# **Advance Care Planning**

Think, Talk and Plan about your future health care

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### Land Acknowledgement

We would like to acknowledge that our places of work and the Vancouver Coastal Health facilities lie on the traditional, unceded homelands of the fourteen First Nation Communities of the Heiltsuk, Kitasoo-Xai'xais, Lil'wat, Musqueam, N'Quatqua, Nuxalk, Samahquam, Sechelt, Skatin, Squamish, Tla'amin, Tsleil-Waututh, Wuikinuxv, and Xa'xtsa.

Aboriginal Health



Source: http://www.vch.ca/Documents/Indigenous-cultural-safety-policy-booklet.pdf







### **The Life Planning Model:** Advance Care Planning is part of life planning





# Our focus for today's session:

Support you in your Advance Care Planning by:

- Sharing information—the <u>why</u>, <u>who</u>, <u>when</u> and <u>how</u> of it!
- Preparing you for the decisions you will need to make
- Increasing your comfort in talking with your family, friends and health-care providers about your health care wishes
- Providing resources for you to continue your planning



# Advance Care Planning is

- **thinking** about your values, beliefs, and wishes for future health and personal care, and
- **sharing** them with the people you trust.

It includes choosing who would make care decisions for you if you cannot.

Advance Care Planning can help you get the health and personal care that's right for you.



### Why should I care about Advance Care Planning?

For you. For your family and friends. For your health-care providers.



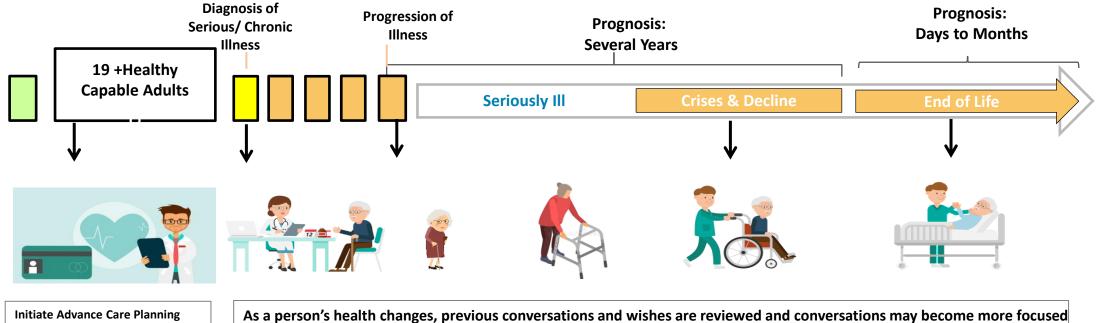


# Who should do Advance Care Planning? When should they do it?





### Multiple Opportunities for Conversations



(ACP)

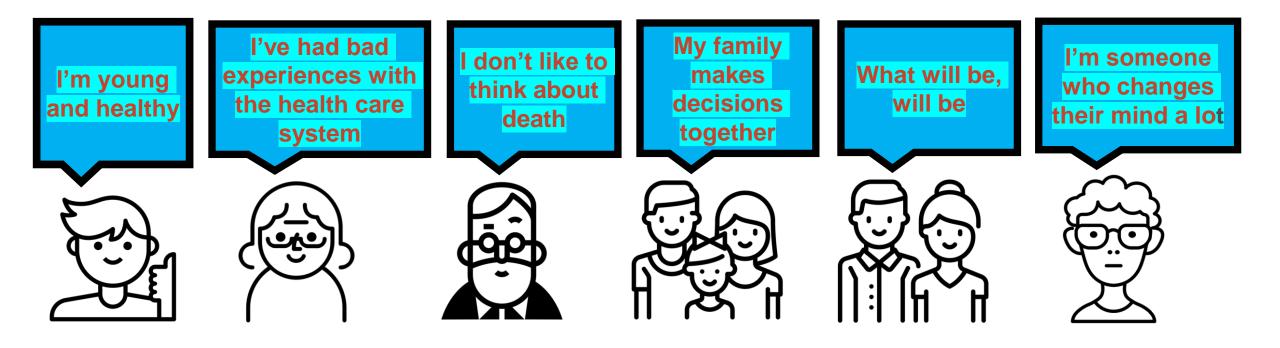
As a person's health changes, previous conversations and wishes are reviewed and conversations may become more focused on specific treatments and interventions, but always based on client's values and beliefs and what matters most to them.

#### Palliative Approach to Care

Adapted from Dana Farber Cancer Institute & Ariadne Labs, 2016



### Yet, we still put it off...





# How to do ACP?







### Think

What matters most to you? Who could make health-care decisions for you if you cannot?

Review

### Talk

**Discuss** your thoughts with:

- the people you trust; and
- your health-care providers.

#### Plan

**Record** your wishes. **Share** your plan with:

- the people you trust; and
- your health-care providers.





# Think: What could you think about?

- What concerns you the most about your future health care?
- What does Quality of Life mean to you? What activities make your life worth living?
- What would matter to you if you became unwell and couldn't communicate?
- Do you have personal beliefs that are important to your health-care wishes?





# **Think:** Who could make health-care decisions for you if you cannot?

### **Capability & Consent**

- If you are able to understand and communicate, you will be asked for **consent**.
- What does it mean to be **capable** of providing consent?
- If you are not capable of providing consent, someone else will be asked.
- Advance Care Planning helps you determine who will speak for you and ensure they will know what to say.





# **Think**: Who could make decisions for you if you cannot?

# In BC\*, you have two choices for a Substitute Decision Maker:

\* provinces differ; check your province

You decide who speaks for you

(Representation Agreement)

or

# Your health-care provider decides who speaks for you

(Temporary Substitute Decision Maker)

A good substitute decision maker:

- Will honor your wishes and instructions, even if they are different from their own.
- Is calm in a crisis.
- Can communicate with health-care providers.
- Will not be pressured into accepting treatment that they know you wouldn't want.
- Can handle conflict or disagreement.



Your health-care provider decides who would make decisions for you if you cannot.

### Temporary Substitute Decision Maker

- 1. Spouse (common law, any gender)
- 2. Child
- 3. Parent
- 4. Brother or sister
- 5. Grandparent
- 6. Grandchild
- 7. Anyone else related by birth or adoption
- 8. Close friend
- 9. A Person immediately related by marriage10.Public Guardian and Trustee or anotherperson appointed by them

The person must be: 19 years of age or older, capable, have no dispute with you, and have been in contact with you in the past year.



**You decide** who would make decisions for you if you cannot.

### **Representation Agreement (Section 9)**

- You can name one or more Representatives by completing a Representation Agreement.
- This is a legal document completed by you as a capable adult.
- You do not need a lawyer or notary.



### **Two types of Representation Agreements**

Section 9 – Enhanced	Section 7 - Standard
Used by a capable person	Can be used by person with lessened capacity
Representative can make personal care and health care decisions	Representative can make personal care and minor and major health care decisions
Includes decisions about life support & life prolonging treatments	Cannot make decisions to refuse life support
Cannot make financial decisions (can make an Enduring Power of Attorney)	Provides for routine management of financial and legal affairs





# " "I make my health-care decisions in advance"

### **Advance Directive**

- Your voice when you are not capable of making a decision.
- A legal document with written instructions about a specific healthcare treatment.
- These instructions must be honoured, as long they address the treatment offered at the time.
- If you are considering an Advance Directive, speak to your healthcare provider to ensure your directive is clear.



Talk: with the people you trust





# Talk: What to Share?

- what is important to you
- your fears and concerns
- treatment decisions you already know
- who will make decisions for you
- how you hope that person will be supported







# Talk: Having the conversations

I was thinking about what happened to John when he was sick. I wouldn't want that. I would want...

> I'm not sick right now, but I want to think ahead and be prepared if something unexpected should happen...





# Talk: to your health-care providers











# Advance Care PLAN

- Documentation of your
- wishes
- Contact information for your Temporary Substitute Decision Makers

### Optional:

- Representation Agreement
- Section 9
- Advance Directive





# Key things to remember

- As long you can understand and communicate, you will make your own health-care decisions.
- You can change your Advance Care Plan at any time.
- Advance Care Planning is not just a one-time event it's a process you should revisit throughout your life.
- Conversations get easier the more you have.
- You have options for how you want to express and record your wishes.







### Resources

• My Voice - BC Ministry of Health

<u>www2.gov.bc.ca/gov/content/family-social-</u> <u>supports/seniors/health-safety/advance-care-planning</u>

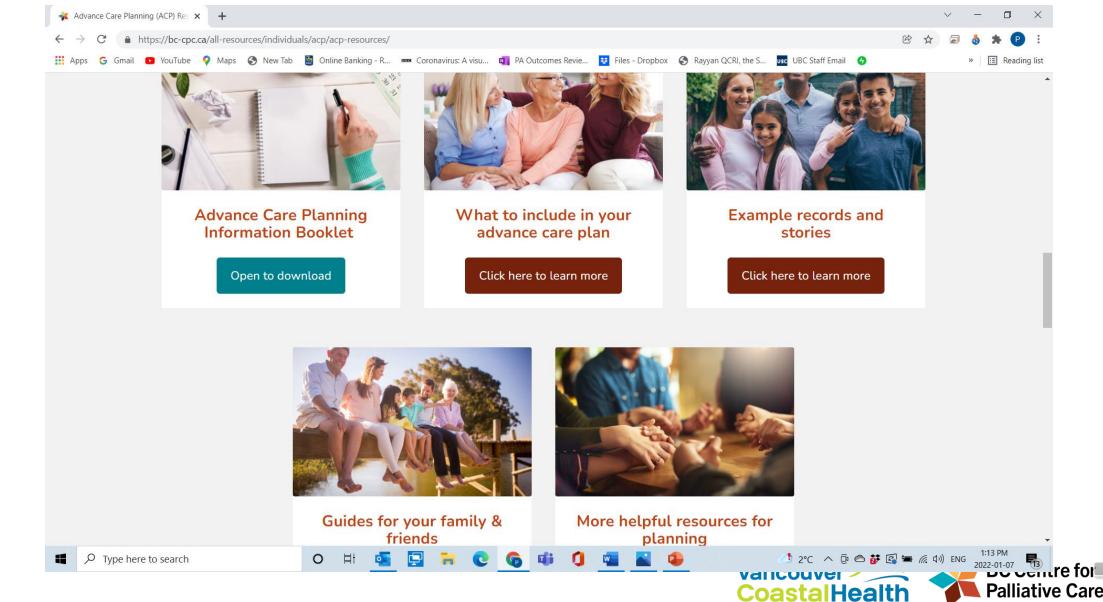
- BC Centre for Palliative Care <u>www.bc-cpc.ca/acp</u>
- Advance Care Planning Canada <u>www.advancecareplanning.ca</u>

Essential Conversations: A Guide to Advance Care Planning in Long Term Care Settings

Essential Conversations: A Guide to Advance Care Planning in Long-Term Care Settings - ACP in Canada | PPS au Canada



## Screen shot of BC CPC website



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# Overwhelmed?



# Like building a puzzle.... one piece at a time!



# Thank you for participating!



