

Advance Care Planning Policy and Procedures

PURPOSE

Consistent with organizational mission, vision and core values, the purpose of this policy is to provide clear, coherent and adequate guidelines for initiating, discussing, determining and documenting the expressed wishes of capable patients/residents regarding their future care and treatment, a process known as advance care planning.

Advance care planning (ACP) is important for guiding care and treatments by health care practitioners in emergency situations where the patient/resident is no longer capable of making his/her wishes known (e.g., comatose state or advanced dementia). This inability to provide autonomous care decisions could be temporary, fluctuate or be permanent. ACP is also important for guiding substitute decision-makers (SDMs) of mentally incapable patients/residents when health care practitioners must turn to them for consent on behalf of the incapable patient/resident. This document serves to assist health care practitioners to enhance competence in the process of advance care planning.

ACP does not constitute informed consent for care and treatments. In a “medical emergency” situation, as defined under the Health Care Consent Act of Ontario 1996 (hereafter referred to as HCCA, 1996), when the patient/resident is incapable of making treatment decisions and every effort to reach an SDM proved to be unsuccessful, information on the ACP document may provide guidance to health care practitioners. Otherwise, even with an ACP document or any other form of recorded wishes or preferences of the patient/resident, if the patient/resident is not mentally capable with respect to treatment decisions, the health care practitioner must still turn to the SDM for consent. The SDM interprets and uses the ACP document or expressed wishes of the patient/resident to guide his/her care decision making on behalf of the patient/resident.

This policy and procedure is intended for use by staff throughout the continuum of care. This includes hospitals, long-term care homes, retirement homes, complex continuing care facilities and community-based care.

This document includes guidelines designed to assist staff, patients/residents and their substitute decision-makers to explore advance care planning. It does not cover every option available in the applicable legislations. It is not meant to be legal advice. Some legal terminology in the statute has been described here in simpler words to make it easier to understand.

KEY TERMS

(You might wish to refer to the Glossary of Terms in Appendix 1 to help you gain a clearer understanding of the concepts used in this document)

Advance Care Planning (ACP)

This is an entirely voluntary process carried out by a person, while he/she is mentally capable and at least 16 years of age, about how he/she wishes to be cared for in the future if he/she should become incapable of making care decisions. ACP is therefore an ongoing process that encourages individuals to engage in conversations about potential future treatment options with their health care practitioners and significant others. ACP may include personal care decisions about health care, food, housing, safety, clothing and hygiene. A person can express their wishes in writing, orally, in a recording device or by any other means, for example, a bliss board.

ACP may include completing a written document, often referred to as an advance care directive or living will. In an advance care directive, individuals may appoint another person(s) to make decisions on their behalf (commonly referred to as proxy directive) and/or outline what care and treatment decisions should be made in the event that they become incapable of making decisions for themselves (commonly referred to as an instructional directive). In Ontario, a Power of Attorney for Personal Care (POAPC) document may serve as both a proxy and instructional directive. It is important to note that only a POAPC can be used to appoint an SDM.

Advance Directive or Living Will

When future care wishes, including health care decisions, are written, it is commonly referred to as an “advance directive” or “living will.” A document in which a capable individual may indicate what, why, how, or by whom personal care decisions, are to be made in the event that he or she becomes incapable to make related decisions. An advance directive is **not** consent for health care treatment. It is an expression of wishes for future treatment. These “wishes” speak to the SDM and not to the physician or other health care practitioners. Informed consent still needs to be obtained from the capable patient/resident or from his or her SDM if incapable, even if an advance directive exists.

Only the **individual** can prepare an advance plan/directive. An SDM cannot. The SDM can only provide consent or refusal of consent to a **plan of treatment** and may consent to a plan of care that includes consent to some future treatments (and withdrawal and withholding of treatments) only if those treatments relate to the patient’s/resident’s present health condition.

Plan of Treatment

In collaboration and agreement with the capable patient/resident (or with his/her SDM in the event of incapacity), a plan of treatment is developed by one or more health practitioners and deals with one or more of the health problems that a person has. The plan may, in addition, deal

with health problems that the person is likely to have in the future, given the person's current health condition. The plan of treatment also provides for the administration of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition. (HCCA, 1996 s.2:1 interpretations)

GUIDING PRINCIPLES

1. The autonomy of every individual must be recognized and respected. Arising from the ethical principle of autonomy is the right to self-governance and, consequently, the required ethical and legal requirement for informed consent to any medical "treatments" (HCCA, 1996). This safeguards and promotes the right of choice and dignity of patients/residents.
2. Effective and compassionate delivery of health care requires respect for individuals' preferences, values and beliefs, sensitivity to cultural and religious traditions, as well as open and honest communication among care providers, patients/residents and their significant others (as appropriate).
3. It is crucial to recognize that the responsible and reasonable use of limited health care resources, under the principles of distributive justice and good stewardship, is an important consideration in the health care delivery process.
4. In Ontario, the Health Care Consent Act (1996) and the Substitute Decisions Act (1992) govern various aspects of the consent process, determination of capacity with regard to health care, and guidelines for substitute decision-making -- including a hierarchy of potential SDMs. It provides, for example, that
 - a. advance care wishes about health care may be expressed in a POAPC, in a form prescribed by the regulations, in any other written form, orally or in any other manner. Additionally, later expressed capable wishes prevail over earlier expressed capable wishes and desires (HCCA, 1996, s.5:2 and 3).

If, after consent to a treatment is given or refused on a person's behalf in accordance with the legislation, the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the treatment governs. (HCCA, 1996, s. 16).

- b. capacity with regard to treatments and admission to a care facility is presumed, and the burden is on health care practitioners to demonstrate otherwise (HCCA, 1996, s.4:2). unless there is evidence otherwise (HCCA, s.4:2) that the person is not capable for a particular purpose. It is the responsibility of the health care practitioner offering treatment to a patient/resident to determine if that patient/resident is mentally capable of giving or refusing consent to treatment. (HCCA, s.10:1). It is the responsibility of an "evaluator" to determine if a patient/resident is mentally capable of giving or refusing consent to admission to a care facility (HCCA s.40:1).

- c. a patient/resident may be incapable with respect to some treatments and capable with respect to others (HCCA, 1996, s.15:1).
- d. a patient/resident may be incapable with respect to a treatment at one time and capable at another (HCCA, 1996, s.15:2).
- e. if, after consent to a treatment is given or refused on a patient's/resident's behalf, the patient/resident becomes capable with respect to the treatment in the opinion of the health practitioner, the patient's/resident's own decision to give or refuse consent to the treatment governs (HCCA, 1996, s.16).

POLICY

1. This organization supports and recognizes the right of patients/residents either directly or, if incapable, via their SDM(s), to make informed decisions about their current and future care and to fully and actively participate in this process.
2. Staff shall actively support and assist capable patients/residents in the consent and ACP process by providing comprehensible, adequate and relevant verbal and written information regarding treatment options, possible short and long-term outcomes, alternatives to the proposed treatment interventions, and ethical issues implicated.
3. The completion of any form of advance care plan is entirely voluntary. Patients/residents are therefore not required to develop an advance care plan or to complete a POAPC document. However, given the substantial benefits to the patient/resident in planning and documenting future care and treatment preferences, every effort would be made to educate, counsel and support patients/residents to participate in ACP with their health care practitioners and their trusted significant others or person(s) that would be their future SDM(s) for the patient/resident in the event the he/she should become incapable. Patients/residents who choose not to participate in ACP should be informed of what will happen to them if an emergency situation were to occur, for example, reasonable efforts would be made to resuscitate them in the event of a cardiac event, unless the care team believed that such resuscitation would not be consistent with an acceptable standard of care and would thus be medically inappropriate or futile given the patient's/resident's overall condition.
4. While SDMs are not allowed to develop an advance care plan for a patient/resident, they can make decisions about emergency and life-sustaining treatments, such as cardiopulmonary resuscitation (CPR), that reflect the current situation and plan of care of the patient/resident. Such decisions should be made in accordance with the Health Care Consent Act's principles of substitute decision-making, that is, based on previously expressed capable wishes, values, beliefs or "best interests" (HCCA, 1996, Sched. A, s.21:2). The SDM(s) also has the responsibility of communicating relevant previously expressed capable wishes of the patient/resident related to advance care treatment decisions, where known, to the interdisciplinary team (for example, if the patient/resident

has expressed wishes relevant to the use of a mechanical ventilator, dialysis or a feeding tube).

5. A POAPC (including an advance care plan or directive) becomes effective or activated only in the event that the patient/resident becomes incapable of making a treatment decision. The primary intent and purpose of an advance care plan or any expression of advance wishes about care is to assist and guide an SDM(s) when making care and treatment decisions.
6. In the event that there is disagreement or consensus cannot be reached among equally ranking SDMs about care and treatments decisions, including the interpretation of an advance care plan or of the prior expressed capable wishes of the patient/resident, interdisciplinary staff should make every effort to help reach a reasonable resolution and/or consensus decision. If a consensus cannot be reached among equally ranking SDMs, and a treatment decision is required, the Treatment Decisions Unit of the Office of the Public Guardian and Trustee will need to be contacted. The Public Guardian and Trustee has the authority to then make treatment decisions on behalf of the incapable patient/resident (HCCA, 1996, s.20:6).
7. The SDM(s), a health care practitioner who proposed the treatment, or an official at the Community Care Access Centre responsible for authorizing admission to the care facility, or the member of the service provider's staff responsible for providing personal assistance service may also apply to the Consent and Capacity Board of Ontario (CCB) for assistance with the following:
 - the interpretation of an advance care plan/directive using a Form D.
 - to depart from prior expressed capable wishes using a Form E.

Furthermore, a health care practitioner who proposed the treatment, or an official at the Community Care Access Centre responsible for authorizing admission to the care facility, or the member of the service provider's staff responsible for providing personal assistance service (and only if the person is a resident in a nursing home or home for the aged), may apply to the CCB to determine compliance with SDM guidelines using a Form G.

A list of common CCB forms is attached to an appendix of this document. Detailed information regarding various applications to the CCB, including accessing the appropriate forms, may be found by contacting the CCB within the Greater Toronto Area at 416 924 4961 or Outside the Greater Toronto Area at 1 866 777 9391 (toll free). Alternatively, these could be accessed at the following CCB website: <http://www.ccboard.on.ca/scripts/english/forms/index.asp>

8. Authorization of admission without consent

According to the legislation, despite any law to the contrary, if a person is found by an evaluator to be incapable with respect to his or her admission to a care facility, the

person's admission may be authorized, and the person may be admitted, without consent, if in the opinion of the person responsible for authorizing admissions to the care facility,

- a. the incapable person requires immediate admission to a care facility as a result of a crisis; and
- b. it is not reasonably possible to obtain an immediate consent or refusal on the incapable person's behalf. (HCCA, 1996, s. 47 (1).

“Crisis” means a crisis relating to the condition or circumstances of the person who is to be admitted to the care facility (HCCA, 1996, s. 39).

Every reasonable effort must, however, be made to reach the incapable person's substitute decision-maker and to promptly obtain a consent or refusal of consent even following the admission.

PROCEDURES

Prior to Admission

1. ACP and SDM brochures should be included as part of all pre-admission packages provided to patients/residents. Patients/residents should be asked to bring a copy of their advance care plans or directives or their Power for Attorney for Personal Care upon admission.

Upon Admission

1. As soon as it is reasonable and realistic to do so upon admission, in the context of establishing an appropriate plan of care for the patient/resident, the most responsible physician will discuss Cardiopulmonary Resuscitation (CPR) with the patient/resident or SDM(s) if the patient/resident is incapable. In the absence of a physician, such as in the community setting or in the event that the patient/resident does not have a physician, another regulated health care practitioner (RHP), such as a nurse, will discuss CPR with the patient/resident or SDM(s) if the patient/resident is incapable. The decision with respect to CPR will be recorded on the Initial ACP Form by the RHP. If a No-CPR Order is agreed upon, the most responsible physician will write a No-CPR order on the appropriate physician order form. The nature and outcome of this ACP discussion should be documented by the RHP in the progress notes.

NB: While there may not be any legislative requirements for a physician's No-CPR order (written or oral) -- as long as the patient has expressed an informed decision not to be resuscitated – some organizations require such orders from physicians.

2. A “No-CPR” notation will be made visible on the patient's/resident's chart and care and treatment plan, bearing in mind confidentiality requirements. The decision regarding CPR will also be recorded on the care and treatment plan, nursing kardex or any other

appropriate communication mechanism. A Do Not Resuscitate Confirmation (DNRC) Form should be completed to reflect the patient's DNR status in the event that he/she requires transfer to another facility. The DNRC form represents documentation by physicians and nurses, which are provided to paramedics and firefighters in situations where the DNR order is part of a patient's/resident's treatment plan.

3. If a discussion about CPR is not held, or a decision is not reached during the first attempt to explore this issue, the reason(s) should be documented in the progress notes and follow-up initiated as needed and appropriate.
4. The appropriate members of the health care team are responsible for determining whether the patient/resident is capable of making decisions regarding his/her future care. There is a presumption of decision-making capacity unless there are reasonable grounds to believe otherwise. The appropriate health care practitioner should record decision-making capacity in Section II on the Initial ACP Form. For further information, refer to Initial ACP & Review Form Guidelines.
5. It is important to remember that it is the responsibility of the health practitioner offering the specific treatment to determine capacity for this treatment (HCCA, 1996, s.10:1). Also, if a plan of treatment is prepared for a patient/resident, then one health practitioner, acting on behalf of all the health practitioners, may determine capacity (HCCA, 1996, s.13), as long as this particular practitioner possesses the professional competency to do so.
6. The RHP responsible for the patient/resident's admission shall complete:
 - Section I - Patient/resident and other persons involved in discussion
 - Section III - Substitute Decision Maker(s)
 - Section IV - Written Documentation of Wishes related to Future Care and Treatment
 - Section V - Current or Previously Expressed Wishes related to Future Care and Treatment
 - Section VI - Desire for Further Discussion on the Initial Advance Care Planning Form.

If the legally authorized SDM(s) is not clearly identifiable, the social worker (or other available resources, for example the clinical ethicist) should be consulted for assistance. If other concerns for follow-up are identified, these should be referred to the appropriate health care practitioner.

7. The name, relationship, and contact information for the SDM(s), and existence of ACP documentation in the health record should be recorded on the care and treatment plan, nursing kardex or any other appropriate communication mechanism by the RHP responsible for the patient/resident's admission.

8. If a patient/resident or SDM(s) does not indicate any current or previously expressed capable wishes and chooses not to engage in further ACP, they should be informed of what will happen if an emergency situation arises (e.g., if the patient/resident has a cardiac arrest, basic CPR will be provided, 911 will be called, and patient/resident will be transferred to acute care, unless the care team believed that such resuscitation would not be consistent with an acceptable standard of care and would thus be medically inappropriate or futile given the patient's/resident's overall condition.). A request for further ACP or a decision not to participate in further ACP at the time should be documented by the RHP responsible for the patient/resident's admission in Section V on the Initial Advance Care Planning Form.
9. The RHP responsible for admitting the patient/resident will document a summary of the nature of the ACP discussion in the progress notes.

Post Admission

1. Opportunities for ACP should be incorporated on an ongoing basis into interdisciplinary care meetings with patients/residents or SDM(s), if applicable, annually at a minimum, and more frequently if needed. Whenever possible, the first interdisciplinary care meeting should be held within one to two weeks of admission. The initial meeting provides an opportunity to review the information collected on the Initial Advance Care Planning Form and to identify any changes/updates or areas requiring further follow-up.
2. Each review would necessitate the completion of an Advance Care Planning Review Form, and placement of the most recent copy at the front of the patient's/resident's chart in front of any previous ACP forms. Any changes to the patient's/resident's resuscitation status should be immediately noted in all relevant areas. If a No-CPR Order is agreed upon, the most responsible physician will write a No-CPR order on the appropriate physician order form. The nature and outcome of this ACP discussion should be documented by the physician in the progress notes. Alternatively, in community-based situations, the RHP is to note the patient's/resident's wish in the progress note and care and treatment plan.

NB: While there may not be any legislative requirements for a physician's No-CPR order (written or oral) -- as long as the patient has expressed an informed decision not to be resuscitated -- some organizations require such orders from physicians.

3. A "No-CPR" notation will be made visible on the patient's/resident's chart, bearing in mind confidentiality requirements. The decision regarding CPR will also be recorded on the care and treatment plan, nursing kardex or any other appropriate communication mechanism. A Do Not Resuscitate Confirmation (DNRC) Form should be completed to reflect the patient's DNR status in the event that he/she requires transfer to another facility.
4. Patients/residents or SDM(s), if applicable, should receive a copy of this revised form.

5. If a patient/resident or SDM(s) does not want to engage in ACP, they should be re-informed of the possible consequences of such a decision (see #8 above) and this should be documented on the Advance Care Planning Review Form.
6. The appropriate RHP will document a summary of the nature of the ACP discussion in the progress notes.

Initial Advance Care Planning and/or Review Forms should be also be reviewed with the patient/resident or SDM(s) if appropriate by the interdisciplinary team when:

- the capable patient/resident wishes to change his/her advance care plans
- there is a significant change in the condition of the patient/resident
- the patient/resident is transferred internally or readmitted

Upon Transfer or Discharge to Another Facility

A photocopy of the patient's/resident's care or treatment plan and most recent advance care planning form should accompany the patient/resident when he/she is transferred or discharged to another health care facility for care and treatment. Additionally, the Do Not Resuscitate Confirmation (DNRC) Form should be completed, as appropriate, by the physician, Registered Nurse or Registered Practical Nurse.

As per Procedures above, critical information from the Initial Advance Care Planning Form and most recent Advance Care Planning Review Form should be transferred onto the patient's/resident's care and treatment plan.

Initial Advance Care Planning Form
(This does not constitute Consent to Treatment)

Name of Patient/Resident: _____ Date: _____

I. Persons present at Discussion

Name	Role/Relationship to Patient/Resident
1.	
2.	
3.	
4.	

II. Decision Making Capacity regarding health care decisions

(Appropriate regulated health care practitioner proposing the treatment plan)

1. Does the patient/resident have the capacity to make decisions about future care? (Note that capacity is presumed by law) Yes
 No
 Uncertain

Comments:

If uncertain, plan of action:

III. Substitute Decision-Maker(s) (SDMs)

1. Is there a legally appointed SDM(s) (e.g., Guardian, Attorney for Personal Care, representative appointed by the Consent and Capacity Board Representative)? Yes
 No (If no, go to Section IV)
- a. Has the documentation been verified? Yes
 No
- b. Has a copy of the documentation been provided and placed in the Advance Care Planning section of the health record? Yes
 No
 Not available (Specify reason below)
- When will this document become available?

- c. If more than one individual is named as a legally appointed SDM, how are decisions to be made? Jointly
 Jointly and Severally
 Other: _____

d. Name of SDM(s): _____ Contact Information: _____

2. In the absence of a legally appointed SDM in Section III.1, who is (or would be) the patient/resident's SDM(s)?

Name	Relationship	Contact Information
1.		
2.		
3.		

IV. Written Documentation of Wishes related to Future Care and Treatment

1. Does the patient/resident have a Power of Attorney for Personal Care or other form of advance care planning document that includes wishes related to future care and treatment? Yes
 No (If no, go to section V)

2. Has a copy of the Power of Attorney for Personal Care or any other advance care planning document been provided and placed in the Advance Directives section of the health record? Yes
 No
 Not available (*Specify reason below*)

When will this document become available?

V. Current or Previously Expressed Wishes related to Future Care and Treatment – may be written, oral, or expressed in any other form

1. Does the patient/resident have any current or previously expressed wishes re cardiopulmonary resuscitation? Yes
 No

If yes, please describe:

**If a wish related to “No Cardiopulmonary Resuscitation” is identified, the most responsible physician must discuss CPR with patient/resident or SDM, if applicable, to ensure informed consent, and if a No CPR decision is agreed upon, the physician must complete the No Cardiopulmonary Resuscitation Physician Order.*

A DNR Confirmation form should also be completed at this time.

2. Does the patient/resident have any current or previously expressed beliefs, values, or wishes related to future care and treatment that should be noted? (e.g., tube feeding, mechanical ventilation, intravenous therapy) Yes
 No

If yes, please describe:

3. Does the patient/resident have any current or previously expressed wishes re organ donation? Yes (*please comment*)
 No

If yes, please describe:

VI. Desire for Further Discussion

1. Would the patient/resident like to engage further in the process of advance care planning? Yes (*please comment*)
 No

Comments:

Plan of action including time-frame(s):

Notes:

1. A copy of this form should be provided to the patient/resident or SDM(s) if applicable.
2. Changes/updates to care directives should be made on the Advance Care Planning Review Form, not on this form.

Regulated health care practitioner proposing the treatment plan:

Name (Please Print)

Signature

Date

Regulated health care practitioner completing form if different from person above:

Name (Please Print)

Signature

Date

Advance Care Planning Review Form
(This does not constitute Consent to Treatment)

The most recent ACPR form is to be attached in front of any previous ACP forms.

Name of Patient/Resident: _____ Date of Review: _____

I. Persons present at Discussion:

Name	Role/Relationship
1.	
2.	
3.	
4.	

Changes Noted in the Following Areas

II. Decision Making Capacity regarding health care decisions

(Appropriate regulated health care practitioner proposing the treatment plan) Yes No

Comments: _____

III. Substitute Decision Maker(s)

Yes (specify below) No

Name of SDM(s): _____

Contact Information: _____

IV. Written Documentation of Wishes related to Future Care and Treatment

Yes No

If yes, please describe: _____

V. Current or Previously Expressed Wishes related to Future Care and Treatment -- may be written, oral or expressed in any other form

Yes No

If yes, please describe: _____

**If a wish related to "No Cardiopulmonary Resuscitation" is identified, the most responsible physician must discuss CPR with patient/resident or SDM, if applicable, to ensure informed consent, and if a No CPR decision is agreed upon, the physician must complete the No Cardiopulmonary Resuscitation Physician Order.*

A DNR Confirmation form should also be completed at this time.

VI. Desire for Further Discussion

Yes (please comment) No

Comments: _____

Regulated health care practitioner proposing the treatment plan:

Name (Please Print)

Signature

Date

Regulated health care practitioner completing form if different from person above:

Name (Please Print)

Signature

Date

INITIAL ADVANCE CARE PLANNING & REVIEW FORM GUIDELINES

The purpose of the Initial Advance Care Planning Form is to communicate and document information related to the patient/resident's decision making capacity, SDM(s), and any current or previously expressed capable wishes related to future care and treatment at the time of admission. The purpose of the Advance Care Planning Review Form is to document outcomes of ongoing discussions regarding ACP. Both forms should be stamped with the patient/resident addressograph. Section II should be completed by the appropriate regulated health care practitioner proposing the care and treatment plan. Sections I, III, IV, V and VI should be completed by the appropriate RHP responsible for patient/resident's admission. This may be same person.

II. Decision Making Capacity

In section II, the health care practitioner is asked to indicate if the patient/resident has the capacity to make decisions about future care. If the answer is yes, no further detail is required. However, it may be helpful to add a statement such as "The patient/resident understood and appreciated the nature of the decisions he/she was making about his/her future care." If the answer is no or uncertain, evidence to support this finding is required. If there is uncertainty, consultation with other members of the health care team may be helpful (e.g., psycho-geriatrician, social worker, clinical ethicist). It should also be noted if the condition is considered temporary or irreversible. If the finding of incapacity is a new one, a detailed progress note should also be completed. It is important to remember that patients/residents are entitled to rights advice and recourse to a Consent and Capacity Board following a finding of incapacity.

III. Substitute Decision Maker(s)

In section III, the legally authorized SDM (and contact information) for the patient/resident, as defined in the *Health Care Consent Act* (1996), should be documented. Although the SDM will only be asked to make decisions in the event that the patient/resident is incapable, this information should be recorded for all patients/residents as part of proactive planning. This information should also be recorded on the patient's/resident's kardex or any other appropriate communication mechanism.

If a person is incapable with respect to personal care decisions, according to the *Health Care Consent Act* (1996) consent may be given or refused on his or her behalf by a person described below and in the following hierarchical order:

1. guardian of the person with authority to make treatment decisions
2. Attorney for Personal Care with authority to make treatment decisions
3. representative appointed by the Consent and Capacity Board
4. spouse or partner (defined in Glossary of Terms)
5. child (16 years and older) unless parent of incapable patient/resident
6. parent who has only a right of access
7. brother or sister
8. any other relative
9. Office of the Public Guardian and Trustee

Although SDM(s) have the authority to make health care decisions, SDM(s) cannot complete an advance care plan or express wishes about future health care on behalf of another person. Only the person, him or herself, can express wishes about future health care or complete an advance care plan or directive. However, an SDM is able to consent to a plan of care that includes the administration or withholding of life-sustaining treatments in the context of the patient's/resident's present health condition. As well, the SDM is authorized to communicate the patient/resident's previously expressed capable wishes.

If the patient/resident has more than one equally ranking SDM, the process for making decisions should be identified. The document may indicate that decisions need to be made jointly (by consensus), jointly and severally (meaning that individuals may act together or independently), or by some other mechanism, such as granting one SDM authority over another, which only the equally ranking SDMs can decide to follow—this type of condition cannot be imposed upon the SDMs by the health providers – it is at the choice of the SDMs if this type of provision is not in the court order or the POAPC.

Documentation to verify legally appointed SDMs should be viewed and the viewing of the document recorded by the appropriate RHP(s) responsible for the patient/resident's admission. A copy should be requested and placed in the Advance Directives section of the chart. Anyone claiming decision-making authority, for example, a POAPC or court order, is required to produce the documentation in order for health care practitioners to verify the identity of the legally appointed attorney(s).

NB: Health care practitioners are permitted to rely on the accuracy of an assertion from a person that he/she is the substitute decision-maker unless it would not be reasonable to do so under the circumstances (HCCA, 1996, s.29:6). There is, therefore, allowance for a discretionary/judgment call with regard to verification of the legitimacy of the substitute decision-maker. Some organizations have taken the position that it is a prudent measure to request such clarification as standard practice.

IV. Written Documentation of Wishes Related to Future Care and Treatment

If the patient/resident has prepared a written advance care plan or directive, living will, or POAPC this should be recorded in this section. As well, it should be prudent and reasonable to request a copy of the document and file it in the Advance Directives section of the chart.

V. Current or Previously Expressed Wishes Related to Future Care and Treatment

Existence of any current or previously expressed wishes re cardiopulmonary resuscitation, organ donation, and other future care and treatments should be documented in the appropriate boxes in this section. This may include wishes currently expressed by a capable patient/resident or the previously expressed capable wishes of a now incapable patient/resident. Wishes related to future care and treatment may relate to the delivery or withholding of life-sustaining treatments such as mechanical ventilation, feeding tubes, transfer to acute care, and intravenous therapy. Details of the expressed wishes should be recorded in the comment sections. If the individual

wishes to donate his/her eyes, organs or tissues, this should be recorded and the appropriate consent forms completed (if not already done).

Wishes include those expressed in written forms, orally, or in another manner. Most recently expressed capable wishes prevail over earlier wishes. It is often useful to use the patient/resident's or SDM's own words when describing expressed wishes. **It is important during this discussion to ensure that the individual is making decisions based on correct information and an accurate understanding and appreciation of the nature and consequences of the wishes they are expressing.** Options should be explained in terms of the expected burdens and benefits for the individual patient/resident. Facility limitations, in terms of provision of treatments, should also be discussed.

VI. Desire for Further Discussion

If the patient/resident has not considered their wishes around future care and treatment options before this admission or would like to discuss future care and treatment options further, please document this request in this section. Further discussions could be held between the patient/resident, SDM(s), and the physician, with other individual members of the health care team including the social worker (or other available resources, for example the clinical ethicist), or with the team as a whole. If the patient/resident or SDM(s) has a preference as to which individual(s) they would like to meet with, please indicate this in the comment section.

A copy of the Initial Advance Care Planning Form should be provided to the patient/resident or SDM(s) if applicable.

APPENDIX 1: Glossary of Terms

Best Interests

The SDM who gives or refuses consent for treatment on behalf of an incapable person must take into consideration: the values and beliefs that the person knows the incapable person held when capable and believe he or she would still act on if capable; any wishes expressed by the incapable person prior to becoming incapable with respect to the treatment; whether the treatment is likely to improve, prevent deterioration or extent and rate of deterioration of the capable person's condition or well-being; if treatment was not provided would the condition or well-being be likely to improve, remain the same or deteriorate; do the expected benefits outweigh the risk of harm and would a less restrictive or less intrusive treatment be as beneficial as the proposed treatment. (HCCA, 1996, s. 21)

Capable

Has the corresponding meaning to capacity.

Capacity

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able 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 able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. (HCCA, 1996, s.4:1)

- A person may be incapable with respect to some treatments and capable with respect to others.
- A person may be incapable with respect to a treatment at one time and capable at another time.
- If, after consent to a treatment is given or refused on a person's behalf in accordance with this Act, the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the treatment governs. [HHCA 1996, c. 2, Sched. A, s. 15 & 16 (1)]

Definition of Treatment

Meaning anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include: the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose; the assessment or examination of a person to determine the general nature of the person's condition; the taking of a person's health history; the communication of an assessment or diagnosis; the admission of a person to a hospital or other facility; a personal assistance service; a treatment that in the circumstances poses little or no risk of harm to the person; and anything prescribed by the regulations as not constituting treatment. (HCCA, 1996, s.2:1; 2000, c.9, s.31)

Do Not Resuscitate Confirmation Form (DNRC)

In the event that a DNR is part of the patient's/resident's treatment plan, the DNRC form, when completed by a physician or nurse, will be honoured by paramedics and firefighters as to exactly what resuscitative actions would be appropriate for the patient/resident in the event of a respiratory or cardio-respiratory arrest.

Emergency Situations

In situations where emergency medical treatment is proposed and a person is incapable to make treatment decisions the health care practitioner proposing the treatment may do so without consent if, in their opinion: an emergency exists; and the delay to obtain consent or refusal on the person's behalf will prolong the suffering or will put the person at risk of sustaining serious bodily harm. (HCCA s.25:2)

Emergency treatment may be continued only for as long as is reasonably necessary to find the incapable person's SDM and to obtain from him or her consent, or refusal of consent, to the continuation of the treatment. (HCCA, 1996, s. 25:6)

If after treatment is begun the person becomes capable with respect to the treatment in the opinion in the health care practitioner, the person's own decision to give or refuse consent to the continuation of the treatment governs. (HCCA, 1996 s. 25:9)

If the consent to a treatment is refused on an incapable person's behalf by the SDM, the treatment may be administered despite the refusal, in the opinion of the health practitioner proposing the treatment: there is an emergency; and is not meeting the legal requirement for following the principles for giving or refusing consent (i.e. the SDM is not following the patient's/resident's prior expressed capable wishes or acting in his/her best interests (HCCA 1996, s. 21)

If the person is capable to make decisions, proposed treatment can be administered without consent if in the opinion of the health practitioner proposing the treatment: there is an emergency; the communication required in order for the person to give or refuse consent to the treatment cannot take place because of language barrier or because the person has a disability that prevents the communication from taking place; steps that are reasonable in the circumstances have been taken to find practical means of enabling the communication to take place, but no such has been found; the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and there is no reason to believe that the person does not want the treatment. (HCCA, 1996, s. 25:3)

Emergency treatment may be continued only for as long as is reasonably necessary to find a practical means of enabling the communication to take place so that the person can give or refuse consent to the continuation of the treatment (HCCA, 1996 s. 25:7)

Health Practitioner

“health practitioner” means,

- (a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,

- (b) a member of the College of Chiropractors of Ontario, including a member who is a podiatrist,
- (c) a member of the College of Chiropractors of Ontario,
- (d) a member of the College of Dental Hygienists of Ontario,
- (e) a member of the Royal College of Dental Surgeons of Ontario,
- (f) a member of the College of Denturists of Ontario,
- (g) a member of the College of Dietitians of Ontario,
- (h) a member of the College of Massage Therapists of Ontario,
- (i) a member of the College of Medical Laboratory Technologists of Ontario,
- (j) a member of the College of Medical Radiation Technologists of Ontario,
- (k) a member of the College of Midwives of Ontario,
- (l) a member of the College of Nurses of Ontario,
- (m) a member of the College of Occupational Therapists of Ontario,
- (n) a member of the College of Optometrists of Ontario,
- (o) a member of the College of Physicians and Surgeons of Ontario,
- (p) a member of the College of Physiotherapists of Ontario,
- (q) a member of the College of Psychologists of Ontario,
- (r) a member of the College of Respiratory Therapists of Ontario,
- (s) a naturopath registered as a drugless therapist under the Drugless Practitioners Act, or
- (t) a member of a category of persons prescribed by the regulations as health practitioners; (“praticien de la santé”)

Informed Consent

The following are the elements required for consent to treatment: consent must relate to the treatment; consent must be informed; consent must be given voluntarily; and consent must not be obtained through misrepresentation or fraud. (HCCA, 1996, s.11:1)

A consent to treatment is informed if, before giving it: the person received the information about the matters set out in subsection (3); that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and the person received responses to his or her requests for additional information about those matters. (HCCA, 1996, s.11:2)

The matters referred to in subsection (2) are: the nature of the treatment; the expected benefits of the treatment; the material risks of the treatment; the material side effects of the treatment; alternative courses of action; and the likely consequences of not having the treatment. (HCCA, 1996, s.11:3)

Meaning of “partner”

“Partner” means, either of two persons who have lived together for at least one year and have a close personal relationship that is of primary importance in both persons’ lives. 2002, s. 10; 2004, c. 3; s. 84 (5, 6).

Meaning of “relative”

Two persons are relatives for the purpose of this section if they are related by blood, marriage or adoption. 1996, s. 20 (10).

Meaning of “spouse”

Two persons are spouses if,

- (a) they are married to each other; or
- (b) they are living in a conjugal relationship outside marriage and,
 - (i) have cohabited for at least one year,
 - (ii) are together the parents of a child, or
 - (iii) have together entered into a cohabitation agreement under section 53 of the Family Law Act. 1996, s. 20 (7); 2004, s. 84 (1-3).

Two persons are **not** spouses for the purpose of this section if they are living separate and apart as a result of a breakdown of their relationship. 2004, s. 84 (4).

Power of Attorney for Personal Care

A legal document that names an SDM (called an attorney) and may contain directions about future health care treatment and items related to personal care. Two people must witness it and it must be in writing. The individual must be 16 years of age and capable to make a POAPC at the time of signature (Substitute Decision Act, 1992). Only an individual can create a Power of Attorney for himself or herself, an SDM cannot prepare a power of attorney on behalf of another person.

Principles for giving or refusing consent on behalf of the incapable patient/resident

A person who gives or refuses consent to a treatment on an incapable person’s behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person’s best interests. 1996, s. 21 (1).

Substitute Decision Maker (SDM)

If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by another person. In order of hierarchy are: the incapable person’s court-appointed guardian; attorney for personal care; representative appointed by the Consent and Capacity Board; spouse or partner; a child or parent; a parent of the incapable person who has only a right of access; a brother or sister; or any other relative. (HCCA, 1996, s.20:1)

Requirements: An SDM may give or refuse consent only if he or she:

1. is capable to understand the proposed treatment;
2. is at least 16 years old, unless he or she is the incapable person’s parent;
3. is not prohibited legally from having access to the incapable person or giving or refusing consent on his or her behalf;
4. is available;
5. is willing to assume the responsibility of giving or refusing consent. (HCCA, 1996, s.20)

A patient/resident cannot name a health care practitioner or the health team or anyone else that provides them with health care as their attorney in a POAPC unless that person is a spouse, partner or relative. Substitute Decisions Act s. 46(3). **The SDM will cease to act on behalf of an incapable person if he or she should regain capacity.**