

Advance Care Planning/Serious Illness Conversations

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1.0 Introduction

1.1 Description

Providence Health Care (“PHC”) believes that all persons are entitled to, and should be encouraged to, participate in conversations about their health care wishes, values, beliefs and fears in order to ensure they receive care that aligns with their preferences. As patients/residents are diagnosed with serious illness and/or are approaching the end of their life, these conversations take on even greater importance. By encouraging discussion regarding patient/resident’s wishes about future health care, this policy complements and supports the PHC Options for Care (CPF 1100) and DNAR (CPF 0700) policies in respecting the dignity of the patient/resident as a free and informed decision maker.

The purpose of this policy is to outline the roles and responsibilities of staff and physicians with respect to advance care planning (ACP) and serious illness (SI) conversations.

1.2 Scope

This policy applies to all patients/residents of PHC in residential, community, acute and outpatient Programs, and to all PHC staff and physicians (for the purpose of this policy, staff is defined as all nurse practitioners, midwives, and all additional nursing and allied health practitioners).

2.0 Policy

Staff and physicians will initiate, facilitate and engage with patients/residents in advance care planning and serious illness conversations, either through facilitating the conversation and/or by directing them to knowledgeable resources. **Staff and physicians will engage in these conversations at 3 key stages:**

1. **By proactively encouraging patients/residents as early in their illness as possible** in considering who they trust to make healthcare decisions with/for them, and encouraging conversations with those persons about their values, wishes, beliefs and health care preferences. This is especially important in out-patient and community clinics/programs, or on discharge from acute care, where teams have opportunities to encourage patient engagement in the advance care planning process.
2. **By having goals of care conversations with patients/residents and/or substitute decision makers (“SDM”s) for persons diagnosed with serious illness.** These conversations include ensuring

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understanding of diagnosis, prognosis and treatment options, learning more about the patients'/residents' values, wishes, beliefs and fears, explaining potential emergencies and developing a care plan and designating the Option for Care that reflects this shared decision making. These conversations are the responsibility of the Most Responsible Provider (MRP), who may delegate within the team but must ensure that a quality conversation takes place unless the patient/substitute decision maker is unwilling to engage.

3. **By having focused end of life conversations with patients/residents and/or SDMs *diagnosed with terminal disease or who may be at significant risk of dying within the next 6 to 12 months.*** Components of this conversation include patient/SDM understanding of their illness, exploring how much information they would like, their fears and worries about the future and what further interventions they are willing to go through for the possibility of more time. These conversations are the responsibility of the physician or MRP, who may delegate but must ensure that a quality conversation takes place.

PHC will provide resources to support the development and availability of training in advance care planning and serious illness conversations for health care providers.

Advance care planning/serious illness conversations should take place prior to establishing the direction of care for the patient. Outcomes from the discussion will be documented on the Options for Care Prescriber's Order Form (PHC-PH254) or the Advance Care Planning (ACP) Serious Illness Conversation Record (PHC-MR101). If consensus is not reached, document "*no decision reached*" on the Options for Care Form. In such situations, health care professionals will continue to be guided by the standards of practice of their respective regulatory bodies.

2.1 Policy Principles

- 2.1.1 PHC recognizes the right of capable adults to direct their own health care. A valid advance care planning document shall be respected unless requests made within that document are not consistent with accepted health care practices.
- 2.1.2 The decisions of an adult who is capable of making his or her own health care decisions supersede an advance care planning document.
- 2.1.3 An Advance Directive, when duly executed and applicable to the situation at hand, authorizes staff and physicians to act on the instructions as set out in the document without direction from an SDM.
- 2.1.4 PHC 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.

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2.1.5 At the patient/resident's discretion, family members, friends or significant others may be included in the advance care planning and serious illness conversations.

2.1.6 Advance care planning is voluntary; individuals are not required to engage in this activity.

2.2 Responsibilities

2.2.1 Physicians will engage in advance care planning and serious illness conversations as described in 2.0.

2.2.2 Social workers will support and supplement the conversations as required.

2.2.3 In residential care, nurses are encouraged to have advance care planning discussions with residents and their SDMs.

In acute care, nurses will advocate for patients diagnosed with serious illness or at end-of-life who have not had an opportunity to engage in ACP/SI conversations. Nurses will be alert to opportunities to engage with patients and families about their fears, and wishes for, future and end of life care. Nurses will forward requests for support and assistance to the appropriate Health Care Provider (HCP).

2.2.4 All other allied health professionals will be alert to patients who indicate a desire to engage in ACP and/or SI conversations, or for whom such a conversation appears not to have happened or is needed, and will refer to the appropriate health care provider.

2.2.5 The Leader, Advance Care Planning is responsible for:

- Leadership and organizational engagement
- Policy updates
- Development and implementation of education programs
- Enhancing patient, family and public engagement
- Acting as a resource to HCPs
- Identifying barriers to implementation of this policy and seeking support for mitigation

2.2.6 Medical Affairs and Chief, Professional Practice & Nursing are responsible for monitoring compliance with this policy.

2.3 Compliance

Care provided contrary to a patient's known preferences will be documented in the Patient Safety Learning System and reviewed by the appropriate Practice lead.

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3.0 Procedure

3.1 Receipt and Management of Advance Care Planning Documents

3.1.1 The health care team will take reasonable measures to determine whether the patient/resident has previously engaged in advance care planning. This will include looking in the Advance Care Planning folder in Chartscan for previously received ACP documents such as Representation Agreements, Advance Directives or other expressions of wishes.

3.1.2 If an ACP document is found, the health care team will verify with the patient/resident/SDM to confirm that the ACP reflects their current wishes. If an HCP becomes aware that there is a more recent version, a copy should be obtained and placed within the blue document holder on the patient/resident chart. Original copies of ACPs will be returned to the patient/resident/family.

3.1.3 HCPs interacting with the patient/resident throughout each episode of care will:

- Note the presence of the blue document holder on the chart,
- Review the contents of the blue folder,
- Incorporate the wishes expressed into planning for care, and
- Ensure that everyone making substitute decisions on behalf of an incapable patient/resident is aware of and honours the adult's previously expressed wishes unless there is evidence that the wishes are no longer valid, or the wishes are contrary to accepted healthcare practices.

3.1.4 A copy of ACP documents for patients discharged from acute care will be scanned by Health Records into the Advance Care Planning visit level folder in SCM and may be used as reference during subsequent admissions unless there are concerns about its validity. The ACP for patients/residents receiving ongoing care through outpatient or residential programs will be retained in a blue document holder on the chart and reviewed annually or when there is a significant change in the patient/resident's health.

3.2 Encouragement and Development of Advance Care Planning

3.2.1 HCPs should encourage all capable patients/residents to engage in Advance Care Planning discussions by facilitating the conversation or by directing them to knowledgeable resources (see section 4.3).

3.2.2 HCPs must initiate Advance Care Planning discussions whenever the patient/resident has a significant chronic or acute illness with significant risk of death within the next twelve months.

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However, it should be noted that Advance Care Planning discussions are voluntary, and patients/residents may decide not to engage in these discussions. A refusal to engage in such a discussion should be documented.

- 3.2.3** PHC promotes the use of the Serious Illness Conversation Guide to initiate these difficult conversations. HCPs are encouraged to participate in the training offered in the use of the guide, or seek assistance from others to have this conversation.
- 3.2.4** Engage Palliative Care, Social Work or other services for help with these conversations or if there is conflict among team members, patient and family members or lack of understanding of patient/family despite explanations. Ethics Services and Risk Management may be contacted as additional resources for difficult situations.
- 3.2.5** Discussions with patients/families about advance care planning will be documented by the HCP on the Advance Care Planning (ACP) Serious Illness Conversation Record (PHC-MR 101), which includes a section to document components from the Serious Illness Conversation Guide. The ACP Record should be filed in the blue document holder in the patient/resident's chart.

3.3 Advance Directives, Consent and Advance Care Planning

- 3.3.1** Staff and physicians are bound by the consent refusals as described in a properly executed Advance Directive *unless* the Advance Directive:
 - is so unclear that it cannot be determined if the adult has given or refused consent to the health care;
 - is in conflict with the patient/resident's known wishes, values or beliefs; or
 - was made prior to changes in knowledge, practice or technology that might substantially benefit the adult, unless it expressly states that it applies regardless of changes in medical knowledge, practice or technology.
- 3.3.2** In emergency situations, when an adult is incapable of providing consent and there is no SDM available, an Advance Directive that sets out refusal of consent to the proposed health care may be followed. Staff and physicians should consider the entire context of the current patient situation to determine applicability and are permitted to follow the instructions within the Advance Directive unless there is concern about the validity of the document.
- 3.3.3** In the absence of an Advance Directive, the consent of a Substitute Decision Maker is required prior to the provision of health care, unless in an urgent or emergent situation. The wishes of an adult in an Advance Care Plan, but with no Advance Directive, should be treated by the SDM and the health care provider as the previously expressed wishes of the patient/resident.

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3.3.4 The Substitute Decision Maker should rely on previously expressed wishes of the patient/resident unless there is some indication that:

- the wishes have changed, or
- the wishes would not apply in the current situation, or
- the wishes are contained in a document about which there are validity concerns.

3.3.5 If there is concern about the validity of a previously expressed wish, the health care provider shall investigate further, particularly when one or more of the following concerns is apparent:

- there are valid concerns about the capability of the person communicating the patient's wishes
- there are valid questions about the capability of the adult at the time when the wishes were expressed
- the wishes are disputed by other sources close to the adult
- there is conflict between the adult and the person communicating their wishes
- there is potential that the adult may be in a situation of abuse or neglect

3.4 Changing or Revoking Advance Care Planning Documents

3.4.1 Capable adults may change their decisions about their treatment or care at any time

3.4.2 The Most Responsible Provider should be advised if Advance Care Planning preferences are changed/revoked

3.4.3 Known changes to a patient/resident's treatment wishes are noted on the ACP Record and any revised copies of ACP documents are placed in the blue document folder on the chart.

3.5 Questions or disputes

3.5.1 If there is a dispute or question about a patient/resident's advance care planning wishes or Advance Directive, the HCP may request consultation with Professional Practice, Ethics Services, Risk Management or the Palliative or Geriatric Outreach Consult Team.

4.0 Supporting Documents and References

4.1 Related Policies

Consent to Health Care
Options for Care
Code Status: Resuscitation and DNAR

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4.2 Related Standards / Forms / Guidelines

Options for Care and Resuscitation / DNAR Orders (PHC-PH254)
Advance Care Planning (ACP) Serious Illness Conversation Record (PHC-MR101)
Identification of Substitute Decision Maker (PHC-MR081)

4.3 Resources

For Health Care Providers:

[Health Care Providers' Guide to Consent to Health Care](#)
[PHC Policy Consent to Health Care](#)
[PHC Connect – Advance Care Planning Intranet Site](#)

For Patients Families

[My Voice: Expressing My Wishes for Future Health Care Treatment Advance Care Planning Guide](#)
[BC Ministry of Health Advance Care Planning Webpage](#)

4.4 Definitions

Advance Care Planning is the process of a capable adult talking over their beliefs, values, wishes or instructions about the health care they wish to consent to or refuse, with their health care provider and/or family, in advance of a situation when they are incapable of making health decisions. This planning is an ongoing process, not a single event, where the patient/resident can reassess their wishes as circumstances change.

Advance Care Plan (“ACP”) is a written summary of a capable adult’s wishes or instructions to guide a substitute decision maker 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 Directive is a capable adult’s written instructions that speak directly to their health care provider about the health care treatment the adult consents to, or refuses. It is effective when the capable adult becomes incapable and only applies to the health care conditions and treatments noted in the advance directive.

Committee of the Person means a person appointed by court order of the Supreme Court of B.C. under the Patients Property Act, giving them broad decision-making powers on behalf of the patient/resident.

Health Care Provider (“HCP”) is a person who, under a prescribed BC Act, is licensed, certified, or registered to provide health care in British Columbia.

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Most Responsible Provider (“MRP”) is the health care provider who has the overall responsibility for the management and coordination of the care of the patient at any given time.

Representative means a person chosen by the patient/resident when the patient/resident was capable, who meets basic criteria and has entered into a Representation Agreement under the Representation Agreement Act.

Serious illness care conversations are those that address planning in the context of serious illness progression. These conversations should include an assessment of patient understanding and information preferences, prognosis, an exploration of the patient’s goals, fears, priorities, acceptable trade-offs, and family understanding.

Serious illness is a condition that carries a high risk of mortality, negatively impacts quality of life and daily function, and/or is burdensome in symptoms, treatments, or caregiver stress.

The **Serious Illness Conversation Guide** is a conversation tool meant to support clinicians and assure adherence to best practices

Spouse is defined as the person who is married to the adult or who lives with the adult in a marriage-like relationship (common law), including same sex relationships.

Staff is defined for this policy as nurse practitioners, midwives, and all additional nursing and allied health practitioners.

Substitute Decision Maker (SDM) means any of: a Committee of the Person, a Representative, or a Temporary Substitute Decision Maker as defined below.

Temporary Substitute Decision Maker (TSDM) means a person temporarily appointed under the Health Care (Consent) and Care Facility (Admission) Act as a substitute decision-maker. See Consent to Health Care Policy.

4.5 References

Alberta Health Services Policy Advance Care Planning and Goals of Care Designation

Beth Israel Deaconess Medical Center Advance Care Planning Guideline

Bernacki RE, Block SD, for the American College of Physicians High Value Care Task Force.

Communication About Serious Illness Care Goals: A Review and Synthesis of Best Practices. *JAMA Intern Med.* 2014;174(12):1994-2003. doi:10.1001/jamainternmed.2014.5271.

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Kelly, AS, Defining 'Serious Illness'. Journal of Palliative Medicine 17(9) August 2014

4.6 Keywords

Adult, ACP, Advance Care Plan, Advance Care Planning, Advance Directive, MOST, Options, Serious Illness Conversation

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