Advance Care Planning During COVID-19

NORTH SIMCOE MUSKOKA HOSPICE PALLIATIVE CARE NETWORK
APRIL 22 2020
Objectives:

Discuss and Differentiate the concepts of ACP and GoC

Discuss Substitute Decision Making as it relates to ACP

Suggest a Process for Integrating GOC conversations into practice
CORONAVIRUS DISEASE (COVID-19)
Chest X-ray images of a 55-year-old critically ill COVID-19 patient in the Seattle area show hazy opacities in the upper and mid-lung zones. The X-ray image, left, was taken at admission and the one on the right, which shows a worsening condition, was taken 24 hours later. COURTESY THE NEW ENGLAND JOURNAL OF MEDICINE 2020
Health Footprint of Pandemic

1st Wave
Immediate mortality and morbidity of COVID-19

2nd Wave
Impact of resource restriction on urgent non-COVID conditions

3rd Wave
Impact of interrupted care on chronic conditions

1st Wave Tail
Post-ICU recovery

4th Wave
- Psychic trauma
- Mental illness
- Economic injury
- Burnout
Some Assumptions We Make:

1. YOUR FAMILY CAN/WILL TAKE CARE OF YOU.

2. YOUR FRIENDS/FAMILY WILL ALL AGREE ABOUT DECISIONS TO BE MADE AND GET ALONG THROUGHOUT THIS ILLNESS TRAJECTORY.

3. HOME CARE WILL BE AVAILABLE WHEN (AND TO THE EXTENT) YOU NEED IT.
Advanced Care Planning

https://www.speakupontario.ca
ACP is a Process Of:

- Reflecting on then communicating Values, Beliefs and Goals of Care
- Planning for a time when you cannot make Treatment Decisions
- Discussing with Family, Friends, and Health Care Professionals
- Determining a SDM and appointing that SDM as your POA
- Sharing your wishes with conversation
Why is it important?

Your Future Health and Personal Care wishes will be known and followed.

Your family and friends will have less stress and anxiety with making decisions.

You and your family and friends will be more satisfied with care.

You will have better quality of life and death.
What is Advance Care Planning in Ontario?

Having conversations about what is important to you while you are Mentally Capable

Identifying or Deciding your future Substitute Decision Maker (SDM)

Share wishes about FUTURE health care with your SDM.
Substitute Decision Maker Hierarchy

- Court Appointed Guardian
- Attorney for Personal Care
- Representative appointed by Consent and Capacity Board
- Spouse or Partner
- Parents or Children
  - Parent with right of access only
- Siblings
- Any other relative
- Public Guardian and Trustee

Ontario’s Health Care Consent Act, 1996

Legally appointed SDMs

Automatic family member SDMs

SDM of last resort
Step 1 in ACP: Identify your SDM

There are 2 ways to identify who would be your substitute decision maker in Ontario:

1. The Health Care Consent Act - Ranked list
2. Power of Attorney for Personal Care - legal document
Requirements of the SDM
They must be:

- Willing and able to make health care decisions on your behalf
- Willing to honor your wishes, even if it’s not what they would choose for themselves
- Mentally capable to speak for you even under stressful times
- At least 16 years old
- Available to make decisions
Power of Attorney for Personal Care
(Made in accordance with the Substitute Decisions Act, 1992)

1. I, ____________________________, revoke any previous power of attorney for personal care made by me and APPOINT: ____________________________, to be my attorney(s) for personal care in accordance with the Substitute Decisions Act, 1992.

   [Note: A person who provides health care, residential, social, training, or support services to the person giving this power of attorney for compensation may not act as his or her attorney unless that person is also his or her spouse, partner, or relative.]

2. If you have named more than one attorney and you want them to have the authority to act separately, insert the words “jointly and severally” here:

   (This may be left blank)

3. If the person(s) I have appointed, or any one of them, cannot or will not be my attorney because of refusal, resignation, death, mental incapacity, or removal by the Court, I SUBSTITUTE: ____________________________, to act as my attorney for personal care in the same manner and subject to the same authority as the person he or she is replacing.

   (This may be left blank)

4. I give my attorney(s) the AUTHORITY to make any personal care decision for me that I am mentally incapable of making for myself, including the giving or refusing of consent to any matter to which the Health Care Consent Act, 1996, applies, subject to the Substitute Decisions Act, 1992, and any instructions, conditions or restrictions contained in this form.

5. INSTRUCTIONS, CONDITIONS and RESTRICTIONS
   Attach, sign, and date additional pages if required. (This part may be left blank.)

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

   ____________________________, ____________________________,

6. SIGNATURE: ____________________________, DATE: ____________________________
   (Sign your name here, in the presence of two witnesses.)
   ADDRESS: ____________________________,
   (Insert your current address here.)

7. WITNESS SIGNATURES
   [Note: The following people cannot be witnesses: the attorney or his or her spouse or partner; the spouse, partner, or child of the person making the document, or someone that the person treats as his or her child; a person whose property is under guardianship or who has a guardian of the person; a person under the age of 18.]

   Witness #1: Signature: ____________________________, Print Name: ____________________________
   Address: ____________________________,
   Date: ____________________________

   Witness #2: Signature: ____________________________, Print Name: ____________________________
   Address: ____________________________,
   Date: ____________________________

NOT FOR SALE
Step 2 in ACP: Share information

Important Conversations Based on your Reflections !!!

1. Share information about your wishes, values, beliefs,

2. Share things that will help your SDM understand how you would like to be cared for

3. Having a conversation before a health crisis allows time for reflection about how that illness will impact your health and your life
What Do you Mean Goals of Care?
Reasons for GOC Discussions

- Treatment or care decision
- Admission/transfer to a new facility
- Code Status Decision
- Follow up from a Previous GOC Discussion
- Information Sharing
How to Engage in GOC Discussions

- Assess the person’s understanding – Explore and listen
- Inform the person why you are having the conversation - Ask Permission
- Discuss Goals and Values - Find out what matters to them
- Make a Plan - Based on their Goals and values
## Guide for Serious Illness Conversations with patients in LTC at risk of COVID-19

### Conversation Flow

<table>
<thead>
<tr>
<th>Step</th>
<th>Suggested Language</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Set up the Conversation</strong></td>
<td>“I’d like to check-in to see how you’re doing during this stressful time of COVID-19. Is that ok?”</td>
</tr>
<tr>
<td><strong>2. Assess Understanding and Preferences</strong></td>
<td>“What is your understanding of how COVID-19 is affecting people like you? [e.g. people who are older and/or frail, people with significant comorbidities, etc.]”&lt;br&gt;“What information about how COVID-19 might affect you would you like from me?”</td>
</tr>
<tr>
<td><strong>3. Share Information &amp; Prognosis:</strong></td>
<td>EG: “COVID-19 is a viral illness that spreads like the flu. We know it is particularly serious in patients like you. I wish this weren’t the case, but I worry that if you contract COVID-19 you could get sick very quickly, and may even be at risk of dying within a short period of time.”</td>
</tr>
<tr>
<td>a. Goals</td>
<td>“What does meaningful quality of life look like for you?”&lt;br&gt;“If you were to get sick with COVID-19, what would be most important to you?”&lt;br&gt;“What would you be most afraid of if you became seriously ill?”&lt;br&gt;“What are sources of strength for you in the face of illness?”&lt;br&gt;“How much does your family know about what’s important to you?”&lt;br&gt;“Is there anyone you would like me to contact?”</td>
</tr>
<tr>
<td>b. Fears</td>
<td>“I’ve heard you say that _______ is important you right now. Keeping in mind what we know about your health and this illness, I recommend that _______.”&lt;br&gt;“How does this plan seem to you?”&lt;br&gt;“We will do everything we can to help you through this.”&lt;br&gt;EG: “I’ve heard you say that being comfortable and free of suffering is important to you. Keeping in mind what we know about your health and this illness, if you become sick with COVID-19, we will coordinate your care to ensure that you are not sent to the hospital. Sending you to the hospital will prolong your suffering without extending your life meaningfully. We have many medications available at this facility to aggressively manage your symptoms and ensure you remain comfortable no matter what happens. How does that sound?”</td>
</tr>
</tbody>
</table>
| c. Sources of Strength                   | 1. Document in your EMR.  
2. Ensure a provincial No CPR form and updated MOST is completed.  
[https://www2.gov.bc.ca/assets/assets/gov/health/forms/302r11.pdf](https://www2.gov.bc.ca/assets/assets/gov/health/forms/302r11.pdf)  
3. Ensure BC Palliative Care Benefits form is completed.  
[https://www2.gov.bc.ca/assets/assets/gov/health/forms/349r11.pdf](https://www2.gov.bc.ca/assets/assets/gov/health/forms/349r11.pdf)  
4. PERSONALIZED INFORM PROVIDER(S) who should know. (i.e. Nursing, DO, etc.)  
5. Update family members if not already done. |
Questions to Identify Values and Wishes

► What do you worry about most when it comes to your future health?
► What is your favorite routine or habit?
► Who is the most likely to know what you are thinking?
► What makes your life meaningful? (e.g., spending time with friends, experiencing new cultures/travelling, skiing every weekend)
► What life circumstances would you find the most unbearable?
► Who do you go to first for advice?
► What is your favorite ceremony or special event?
How Does This Link to Effective Decision Making?
TWO Outcomes From GOC Discussion’s During COVID-19

1. People’s wishes about their future care can be identified and documented in preparation for the coming weeks.

2. Individuals and their SDM’s are prepared for the possibility that deterioration may occur at a time in which critical resources are scarce and care escalation may not be possible.
Effective Decision Making

How a person makes healthcare decisions

Person

Values
- What's important
- Why it's important

Goals

Treatment

Information
- About disease

Evidence
- About treatments

Decisions

Two parts of the equation
Both are needed to be effective
Components of Person-Centered Decision Making

A person’s values, wishes, beliefs and goals for their care

- Capable person
  - Advance care planning
- Capable patient OR SDM(s)
  - Goals of care discussion
  - Consent
  - Treatment or Plan Initiated

© 2017 by Dr. Jeff Myers, Dr. Nadia Incardona & Dr. Leah Steinberg, Components of person-centred decision-making. This work is licensed under the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License.
Person Centered Decision Making

Clinical Algorithm

https://www.speakupontario.ca/person-centred-decision-making
1. You will not harm a person by talking about their illness and their future.

2. People want and need the truth about what to expect as this enables them to make informed decisions.

3. Palliative care is active care with a focus on QOL, symptom management and patient centered goals.
Please Remember that ACP is Not...

NOT A: ONE CONVERSATION ONLY ABOUT TREATMENT OPTIONS WITH A PHYSICIAN OR OTHER HCP

NOT: CONSENT TO TREATMENT

NOT: STRICTLY A REFUSAL OF MEDICAL TREATMENTS

NOT A: DOCUMENT/FORM/OR CHECKLIST TO BE COMPLETED
Please continue the conversations....

IT TAKES PRACTICE,
ALLOW SILENCE,
ACKNOWLEDGE EMOTIONS
FOCUS ON PERSON CENTERED GOALS
I wish we were not in this situation……

But I worry what might happen if you become sick with COVID-19 or your other health problems were to worsen……..

I wonder if we could talk about this …..
Advance Care Planning Workbook Ontario Edition

Who will speak for you? Start the conversation. It's how we care for each other.

www.speakupontario.ca
COVID-19 Toolkit
COVID-19 Toolkit

At the North Simcoe Muskoka Hospice Palliative Care Network (NSMHPCN) we are committed to protecting the safety and well-being of our clients and their loved ones. In line with provincial, national and international public health organization directives, we fully support and encourage the need for social distancing and self-isolation. During these unprecedented times, we want to ensure that everyone has access to the most current information available. We will be posting information, and linking to appropriate websites/documents regarding the current COVID-19 pandemic.

The NSMHPCN nurse consultants will continue to support education, pain and symptom management, mentoring, and consults through a virtual platform. If you would like to refer a client to receive support from a nurse consultant please complete the referral form.

We are working towards ensuring that people have the appropriate information and access to bereavement support within their community. In response, we have created the Regional Bereavement Support Line. The intention of this support line is to provide information about supports in your area. If you are anticipating the loss of a loved one or have recently lost a loved one, this support line can connect with you with supports to help you through your grief journey. This line is monitored from 8am to 8pm daily (beginning between April 8-10). All calls received after hours will be returned on the next day in order they were left. Please note that this is not a COVID-19 information resource, nor is it a mental health or crisis line.

Regional Bereavement Support Line: (705) 325-7871

If you are in crisis please call

Telecare (Greater Simcoe) 705-325-9534 or 705-726-7922

COVID-19 Information

OPCN PC Resources for Frontline Workers for COVID-19, March 26 2020
OPCN Planning for Palliative Care During the COVID-19 Pandemic, March 26, 2020
CDC Personal Protective Equipment Sequence
Home Visit PPE Full Procedure v7_1
Pallium Canada – COVID-19 Response, Free Online Modules
Palliative Care for Aboriginal Communities
Pandemic Palliative Care – Beyond Ventilators
References:

- https://www.speakupontario.ca/
- https://www.ariadnelabs.org/areas-of-work/serious-illness-care/
Questions

???