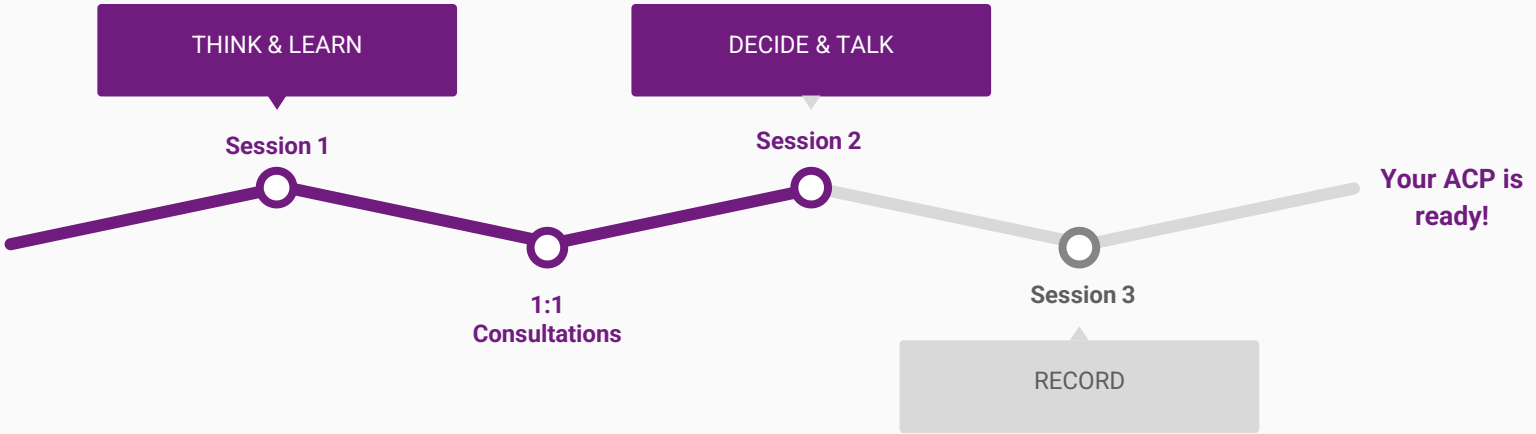
Dr. Bob KEMP HOSPICE
Compassionate Palliative Care & Bereavement Services

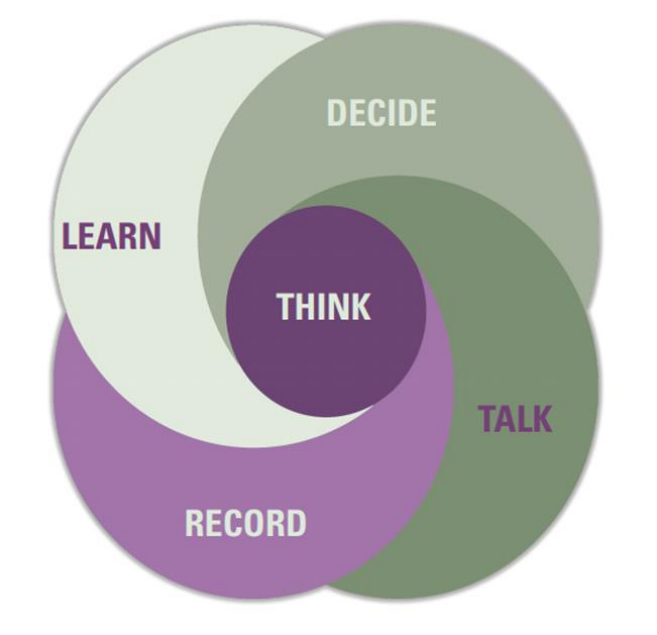
Advance Care Planning

Self-paced Workshop - Session 2
April 2023

Self-guided Workshop Roadmap



Key Steps in Advance Care Planning



THINK- about your wishes and values
LEARN - about your health & legal requirements
DECIDE - your substitute decision maker
TALK - to professionals and your family
RECORD - your ACP journey

Recap of Session 1

Step 1: THINK
☐ I have thought about my wishes and values and how they may influence my future health care decisions.
☐ I have considered any current health issues and decisions that may need to be made.
☐ I have reflected on previous experiences with my own health or of others and how this may impact a future health care choice for myself.

Step 2: LEARN
☐ I have sourced out information on advance care planning terms and medical procedures (such as resuscitation and feeding tubes).
☐ I have contemplated what quality of living means to me.

Step 3: DECIDE

Who will speak for me if I could not speak for myself?

Step 3: DECIDE

Listed below are the tasks you will complete by the end of Step 3:

☐ I have chosen who will make medical, shelter and personal decisions on my behalf if I am not able to make these decisions from myself. (Substitute Decision Maker).

☐ I have identified an alternate person in case my first choice is unable to fulfill this role.

Step 3: DECIDE

Learning Resource:

- Watch the following video https://youtu.be/D_oSUJSb8q0?t=36 (4 Mins)
- Watch the following video https://www.youtube.com/watch?v=W8pHPbvJK98 (2 Mins) on how to Decide who should be your Substitute Decision Maker.
- Watch the following video https://www.youtube.com/watch?v=CV2aTQih5SA (2 Mins) on what you need to do if you are a Substitute Decision Maker for someone else.

Step 3: DECIDE

A Substitute Decision Maker will be responsible for:

- Making medical decisions on your behalf when you are unable to make your own health care decisions
- Deciding on care facilities should you require assistance ensure your personal care needs are meet (clothing, food, transportation etc.)
- Fostering previous relationships you have had with others
- Can refer to written documents/plans, such as your Advance Health Care Directive, to communicate, advocate and make decisions on your behalf
- Should understand your wishes and have a copy of your most recently directives
- They may need help or support from your family and friends when deciding on your behalf if they are unclear what you would want

Step 3: DECIDE

Who will be my Substitute Decision Maker?

- Every person in Ontario has a SDM according to a ranking list laid out in the Ontario Health Care Consent Act.
- A Power of Attorney for Personal Care (POA) is a person you appoint to be your SDM.
- A POA is the highest-ranking SDM unless the courts have appointed a SDM.
- If you do not appoint a SDM one will be appointed for you according to a ranking list.
- Ontario ranking order for determining who will be your SDM

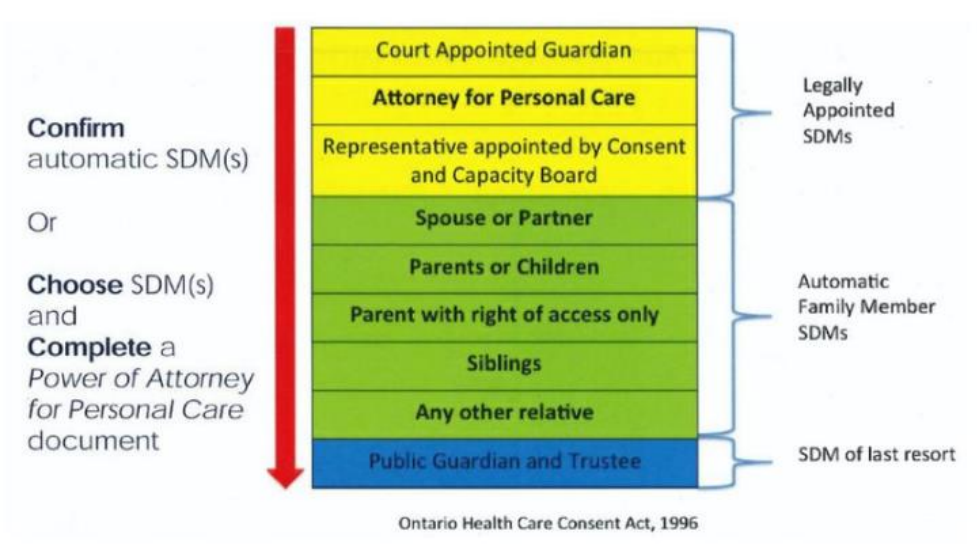
Step 3: DECIDE

If there are two or more people who rank equally they will all be entitled to act as your SDM . (i.e. 3 children or 1 child and 1 parent, 5 cousins, 2 siblings etc.)

If you have more than one Substitute Decision Maker they must:

- Make decisions jointly.
- Come to an agreement on your care needs (it must be by consensus, NOT majority).
- If they cannot agree the default is the Public Guardian and Trustee

It is wise to clearly make your wishes know to your SDMs to avoid conflict and disagreement.



Step 3: DECIDE

Exercise:

1. If you were unable to speak for yourself and someone was going to make a medical decision on your behalf, what kind of person would I want them to be? Write down the qualities you'd like to have in your SDM.
2. Who do I talk with about important things? Who knows me the best?
3. Could this person set aside there own values and honour my wishes? Yes or No? Why Not?

Step 3: DECIDE

Answers:

Step 3: DECIDE

Answers:

Step 4: TALK

One conversation can make all the difference. Imagine how easy ongoing conversations will be once you begin the first one.

Step 4: TALK

Listed below are the tasks you will complete by the end of Step 4:

☐ I have discussed my health, shelter, and personal care preferences with my Substitute Decision Maker and those closest to me including my health care professionals.

Step 4: TALK

Learning Resource:

- Watch the following video https://youtu.be/UOAMpul6UA4?t=32 (4 Mins)
- Watch the following video https://www.youtube.com/watch?v=2R3Njv0LjjM (12 Mins) of a Ted Talk video “What’s wrong with dying”.
- Watch the experience of one Ontarion family who experienced the outcome of not talking about wishes and health preferences before tragedy struck. https://www.youtube.com/watch?v=Jza-91GwN2Q (2Mins)

Step 4: TALK

Reflection:

Think about the barriers or challenges you face when it comes to having conversations about death and dying. Come prepared to share with your small group members a couple challenges you have faced or anticipate will occur as you begin to talk with your loved ones about your advance health care plan.

Step 4: TALK

Exercise:

- Now that I have started to think about this, who do I want to talk to about my wishes?
- Is there someone I may be asked to make decisions on their behalf?
- When is a good time to talk to them? Think about when you might approach those who matter to you. For example, at a social gathering, before your next big trip etc.
- Where is a good place to talk? Think about where you might have the conversations. For example, at the kitchen table, at a restaurant, during a walk etc.

Step 4: TALK

Answers:

Step 4: TALK

Answers:

Step 4: TALK

Conversation Starters - To describe your wishes to others:

- My doctor and I talked today about my future health care needs and I realized that I haven't told you about my wishes – we should talk about that.
- I have just completed a document outlining my future health care wishes and I want to share it with you.
- That story about the woman fighting with the doctors to keep her husband alive on machines made me realize that we should talk about these things so we both understand what each other would want.
- Remember our neighbor who died after being in the hospital for such a long time? I would never want that to happen to me.
- Do you remember when Auntie Kay was in a coma for a while? She did not talk to her daughters about her wishes so I want to make sure I talk to you about what I would want.

Step 4: TALK

Conversation Starters - To ask others what their wishes are:

- I am happy you asked me to be your Power of Attorney, I would really like to know your wishes and health preferences so that I can make good decisions for you.
- You seem to really be struggling (tired, sad etc.), and I am worried for you. I am wondering if you would find it helpful to talk with me about your day-to-day challenges and what the future might look like for you.
- I did not realize there are so many choices a person could make about health care and housing as they age. I am interested in getting your thoughts about optional housing.
- I know I might be in the position of having to make decisions for you. We have not really talked about what you would want for yourself. I would feel better and more prepared if we did.

Pause…

You've completed the second session of the self-guided ACP Workshop, and the key steps 3 and 4 of preparing your own Advance Care Plan!

Pause and take a breath

You can always go back and change your answers, that's what ACP is!

See you in Session 3.

Ask an Expert

Sandra Andreychuk is a Health Care Ethicist, a Registered Nurse at the Bob Kemp Hospice and is an Advance Health Care Consultant for Cambridge Law, within their estate planning division. Sandra also has an independent Advance Care Planning practice which you can learn more about her services at https://www.qualitylifeplanning.com/

Sandra will be available for 1:1 Consultations about your ACP.

All resources and updates for the consultation and the session will be available on: https://kemphospice.org/advance-care-planning/