Advance Care Planning: Development and Management

1. Introduction

Description

Vancouver Coastal Health (VCH) supports the right of capable adults to direct their own health care. Advance care planning is a process whereby a patient, in consultation with health care providers, family members and important others, makes decisions about his or her future health care. Grounded in the ethical principle of autonomy and the legal doctrine of consent, advance care planning helps to ensure that the norm of consent is respected should the patient become incapable of participating in treatment decisions.

The purpose of this policy is to outline the responsibilities of physicians, other health care providers, capable adults, and Substitute Decision Makers (SDMs) with respect to advance care planning.

Scope

This policy is guidance for all sites, programs, and providers of VCH.

2. Policy

2.1. Advance Care Planning Discussion and the Health Care Team

The Health Care Team (HCT) will encourage and make capable adults and their families aware of the option to have advance care planning discussions, and will respond to capable adults' wishes to engage in advance care planning by either facilitating the conversation or directing the client to knowledgeable resources.

2.2. Use of Advance Care Plans

The HCT will take reasonable measures to confirm whether an adult has an advance care plan (ACP), and to engage with a capable adult to confirm that any ACP reflects his or her current wishes.

Advance care planning documents include Representation Agreements, Advance Directives, living wills, and any other record or communication of previously expressed wishes that identifies either who the capable adult wishes to have make decisions for him/her and/or how decisions are to be made in terms of specific wishes, values, beliefs, and/or instructions.

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VCH recognizes the *My Voice: Expressing My Wishes for Future Health Care Treatment Advance Care Planning Guide* (developed by the British Columbia Ministry of Health) as the primary resource for VCH staff, and as the likely means for capable adult British Columbians to document their wishes for future health care treatment. However, other documents that are created by a capable adult setting out that adult's wishes, values or beliefs with respect to desired health care are accepted and considered by the HCT. Advance Directives or Representation Agreements not written on the suggested forms must comply with the legal requirements to be considered a Representation Agreement or an Advance Directive.

2.3. Encouragement and Development of Advance Care Planning

The HCT will encourage capable adults and their families to have advance care planning discussions and the HCT will document the nature of these discussions in the Advance Care Planning Record, or equivalent, in the electronic chart.

VCH health care providers will respond to capable adults' wishes to engage in advance care planning by either facilitating the conversation or directing the client to knowledgeable resources (e.g. *My Voice: Expressing My Wishes for Future Health Care Treatment Advance Care Planning Guide*).

VCH health care providers who facilitate advance care planning will be knowledgeable about health care consent legislation, and the health care decisions which are likely to arise given the client's health status. Health care providers will work collaboratively with their interdisciplinary team, recognizing the capable adult and SDM may need to discuss elements of their plan with physicians or other members of the team.

Discussions with patient/families about advance care planning will be documented in the health record by the health care provider.

Section 19(1)b of the Health Care (Consent) and Care Facility (Admission) Act of British Columbia confirms adults' control over their own health care consent decisions by legally recognizing prior expressed instructions or wishes. VCH supports the right of capable adults to direct their own health care. The health care provider shall respect the capable adult's wishes when offering a course of treatment, but is not compelled to offer intervention considered to not be beneficial.

2.4. Receipt and Management of Advance Care Plan (see also **Greensleeve Guidelines**)

The HCT will take reasonable measures to confirm the existence of advance care planning. Consistent with team-based protocols and procedures for involving clients in their own health care, health care providers ask capable adults and/or their SDM whether they have considered an ACP.

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If they have done so, clients are encouraged to discuss their wishes with the HCT and, if documented, are invited to provide a copy to VCH for our records (client retains original).

If they do not have one and are interested to explore the opportunity further, staff will provide a copy of an Advance Care Planning Brochure.

If a copy of an advance care planning document is provided to VCH, the staff member receiving same initiates a Greensleeve for the client's chart, and indicates its presence on an alert record at the front of the chart.

A copy of advance care planning documents provided to VCH will be retained on the health record of the adult following discharge. The original document is returned to the adult or SDM.

2.5. Reliance on ACP during the Provision of Care or Offering a Course of Treatment

Health care providers and SDMs will consider ACPs when proposing care options offered by the HCT, including in emergency situations, unless there is evidence that the expressed wishes have changed or are otherwise not valid.

Members of the HCT interacting with the client throughout each care episode are aware of the presence of the advance care planning documents, and are mindful of the differences in application among the types of these documents:

2.5.1. Representative Agreement

When duly executed[1], authorizes a specific individual ("Representative") to make decisions for an adult, and may provide instructions to the Representative about how to make that decision.

2.5.2. Advance Directives

When duly executed[2] and applicable to the situation at hand, authorize a health care provider to act on the instructions as set out in the document. Providers act in accordance with the instructions, but communicate as reasonable with others who may be authorized (e.g. as temporary substitute decision maker (TSDM)) concerning decisions not addressed by the Advance Directive.

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[1] The form recommended in the British Columbia Ministry of Health's *My Voice: Expressing My Wishes for Future Health Care Treatment Advance Care Planning Guide* describes the necessary signatures and, if relevant, additional forms to be completed. When in doubt, contact VCH Risk Management.

[2] Signatures of the adult and two witnesses, and clearly indicating on the document that the patient is aware that making an Advance Directive means that: 1) the health care provider may not ask someone accompanying the adult for a decision; and 2) the care mentioned in the Advance Directive may not be provided.

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NOTE: If a client has both a Representation Agreement and an Advance Directive:

- The health care provider must obtain the health care decision from the Representative, unless the adult has provided in the Representation Agreement that the health care provider may act on an Advance Directive without the consent of the Representative; and
- The Representative must make the health care decision considering that the instructions set out in the Advance Directive are the wishes of the adult.

2.5.3. Advance Care Plan

A summary of a capable adult's wishes or instructions to guide an SDM if that person is asked by a physician or other health care provider to make a health care treatment decision on behalf of the adult. The HCT must:

- Review the contents of the ACP and discuss with the capable client the wishes expressed in the documents, incorporating the wishes into planning for care; and
- Ensure that anyone making substitute decisions on behalf of an incapable client is aware of and honours the client's previously expressed wishes unless there is evidence that the wishes have changed since the advance care planning document was created.

The HCT will consider the capable adult's wishes when offering a course of treatment, but is not compelled to offer treatment not considered beneficial (see Resolution of disputes about expectations for care not considered beneficial).

2.6. *Emergency Situations*

In emergency situations in which an adult is incapable of providing consent and there is no SDM available, an Advance Directive that sets out refusal of consent applicable to the proposed health care must be followed. Health care providers should consider the entire context of the current patient situation to determine applicability and follow the Advance Directive instructions unless there is concern about the validity of the document.

2.7. *Changing or Revoking Advance Care Planning Documents*

A capable adult may at any time express their decision regarding health care or change their current wishes regarding desired medical treatment in their ACP. The HCT, especially the attending physician, needs to be advised if an ACP is revoked.

- Changes to the ACP must be documented on the ACP Record, and updated copies of documentation placed in the Greensleeve.

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- Health care providers aware of any change in an ACP must remind the adult to update any other copy of the ACP that may be on file at VCH or elsewhere.

Capable adults have the responsibility of informing the HCT of any change in their ACP.

2.8. Resolving of Questions or Disputes

In the event of a dispute or other question concerning the client's expressed wishes, substitute decision-making, or other aspects of advance care planning, the HCT is invited to contact the Health Service Delivery Area Risk Management contact for assistance.

2.9. Role of Advance Care Planning for Substitute Decision Makers

Unless there is an emergency situation, or there is an Advance Directive which addresses the required health care[3], the consent decision of an SDM is required prior to the provision of health care. The wishes of an adult as stated in an ACP should be treated by the SDM and the health care provider as the previously expressed wishes of the patient/resident.

The SDM:

- Consults with the adult to the greatest extent possible;
- Complies with any instructions or wishes the adult expressed while capable;
- Gives or refuses consent on the basis of the adult's wishes, or if not known, beliefs and values, or if these are not known, in the adult's best interests.

2.10. Validity of an Advance Care Plan

The *Health Care (Consent) and Care Facility (Admission) Act* of British Columbia sets out that the SDMs are required to rely on previously expressed wishes unless there is some indication that the wishes have changed, would not apply in the circumstances at hand, or that the document is not a valid document.

The HCT should investigate further an advance care planning document or a statement of a patient's previously expressed wishes, in the event one or more of the following concerns is apparent:

1) If the previously expressed wishes are being communicated by someone whose capability is in question;

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[3] If there is a Representation Agreement and Advance Directive (which does not exclude the Representative from the decision at hand), the Representative is the decision maker, but must follow the instructions set out in the Advance Directive.

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2) There is some question as to the capability of the adult at the time the wishes were expressed (either verbally or in writing);
3) The wishes are disputed by other sources close to the adult (e.g. family members, friends);
4) The date of the advance care planning document appears suspicious (e.g. created 15 minutes before an ambulance was called for the current episode of care; after an event which may affect capability to make decisions, such as a stroke);
5) The advance care planning document exhibits evidence of tampering;
6) Apparent conflict of interest; or
7) Potential that the adult may be in a situation of abuse or neglect (see Abuse, Neglect or Self-Neglect of Vulnerable Adults policy, REACT website).

2.11. Principles

- VCH recognizes the right of capable adults to direct their own health care.
- The decisions of an adult who is capable of making his or her own health care decisions supersede an advance care planning document.
- VCH recognizes the value of encouraging advance care planning discussions with individuals and their families. Advance care planning is recognized as an ongoing process, not a single event, where the capable adult can reassess his/her wishes as circumstances change.
- Advance care planning is voluntary; individuals are not required to engage in this activity.
- In British Columbia, health care providers respect the wishes expressed by adults when they were capable.

3. References

Tools, Forms and Guidelines

- Advance Care Planning Brochure (British Columbia Ministry of Health)
- Advance Care Planning Record (VCH)
- Cardiopulmonary Resuscitative Intervention Guidelines (VCH)
- Greensleeve Guidelines (VCH)

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- Health Care Provider's Guide to Advance Care Planning Documents (VCH)
- My Voice: Expressing My Wishes for Future Health Care Treatment Advance Care Planning Guide (British Columbia Ministry of Health)
- Quick Guide to Advance Care Planning Documents (VCH)
- Resolution of disputes about expectations for care not considered beneficial (VCH)

Related Policies

- Consent to Health Care
- *Health Care (Consent) and Care Facility (Admission) Act* of British Columbia
- Medical Orders for Scope of Treatment

Keywords

Adult, Advance Care Plan, Advance Care Planning, Capability, Capable Adult, Committee of the Person, Consent, Goals of Care, Greensleeve, Options for Designation, Personal Guardian, SDM, Substitute Decision Maker, Representative, Temporary Substitute Decision Maker, TSDM

Definitions

"**Adult**" is a person 19 years or older in British Columbia.

"**Advance Care Plan (ACP)**" is a summary of a capable adult's wishes or instructions to guide an SDM if that person is asked by a physician or other health care provider to make a health care treatment decision on behalf of the adult.

"**Advance Care Planning**" is a process by which a capable adult talks over their beliefs, values and wishes for health care with their close family/friend(s) and a health care provider in advance of a time when they may be incapable of deciding for themselves.

"**Advance Care Planning Documents**" are any written record containing the previously expressed wishes of a capable adult, which may or may not have formal execution requirements as set out in law (e.g. common examples are living will, degree of intervention, Representation Agreement, Advance Directive, or an ACP.)

"**Advance Care Planning Record**" means a VCH form to be used by all members of the HCT to document the fact and nature of discussions with the capable adult, family and/or SDM.

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"**Capability**", as set out in the *Health Care (Consent) and Care Facility (Admission) Act of* British Columbia, refers to adults presumed to be capable of making a particular health care decision until the contrary is demonstrated (i.e. there is clear evidence that the adult is incapable of making a particular decision). Incapability is assessed based on the adult's understanding of the following:

- The condition for which the specific health care must be provided;
- The nature of the health care;
- The risks/benefits of receiving the proposed care or not;
- That this information applies to their own situation.

"**Goals of Care/Options for the Designation**" refers to documents setting out goals of care for imminent care decisions, in alignment with ACPs and other wishes expressed by a capable adult. Goals of care may be considered as agreed-upon decisions only if agreed to by a capable adult or an SDM. Goals of Care set solely by a health care provider or team (and not the capable adult or SDM) should not be considered as agreed-upon decisions, but rather as a statement of what care will be offered. See Cardiopulmonary Resuscitative Intervention Guidelines .

"**Greensleeve**" is a green, clear, plastic page protector placed at the front of a patient chart and used to quickly identify goals of care/advance care planning documents (see Greensleeve Guidelines).

"**Health Care**" is anything done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health care purpose (including research) and may be a series of similar treatments or care (e.g. administration of blood pressure pills, wound care) given over time, or a plan for a variety of care purposes for up to one year (at which time the consent decision is to be reviewed).

"**Substitute Decision Maker (SDM)**" is a capable person with the authority to make health care treatment decisions on behalf of an incapable adult, and includes a personal guardian (committee of the person), representative and/or TSDM. Health care providers acknowledge SDM in descending hierarchy as follows:

- "**Personal guardian (Committee of the Person)**" is a person appointed by the court to make health and personal decisions for the benefit of the adult when they are incapable of deciding on their own.

- "**Representative**" is a person 19 years or older who is named by a capable adult, in a Representative Agreement, to make health care treatment decisions on their behalf when they are incapable of deciding. There are two types of Representation Agreements Standard (Sec. 7) and Enhanced (Sec. 9). A Representative under the standard agreement cannot make a decision to limit life supporting care or treatment.

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- "**Temporary substitute decision maker (TSDM)**" is a capable adult chosen by a health care provider to make health care treatment decisions on behalf of an incapable adult when care is needed. A TSDM is not chosen if the adult has an Advance Directive that addresses the care needed at the time, or if the adult has an available personal guardian or Representative.

The health care provider must choose the first of these who is available and qualifies (i.e. is 19 years of age or older, has been in contact with the adult in the past 12 months, has no dispute with the adult relevant to the decision, is capable of making the decision, and commits to making the decision according to the adult's wishes, values and beliefs):

- The patient/resident's spouse (in the case of a married person who is separated but in a common law relationship, the common law spouse should be selected);
- The patient/resident's adult child;
- The patient/resident's parent;
- The patient/resident's brother or sister;
- The adult's grandparent;
- The adult's grandchild;
- Anyone else related by birth or adoption to the patient/resident;
- A close friend of the adult;
- A person immediately related to the adult by marriage.

See Consent to Health Care policy.

Questions

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