

Leadership in Advance Care Planning in Ontario

As a leader within our health care system, the Health Care Consent (HCC) and Advance Care Planning (ACP) Community of Practice (CoP) invites you to consider how the knowledge and practices you model related to HCC and ACP impact the individuals and organizations you serve.

The information and tool that follow are intended to support your leadership role around HCC and ACP in Ontario. The Ontario legal framework must be reflective in all HCC ACP work and projects. With this in mind, we ask that you reflect upon the following:

How am I, in a leadership position, contributing to the discussion here in Ontario?

- Do I have a working knowledge of ACP and its connection to HCC in the Ontario legal framework
- Do I use opportunities to educate and mentor understanding and accuracy (e.g. do terms such as Advance Care Directives, Living Will, Advance Care Plan trigger those education opportunities)
- Do I review materials for accuracy and consistency based on the Ontario legal framework

Advance Care Planning is a *process* of reflection and communication. It is an opportunity for a person to reflect on their values and wishes and to let others know what kind of health and personal care they would want in the future if they became incapable of consenting to or refusing treatment or other care. Advance Care Planning includes understanding who would be your Substitute Decision Maker (SDM) through the Hierarchy of Substitute Decision Makers as outlined in the Health Care Consent Act (HCCA) or naming a SDM through completing a Power of Attorney for Personal Care document (POAPC).

Health Care Consent (informed consent) refers to the permission a person (if capable or their SDM if not capable) gives to health care providers that allows medical investigations and/or treatments. Health care providers are required to share the context of the treatment that is being offered (or withdrawn or withheld), the details of the investigation/treatment and the risks, benefits and side effects. This includes any alternative options and what would happen if a person (if capable or their SDM if not capable) does not choose the offered treatment/investigation. Health care providers are also required to answer any questions that arise. This is the level of information that must be provided before a person gives consent.

[2014 Law Commission of Ontario Report on Health Care Consent and Advance Care Planning](#)

Advocacy Centre for the Elderly (ACE) tip sheets: [Health Care Consent and Advance Care Planning: the Basics](#) and [Hierarchy of SDMs in the Health Care Consent Act \(HCCA\)](#)

Do I understand and share an Ontario based knowledge of what ACP is:

- the process of the expression of wishes ('advance care planning')
- that wishes in Ontario can be expressed orally, in writing or by any other communication means
- the writing down of wishes is not specified in Ontario law and that the use of terms such as advance directive, living will and advance care plan are borrowed from other jurisdictions and can mislead and mislead health care professionals and the public into making assumptions about written wishes
- the role of the SDM
- how wishes can help guide SDM's in providing informed consent for health care decisions
- the misuse of terms such as next of kin, proxy, etc.
- the SDM hierarchy
- the expression of wishes can help inform a care plan or plan of treatment that a health care provider would create when a person shares their wishes based upon their current condition

[2014 Law Commission of Ontario Report on Health Care Consent and Advance Care Planning](#)

[Consent and Capacity Board information sheets](#)

Do I use terminology that consistently conveys Ontario based knowledge on how ACP can help inform a treatment plan or plan of care decision through:

- sharing that health care law in Ontario allows for the development of a plan of treatment or care plan based on a person current condition (even if it is in anticipation of issues to come with disease progression)
- actively working to remove and end the practice of level of care forms within health care organizations
- understanding that one could use the wishes and values/beliefs shared in the process of wish expression (advance care planning) to inform a current care plan
- understanding that expressed wishes can be the start of creating a treatment plan or care plan that is reflective of those conversations (a treatment plan can be created even if the plan comes into effect in the future in situations of a known health condition)
- speaking up when I see terms in proposals, policies, presentations that can confuse informed consent and the process of ACP (see **Important Words** information sheet below)

[2014 Law Commission of Ontario](#) - survey of Institutional Policies and Practices (pages 227-237) and Issues Identified in Ontario (pages 269-277)

I can and will contribute to the encouragement and support of the process of wishes expression, the responsibility of health care providers and organizations to get it right by:

- screening/vetting proposals, projects, presentations and resource materials etc. for language, representation that is accurate
- sharing or providing resources and tools that come from an Ontario legal framework and not other provinces, or countries that do not reflect the Ontario reality
- actively encouraging, cueing, and educating based on an Ontario legal framework
- personally being accurate in the use of terms and information I share on ACP, HCC
- creating opportunities to ensure common understanding when attending meetings and sessions that are speaking to the subject of ACP (expression of wishes) or HCC
- Working and collaborating to ensure and inform national, provincial and regional directions, expectations and work that is promoting HCC and the process of ACP into the system as a whole

[2014 Law Commission of Ontario](#) - Recommendations pages 278 to 291

This is an exciting time in Ontario with changes to health care, hospice palliative care and opportunities to work together. Your role as a leader is critical to shaping the path, and empowering those that we work with to influence change.

Valuable Resources

¹[Health Care Consent Act](#)

²[A Guide to the Substitute Decision Act](#)

Advocacy Centre for the Elderly (ACE) tip sheets:

[Health Care Consent and Advance Care Planning: the Basics](#)

[Hierarchy of SDMs in the Health Care Consent Act \(HCCA\)](#)

[25 Common Misconceptions About The Substitute Decision Act and Health Care Consent Act](#)

[Ontario Seniors' Secretariat: A Guide to Advance Care Planning](#)

[HCC & ACP Publications](#)

Consent and Capacity Board - [Information Sheets](#)
- [Frequently Asked Questions](#)

[The Office of the Public Guardian and Trustee Power of Attorney Kit](#)

[2014 Law Commission of Ontario](#)

Ontario Medical Association – [ACP webpage](#) with resources and [ACP Backgrounder](#)

[Community Legal Association of Ontario \(CLEO\) re Power of Attorney for Personal Care](#)

[Speak Up Start the conversation about end-of-life care website](#)

[Speak Up Start the conversation about end-of-life care Provincial Resources](#)

- [Ontario ACP workbook](#)
- [ACP Quick Guide](#)

[Hospice Palliative Care Ontario \(HPCO\) Educational Resources](#)

For Health Care Providers

- Full PowerPoint Presentation and Facilitator Guide
- Condensed PowerPoint and Facilitator Guide
- Video – Health Care Consent in Relation to Advance Care Planning for Providers
- Video – Health Care Consent and Advance Care Planning: Getting it Right in Ontario for Health Practitioners

For Public

- Full PowerPoint Presentation and Facilitator Guide
- Condensed PowerPoint and Facilitator Guide
- Video – Advance Care Planning and Health Care Consent in Ontario: Making Your Wishes Known

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References for the above information can be found within: the HCCA, the SDA and the Research Paper for the Law Commission of Ontario: Health Care Consent and Advance Care Planning in Ontario, J.Wahl, , B. Gray (Advocacy Centre for the Elderly) M.J. Dykeman (Dykeman, Dewhurst, O'Brien LLP) <http://lco-cdo.org/en/capacity-guardianship-commissioned-paper-ace-ddo>

| Important Words | Below is a listing of common words, concepts as well as misconceptions about HCC & ACP in Ontario. Shaded boxes indicate a call to action: i.e. learn more about it, correct and update documents, provide education and reinforce appropriate language. |
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| Advance Directive, Directive, Living Will | The terms “Advanced Care Directives”, “Directive”, “Advance Care Plan”, and “Living Will” are not Ontario terminology nor used within the law. These terms should not be used in any policies, conversations and/or documents. |
| Written down, Document, Documented | Advance care planning (ACP) is a guide to the incapable person’s Substitute Decision Maker (SDM) not health care providers (HCP). ACPs are not informed consents. Health practitioners are required by law to get an informed consent from a person (patient or incapable person’s SDM) before any treatment except in an emergency. (sect. 10 Health Care Consent Act) The only time advance wishes may be used directly by a health provider is in the case of an emergency when it is not possible to get an informed consent from the patient or appropriate SDM. Focusing on the writing of wishes (ACP) contributes to the mistaken belief that the document holds legal power. In Ontario wishes may be communicated in writing, orally, or by alternative means (video, communication board etc.) |
| Next of Kin | Many forms refer to a patient’s “next of kin” or “POA” rather than the patients SDM if he or she should become incapable for making decisions regarding treatment. Often health practitioners refer to a patient’s ‘next of kin’, as if this were a legal category of SDM. These terms should not be used in any policies, conversations and/or documents |
| Expression of Wishes, Wishes | ACP involves discussions about ‘wishes’ not ‘choices’ or ‘decisions’. Wishes, values, beliefs need not be about specific treatments but can be about what they think is quality of life – anything that would help the SDM feel confident when called on to make decisions for an incapable patient. Most APCs wishes are NOT in context of the patient’s condition. The patient may have expressed a wish without having any information of their condition(s) or possible options for treatment. They may base it on something they saw on TV or on an experience a friend or family member had. In other words, ACP is not a <i>treatment plan</i> , is not a <i>plan of care</i> and is not <i>goals of care</i> . It is an expression of ones wishes only and not informed consent needed to implement treatment plans. |
| POA, Power of Attorney | The document is called the Power of Attorney for Personal Care (POAPC). The person(s) named within the POAPC is called an “attorney” which is a type of SDM. It is important to reference the POAPC and not just a Power of Attorney (POA) since there are two types of POAs. The only one relevant to health decision making is the POAPC. Only a POAPC, which is a form of an ACP, may name or appoint an SDM. |
| Hierarchy of Substitute Decision Maker(s) (SDM(s)) | A patient needs to understand who would be his/her SDM for health care if he/she became mentally incapable to make health decisions. Every patient automatically has a person who will have legal authority to act as his/her SDM if they become incapable. The HCCA states that a Patient’s SDM will be the person or persons who are highest ranked on the HIERARCHY of SDMs list that legislates who is to be the SDM. A patient may decide they are satisfied having the individual(s) with the highest ranking in the hierarchy to act on their behalf should they become incapable, or they may choose someone else through naming or appointing in a POAPC. SDMs CANNOT ACP, but can <u>only</u> give or refuse consent to treatment or make other health decision for the incapable patient. |
| Health Care Consent (Informed Consent) | Obtaining informed consent (IC) is more than ticking a box on a form. It involves a rich and robust discussion between a patient (or the incapable patient’s SDM) and health care provider(s). Informed consent is a DECISION about health care obtained before treatment commences after communication about the patient’s condition, treatment options, and the risks, benefits, side effects, alternatives and what would happen if the patient refused the treatment has taken place. IC includes planning about care (immediate care options but also setting goals for care and future plans related to the patients’ present health condition). |
| <p>References for the above information can be found within: the Health Care Consent Act, the Substitute Decisions Act and the Research Paper for the Law Commission of Ontario: Health Care Consent and Advance Care Planning in Ontario, J.Wahl, , B. Gray (Advocacy Centre for the Elderly) M.J. Dykeman (Dykeman, Dewhurst, O’Brien LLP) http://lco-cdo.org/en/capacity-guardianship-commissioned-paper-ace-ddo</p> <p style="text-align: right;">Created by The HCC & ACP CoP, ON, October 2015</p> | |