ADVANCE CARE PLANNING POLICY

Summary of Changes

	NEW	Previous
BC Cancer	October 11, 2019	October 2018

1. Introduction

1.1. Purpose

To promote best practices in advance care planning (ACP), in accordance with consent legislation and policy, using a standardized process for initiating discussions, honouring, developing, recording and sharing goals of care orders for patients within the BC Cancer (BCC).

To support the identification and integration of Advance Directives, Representation Agreements and other Advance Care Planning documents into BCC care plans, goals of care orders and medical orders.

1.2. Scope

Applies to adults (19 years of age or older) with whom conversations may be clinically relevant in all BCC care settings.

Applies to all BCC physicians, nurse practitioners and other health care providers.

This policy does not replace requirements within the PHSA Consent to Treatment/Procedures AS_170.

1.3. Exceptions

None.

2. Policy

BCC recognizes the rights of capable adults to direct their own health care. The Health Care Consent and Care Facility (Admission) Act of B.C. confirms adults control over their own health care by legally recognizing prior expressed instructions or wishes.

Advance Care Planning including goals of care discussions are ongoing processes where capable adults can reassess their wishes as circumstances change.

BCC is committed to the documentation of goals of care for patients receiving care and treatment, and at any transitions during the patient's course of care/or treatment.

2.1. Policy Statement

2.1.1 Goals of Care Orders/code status must be completed when appropriate. (See ACP procedure)

2.1.2 Members of the interprofessional health team will provide information and support to patients as appropriate/requested for advance care planning discussions and document conversations in the medical record (see ACP procedure).

3. Responsibilities and Compliance

3.1. Responsibilities

- All Health Care Providers:
  1. Document advance care planning conversations in the medical record.
  2. Use the serious illness conversation guide to facilitate communication with patients/SDM.
  3. Refer to the BC Cancer "Introduction to Advance Care Planning" learning hub course.

- Physicians/Nurse Practitioners:
  1. Complete/update Goals of Care (GOC) Orders/code status with patients, as indicated.

3.2. Compliance

- The BCC advance care planning key performance indicator will be used to assess policy compliance. This indicator assesses the completion of goals of care and advance care planning conversations.

4. Related Documents

- PHSA MAiD Guideline – provides an overview of MAiD, general guidance for all staff and physicians, and process steps for responding to request for MAiD.

5. Definitions

1. Adult: The term “adult” is defined by the B.C. Health Care (Consent and Care Facility (Admission) Act (HCCFAA) as anyone 19 years of age or older.

2. Advance Care Planning (ACP): is the process of a capable adult talking over their beliefs, values, and wishes 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.

   At BCC ACP includes:
   - Participation in serious illness conversations with the patient/SDM using the serious illness conversation guide;
   - Completion of goals of care orders/code status in collaboration with the patient/SDM; and
   - Documentation of ACP discussions.

3. Advance Care Plan: is a written summary of the capable adults advance care planning conversations and wishes to guide their substitute decision-maker if called to make a healthcare decision in the event the adult is incapable of making decisions. This may include Advance Directive and/or Representative Agreement.

4. Advance Directive: The term “Advance Directive” is defined by the HCCFAA to mean a written legal document made by a capable adult that:
   Gives or refuses consent to healthcare for the adult in the event that the adult is not capable of giving the instruction at the time the health care is required, and complies with the requirements of part 2:1 of the HCCFAA. A document made before September 1st, 2011, which complies with the legislative requirements prescribed on September 1st, 2011, is deemed to be an Advance Directive.

5. Goals of Care: The intended purposes of health care interventions and support as recognized by both a Patient and Substitute Decision Maker, and Health Care provider.

6. Goals of Care Order: Orders documented based on an adults Advance Care Planning conversations that details a variety of medical interventions that will or will not be initiated. Also known as code status.

7. Patient: Any adult (19 years of age or older) who is receiving healthcare in the BCC facilities as an inpatient or outpatient.

8. Representative Agreement: A Representation Agreement is the key legal document in British Columbia for personal planning/advance care planning. It is a legally enforceable document and used in case of incapacity, for end-of-life, and other support needs.

9. Substitute Decision Maker (SDM): An individual who acts on behalf of the Patient who is incapable of giving or refusing consent to healthcare, There are three categories of Substitute Decision- Makers:
   i. Personal Guardians;
   ii. Representatives;
   iii. Temporary Substitute Decision Makers

10. Temporary Substitute Decision Maker (TSDM): A Temporary Substitute Decision Maker (TSDM) is appointed when an adult is incapable of making specific major or minor health care consent decisions and there is no Personal Guardian or Representative appointed nor an Advance Directive dealing with the situation. A TSDM is chosen by the Most Responsible Provider in accordance with the list set out in the *Health Care (Consent) and Care Facility (Admission) Act*. A health care provider must choose the first, in the listed order, of the following who is available and qualifies:
    1. The adult's spouse;
    2. The adult's child;
    3. The adult's parent;
    4. The adult's brother or sister;
    5. The adult's grandparents;
    6. The adult's grandchild
    7. Anyone else related by birth or adoption to the adult;
    8. A close friend of the adult (see Glossary for a definition);
    9. A person immediately related to the adult by marriage;
    10. The Public Guardian and Trustee.

    To qualify the person must:
    - Be at least 19 years of age;
    - Have been in contact with the adult during the preceding 12 months;
    - Have no dispute with the adult;
    - Be capable of giving, refusing or revoking substitute consent; and

- Be willing to comply with the duties of a Temporary Substitute Decision Maker.

6. References

1. Freedom of Information and Privacy Act (B.C)
2. Health Care (Consent) and Care facility (Admission) Act (B.C.) Hospital Act and Regulations BC
3. Alberta Health Services. (2008). Advance Care Planning: Goals of Care Designation. Regional Policy Manual. Retrieved from: http://www.albertahealthservices.ca/3917.asp
4. BC Ministry of Health http://www.health.gov.bc.ca/hcc/advance-care-planning.html Cancer Care Manitoba, (2011). Advance Care Planning, Cancercare Manitoba Patient Care Policy and Procedure Manual.
5. Fraser Health Authority. (2011). Advance Care Planning and Medical Orders for Scope of Treatment. Fraser Health Authority Policy Health Care Providers Guide to Consent, Victoria, BC. Author
6. London Health Science Centre. (2011) End of Life Decision Making. Policy Administration Console.
7. Vancouver Coastal Health Authority (2014). Medical Orders for Scope of Treatment and Advance Care Planning: Development and Treatment Policies.

7. Appendices

none

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