Perth and Smiths Falls District Hospital

Patients and Families THE Heart OF Care

Advance Care

Planning in Ontario

It's about conversations.

It's about decisions.

It's how we care for each other.

Speak Up

This guide was created by the Palliative Care Department at the Perth and Smiths Falls District Hospital (PSFDH). It supports Advance Care Planning in Ontario. It is based on the resources provided by the **Canadian Hospice Palliative Care Association** www.advancecareplanning.ca and the **End of Life Planning Society Canada** https://elplanning.ca . Their advance care planning guides and workbooks have been adapted to best meet the needs of our patients and families.

The purpose of this guide is to provide information about Advance Care Planning (ACP). It is to prepare you to make decisions about your healthcare, in the event that you might suddenly become ill or injured, and not be able to express your wishes.

Disclaimer: The information provided in this guide is included as a public service and is for general reference only. Every effort is made to ensure the accuracy of the information found here. This information is not considered legal, medical or financial advice and does not replace the specific medical, legal or financial advice that you might receive or the need for such advice. If you have questions about your health or medical issues, speak with a health care professional. If you have questions about your own or someone else's legal rights, please speak with a lawyer or contact a community legal clinic.

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Introduction to Advance Care Planning (ACP)

No one knows what tomorrow will bring, or can predict what might become of our health. It's difficult to think about a time when, due to illness or injury, we may be unable to speak for ourselves about our healthcare wishes.

If you had a medical emergency and couldn't speak for yourself, who would speak for you and make decisions about your care? Would they know what your preferences are?

Advance Care Planning is a process of reflection and communication. It is a time for you to think about your values and wishes, and to let others know what kind of healthcare and personal care you would want in the future if you became incapable of consenting to or refusing treatment or other care.

It means choosing your Substitute Decision Maker(s) and sharing your wishes about care that you may or may not want. A Substitute Decision Maker is the person or people who will provide consent, or refusal of consent, for care and treatments if you are not capable to do so for yourself. An advance care plan is a way to give your substitute decision maker the confidence to make decisions on your behalf if you are not capable to do so.

Advance care planning also includes having discussions with your healthcare providers to ensure you have accurate medical information on which to make decisions (consents) or to express wishes about future care and treatment. It involves recording your preferences. It can include consulting with legal professionals.

As long as you are CAPABLE, you will be asked to make your own healthcare decisions. Your Substitute Decision Maker(s) will only be called upon to speak on your behalf if you are not able to.

Being capable means that you have the ability to understand the information you are given about your health conditions and recommended treatments. It also means that you have the ability to appreciate the risks and benefits of the treatments, as well as the consequences of accepting or refusing them.

You may never need your advance care plan, but if you do, you'll be glad to know that your voice will be heard, your wishes will be followed and your Substitute Decision Maker(s) will have the knowledge and confidence to speak for you.

You can change your Advance Care Plan at any time, as long as you are capable. Please refer to *Step 6. Review Your Plan Regularly* on page 16 for further information.

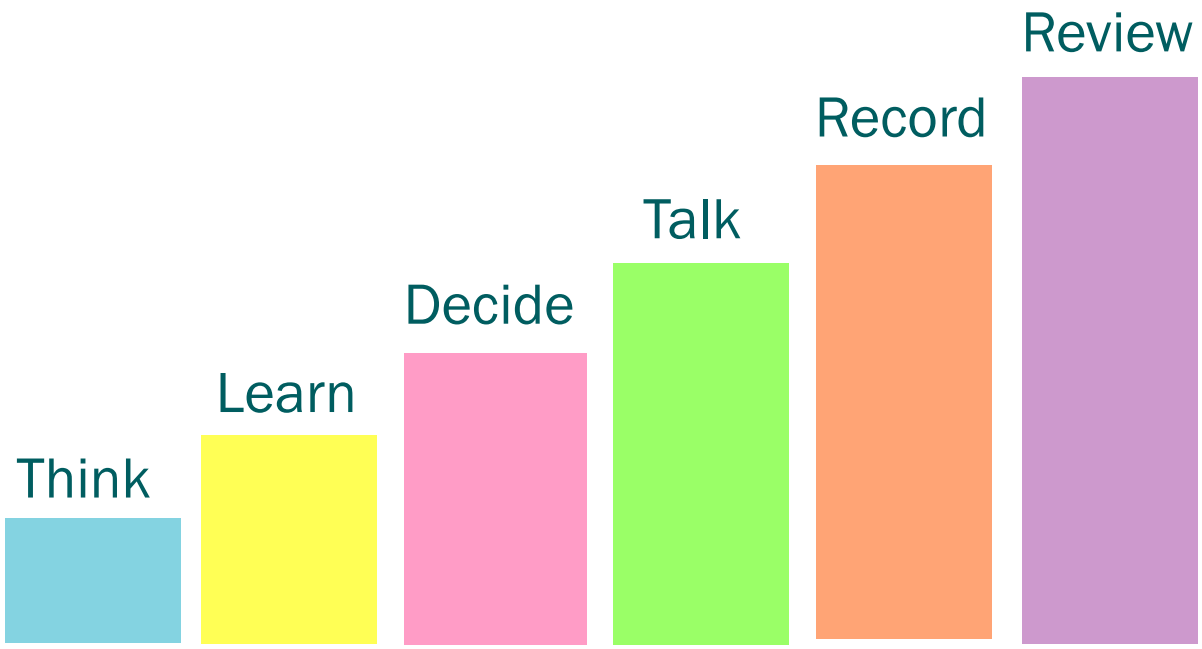
An Advance Care Plan will answer the following questions:

- Who do you trust to make your healthcare decisions for you, if you're unable to?
- What healthcare treatment (s) do you agree to, or refuse?
- Would you accept or refuse life support and life-prolonging medical interventions for certain conditions?
- What are your preferences if you are not able to be cared for at home?

Working through this guide will help you to think about and express your wishes, values and choices about your future health and personal care, in the event you are unable to do so. Your Advance Care Plan provides your Substitute Decision Maker (s) and healthcare providers with the knowledge and tools they need to make decisions for your care and treatment, based on your wishes.

The 6 Steps

of Advance Care Planning



1 STEP 1
THINK ABOUT WHAT'S RIGHT FOR YOU

What do you value most in terms of your mental and physical health?

(e.g. being able to live independently, being able to communicate, spending time with loved ones, reading, watching television, listening to music, enjoying the outdoors, practicing your faith)

Notes: _____

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What concerns do you have when you think about having a serious illness?

(e.g. uncontrolled pain and other symptoms that cannot be managed, struggling to breathe, losing control of bodily functions, being alone, not being able to be at home, being a burden to loved ones, not being able to say goodbye to loved ones).

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What would make prolonging life unacceptable for you?

(e.g. not being able to communicate, being kept alive by machines, not being able to return to your previous function)

Notes: _____

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If you were nearing death, what would you want in order to make the end more peaceful for you?

(e.g. having family nearby, someone holding your hand, having a spiritual/religious leader visit, hearing loved ones talk about happy memories, listening to music).

Notes: _____

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2 STEP 2

LEARN ABOUT YOUR HEALTH CONDITION (S) AND THE PROCEDURES AND TREATMENTS THAT MAY BE OFFERED

Some of the hardest decisions deal with the use of life support and life-prolonging medical interventions. Medical interventions can include a ventilator to help with breathing, tube feeding, hemodialysis or cardiopulmonary resuscitation (CPR) to restart your heart and lungs.

The questions below can help you think about the life support or life-prolonging medical interventions you may wish to accept or refuse in the future.

If you have a longstanding chronic health condition:

- **What stage is my health condition at and how might it progress?**
- **Can my condition affect my memory or ability to decide for myself in the future?**
- **Will it become life-threatening?**
- **What life support or life-prolonging medical interventions might I need due to this condition?**
- **What does my healthcare provider suggest I consider and address in my advance care plan, with respect to my needs and desires of how I wish to die?**

Notes: _____

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If you have a life-threatening illness or injury, do you want to accept or refuse:

- **Cardiopulmonary resuscitation (CPR)?**
- **Other life support or life-prolonging medical interventions, such as hemodialysis, surgery, a feeding tube, IV fluids and antibiotics?**
- **A trial period of life support and life-prolonging medical interventions, but allowing for natural death to occur if your condition is not going to improve?**
- **A palliative approach, which is care that relieves pain and other uncomfortable symptoms, and addresses your physical, emotional and spiritual needs, as well as the needs of the family and friends who support you.**

Notes: _____

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You may want to ask yourself, "Would I want life support or life-prolonging medical interventions if it means I could no longer":

- **Enjoy my life and activities the same way I do now?**
- **Get out of bed, walk or go outside on my own?**
- **Recognize and communicate meaningfully with my family and friends?**
- **Think for myself?**

Notes: _____

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STEP 3

DECIDE WHO WILL BE YOUR SUBSTITUTE DECISION MAKER

A Substitute Decision Maker (SDM) is a person you trust, who will make important health and personal care decisions for you **if you are not capable of making them for yourself.**

Some examples of being unable to express yourself are:

- Serious illness when you can't communicate
- Advanced dementia
- Being unconscious during surgery

Your SDM(s) will use your expressed wishes, values and beliefs to help them make decisions (provide consent) for you.

Examples of health and personal care decisions they may need to decide for you include: surgery, medications, tube feedings, cardiopulmonary resuscitation (CPR) and life support, hemodialysis and place of care (home, long-term care home or hospice).

Remember that you will make your own decisions about your healthcare, as long as you are able to.

In Ontario, every person automatically has a Substitute Decision Maker defined in the law, as stated in the Ontario Health Care Consent Act, 1996. **By default, this will be your closest living family member(s), unless someone has been legally appointed as your Power of Attorney for Personal Care.**

The table below lists the SDM Hierarchy that would be followed, with the highest ranked person at the top.

THE SUBSTITUTE DECISION MAKER HIERARCHY

Hierarchy of Legally Appointed SDM's are:	**Hierarchy of Automatic Family Member SDM's are:**	**The SDM of Last Resort:**
• Court Appointed Guardian • Power of Attorney for Personal Care • Representative appointed by the Consent and	• Spouse or Partner • Parents or Children • Parent with right of access only • Brother or Sister • Any Other Relative	• Public Guardian and Trustee

Your SDM(s) must be:

- Willing to accept the role as your SDM
- Available when decisions need to be made
- Capable of providing consent
- At least 16 years old
- And are not prevented by a court order or separation agreement from acting as your SDM

To assist you with choosing your SDM, you should ask yourself if this person is:

- **Willing to talk with you to understand your wishes, values and beliefs?**
- **Willing to honour and follow your wishes as much as possible?**
- **Willing to learn about and understand your care needs and what it's like to live with your condition?**
- **Able to ask questions and talk to your doctors and healthcare team?**
- **Able to make important and difficult decisions?**

If you feel your default SDM, as listed in the Health Care Consent Act Hierarchy, is not the right individual to take on this role, then you should appoint an Attorney for Personal Care.

You can name an Attorney for Personal Care by obtaining the document called 'A Power of Attorney for Personal Care.' It is available, free of charge, from The Office of the Attorney General in Ontario.

The Office of the Attorney General for Ontario contact information is:

www.attorneygeneral.jus.gov.on.ca
Toronto: 416-326-2220
Toll Free: 1-800-518-7901

You may choose to hire a lawyer, but it is not required in order to appoint an attorney for personal care.

STEP 4

TALK ABOUT YOUR VALUES, BELIEFS AND WHAT IS MOST IMPORTANT TO YOU

Share your choices about your future personal and medical care with your Substitute Decision Maker(s), family and healthcare providers. This will start the conversation about what you want, and will ensure your SDM(s) understand(s) your wishes.

STEP 5

RECORD YOUR WISHES AND WHAT IS MOST IMPORTANT TO YOU

You can communicate your wishes in many ways-through conversation, in writing or by recording them on video or tape.

If you do write your wishes down, remember to put a date on what you have written and destroy all previous written wishes, to avoid confusion.

Always provide your SDM(s) and anyone else that you gave your written wishes to with a new copy of your current written wishes. It is a good idea to request having this document placed in your medical file.

6 STEP 6
REVIEW YOUR PLAN REGULARLY

It's important to regularly review your healthcare wishes with your Substitute Decision Maker(s), especially if your health changes or there is a major change in your life. Talking about what is important to you will make it easier for your SDM(s) to make a decision that honours your wishes and goals.

You can change your Advance Care Plan at any time as long as you are capable. Your new wishes will take precedence over any prior known wishes, even if those wishes were written down.

For convenience, we have provided a wallet-sized card for your Substitute Decision Maker(s) contact information.

Advance care planning is the best way to ensure that your wishes are known to your SDM(s), family and health care providers. By doing it now, you ease the future burden of decisions that might have to be made, under difficult circumstances, by those who love and care for you.

Congratulations on participating in Advance Care Planning!

REFERENCES

For additional Ontario specific advance care planning and health care consent information, please refer to the following websites:

The Advance Care Planning Workbook – Ontario Version. Go to www.advancecareplanning.ca and click on 'Resources in your Province/Territory' in Quick Links. Under Ontario you will see the Advance Care Planning Workbook – Ontario Version.

Advocacy Centre for the Elderly (ACE): http://www.acelaw.ca/

Health Care Consent Act: Go to http://www.e-laws.gov.on.ca. Search for 'consent' and look for the Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A

Making My Wishes Known – www.makingmywishesknown.ca for an online, interactive Advance Care Planning workbook.

Substitute Decision Act: Go to http://www.e-laws.gov.on.ca. Search for 'substitute decision act' and you will find the Substitute Decision Act.

Consent and Capacity Board: http://www.ccboard.on.ca

Ontario Seniors' Secretariat: A Guide to Advance Care Planning: Go to www.seniors.gov.on.ca and search for advance care planning.