Person-Centred Decision-Making: Quick Reference Guide

	ACP: Capable Healthy Person	ACP: Capable Person with Serious Illness	Prepare SDMs of an incapable person for future decisions	Goals of Care Discussion	Informed Consent
Role of HCP	**Facilitator** (if HCP is present but not necessary)	**Facilitator + Illness educator**	**Illness educator**	**Coach, guide and facilitate** a person and/or SDM through GOC Conversations to propose/offer treatments or care	**Obtain consent**
Tasks	**Introduce** ACP and assess readiness **Educate** about what ACP is & role of future SDM (provide consent when person is incapable) **Confirm/Identify** SDM **Prepare** SDM for future decision-making by discussing wishes, values & beliefs **Provide** resources **Address** expectations of person around ACP and uncertainty of future health care needs	Same as for ACP with a healthy capable person **PLUS:** **Explore and Educate** the person & SDMs about illness (expected course, where the person is at on the disease trajectory & management) **Explore** the person's & SDMs. information needs	**Explore and Educate** the SDMs about the person's illness (expected course, where the person is at on the disease trajectory) & management **Educate** about the role of the SDM in decision-making and consent **Explore** SDMs information needs **Address** expectations about the role of this conversation and the uncertainty of future health care needs	**Educate** to prepare a person or SDMs for upcoming decisions **Ensure** illness or event is understood **Inquire** about previous discussions of values, beliefs and wishes **Provide information** about current illness, (including trajectory and what to expect in the future) or decision and options (preparation for informed consent) **Explore** and identify the person's goals **Determine together** the treatment and care that best fits with the person's goals	**Determine capacity** of the person **Identify the correct SDM** If person is NOT capable of providing consent **Provide translator** if needed **Provide assistance** if communication barriers exist (non-verbal, hearing impaired etc.)
How	**Use conversation guides/education modules** focused on values rather than checklists. Examples: • ACP Conversation Guide • Speak Up • Respecting Choices* • HPCO ACP modules *with modification for Ontario context	**Use Conversation guides/education modules** focused on values rather than checklists Examples: • ACP Conversation Guide • Speak Up • Respecting Choices* • Serious Illness Conversation* • HPCO modules *with modification for Ontario context	**Use skills** learned from conversation guides/modules to: • Educate the SDM on their role • Focus on values and priorities SDMs cannot express wishes on behalf of incapable persons Any documentation must clearly indicate that these are reflections of SDMs and are neither consent nor the persons' prior capable wishes.	**Use conversation guides/education modules** to learn skills Examples: • Serious Illness Conversation* • GOC module or HCPO modules *with modification for Ontario context	**Use Health Care Consent Act** Ensure information is provided at health literacy level of the patient Discuss risks/benefits in relation to individual patient goals and priorities

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Outcome	☐ SDM confirmed ☐ SDM understands role ☐ Goals and values explored between patient and SDM	☐ SDM confirmed ☐ SDM understands role ☐ Illness is understood ☐ Information needs are met ☐ Goals & values explored between person & SDM	☐ SDM confirmed ☐ SDM understands role ☐ SDM understands illness ☐ SDM reflects on person's prior capable wishes values, beliefs and how these will relate to decision-making (when it's required)	☐ Decisions or care plans aim to align with person's goals (e.g. dialysis, feeding tubes, transfer) ☐ If available treatments do not align with person's goals, practice supportive counselling and non-abandonment ☐ Capable person or SDM prepared to engage in consent conversation	☐ Person or SDM either provides or refuses consent to proposed treatment/care
When	Anytime a person is capable Use EMR to set reminders Link to existing routine care: • Periodic health exam • Preventive health screening	Anytime a person is capable, and no treatment or care decision is being made Use EMR to set reminders Link to existing routine care: • Periodic health exam • Preventive health screening • Routine disease monitoring visits • Following resolution of acute illness or change in health status	Anytime a person lacks capacity, and no treatment or care decision is being made Link to existing routine care: • Routine disease monitoring visits • Following resolution of acute illness or change in health status • Periodic LTC health review	Anytime a treatment or care decision is to be made May require a series of conversations Each GOC conversation doesn't necessarily lead to a treatment decision Goals and priorities need to be re-assessed with changes in health status and/or each treatment	Must be obtained before any treatment or care is initiated Consent is required even if ACP or GOC conversations have not occurred
Role of SDM	**Learn** about potential future role **Understand** person's wishes, values & beliefs **Participate** in ACP conversations	**Learn** about potential future role **Understand** person's wishes, values & beliefs as well as person's illness **Participate** in ACP conversations and attend healthcare visits at the patient's discretion	**Learn** about their role **Reflect** on a person's wishes, values & beliefs and prepare to apply them when decisions need to be made	**Incapable** person: SDM takes active role in decision-making and consent **Capable person:** SDM can support decision making but no specific role for decision or consent	**Provides** (or refuses) consent on behalf of the incapable person
Role of non-HCP	**Support** the person in exploring values/beliefs **Encourage** sharing of info with SDM	**Support** the person in exploring values/beliefs **Encourage** sharing of info with SDM **Refer** to HCP for medical info	**Support** the SDM/caregivers in exploring values/beliefs of the person and their own feelings about the illness experience **Refer** to HCP for medical info	**Support** the SDM/caregivers in exploring values/beliefs of the person and their own feelings about the illness experience **Refer** to HCP for medical info	**No role** as consent occurs between the patient/SDM and the HCP
Relevant section of HCCA	• Capacity • SDM Hierarchy • ACP discussions may be a source of prior capable wishes	• Capacity • SDM Hierarchy • ACP discussions may be a source of prior capable wishes	• Capacity (person is incapable) • SDM Hierarchy	• Capacity • Informed consent • SDM Hierarchy • Principles of substitute decision-making (prior capable wishes, best interests)	• Capacity • Informed consent • SDM Hierarchy • Principles of substitute decision-making (prior capable wishes, best interests)

This table aims to convey the similarities, differences and key components for each conversation involved in providing person-centred care. Please see related HPCO diagrams to explore the definitions, relationship and flow between these conversations. The following abbreviations have been used in this table: **HCP:** *Health Care Provider (any regulated health care professional)* Non-HCP: *may include Personal Support Workers, spiritual leaders, community leaders, volunteers etc.* **SDM:** *Substitute Decision Maker* **HCCA:** *Ontario Health Care Consent Act*

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