop Ontario based best practice HCC ACP LTC resources
  • To support positive change with HCC ACP practices across LTC Homes in Ontario
  • To incorporate a knowledge translation approach in all of the project activities to ensure that best practice theory is translated to practice and is sustainable.

• Work Plan:
  • Environmental Scan of Current State, Issues and Challenges
  • Repository of innovative/compliant HCC ACP Hospital initiatives
  • Alignment with Law Commission of Ontario Paper Recommendations
  • Develop principles, guidelines and templates
  • Support Education/Knowledge Translation
  • Capacity Building

• Working with Senior Friendly Hospitals Initiative, Northern Ontario School of Medicine

• Partnership with OHA & OMA
www.speakupontario.ca
Ontario Advance Care Planning Workbook
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. Medical Assistance in Dying (MAiD) (Previously 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
Key Ontario Reference Sites

• Ontario Health Care Consent Act, 1996 - https://www.ontario.ca/laws/statute/96h02


• 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
Repository of Examples of Resources that meet the Ontario Legal Framework

• ACP CONVERSATION GUIDE, *Produced by Dr. Nadia Incardona and Dr. Jeff Myers, 2016, includes:*
  • ACP Conversation Guide template, Clinical Primer

• The Waterloo Wellington ACP Education Program “CONVERSATIONS WORTH HAVING”
  • General Public Fact Sheet, Health Care Fact Sheet, Wallet Card

• East Toronto Health Link’s ONTARIO ACP TOOLKIT FOR PATIENTS WITH CHRONIC DISEASES AND THE HEALTHCARE PROVIDERS WHO CARE FOR THEM
  • ACP Brochure, ACP Workbook, cpr Brochure, sdm Brochure, Wallet Card
Provincial Webinars on “HCC ACP in Ontario”

2016 Education Series:
• LHIN Staff - June 1, 2016,
• Provincial Associations - July 19, 2016
• Health Links and Community Partners - September 28, 2016
• Long Term Care Homes - October 7, 2016
• Hospitals - November 18, 2016
• Community Care Access Centres - December 9, 2016

2017 Education Series:
• General Session – January 13th, 2017
• Regional HPC Networks – February 10th, 2017
• LTC Corporations and Compliance Officers – March 10th, 2017 (AM)
• Primary Care – March 10th, 2017 (PM)
• Lawyers and Legal Clinics – May 12th, 2017
• Clinical Ethicists and Social Workers – June 9th, 2017
How we can help you to GET THIS RIGHT?

To become a member of the Community of Practice simply register at:

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

To schedule a resources review or to request additional support or assistance from the CoP simply go to:

http://www.speakupontario.ca/resource/ontario-guides/
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)
• 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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jdarnay@hpco.ca

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HCC ACP Project Lead  
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www.hpco.ca
Questions and Discussion
Thank you for attending this webinar!

You will receive a quick evaluation survey by email – please share your suggestions and topics for future sessions.

A link to presentation slides and a recording will be provided after completing the evaluation.

Please save this date and join our next webinar on: Tuesday April 25 2017 at 12-1pm.

The Music Project
A program based on overwhelming evidence showing the benefits of music and stimulation on people living with dementia.

Alzheimer Society of Toronto

If you have additional questions, contact ken.wong@sunnybrook.ca

www.rgp.toronto.on.ca
www.seniorfriendlyhospitals.ca