

“Your Wishes Matter”

Creating Your *Advance Care Plan*



Baycrest Health Sciences
is fully affiliated with the
University of Toronto

3560 Bathurst Street
Toronto, Ontario,
Canada, M6A 2E1
T: 416-785-2500

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As a Baycrest client, Advance Care Planning is an important part of your overall care plan. It helps give you control of what treatments you would want if a medical emergency or other circumstance left you unable to communicate. Advance Care Planning allows you to make these choices now, while you are capable.

Planning your future care starts by discussing your wishes today with the people closest to you – your family, trusted friends, your health care team, and the person or persons you would want to decide for you if you cannot (your substitute decision-maker(s)).

This guide is designed to help you have these important conversations. It is written for all Baycrest clients, including:

- Residents of Terraces of Baycrest and Apotex Jewish Home for the Aged
- Patients of Baycrest Hospital
- Clients attending a social or treatment program at Baycrest
- Clients of Baycrest Community Day Care Centre for Seniors
- Clients attending Baycrest day and outpatient programs whose health care is being directed by a family physician

Your “Advance Care Plan” Meetings at Baycrest

All clients will be asked to attend Advance Care Plan meetings, where their Advance Care Plan will be discussed. These will be arranged for you and, if you wish, your future substitute decision-maker(s), family members and anyone else close to you may attend.

Please bring this booklet to the meetings.

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Advance Directive (Living Will)

In addition to your Advance Care Plan, some of you may have already completed an Advance Directive (Living Will) under a Health Care Directive or a Power of Attorney for Personal Care. Please answer the following questions with a check mark next to your answer:

1. I have an Advance Directive(Living Will)
 Yes No

2. I have shared my Advance Directive (Living Will) with others
 Yes No

3. Two or three copies are at home
 Yes No

4. Two or more copies are for my family members
 Yes No

5. One copy is for my substitute decision-maker
 Yes No

6. One copy is for my family physician
 Yes No

7. One copy is for my Baycrest health care team
 Yes No

Note: Even though you may have an Advance Directive (Living Will), we recommend that you complete the following pages to ensure your wishes are up to date.

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1. DETERMINING YOUR ADVANCE CARE PLAN

Here are steps to help you (and your loved ones, should you choose to involve them) determine your future care goals.

LEARN

If you have an existing medical condition, talk to your doctor and other health care providers. Ask about your prognosis - what you might expect to experience in the future as a result of the condition. Learn about possible treatments for existing or future health conditions and about the type of care decisions you may be asked to make in the future.

THINK

The following questions and statements are designed to help you start to consider what is important to you in your health care. You may wish to use the space below each question or statement that follows below and on the next page under the “*Examples*” section to jot down your own ideas. Jotting down your own thoughts should help you to determine your Advance Care Plan. A formal area to document your Advance Care Plan is provided on pages 7-8.

What values and beliefs might influence my health care wishes?

What does quality of life mean to me?

What kind of changes to my health or life in the future might affect my wishes?

Under what circumstances would I (or would I not) want a given treatment

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EXAMPLES

I can accept treatments that try to fix problems. But if I am not getting better or achieving a certain quality of life, I would want to focus only on my comfort and allow natural death to occur.

Length of life is most important to me regardless of my recovery or changes to the quality of my life. My wish is to use all medical therapies including resuscitation and artificial life-sustaining treatments in intensive care to keep me alive if at all possible.

My wish is for full medical care but without the use of resuscitation or artificial life-sustaining intensive treatments if these are either unlikely to prolong my life or to restore my quality of life.

My wish is for health care to focus on my comfort and alleviate suffering. I would like medical care that focuses only on my quality of life. I would like to avoid being kept alive by medical treatments, resuscitation, or artificial life-sustaining intensive treatments.

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2. DOCUMENT

Now that you have considered the above, it is important to document your Advance Care Plan. These should someday guide your substitute decision-maker in consenting - or not consenting - to a treatment being proposed for you. Written wishes help give clearer directions to your substitute decision-maker(s) and may also reduce conflict or distress for those who might be concerned about what you would have wanted in a given situation. Please document your Advance Care Plan on Pages 7 - 8.

Update your Advance Care Plan document as required and inform your substitute decision-maker(s) and health care team.

To learn more about substitute decision-makers role see next section.

3. CHOOSE

Think about who will act as your substitute decision-maker. You can choose anyone who is willing, able and permitted under the law to communicate on your behalf with your physician and other members of your health care team. If the list in the Health Care Consent Act (Appendix A) gives the highest ranking to the person (or persons) you wish to appoint – your spouse for example – you don't need to take further action. However, if you prefer someone lower down the list (or not on the list at all, such as a close friend), or wish to designate one child or more (but not all your children), you will need to arrange this through a Power of Attorney for Personal Care. A booklet explaining how power of attorney works is available free of charge from the Ministry of the Attorney General.

Download it at <http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf>

Whoever you choose, be sure you trust the person (or persons) to make good decisions with your health care team, based on the wishes you expressed when capable or consistent with your values and beliefs. Is this person (or persons) able to communicate clearly? Do they fully understand your wishes? Are they willing and available to make treatment decisions for you if someday you are unable to do so?

4. COMMUNICATE

Completing this document is a form of communication with your designated substitute decision-maker and your health care team. Doing so should help ensure your wishes will be known. Your substitute decision-maker's role is to make decisions about any proposed treatments that reflect your wishes about your health circumstances. Your wishes may change over time as your health and/or views change, so be sure to keep the conversation open with your substitute decision-maker and health care team and to communicate any changes in your wishes.

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Creation of Advance Care Plan Checklist

Complete this checklist to ensure you have included the important steps in your planning. I need more information about my health to be able to determine my Advance Care Plan for the future. Specifically, I would like to know more about:

1. I have thought about my values, beliefs and personal goals as I plan for my future health care.

Yes No

2. I have written down my thoughts about the health care treatments discussed on pages 3 and 4 of the “*Think*” and “*examples*” sections.

Yes No

3. I have chosen my substitute decision-maker.

Yes No

4. I have discussed my future treatment wishes with my substitute decision-maker

Yes No

5. I have discussed my treatment wishes with my physician(s) and other members of my health care team

Yes No

6. I have completed and documented my Advance Care Plan on pages 7-8.

Yes No

Any other outstanding issues regarding Advance Care Plan:

APPENDIX C Health Care Consent Act

Ranking of individuals who may make a treatment decision on behalf of an incapable person

20. (1) if a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the Power Of Attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the [Consent and Capacity] Board if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person (or children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent).
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.

If more than one person is equally ranked with another (e.g., two or more adult children, where nobody has been named in a Power Of Attorney for personal care to make future decisions and therefore outrank the others), all equally ranked persons must agree on the proposed treatment. If they do not agree, the Public Guardian and Trustee, an office of the Government of Ontario, must step in and make the decision about proposed treatment.

To be a substitute decision-maker for someone else, you must be:

- Willing
- Available
- Capable (i.e., capable yourself of giving or refusing consent to the pro-posed treatment)
- Not prohibited by court order or separation agreement from acting for the person
- At least 16 years of age* (one legal exception will not arise at Baycrest, it
- involves a parent under 16 years of age making decisions on behalf of his/her young child)

Principles for giving or refusing consent

21. (1) a person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

Best interests

21. (2) in deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

- a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
- c) the following factors:
 1. Whether the treatment is likely to,
 - i. improve the incapable person's condition or well-being,
 - ii. prevent the incapable person's condition or well-being from deteriorating, or
 - iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
 3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
 4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

Information

22. (2) before giving or refusing consent to a treatment on an incapable person's behalf, a substitute decision-maker is entitled to receive all the information required for an informed consent