BC Centre for Palliative Care

Advance Care Planning

Think, *Talk* and *Plan* about your health care – now and when you can't speak for yourself

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What I Do Matters.

Welcome and Introductions

- QDHPCA Board Members:

  CL Smith

- Presenter:

  Deborah Pedersen

Housekeeping

- This will be an interactive presentation and we will take questions throughout
- We encourage open participation and ask that you are respectful of how individual we are in processing this information
- Please also respect the confidentiality of others in the group

Advance Care Planning supports you to:

√ **Think** about what matters most to you and who could be your voice

√ **Talk** with those closest to you about your thoughts and if you have chronic or serious illness, talk with your health-care team

√ **Plan**, learn about the options and best ways for you to plan; share your plan with your family, substitute decision maker and your health-care team.

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What I Do Matters.

Our focus for today's session:

We want to support you in your advance care planning by:

- sharing information about advance care planning—the "why", the "what ", and "how" of it!
- increasing your comfort in talking to those closest to you--your family, friends-- and the health care team
- providing you with resources to support your planning

Why is advance care planning important?

https://www.youtube.com/watch?v=_6gFzCiMnlg

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Getting started: Think about what matters most to you

- What makes each day worthwhile?
- What makes you happy?
- What matters most to you?
- What beliefs guide you?

What do I value most in terms of my mental and physical health?

Examples:

- being able to live independently,
- being able to recognize others,
- being able to communicate with others

What would make prolonging life unacceptable for me?

Examples:

- Not being able to communicate with those around me
- Being kept alive with machines but with no chance of survival
- Not having control of my bodily functions

When I think about death, I worry about certain things happening

For example:

- Struggling to breathe
- Being in pain
- Being alone
- Losing my dignity

If I were nearing death, what would I want to make the end more peaceful for me?

For example:

- Family and friends nearby
- Dying at home
- Having spiritual rituals performed

Do I have any spiritual or religious beliefs that would affect my care at the end of life?

For example:

- Beliefs about the use of certain medical procedures

Think about who could be your voice

- A good substitute decision maker(s) is someone who could your honor your wishes and instructions (this is their legal role), even if they are different from their own, are calm in a crisis and able to handle conflict.

Think about who could be your voice

- Who knows what gives your life meaning, joy and purpose?

- Who do you trust to respect your wishes and make decisions you would make for yourself?

Think: who could be your voice?

The choices….

Temporary Substitute Decision Makers-
The law ensures you always have a substitute decision maker(s). If you haven't chosen a representative ahead of time, your health care provider will follow the Temporary Substitute Decision Maker (TSDM) list. This is a legal list.

Temporary Substitute Decision Maker List

1. Spouse (common law, same gender)
2. Adult children (equally ranked)
3. Parent (equally ranked)
4. Brother or sister (equally ranked)
5. Grandparent (equally ranked)
6. Grandchild (equally ranked)
7. Anyone else related by birth or adoption
8. Close friend
9. A Person immediately related by marriage
10. Public Guardian and Trustee or another person appointed by them

* To qualify, the person must: be 19 or older, be capable, have no dispute with you, and have been in contact with you in the past year.

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Think: who could be your voice?

Representation Agreement

- If you know who you would like to be your voice, you can name them ahead of time by completing a Representation Agreement.

Talk to those closest to you

- Pick a time when you feel relaxed and have time to talk. Choose a place where you are comfortable.
- Share your thoughts about what is important to you and what your goals are. Talk about what your biggest fears and worries about your future health.
- Discuss who could speak for you and how you hope that person(s) will be supported

Talk to those closest to you—starting the conversation….

- *I want you to be prepared if you had to make decisions on my behalf.*
- *I want to make sure you understand and could honour my wishes.*
- *I want to talk with you about what is important to me.*
- *I would like you to go with me to medical appointments.*
- *I think it's really important all of the family understand my wishes.*

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Talk with your healthcare team

- Many Canadians, 60 per cent, either have a chronic illness or someone in their family does.
- If you are living with chronic illnesses such as heart, lung or kidney disease, cancer, diabetes – what you think matters most and your wishes for your health care may change and become more treatment specific over time.

For those with illnesses, talk with your healthcare team

Review with the team what is important to you, what living well means to you, how you want to spend your time, and what treatments you are willing to go through.

You could ask:

- *Are my illnesses easily treatable?*
- *What do my illnesses look like for me in one, two or five years from now?*
- *What possible interventions and complications may I face in the future?*

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Planning Options

- Depending on where you are in life and how you like to plan, what and how you decide to plan will be different.

Planning Options

All advance care plans should include:

√ documenting or recording your wishes &

√ list of your temporary substitute decision makers

Planning Options

A Representation Agreement

- This is a legal document completed by you as a capable adult. You do not need a lawyer or notary but you may wish to involve one.
- Alternate representatives can be included in this document.
- http://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf

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Planning Options

Advance Directive

- Your advance directive is your voice when you are no longer capable. It's like a consent form ahead of time. Your substitute decision maker(s) and health-care provider must honour the instructions you put in your advance directive, as long as what is written is current and addresses the treatment you need at the time.

Planning Options

Medical Orders

- All health authorities have medical orders that guide the treatments you get in an emergency when you can't speak for yourself. Depending on where you live or get care, this is known as medical orders for scope of treatment (MOST), goals of care, options for care, or No CPR.

Planning Options

- In Northern Health, physicians use a form called **MOST, Medical Orders for Scope of Treatment**
- The doctor completes the form which is a record of the patient's wishes after a discussion with the patient or their substitute decision maker

Planning Options

This is the link to the MOST form on Northern Health's website:

https://northernhealth.ca/Portals/0/Your_Health/AdvanceCarePlanning/10-111-5171%20Medical%20Orders%20for%20Scope%20of%20Treatment%20(2).pdf

Planning Options

Medical Orders

- If you have heart, lung or kidney disease, cancer, Parkinson's disease, ALS – your health-care team might talk with you about specific treatments and complete a medical order. Most often these orders are done if you have chronic or life-limiting illness.

We hope we have supported you to begin the process!

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Resources

BC Centre for Palliative Care:
www.bc-cpc.ca/cpc/

BC Ministry of Health:
www.seniorsbc.ca
www.healthlinkbc.ca

Northern Health:

https://northernhealth.ca/YourHealth/AdvanceCarePlanning.aspx

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Resources

Speak Up

www.advancecareplanning.ca

Quesnel & District Hospice Palliative Care Association

www.QDHPCA.org/advance-careplanning

THANK YOU!

- Closing remarks, summary
- Evaluations