

Advance Care Planning/Serious Illness Conversations

1. Introduction

Providence Health Care (PHC) believes that all persons are entitled to, and should be encouraged to participate in conversations about their healthcare wishes, values, beliefs and fears in order to ensure they receive care that aligns with their preferences. As patients or 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 or resident wishes about future healthcare, this policy complements and supports the [Code Status \(Options for Care Policy\)](#) in respecting the dignity of the patient and resident as a free and informed decision maker.

1.1. Purpose

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 and residents of PHC in Long Term Care (LTC), 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. Policy

Staff and physicians will initiate, facilitate, and engage with patients and residents in Advance Care Planning and Serious Illness Conversations, either through facilitating the conversation and/or by directing the patient/resident to knowledgeable resources. Staff and physicians should encourage all capable patients and residents to engage in Advance Care Planning discussions, but at a minimum will engage in these conversations at 3 key stages:

1. **During early illness: proactively encourage patients and residents to consider as early in their illness as possible** who they trust to make healthcare decisions with/for them, and encouraging conversations with those persons about their values, wishes, beliefs and healthcare preferences. This is especially important in out-patient and community clinics/programs, on admission to LTC or on discharge from acute care, where teams have opportunities to encourage patient engagement in the Advance Care Planning process.
2. **At diagnosis of serious illness: Have goals of care conversations with patients, residents and/or substitute decision makers (“SDMs”) for persons diagnosed with serious illness.** These conversations include ensuring understanding of diagnosis, prognosis, and treatment options, learning more about the patient or residents’ values, wishes, beliefs and fears, explaining potential emergencies and developing a care plan, and designating the Code

Status (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/resident/substitute decision maker is unwilling to engage. These conversations should take place during outpatient encounters where appropriate and in advance of an emergency, acute or long term care admission.

3. **At diagnosis with terminal illness: Have focused end-of-life conversations with patients and residents and/or SDMs diagnosed with terminal illness or who may be at significant risk of dying within the next 6 to 12 months.** Components of this conversation include offering opportunities for patients/residents to understand their illness, explore how much information they would like, express their fears and worries about the future, and articulating what further interventions they are willing to go through for the possibility of more time. As in 2., these conversations are the responsibility of the physician or MRP,] who may delegate but must ensure that a quality conversation takes place, and should occur during outpatient encounters where appropriate in advance of an emergency, acute or long term care admission.

Advance Care Planning/Serious Illness Conversations should take place prior to establishing the direction of care for the patient/resident. Outcomes from the discussion will be documented in the Goals of Care Powerform in Cerner (in LTC only, nurses will document on the ACP/Serious Illness Conversation Record (MR101) until they have full Cerner documentation access). In situations where consensus cannot be reached, refer to the Dispute Resolving Mechanism outlined in the [Code Status \(Options for Care\)](#) policy. 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

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.

The decisions of an adult who is capable of making his or her own health care decisions supersede an Advance Care Planning document.

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.

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 their wishes as circumstances change.

At the patient or resident's discretion, family members, friends or significant others may be included in the Advance Care Planning and Serious Illness Conversations.

Advance Care Planning is voluntary; individuals are not required to engage in this activity.

3. Procedure

3.1. Receipt and Management of Advance Care Planning Documents

- 3.1.1. If a Health Care Provider (HCP) becomes aware that a patient or resident has an ACP document, or learns there is an updated version of a previously retained ACP document, the HCP should ask the patient, resident or SDM if they wish to provide a copy of the document for entry into their health record. In acute care, the copy will be placed in the Chartlet and the document will be scanned into the "Advance Care Planning Scanned" folder on discharge. In LTC, or for patients and residents receiving ongoing care through outpatient programs, ACP documents will be retained in the Chartlet (and scanned by the Unit Coordinator into Cerner where this option is available). Original copies of ACPs will be returned to the patient, resident, or family.
- 3.1.2. The health care team will take reasonable measures to determine whether the patient or resident has previously engaged in Advance Care Planning throughout each episode of care. This will include looking in the "Advance Care Planning Scanned" folder (located in the Advance Care Planning and Goals of Care tab found within Provider, Rounding or Results Review windows in Cerner) for previously received ACP documents such as Representation Agreements, Advance Directives or other expressions of wishes. Providers will also check the Chartlet for additional ACP documents not yet scanned. If an ACP document is found, the health care team will verify with the patient, resident or SDM to confirm that the ACP reflects their current wishes. HCPs may also check PARIS for evidence of previous ACP documents or conversations which occurred in the community and which may be relevant and/or contribute to the current episode of care.
- 3.1.3. HCPs interacting with the patient or resident throughout each episode of care will:
 - Note the presence of and review any ACP related documents in the Chartlet and/or the "Advance Care Planning Scanned" folder, plus any documentation of previous conversations in the Goals of Care Powerform,
 - Ensure that everyone making substitute decisions on behalf of an incapable patient or 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, and
 - Incorporate the wishes expressed into planning for care as appropriate to the decisions at hand.

3.2. Encouragement and Development of Advance Care Planning

- 3.2.1. HCPs should encourage all capable patients and residents to engage in Advance Care Planning discussions by facilitating the conversation or by directing them to knowledgeable resources (see section 5.2.)
- 3.2.2. HCPs must initiate Advance Care Planning discussions whenever the patient or resident has a significant chronic or acute illness with significant risk of death within the next twelve months. However, it should be noted that Advance Care Planning discussions are voluntary, and patients or 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" approach and other related resources 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 and families about Advance Care Planning and Goals of Care will be documented by the HCP in the Goals of Care Powerform in Cerner. In LTC, until nurses have access to documenting in the Goals of Care Powerform, nurses will document on the ACP/Serious Illness Conversation Record (MR101) which will be placed in the Chartlet behind the ACP tab. Also, until that time, documentation in the Goals of Care Powerform by other HCPs (e.g. physicians & social workers) will be printed & placed in the Chartlet behind the ACP tab.

3.3 Advance Directives, Consent and Advance Care Planning

- 3.3.1. Staff and physicians are bound by 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 or 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/resident 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 to an incapable patient/resident, unless it is 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 or resident.
- 3.3.4. The Substitute Decision Maker should rely on previously expressed wishes of the patient or 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 MRP should be advised if Advance Care Planning preferences are changed/revoked

3.4.3. Known changes to a patient or resident's treatment wishes must be documented in the Goals of Care Powerform; any revised copies of ACP documents are placed in the Chartlet (and scanned into Cerner as described in [3.1.1.](#)).

3.5 Questions or Disputes

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. Responsibilities

4.1. Physicians

Physicians will engage in Advance Care Planning and Serious Illness Conversations as described in 2.0.

4.2. Nurses

In LTC care, nurses are encouraged to have Advance Care Planning and SIC 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/SIC 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.

4.3. Social Workers

Social workers will support the ACP and SIC responsibilities of the MRP described in 2.0 by engaging in, supporting and supplement ACP/SIC conversations as required and understood within each program, or as individual referrals are received. Social workers will assist in the education of patients, residents &/or their SDMs by offering education and referral to resources appropriate to the circumstances.

4.4. Other Allied Health Care Professionals

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

4.5. Leader, Advance Care Planning

The leader for Advance Care Planning acts as resource to PHC staff and medical staff, provides leadership and organizational engagement, leads the development and implementation of educational initiatives, training and resources, and ensures the optimization of documentation procedures. The lead manages ACP/SIC-related policy updates, identifies barriers to

implementation and seeks support for mitigation. The lead also works to enhance patient, family and public engagement within PHC and works with regional counterparts to promote ACP/SIC education and engagement in the communities that PHC serves. The lead makes certain audits are conducted to ensure clinics and programs are in compliance with this policy, and leads research initiatives that contribute to better understanding of ACP and SICs at Providence and beyond to the wider community we serve.

4.6. Medical Affairs and Chief, Professional Practice and Nursing

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

5. 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.

6. Supporting Documents

6.1. Related Policies

[Code Status \(Options for Care\)](#)

Consent to Health Care

6.2. Guidelines, and Other Resources

Up-to-date resources may be found internally on [PHC Connect: Advance Care Planning and Serious Illness Conversations](#)

Externally, similar resources may be found at [BC Centre for Palliative Care: Resources for Health Care Providers](#)

And the frequently requested ACP guide for patients, residents and their families:

[My Voice: Expressing My Wishes for Future Health Care Treatment. Advance Care Planning Guide \(February 2013\)](#)

7. Definitions

“Advance Care Planning” is the process of a capable adult stating and/or documenting 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 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. Advance Directives are defined in [Part 2.1 of the Health Care \(Consent\) and Care Facilities \(Admission\) Act](#).

“Committee of the Person/Personal Guardian” means a person appointed by court order of the Supreme Court of B.C. under the [Patients Property Act](#), giving the appointee broad decision-making powers on behalf of the patient or 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.

“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 or resident when the patient or resident was capable, who meets basic criteria and has entered into a Representation Agreement under the [Representation Agreement Act](#).

“Serious Illness 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.

“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.

“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.

8. References

1. Alberta Health Services Policy Advance Care Planning and Goals of Care Designation
2. Beth Israel Deaconess Medical Center Advance Care Planning Guideline
3. Bernacki RE, Block SD, for the American College of Physicians High Value Care Task Force.

4. 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.
5. Serious Illness Conversation Guide ©2012 Ariadne Labs: A Joint Center for Health Systems Innovation and Dana-Farber Cancer Institute
6. Kelly, AS, Defining 'Serious Illness'. *Journal of Palliative Medicine* 17(9) August 2014
7. [Health Care \(Consent\) and Care Facility \(Admission\) Act \[RSBC 1996\] Chapter 181](#)
8. [Representation Agreement Act \[RSBC 1996\] Chapter 405.](#)
9. [Patients Property Act \[RSBC 1996\] Chapter 349](#)

Effective Date:	26-OCT-2022
First Released:	8-FEB-2012
Last Revised:	26-OCT-2022
Last Reviewed:	26-OCT-2022
Approved By:	PHC
	Senior Leadership Team / VP Quality & Safety
Owners:	PHC
	Exec Director, Patient Safety & Quality Improvement and In-House Counsel