Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS Community Health Nursing		
TITLE:		**SECTION:**	**POLICY NUMBER:**
Advance Directives		Nursing Practice	07-016-00
EFFECTIVE DATE:	**REVIEW DUE:**	**REPLACES NUMBER:**	**NUMBER OF PAGES:**
February 10, 2018	February 2021		7
APPLIES TO:			
Community Health Nurses			

POLICY 1:

The Department of Health and Social Services promotes an environment which respects and encourages client self-determination. Clients will be encouraged and assisted to be active participants in the decision making process regarding their care through education, inquiry and assistance as requested.

Clients will be encouraged to communicate their desires in regard to advance directives to their significant others, to allow for guidance of significant others and healthcare providers in following the client's wishes should the client become incapacitated, rendering them unable to make decisions. The existence of an advance directive, or lack thereof, will not determine the client's access to care, treatment and services.

POLICY 2:

In an advance directive, the client may provide guidance as to his/her wishes in certain situations, or may delegate decision making to another individual as permitted by relevant legislation.

The delegated individual must identify themselves through legal transfer of the client's rights/power of attorney. If such an individual has been selected by the client to make treatment decisions, relevant information shall be provided to the representative so that informed healthcare decisions can be made for the client. However, as soon as the client is able to be informed of his/her rights, the Department of Health and Social Services shall provide that information to the client.

POLICY 3:

When the registered nurse or physician discuss advanced care planning with a client/ substitute decision maker/ power of attorney, the practitioner shall use the *Nunavut Care Level Planning* form in addition to documenting the details of the discussion in the client's health record.

DEFINITIONS:

Advance Directives refer to the means used to document and communicate a person's preferences regarding life-sustaining treatment in the event that they become incapable of expressing those wishes themselves. There are two forms:

- *Instruction directive:* commonly referred to as a living will, which details what life-sustaining treatments a person would want or not want in given situations
- *Proxy directive:* which explains who is to make healthcare decisions if the person becomes incompetent

Capability: All adults are presumed to be capable of making health care decisions until there is clear evidence that the adult is incapable of making a clear decision. Capability and incapability is assessed on the client's understanding:

- Of the information being given to him/her
- That the information applies to his/her own situation.

PRINCIPLES:

- Nunavut does not have legislation governing Advance Directives
- Advance Directives encourages an atmosphere of respect and caring and maximizes the client's ability and right to participate in medical decision making.
- Advanced directives promote the ethical value of autonomy. Autonomy is the principle that a person should be free to make his or her own decisions. Individual freedom is the basis for the modern concept of bioethics.

RELATED POLICIES, GUIDELINES AND LEGISLATION:

Template 07-016-01	Nunavut Care Level Planning
Policy 07-017-00	Do Not Resuscitate Order

REFERENCES:

Canadian Nurses Association (2008). *Code of Ethics for Registered Nurses.* Ottawa, ON.
Canadian Nurses Association (2008). *Position Statement: Providing nursing care at the end of life.* Ottawa, ON.
Canadian Nurses Association (1998). Advance Directives: The Nurse's Role. *Ethics in Practice.*
GUARDIANSHIP AND TRUSTEESHIP (S.N.W.T. 1994,c.29, as as duplicated for Nunavut by s.29 of the *Nunavut Act*, S.C. 1993, c.28)

Approved by:		Effective Date:
	11 FEB 2011	
Chief Nursing Officer	**Date**	April 1, 2011
	February 11, 2011	
Deputy Minister of Health and Social Services	**Date**	

TEMPLATE 07-016-01

The practitioner discussing advanced care planning with a client must ensure the *Nunavut Care Level Planning* form is completed by the physician/registered nurse, client or substitute decision maker/ power of attorney, and the interpreter (if applicable).

This form is filed in the client's health record. If the client is transferred to a referral site/ hospital, then a copy of this form should accompany the client.

Nunavut Care Level Planning
ᓄᓇᕘᒥ ᐃᓄᑐᖃᕐᓄᑦ ᐸᓇᓱᐊᒐᖅ

Your health care team would like to know how to provide the best care for you and your family. We would like to listen to you.

To provide the best care we need to have a difficult conversation with you and your family. We will only talk about your illnesses with your family with your permission. We would like to talk about what happens when you become sick and may be dying and what forms of care you would like to receive. We would like to know where you would like to receive your care (for example in your home community, Iqaluit, or Ottawa). If possible we would like to provide care at the end of your life with your family with you at home or in Iqaluit.

Thank you for allowing your nurses and doctors to talk about this with you.

If you do not wish to talk about your illness and care please let us know and we will not discuss it with you.

ᐋᓐᓂᐊᖅᑐᓕᕆᓂᕐᒧᑦ ᑲᒪᔨᒋᔭᔅᓯ ᖃᐅᔨᔪᒪᖕᒪᑕ ᖃᓄᖅ ᐊᑲᐅᓂᖅᐹᒃᑯᑦ ᑲᒪᒋᔭᖃᑦᑎᐊᕈᓐᓇᕐᒪᖕᒑᑦ ᐃᓕᖕᓂᒃ ᐃᓚᒋᔭᔅᓯᓐᓂᓪᓗ. ᐃᓕᔅᓯᓐᓂᒃ ᓈᓚᒍᒪᕗᒍᑦ.

ᐊᑲᐅᓛᒃᑯᑦ ᑲᒪᒋᔭᖃᑦᑎᐊᕈᓐᓇᖁᓪᓗᑕ ᐊᔪᕐᓇᖅᑐᒃᑯᑦ ᐅᖃᖃᑎᖃᓚᐊᖃᕋᑦᑕ ᐃᓕᖕᓂᒃ ᐃᓚᒋᔭᔅᓯᓐᓂᓪᓗ. ᐅᖃᐅᓯᖃᑐᐃᓐᓇᕐᓂᐊᖅᑐᒍᑦ ᐋᓐᓂᐊᕆᔭᕐᓂᒃ ᐃᓚᒋᔭᔅᓯᓐᓄᑦ ᐊᖏᕈᑎᖃᓚᐅᖅᑎᓪᓗᑎᑦ. ᐅᖃᐅᓯᖃᕈᒪᒐᑦᑕ ᐋᓐᓂᐊᓕᕐᒌᖕᒐᕕᑦ ᖃᓄᐃᓕᐅᖃᑦᑕᕐᒪᖕᒑᔅᓯ ᑐᖁᑐᐃᓐᓇᕆᐊᖃᓕᕐᓗᑎᓪᓗᓐᓂᑦ ᖃᓄᕐᓗ ᑲᒪᒋᔭᐅᖃᑦᑕᕈᒪᖕᒪᖕᒑᖅᐱᑦ. ᖃᐅᔨᔪᒪᕗᒍᑦ ᓇᓂ ᑲᒪᒋᔭᐅᔪᒪᓇᔭᕐᒪᖕᒑᖅᐱᑦ (ᐅᓇ ᐆᒃᑑᑎᒋᓗᒍ ᓄᓇᔅᓯᓐᓂ, ᐃᖃᓗᖕᓂ, ᐋᑐᕚᒥ ᓘᓐᓃᑦ). ᐊᔪᕐᓇᙱᑉᐸᑦ ᑲᒪᒋᔪᒪᓇᔭᖅᐸᑦᑎᒋᑦ ᐃᓅᓯᖅᐱᑦ ᐃᓱᐊᓄᑦ ᐃᓚᒋᔭᑎᑦ ᐱᖃᑎᒋᓗᒋᑦ ᐊᖏᕐᕋᔅᓯᓐᓂ ᐃᖃᓗᖕᓂᓪᓘᓐᓃᑦ.

ᖁᔭᓐᓇᒦᒃ ᐋᓐᓂᐊᓯᐅᖅᑎᓯᓐᓂᒃ ᓘᒃᑖᓯᓐᓂᓪᓗ ᐱᕕᖃᖅᑎᑦᑎᓚᔅᓯ ᑖᔅᓱᒥᖓ ᐅᖃᐅᓯᖃᖅᑎᓪᓗᑕ ᐃᓕᖕᓄᑦ.

ᐅᖃᐅᓯᖃᕈᒪᙱᒃᑯᕕᑦ ᐋᓐᓂᐊᕐᓂᖅᐱᑦ ᒥᒃᓵᓄᑦ ᑲᒪᒋᔭᐅᔭᓇᐊᖅᓯᓐᓂᕐᓄᓪᓗ ᖃᐅᔨᑎᓐᓂᐊᖅᐸᑦᑎᒍᑦ ᐅᖃᓪᓚᖃᑎᒋᔅᓴᙱᑉᐸᑦᑎᒋᓪᓗ.

Nunavut Care Level Planning

I, ____________________________________, would like the following level of care to be provided to me,
ᐅᕙᖓ, ____________________________________, ᐃᒫᒃ ᑲᒪᒋᔭᐅᔪᒪᓂᖃᖅᑐᖓ ,

________ acute medical care, including transport and care in referral hospitals in Southern Canada.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ, ᐃᓚᖃᓯᐅᑎᓗᒍ ᐃᖏᕐᕋᔾᔪᑎᒋᓂᐊᖅᑕᒃ ᐊᒻᒪᓗ ᑖᒃᑎᓕᐊᕐᕕᖕᓂᓗ ᐋᓐᓂᐊᕐᕕᖕᓂ ᖃᓪᓗᓈᓂ.

________ acute medical care, including transport and care in referral hospitals in Southern Canada, but do not wish CPR/intubation/cardioversion.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ, ᐃᓚᖃᓯᐅᑎᓗᒍ ᐃᖏᕐᕋᔾᔪᑎᒋᓂᐊᖅᑕᒃ ᐊᒻᒪᓗ ᑖᒃᑎᓕᐊᕐᕕᖕᓂᓗ ᐋᓐᓂᐊᕐᕕᖕᓂ ᖃᓪᓗᓈᓂ, ᑭᓯᐊᓂ ᐋᓐᓂᖅᓵᖅᑎᑕᐅᓇᓱᐊᕈᒪᓂᐊᖏᑦᑐᖓ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/ᐆᒻᒪᑎᑲ
ᑎᒡᓕᓕᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᖁᙱᑦᑕᕋᓗ.

________ acute medical care to be provided at Qikiqtani General Hospital only, recognizing that CPR/intubation/cardioversion will not be performed as this will then involve transport to a hospital in Southern Canada. In stabilization and transport to QGH I do not wish CPR/intubation/cardioversion. I may desire transport for medically relevant investigations, but this will be reviewed with my health care team on an individual basis.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ ᐃᑲᔪᖅᑕᐅᔪᒪᔪᖓ ᕿᑭᖅᑖᓗᑉ ᐋᓐᓂᐊᕐᕕᖓᓐᓂ ᑭᓯᐊᓂ, ᖃᐅᔨᒪᑦᓯᖓᓗ
ᐋᓐᓂᖅᓵᖅᑎᑕᐅᓇᓱᐊᕈᒪᓂᐊᖏᑦᑐᖓ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/ᐆᒻᒪᑎᑲ
ᑎᒡᓕᓕᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᖁᙱᑦᑕᕋᓗ
ᖃᐅᔨᒪᒐᒪ ᐊᓯᐊᓄᑦ ᐋᓐᓂᐊᕐᕕᖕᒧᑦ ᐊᒡᔭᖅᑕᐅᔭᕆᐊᖃᕐᓂᐊᕋᒪ ᖃᓪᓗᓈᓄᑦ.
ᖃᓄᐃᒍᓐᓃᔾᔪᒥᑎᑕᐅᓇᓱᐊᖅᑎᓪᓗᖓ ᐊᒡᔭᖅᑕᐅᑎᓪᓗᖓᓗ ᕿᑭᖅᑖᓗᑉ ᐋᓐᓂᐊᕐᕕᐊᓄᑦ ᐆᒻᒪᑎᑲ
ᑎᒡᓕᓕᖅᑎᑦᓯᓇᓱᐊᖅᑕᐅᖁᙱᑦᑕᕋ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/.
ᐊᒡᔭᖅᑕᐅᖃᑦᑕᕈᒪᓂᐊᖅᑐᖓ ᑎᒥᒐ ᓇᓗᓇᐃᖅᑐᖅᑕᐅᔭᕆᐊᖅᑐᕆᐊᖃᕌᖓᑦ ᓘᒃᑖᓄᑦ, ᑭᓯᐊᓂ
ᑕᒪᓐᓇ ᕿᒥᕐᕈᔭᐅᓂᐊᖅᑐᖅ ᐊᑐᓂ ᐋᓐᓂᐊᖅᑐᓕᕆᔨᒃᑯᓐᓄᑦ.

________ acute medical care to be provided at ______________________ only, recognizing that CPR/intubation/cardioversion will not be performed as this would then involve transport out of my community. I may desire transport for medically relevant investigations, but this will be reviewed with my health care team on an individual basis.
ᐋᖅᑭᒃᑕᐅᓴᕋᐃᑦᑐᒧᑦ ᐃᑲᔪᖅᑕᐅᔪᒪᔪᖓ ᐅᕙᓂ ___________________ ᑭᓯᐊᓂ, ᖃᐅᔨᒪᑦᓯᖓᓗ
ᐋᓐᓂᖅᓵᖅᑎᑕᐅᓇᓱᐊᕈᒪᓂᐊᖏᑦᑐᖓ/ᓱᓪᓗᓕᖅᑐᖅᑕᐅᔪᒪᓇᖓᓗ ᑎᒥᒃᑯᑦ/ᐆᒻᒪᑎᑲ
ᑎᒡᓕᓕᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᖁᙱᑦᑕᕋᓗ ᓄᓇᑦᑎᓐᓂᒃ ᐊᐅᓪᓚᖅᑎᑕᐅᔭᕆᐊᖃᕐᓂᐊᕋᒪ.
ᐊᒡᔭᖅᑕᐅᖃᑦᑕᕈᒪᓂᐊᖅᑐᖓ ᑎᒥᒐ ᓇᓗᓇᐃᖅᑐᖅᑕᐅᔭᕆᐊᖅᑐᕆᐊᖃᕌᖓᑦ ᓘᒃᑖᓄᑦ, ᑭᓯᐊᓂ ᑕᒪᓐᓇ
ᕿᒥᕐᕈᔭᐅᓂᐊᖅᑐᖅ ᐊᑐᓂ ᐋᓐᓂᐊᖅᑐᓕᕆᔨᒃᑯᓐᓄᑦ.

palliative care at _________________________. I realize I have an illness which is terminal and desire quality comfort care at _________________.
I would like my family involved with my care.

________ I do not wish CPR/intubation/cardioversion.
ᐋᓐᓂᐊᖃᖅᑐᓄᑦ ᑲᒪᒋᔭᐅᕕᖕᒦᒍᒪᔪᖕᖓ ________________________. ᖃᐅᔨᒪᔪᖕᖓ
ᐋᖅᑭᒃᑕᐅᔪᓐᓇᖕᒋᑦᑐᒥᑦ ᐋᓐᓂᐊᖃᓕᕐᓂᓐᓄᑦ ᐅᕝᕙᓂᓗ ᑲᒪᒋᔭᐅᔪᒪᑦᓯᐊᖅᑐᖓ ________________.
ᐃᓚᒃᑲ ᐅᕙᓐᓂᒃ ᑲᒪᖃᑕᐅᖁᔭᒃᑲ. ᐃᓅᒍᓐᓃᕐᐱᒃᓴᕋ ᓇᓪᓕᐅᑎᒃᐸᑦ ᐊᒻᒪᓗ ᐆᒻᒪᑎᒐ
ᑎᓪᓚᓚᖅᑎᑕᐅᓇᓱᐊᖅᑕᐅᖁᖖᒋᑦᑕᕋ/ᓱᓪᓗᓚᖅᑐᖅᑕᐅᔪᒪᓇᖕᒐᓗ ᑎᒥᒃᑯᑦ/

I understand I may change my mind at any time and that this will be respected.
ᑐᑭᓯᐅᒪᑦᓯᐊᖅᑐᖓ ᖃᖓᑐᐃᓐᓇᖅ ᑕᒪᓐᓇ ᐊᓯᔾᔨᖅᑕᐅᔪᓐᓇᖁᔪᓐᓇᖅᑕᕋ ᐊᒻᒪᓗ ᑕᒪᓐᓇ ``ᑲᒪᓱᒋᔭᐅᑦᓯᐊᖁᔭᕋ.

Discussed at: ______________________ Date: ______________________
ᐅᖃᐅᓯᐅᔪᖅ ᐅᕙᓂ: ______________________ ᐅᓪᓗᒥ: ______________________

Discussion in Inuuktituit: Y N
ᐅᖃᐅᓯᐅᔪᖅ ᐃᓄᒃᑎᑐᑦ: ᐄ ᐋᒡᒐ

If yes, then interpreter name: ____________________________
ᐊᖕᒋᖅᑕᐅᒍᓂ, ᑐᓵᔨᐅᑉ ᐊᑎᖓ: ____
Signature: ____
ᐊᑎᓕᐅᕈᓯᖓ: ____

Family and others present at discussion:
ᐃᓚᒋᔭᐅᔪᑦ ᐊᓯᖏᓪᓗ ᓈᓚᖃᑕᐅᔪᑦ ᐅᓇ ᐅᖃᐅᓯᐅᑎᓪᓗᒍ:
____
____
____

Signatures:
ᐊᑎᓕᐅᕐᓃᑦ:

_________________________ _____________________ ____________________
Patient or POA for personal care MD or RN discussing care witness
ᐋᓐᓂᐊᖅᑐᖅ ᓘᒃᑖᖅ ᒧᓇᖅᓯᓘᓐᓃᑦ ᐅᖃᐅᓯᖅᑐᖅ ᑕᐅᑐᒃᑐᖅ