Saskatchewan
Health Authority

FUTURE HEALTH CARE DECISIONS:

PRACTITIONER'S GUIDE

Advance Care Planning Program

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Future Health Care Decisions

What is *Future Health Care Decisions*?

Future Health Care Decisions (CS-PIER-0275) was created as a more specific and condensed alternative to the Advance Care Planning Program's My Voice Workbook. This version is meant to help those with a specific health condition who have a good understanding of their current health and are planning for things that may happen due to this condition. It includes:

- A brief explanation of advance care planning and substitute decision makers (SDM)
- The nearest relative list from the Health Care Directives and Substitute Health Care Decision Makers Act, 2015
- A form to designate a proxy (SHA 0326)
- A health care directive (HCD) template that considers the patient's current health status with a foreseeable disease progression and/or prognosis that can be used after a conversation with a member of a patient's healthcare team

This guide is an educational and supportive tool for patients that may not result in any paperwork being completed. The original My Voice workbook works well for individuals who do not have a specific health context in mind to discuss with their care provider and would like to consider the advance care planning process to potentially make a general directive for the future.

When and how should *Future Health Care Decisions* be used?

This version is meant to help those with long-term conditions who have a good understanding of their health and are planning directions for things that may happen. It should be created after a conversation about their current health and anticipated future decisions.

When assisting patients in completing the *Future Health Care Decision Making Guide*, it is important to prioritize high quality conversations with appointed proxies and to emphasize that HCDs are only in effect when patient does not have capacity.

Who can assist patients in completing *Future Health Care Decisions*?

Any member of the patient's health care team with knowledge of the patient's health status and prognosis can assist them in completing any portion of this booklet. They should read this guide prior and be confident they have the necessary knowledge to assure the patient has an adequate understanding of their current health. Creating a HCD is completely voluntary and a patient should be given choice in what they would like to complete and with what assistance.

Does *Future Health care Decisions* need to be completed in its entirety?

No—the patient may be comfortable with their nearest legal relatives as SDM. They may also choose to appoint a proxy and simply have conversations with them about their wishes instead of creating a HCD. Some may opt to create a HCD and further specify their wishes. It is also acceptable, but not recommended, to create a HCD and not appoint a proxy.

Where does the end result go?

The Advance Care Planning Program (ACPP) yellow sleeve is a plastic envelope in which a patient can store their medical and personal information, their HCD and proxy appointment. It should be stored on or near the fridge so paramedics will know where to look for it in a medical emergency. In long term or acute care, a copy should be placed in the green sleeve in the chart.

Patients can obtain a Yellow Sleeve package from ACPP Educators, at admission to primary care services, upon admission or discharge from a facility/unit or from EMS services. If you are unable to provide a yellow sleeve, you can instruct the patient to contact the ACPP team.

If patient is admitted to acute or long term care, they can bring their yellow sleeve for copies to be made of their documents. These copies can then be placed in the ACP Green Sleeve in their chart. The patient owns their health care directive and proxy appointment documents. Return all original documents to the person who made them. The person is responsible for making changes to or revoking these documents. You should remind the patient to update their yellow sleeve information sheet as information changes.

Page by Page Guide

When reading through Future Health Care Decisions with a patient, there may be some important points for you to understand or to discuss with the patient in addition to what is included in the booklet. These topics may come up in conversation, so it is important you have an understanding of advance care planning basics. The following information is organized by the pages of Future Health Care Decisions where it's most likely to be useful. It may be useful to have a copy of Future Health Care Decisions available the first time you read this guide.

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- An individual can make changes to their directive and proxy at any time as long as they have capacity to make their own decisions. Having capacity means understanding their current health and treatment options, knowing what may happen if they accept or decline a treatment, and being able to communicate their decision.
- According to the Health Care Directives and Substitute Health Care Decision Makers Act (2015), having capacity means having the ability to understand the information relevant to a health care decision, appreciate the reasonably foreseeable consequences of the decision, and communicate that decision. Capacity is both decision and time specific. A person may have enough capacity to make some decisions but not others. For example, someone might lack capacity to make complex medical decisions and hence change their HCD, but still have capacity to change or appoint a proxy.
- These documents do not expire until the person who wrote them verbally revokes them or writes new ones. All Saskatchewan residents who are 16 years of age and older can make their own health care directive, make changes to it, or cancel the directive at any time while they have capacity.
- A patient's directive is only in effect if they do not have capacity.

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- Health Care Directives and Substitute Decision Makers in Saskatchewan are legislated under the Health Care Directives and Substitute Health Care Decision Makers Act, (2015). This act determines the nearest relative list.
- If the patient is comfortable with the first few nearest relatives on the list making decisions for them in that specific order, they may not need to create any formal documents. If so, the patient should make sure the nearest relatives are agreeable and make sure caregivers have the names and contact information of the relatives.

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- Giving someone Power of Attorney (POA), is not the same as appointing them as a proxy. POA is typically for financial decisions.
- If a patient appoints a proxy who knows them well and has quality conversations with them about their wishes, it can be the best way for decisions to be made in the patient's best interest if they lose capacity.
- If the patient is confident their proxy knows their wishes well, it may not be necessary to complete a HCD.
- Proxies can be asked to work together or separately.
- Jointly: Proxies work together to make decisions. If they cannot agree, there are rules about what happens. Patients should be aware of this if considering having multiple joint proxies.
- Succession: The first person in the list makes choices until they are no longer able or willing to.

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- Substitute Decision Maker: the legal person (or people) that the health care team would talk to about healthcare decisions if the patient could not speak for themselves.
- Proxy: a type of substitute decision maker that is chosen by creating a document called an Appointment of Proxy.
- Legal Guardian: a type of substitute decision maker chosen in court to make decisions for an adult who is unable to make their own decisions long term, only used if there is no appointed proxy.
- Legal Nearest Relative: a type of substitute decision maker that is chosen by a list of priority relatives in the legislation, only used when there is no proxy or legal guardian

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- The Appointing a Proxy form (SHA 0326) is a legal document. It can be done alone or as part of a larger health care directive.
- If the patient is unable to physically sign their name to the document and uses a mark, the document must be witnessed. The witness cannot be a proxy or their spouse. An SHA employee can witness directives.

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- Patients cannot be required to create a HCD. It is completely voluntary.
- A HCD cannot cover all possible situations. It is important for patients to have an informed proxy for situations they have not anticipated.
- You should ensure the patient has had ample conversations about their conditions and understands their current expected disease trajectory. This template has been created for the patient to provide directions for specific chronic or terminal conditions.
- HCDs can be general or specific.
- Specific Directives: If a directive provides direction for specific or anticipated circumstances, it will be followed specifically for the indicated situation(s).
- General Directives: If a directive does not clearly anticipate or give direction for specific circumstances which exist or may be anticipated, it is considered a general directive and will be used as a guide.

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- Provide a Yellow Sleeve to the patient if they create a legal document, or assist them in acquiring one from the Advance Care Planning Program.
- Let's Talk Advance Care Planning (CS-PIER-0340) can be a useful additional resource from the Advance Care Planning Program if the patient needs some more prompts to think about their wishes and values before creating a HCD.

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- This is the first page of the legal health care directive. Make sure that the patient understands they are creating a legal and enduring document.
- In the box near the bottom, the patient should clarify that you assisted them and in what circumstances.
- The context in which a directive was created is helpful when being interpreted in the future. Make sure the patient write down their understanding of their current condition and why they are making the directive. The specific instructions on the next page will relate to this health context exclusively. The following page allows for more general guiding information for unanticipated other circumstances. All other decisions will go to the substitute decision maker.
- The initial boxes at the bottom of the page are a reminder to make sure the patient understands that this HCD is only in effect only when they do not have the capacity to make health care decisions and that the next page applies only to the specific health condition mentioned above.

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- The most important information for providers to have from a HCD is usually what outcomes the patient would accept as a tolerable quality of life and what they would be willing to go through to achieve those outcomes.
- It is important that patients are able to express their values and goals, and some may not be able to do that in specific medical terms. This means that we cannot simply hand patients a list of medical interventions to check off the ones that are acceptable to them. Check boxes can be perceived as leading at times, and it is important to have no bias in an important legal document such as this. Patients have varying levels of health literacy, and the free form answers allow them to frame their wishes as they choose.
- You can facilitate a conversation with your patient about expected disease progression to assist them in visualizing what they would want in those situations and any worries they may have.
- Give a direct, honest prognosis for your patient's condition to the best of your knowledge, within your own scope of practice. Allow silence. Focus on patient-centred goals and priorities not medical procedures. Do not offer a menu of interventions, especially those that are not clinically beneficial.
    - Use the "wish, worry, wonder" framework:
    - "I wish" allows for aligning with the patient's hopes.
    - "I worry" allows for being truthful while sensitive.
    - "I wonder" is a subtle way to make a recommendation.
- The first box can include any possible health effects the patient's condition may cause in the future. The patients can consider their goals in these situations and record them in the second box. The third box allows the patient to indicate what they would be willing to tolerate and for how long in order to reach those goals. The last box allows the patient to decide when they would be agreeable to their SDM and care team deciding to move to comfort focused care and cease any treatment. For example, someone with COPD may write "acquire pneumonia" and/or "respiratory arrest" in the first box. In the second, they may write something along the lines of "be able return to my home to live independently" or "be alive to see my children grown up". The third box may say "I would accept non-invasive ventilation and medications" or "I want no resuscitation interventions or prolonged invasive ventilation". They might write "prolonged invasive ventilation is required" or "breathless at rest, even with treatment".
- The patient can number different scenarios with different goals.
- Make sure to have each page of the directive signed (witnessed if possible) and dated.

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  - This page is optional.
  - This page is intended to provide general important information for unanticipated future healthcare decisions, perhaps not related to the patient's current condition (For example, an acute severe injury or stroke). This can be a helpful way to guide the health care team and SDM in future unrelated health care decisions. The patient may not be able to anticipate the circumstances, but may have strong feelings about certain outcomes or interventions.
  - Potential questions that you may want to ask the patient for this page:
    - Do you have any strong feelings about intubation, feeding tubes, tracheotomy, dialysis?
    - Would you consider time limited trials?
    - Do you have strong feelings about organ and tissue donation?
    - Are there any cultural or spiritual rituals that are important to you that your health care providers should know about?
- Remember to sign, date, and witness this page as well if it is to be included.
- Make sure the patient has a yellow sleeve to store their completed documents in and that it is located near the refrigerator.

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  - If the patient would like more information on any of these topics, they can scan the QR codes with a smart phone for links to resources from our website. They can also click the QR codes for a link on a digital version, visit our website, or contact the Advance Care Planning Program for more information.

Thank you for assisting someone in the important process of advance care planning.

Advance Care Planning Program

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