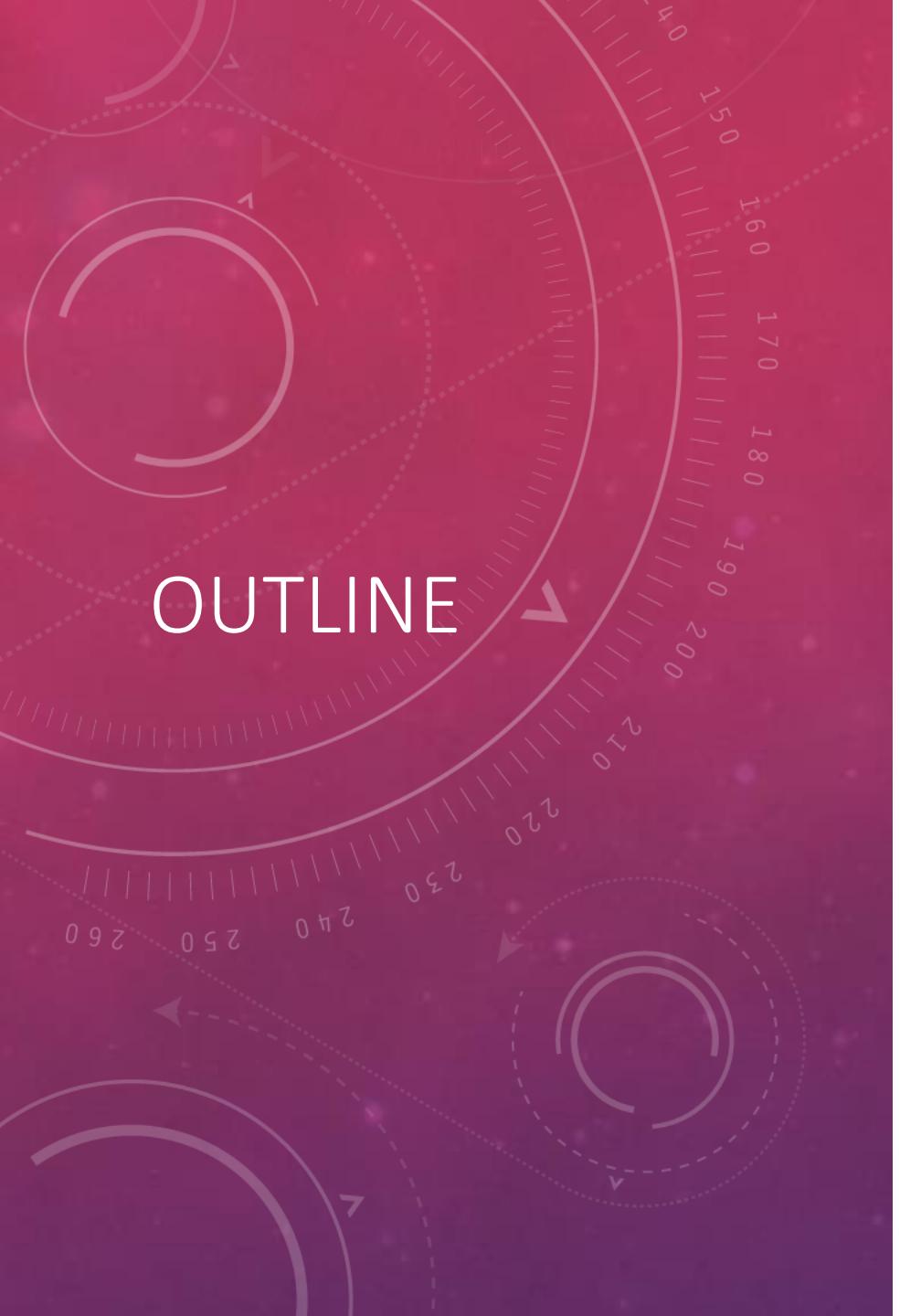




ELDERLY PATIENT CARE

PRA-BC CENTRALIZED ORIENTATION 2025



OUTLINE

Aging Safely

- Geriatric Assessment/Care-Planning
- Driving Safety

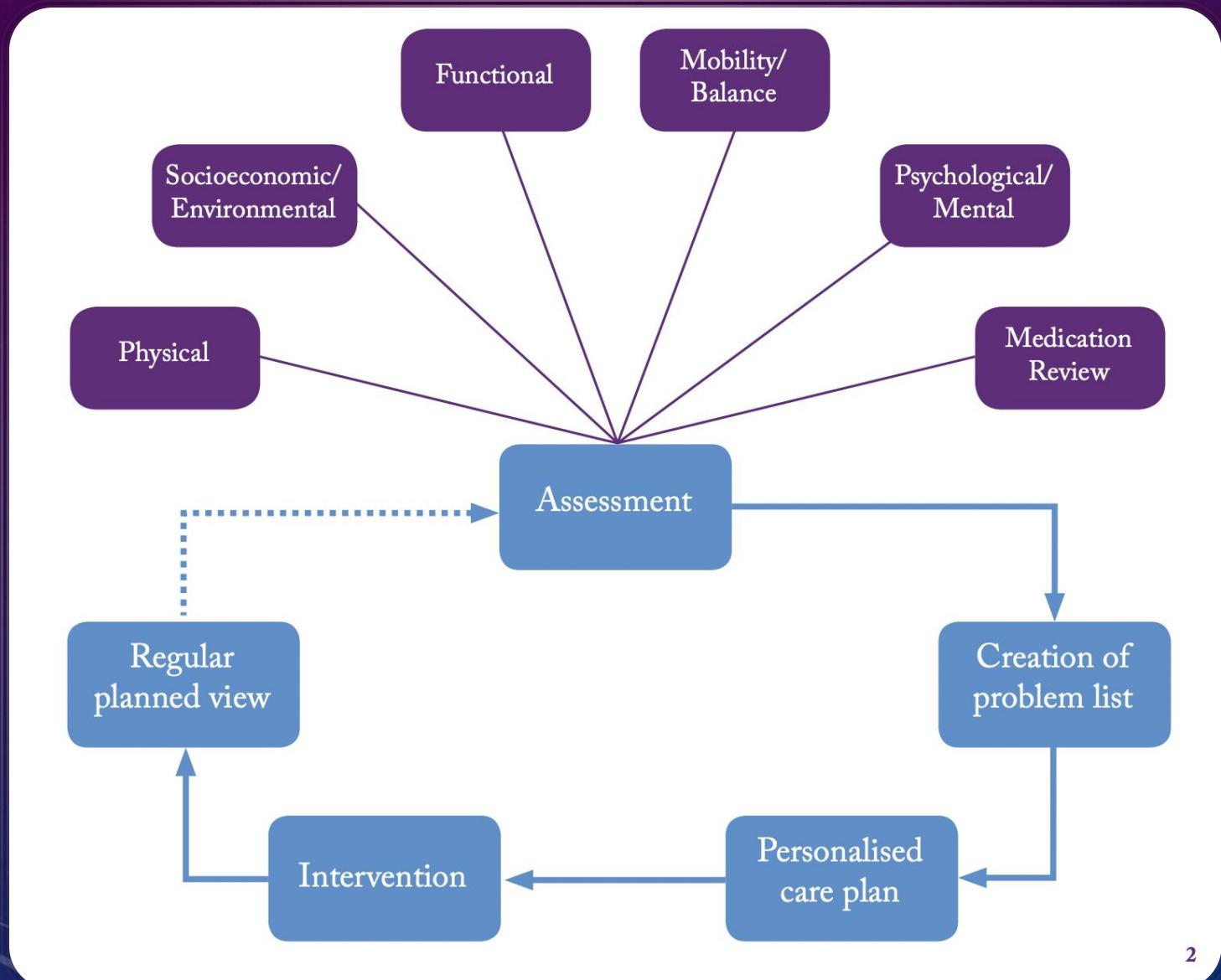
What is Geriatric Depression?

- Screening
- Diagnosis
- Treatment

Capacity

- Capacity for Consent
- Substitute Decision Making
- Mental Health Act - Extended Leave
- Advanced Directives
- MAID

THE GERIATRIC ASSESSMENT



- [BGS - Comprehensive Geriatric Assessment Toolkit](#)
- [BC Frailty Guidelines](#)
- [Comprehensive Geriatric Assessment Template \(U of T\)](#)

PHYSICAL ASSESSMENT

- Visual clues – observing gait, mobility aids, clothing, footwear
- Weight loss – dentition, swallowing
- Lying and standing blood pressures
- Hearing loss
- Gross visual testing
- Balance/mobility
- Constipation/continence
- Pain
- Smoking/Substance use

FUNCTIONAL ASSESSMENT

- What can they do? What has changed?
- ADLs, iADLs
- Mobility
 - Gait/speed
 - Balance
 - Footcare/footwear
- Safety
 - Falls risk/prevention

ASSESSMENT

Timed Up & Go (TUG)

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

① Instruct the patient:

When I say “Go,” I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

NOTE:
Always stay by
the patient for
safety.

② On the word “Go,” begin timing.

③ Stop timing after patient sits back down.

④ Record time.

Time in Seconds: _____

An older adult who takes ≥ 12 seconds to complete the TUG is at risk for falling.

Patient _____

Date _____

Time _____ AM PM

OBSERVATIONS

Observe the patient’s postural stability, gait, stride length, and sway.

Check all that apply:

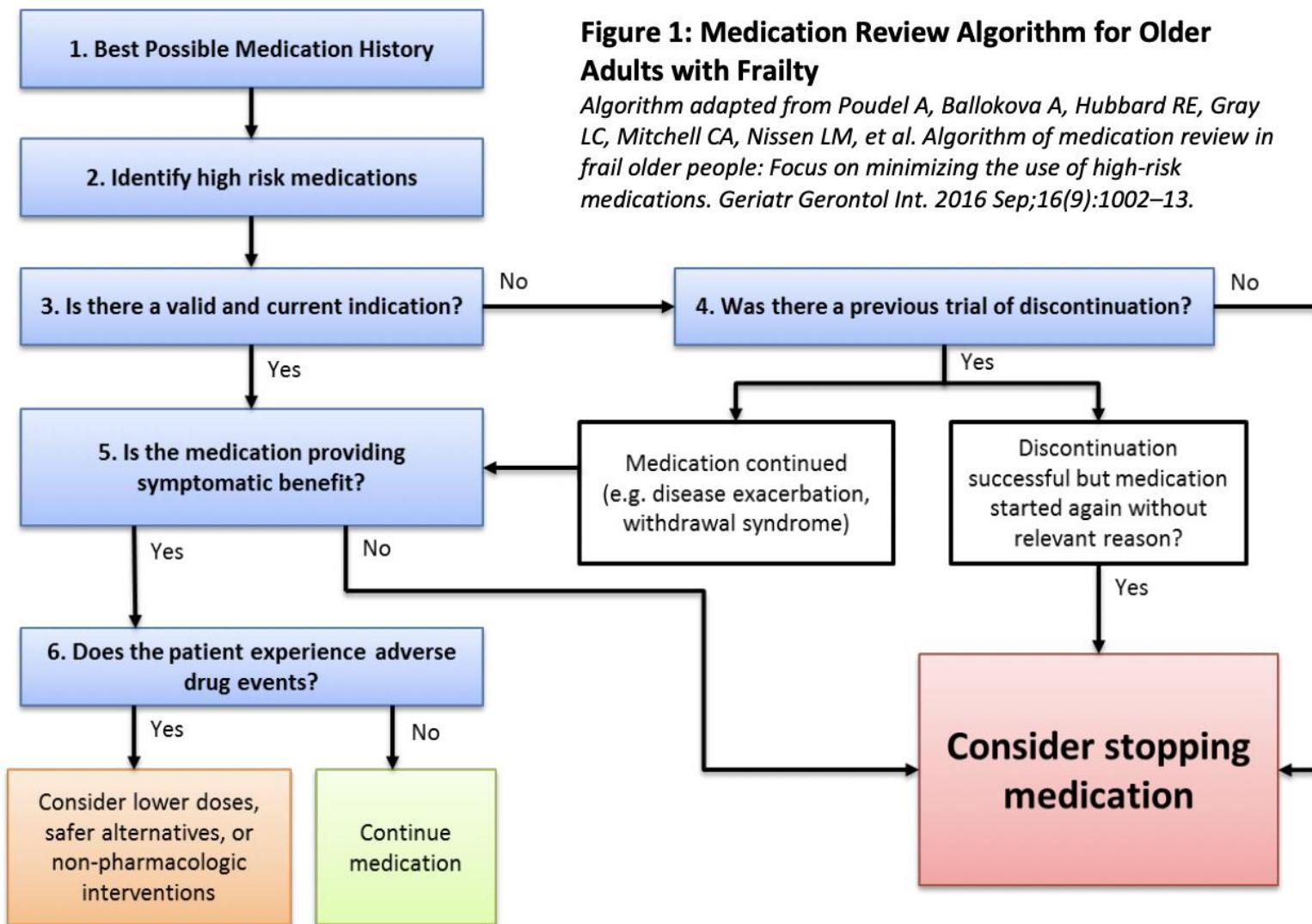
- Slow tentative pace
- Loss of balance
- Short strides
- Little or no arm swing
- Steadyng self on walls
- Shuffling
- En bloc turning
- Not using assistive device properly

These changes may signify neurological problems that require further evaluation.

MOOD/COGNITION

- Screen for depression – GDS
- Sleep
- Screen for cognitive changes – MOCA, MMSE
- Engage family/care-givers
- Capacity

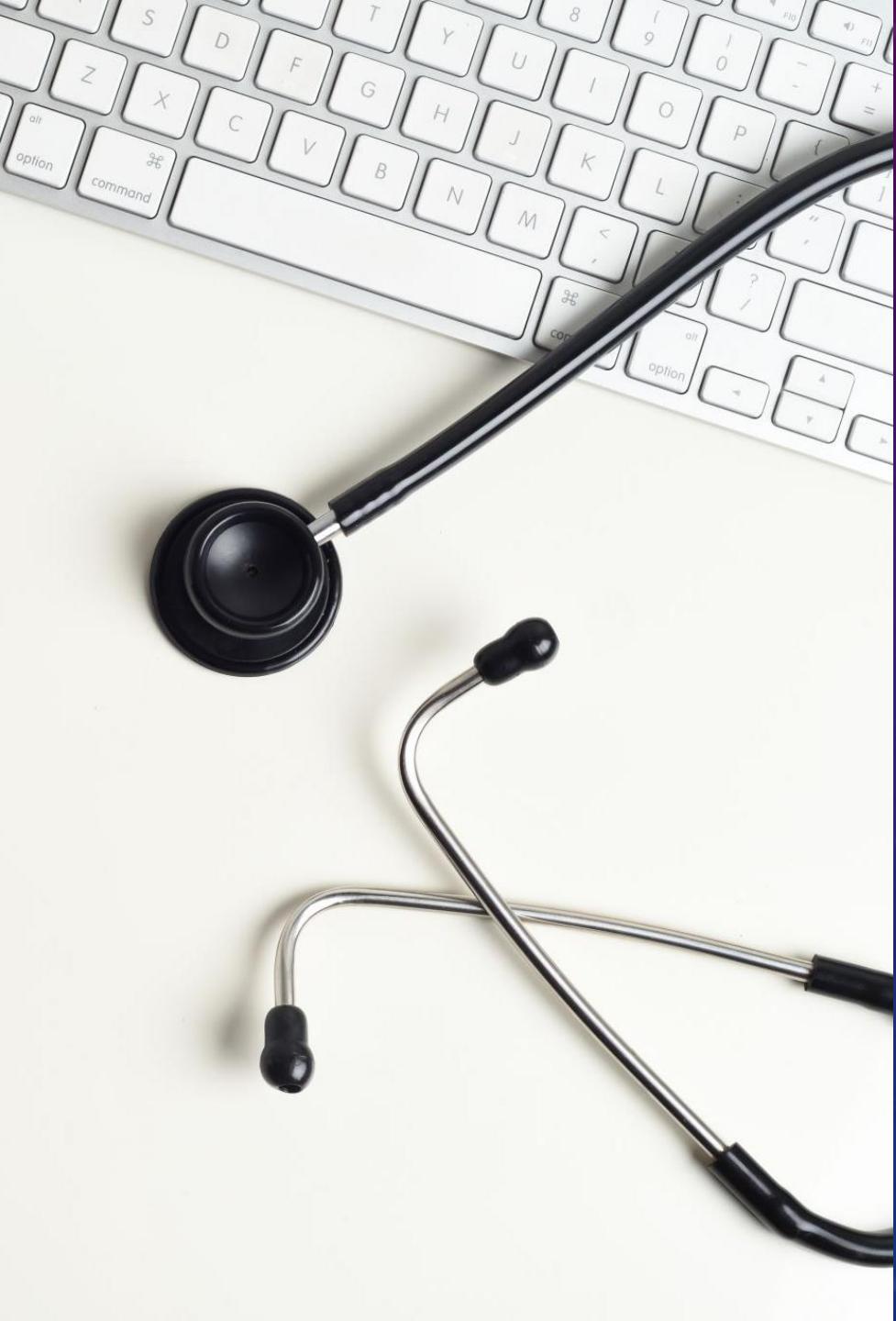
MEDICATION REVIEW



- [BC Frailty Guidelines - Medication Review](#)
- [Pharmanet Access](#)

SOCIOECONOMIC/ENVIRONMENTAL

- Social situation – Family supports (ask about care-giver stress/burnout)
- Access to supports
 - <https://www.familycaregiversbc.ca/>
- Living situation – safety at home, medical equipment
 - <https://betterathome.ca/>
- Food insecurity
- Financial situation – financial capacity, banking, POA
- Social Isolation



HOME AND COMMUNITY CARE

- Identify patients in need of supports and facilitate intake into the system
- Home and Community Care exists to provide *case managed* services to eligible patients
 - community nursing for acute, chronic, palliative or rehabilitative support
 - community rehabilitation by licensed physical and occupational therapists
 - adult day services for personal care, health care and social and recreational activities
 - home support for assistance with activities of daily living
 - caregiver respite and relief
 - assisted living and residential care
 - end-of-life care services
- Information on social and health resources in particular communities
 - [FETCH \(For Everything That's Community Health\)](#)

Partners in Care: Navigating Resources for Frail Seniors

VANCOUVER PRIMARY CARE NETWORKS | MARCH 13, 2024

THE PCN INTERPROFESSIONAL TEAM



HOME AND COMMUNITY CARE SERVICES

OLDER ADULTS MENTAL HEALTH AND SUBSTANCE USE

SUPPORTS PATIENTS WITH:

- ✓ Short-term, goal-oriented care
- ✓ Education
- ✓ Self-management and behavioural
- ✓ Strategies of life promotion
- ✓ Evidence based decision-making
- ✓ Assessment and brief intervention
- ✓ Links to community resources

To check on your eligibility for PCN Supports, please contact your Community Network Manager

Visit the website

Provide a range of supports and services for people with acute, chronic, and palliative health care needs such as home health services, mental health services and home support.

Services are intended for people who have ongoing or chronic health issues requiring support to continue to live safely at home.

Services support patients who need care at home:

- to prevent acute episodes leading to hospitalization
- post hospitalization to support recovery and prevent readmission
- to support clients with a life limiting illness needing help with activities of daily living

Vancouver
Tel (604) 263-7377
Fax (604) 267-3419

SUPPORTING FRAIL SENIORS
IT TAKES a COMMUNITY

Visit the website

Serves older adults (generally aged 65+) with mental health conditions and/or problematic substance use which have an adverse effect on function, health status and/or quality of life, or with progressive dementia (at any age) that is complicated by moderate to severe behavioural and/or psychiatric symptoms.

Services offered are based on individual's clinical needs:

- Geriatric psychiatric assessment, consultation & treatment
- Case management & care coordination
- Medication review & monitoring
- Therapeutic groups
- Psychoeducation & family support
- Substance use counselling



Monday to Friday
8:30-4:30
Referrals can be submitted directly to the OA MHSU Program.
604-709-6785
Intake Line

- **VDOFP:**
Navigating Resources for Frail Seniors:

Family Caregivers of British Columbia

ASK CAREGIVERS are You OK?

CAREGIVER RX
with their permission

34% HAVE a CAREGIVER in DISTRESS

I'M FINE... I'M FINE...

Caregiver Toll-Free Support Line
1-877-520-3267
Mon-Fri 8:30am - 4pm

familycaregiversbc.ca

211 British Columbia®

LIFE CAN BE HARD.
FINDING HELP CAN BE EASY.
Dial or Text 2-1-1

240 LANGUAGES
24/7, FREE

bc.211.ca

Nidus

211 connects you to non-emergency community health + social services - IN YOUR AREA

EDUCATION, SUPPORT AND ASSISTANCE WITH PERSONAL AND HEALTH-CARE PLANNING

THESE ARE MY HEALTHCARE WISHES and PRIORITIES

NIDUS IS AN EXPERT ON REPRESENTATION AGREEMENTS

Empowering adults to form a legal plan for their present or future healthcare needs, should they no longer be able to speak for themselves.

nidus.ca

PGT Public Guardian and Trustee of British Columbia

Available to consult on complicated situations
Make health care and/or care facility admission decisions when:

- An adult is determined to be incapable of making proposed healthcare decisions
- PGT is the adult's Committee of Person or
- there are no family/friends who meet the criteria to act as temporary substitute decision maker (TSDM) or substitute decision maker (SDM)

SUBMIT REFERRALS BY EMAIL, TELEPHONE OR FAX

trustee.bc.ca

CARE PLANNING

- What are the patient's primary concerns?
- Review goal's of care, values, preferences
 - Identify safety risks
 - Manage co-morbidities in relation to patient's wishes
 - Appropriate prevention activities
 - Self-management support
 - Look for patients who would benefit from palliative approach
 - My Voice patient guide
- Advanced Care Planning
 - No CPR Form
 - Medical Order For Scope of Treatment Form (MOST)

MOST FORM

MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

ADULTS, AGE 19 AND ABOVE

IDENTIFICATION LABEL

A I anticipate CPR to be of clear benefit and medically appropriate for the patient in the event of a medical crisis.
I have not discussed this with the patient/SDM:

Attempt CPR and refer to Critical Care -

Responsible Provider Signature (or delegate)

Date

Physician's Printed Name

OR

B I have had a discussion with patient and / or substitute decision maker:

Patient/Resident: is at this time capable to make own medical decisions

is NOT currently capable to make own medical decisions

Patient / Resident / Substitute Decision Maker (SDM) consulted in development of Order / advised of Order:

Patient / Resident

TSDM

Representative

Personal Guardian

Other (explain below)

None (explain below)

Client / SDM
disagrees
with Order
(see 2c, over)

Explain:

Optional space for signature of Client or SDM aware of Order, intended for use in residential care. Order valid with or without signature.

SUPPORTING DOCUMENTATION: Ask each patient / family if patient has expressed or documented wishes about future care

Previous DNACPR / MOST

Provincial No CPR

VCH ACP Record

Advance Directive

Representation Agreement

Section 9

Section 7

Other:

IN THE EVENT OF SERIOUS ACUTE MEDICAL EVENT:

Attempt Cardiopulmonary Resuscitation (CPR)

In the event of acute medical event, maximum therapeutic effort.

OR

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR: No chest compressions or other direct means of restarting the heart), and:

Option 1 (M1)* No CPR. Supportive care, symptom management, and comfort measures. Allow natural death.

Option 2 (M2) No CPR. Option 1 (M1) plus therapeutic measures and medications to manage acute conditions within the current setting. If in residential care or hospice, transfer to acute care will not occur except in special circumstances (eg fracture).

Option 3 (M3) No CPR. Option 2 (M2) plus admission to an acute care hospital (if not already admitted) for medical/surgical treatment as indicated. No referral to Critical Care.

Option 4 (C1) No CPR. Maximum therapeutic effort as in Option 3 (M3) including referral to Critical Care but **not including** intubation and ventilation.

Option 5 (C2) No CPR. Maximum therapeutic effort as in Option 4 (C1) including referral to Critical Care and **including** intubation and ventilation.

Specific comments on Order /
Goals of Care to aid interpretation:

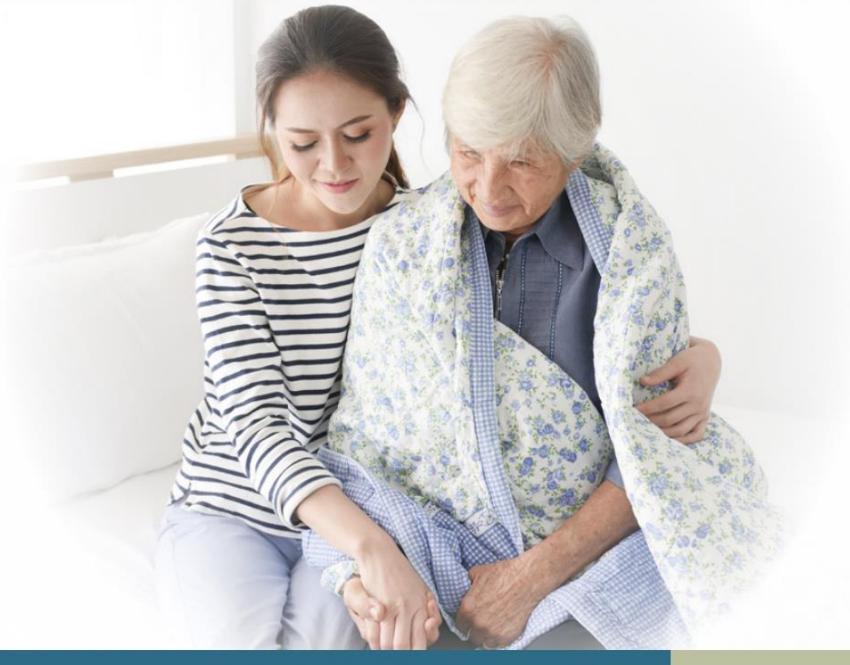
DNACPR as detailed on this MOST will automatically be suspended for surgery and other procedures involving anesthesia or procedural sedation until return to the usual care area. Treatment will be provided at the discretion of the Most Responsible Provider, unless specific direction is provided below:

Provider detailing circumstances of suspension of DNACPR / MOST

WHAT DO THE LEVELS MEAN?

- Caveats:
 - BiPAP support can be provided to a MOST M3 depending on the situation
 - Fracture or laceration may necessitate transfer for a MOST M2
 - LFP billing requires documentation of MOST M1 (and PPS of 20% or less) to qualify for End of Life Visit code

	Symptom Control	Resuscitation	Intubation	ICU	Site Transfer	Treat Reversible Conditions
DNR M1	✓	✗	✗	✗	✗	✗
DNR M2	✓	✗	✗	✗	✗	✓
DNR M3	✓	✗	✗	✗	✓	✓
DNR C1	✓	✗	✗	✓	✓	✓
DNR C2	✓	✗	✓	✓	✓	✓
CPR C2	✓	✓	✓	✓	✓	✓

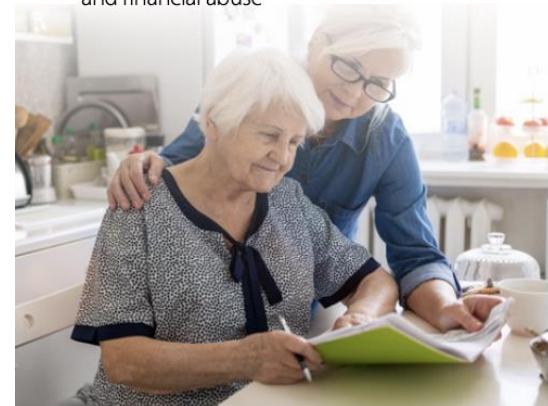


Frailty Roadmap for Families

A guide to help ensure safety, provide comfort, and improve the quality of life for you or your loved one

CARE PLANNING

- [Frailty Roadmap](#)



Having Less Energy

- Moving more slowly
- Less steady walking
- Often feeling tired; needing to stop and rest
- Getting less done in a day
- Socializing less

Needing More Help With

- Getting around town
- Looking after the house and yard
- Doing taxes/paying bills
- Managing medications
- Shopping and making meals
- Managing dribbling or urinary incontinence

Concerns About Safety

- Driving
- Risk of falls, and unsafe walking outside alone
- Vulnerability to computer/phone scams and financial abuse

Forgetting recent events, or repeating stories

Needing more help with meals, the stove, medications, or money

Losing the ability to walk or do stairs; needing a cane or walker

Acute "spells" of confusion, dizziness, or fainting

Fall or fracture, especially if unable to call for help

Needing more personal help with baths, hygiene, or incontinences

What things do I feel less confident about doing now?

Am I more anxious about managing things by myself?

How safe am I alone at home? Can I call for help when I need it?

Do I have family or a support network, for times when I need more help?

What supports do I need to stay at home safely?

What changes need to be made in my house to help me stay at home longer?

Is it time to talk about moving into a smaller place, supported housing or assisted living?

Am I making good choices about my safety?

Am I limiting my driving; at night, or outside my neighbourhood?

Do other people feel safe riding in the car with me?

1. Optimize what we can

- Vision, hearing, nutrition
- Walking strength, balance, and safety
- Medical conditions, to avoid crisis trips to the ER
- Promote healthy socialization and avoid isolation

2. Reduce the burden of too many pills

- Talk to your doctor and pharmacist about simplifying medications to reduce side effects like confusion, fatigue, and stomach upset

3. Focus on comfort and quality of life

- Manage pain, bowels, sleep, and mood (anxiety, depression)
- Provide dignity-preserving help with incontinence

4. Get supports to improve safety and reduce stress

- Connect with a case manager or home support nurse to do a home assessment
- Consider home support for meals, help with medications, bathing or dressing

• Look into getting help for housework, yard, errands, or shopping

• Consider supports like a personal emergency call system, Meals on Wheels, auto-bill payments

5. Make home safer

- Handrails for stairs, toilet, and tub
- Bath chair, bathtub mat, hand shower nozzle, home support worker
- Removing tripping hazards like throw rugs and electrical cords
- Adding nightlights and motion sensor activated lights for stairs and doorways
- Moving to a main floor bedroom

6. Put affairs in order

Finances

- Joint bank accounts to allow family support managing bills and finances
- Enduring Power of Attorney; allows appointed person to manage finances/ pay bills and taxes if you or your loved one becomes unable
- Will and Estate Planning

Healthcare

- Appoint a substitute decision maker or representative to speak for you if you are no longer able to speak for yourself
- With your doctor, consider the risks and benefits of proposed medical interventions or surgery. As we become more frail and medically complex, our risk of complications or poor recovery is greater
 - Will this test/procedure help me maintain my abilities or quality of life if things go well?
 - What are the risks if things go badly, and how much might it cost me, in terms of time spent in hospital, loss of strength and abilities while bedbound, or other potential complications?

7. Have conversations now about what we would like the natural end of our life to look like

- Heart attack, stroke, pneumonia, or a fall/ hip fracture often come without warning. It's important to discuss our preferences with our loved ones and doctor now. We need to know:
 - Would I ever want to be kept alive on machines, short or long term, if my death was imminent with little chance of recovery?
 - If I was very sick and maybe dying, would I want to go to hospital, to the ICU to be put on a breathing machine or other 'life supports', or to surgery?
 - What things would be most important for me in my last weeks and days?
 - What are my hopes for the end of my life, and what are my biggest fears?
 - Where would I prefer to die; at home, in a hospice or long term care facility, or hospital?
 - Have conversations with your family and doctor about recording your wishes now, in a Medical Orders for Scope of Treatment (MOST) document, also sometimes called a Do Not Resuscitate (DNR) order.

8. Plan for the future

- Have conversations about when we'll know it's time to get more help with things at home, move to a safer place, or stop driving



Serious Illness Conversation Guide

CONVERSATION FLOW

PATIENT-TESTED LANGUAGE

1. Set up the conversation

- Introduce purpose
- Prepare for future decisions
- Ask permission

"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**"

2. Assess understanding and preferences

"What is your **understanding** now of where you are with your illness?"

"How much **information** about what is likely to be ahead with your illness would you like from me?"

3. Share prognosis

- Share prognosis
- Frame as a "wish...worry", "hope...worry" statement
- Allow silence, explore emotion

"I want to share with you **my understanding** of where things are with your illness..."

Uncertain: "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility."

OR

Time: "I **wish** we were not in this situation, but I am **worried** that time may be as short as ____ (express as a range, e.g. days to weeks, weeks to months, months to a year)."

OR

Function: "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."

4. Explore key topics

- Goals
- Fears and worries
- Sources of strength
- Critical abilities
- Tradeoffs
- Family

"What are your most important **goals** if your health situation worsens?"

"What are your biggest **fears and worries** about the future with your health?"

"What gives you **strength** as you think about the future with your illness?"

"What **abilities** are so critical to your life that you can't imagine living without them?"

"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"

"How much does your **family** know about your priorities and wishes?"

5. Close the conversation

- Summarize
- Make a recommendation
- Check in with patient
- Affirm commitment

"I've heard you say that ____ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we _____. This will help us make sure that your treatment plans reflect what's important to you."

"How does this plan seem to you?"

"I will do everything I can to help you through this."

6. Document your conversation

7. Communicate with key clinicians



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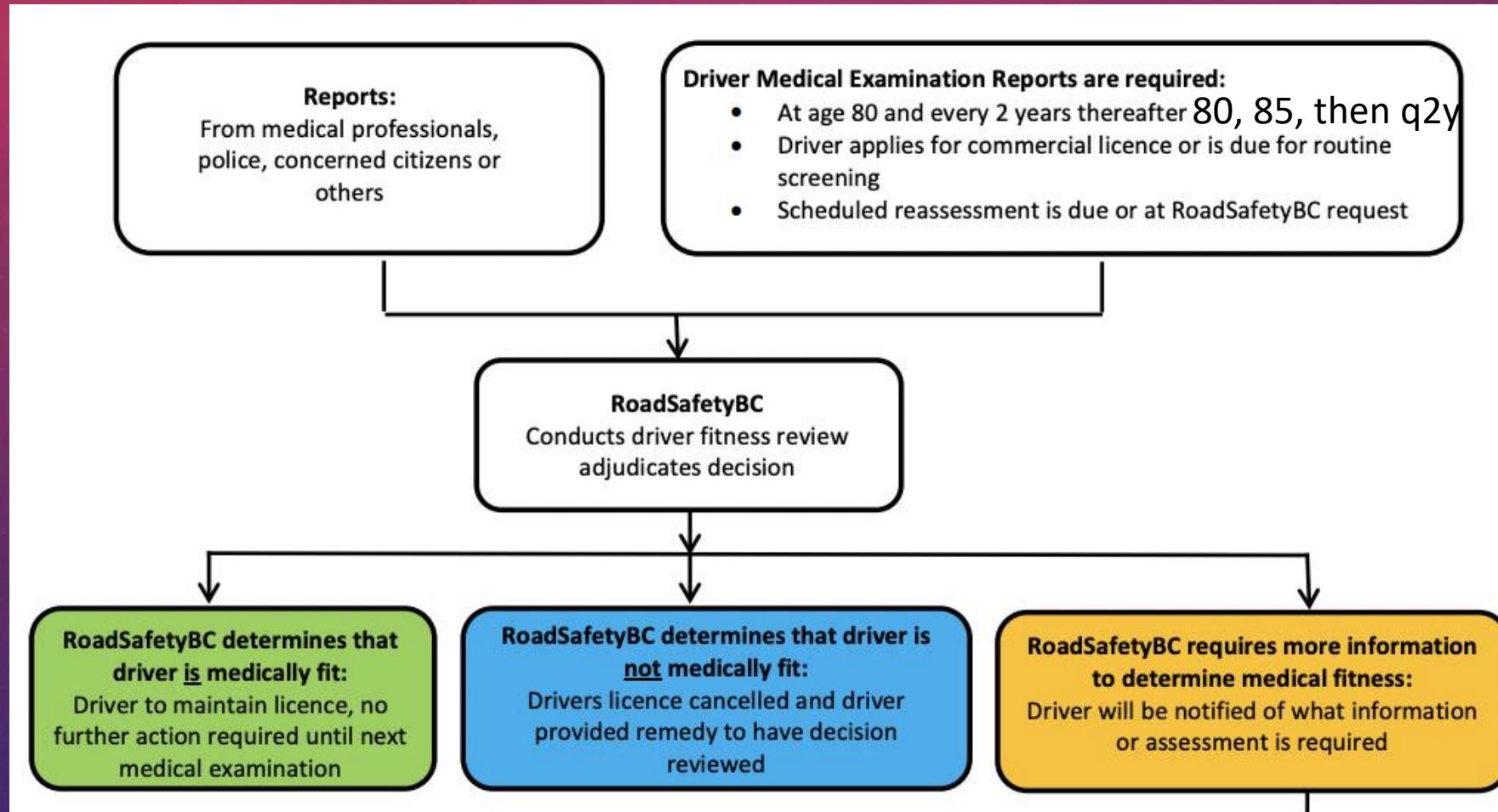
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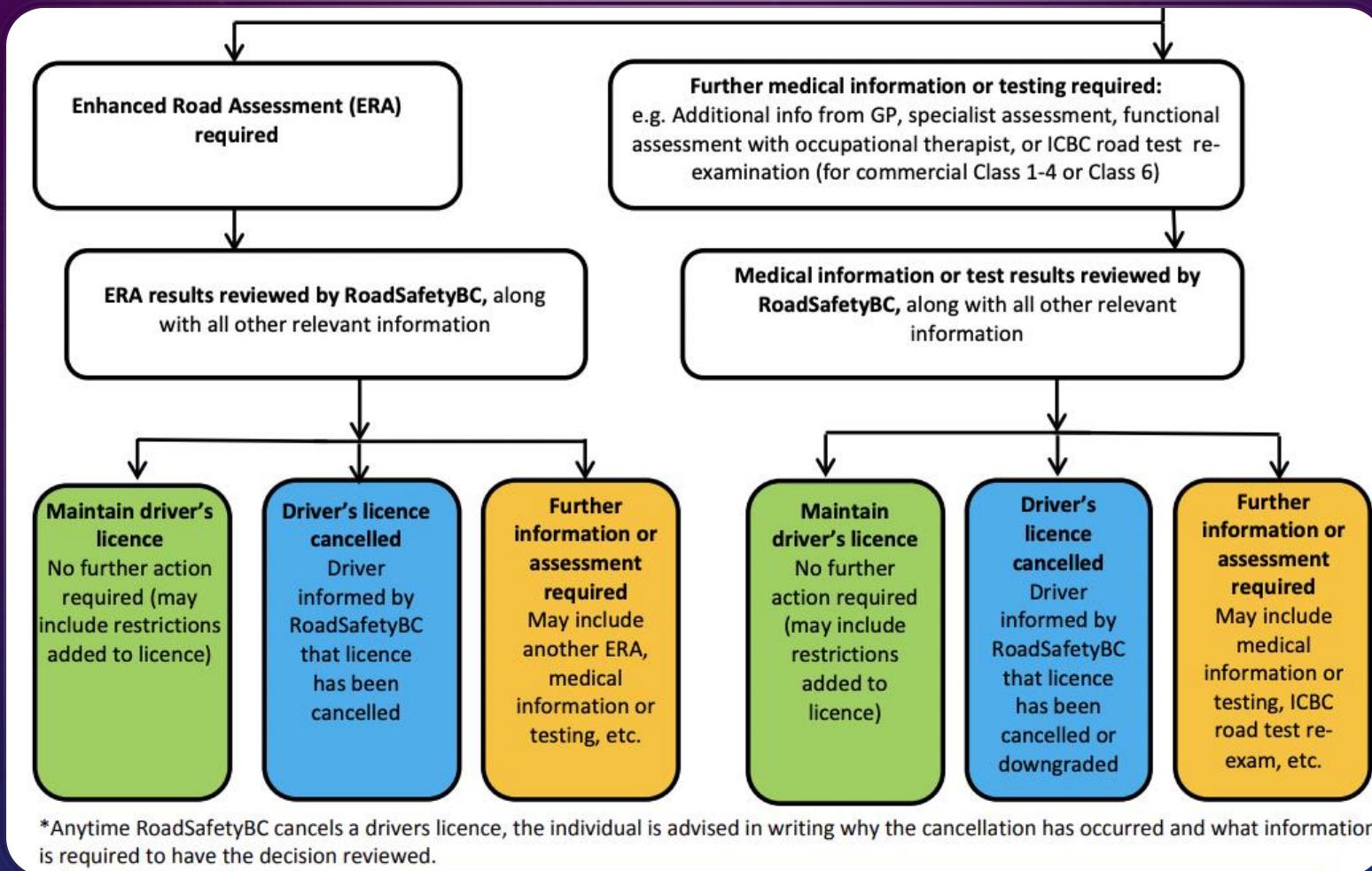
SERIOUS ILLNESS CONVERSATION GUIDE

- [Serious Illness Conversation Guide Brochure](#)

DRIVER SAFETY



DRIVER SAFETY



*Anytime RoadSafetyBC cancels a drivers licence, the individual is advised in writing why the cancellation has occurred and what information is required to have the decision reviewed.

- Cognitive testing
 - MMSE
 - MOCA
 - SIMARD-MD
 - Trails Making Test A and B

WHEN TO REPORT

- Section 230 - applies to every legally qualified and registered psychologist, optometrist, medical practitioner, nurse practitioner with a patient who is 16 years or older who:
 - In the opinion of the medical practitioner that has a medical condition that makes it dangerous to the patient or to the public for the patient to now drive a motor vehicle
 - Continues to drive a motor vehicle after being warned of the danger by a medical practitioner
- Must be reported to the superintendent with the name, address and medical condition of the patient
- No action for damages may be brought against a professional for making a report under this section unless it was made falsely and maliciously

WHEN TO REPORT

WHEN to report

As per [Section 230](#) of the BC Motor Vehicle Act:

Definitely unfit to drive	+	Continues to drive after being <u>warned not to</u>	=	REQUIRED to report
Imminent danger to self/others	+	Definitely will drive	=	REQUIRED to report
<i>(e.g. intoxicated patient leaving the ED in a car)</i>				
Potentially unfit to drive	+	May or may not continue to drive	=	MAY report
Imminent danger to self/others	+	Suspected drive to	=	MAY report

-No action for damages may be brought against the physician unless the report was made falsely and maliciously.

-It is NOT obligatory to inform the patient that you are reporting them.

WHO TO REPORT

SEE FULL LIST OF MEDICAL DISORDERS [HERE](#)

Any patient whose ability to drive safely you question.

DO report	DON'T report
✓ Conditions causing persistent functional impairment	✗ Temporary conditions
✓ Conditions that cause episodic incapacitation	✗ Short-term after effects of surgery
✓ Cognitive decline and dementia	✗ Fractures
✓ Cerebrovascular accident (CVA) with lasting deficits	✗ Concussions
✓ Uncontrolled psychiatric conditions impacting judgement	✗ Eye surgery
✓ Uncontrolled seizures	
✓ Patients with diabetes experiencing frequent hypoglycemic events	

HOW TO REPORT

- Include in the report:
 - Diagnosis
 - Severity
 - Symptoms
 - Prognosis
 - Treatment
 - Tests and assessments
 - Specialist reports



RoadSafetyBC

REPORT OF A CONDITION AFFECTING FITNESS AND ABILITY TO DRIVE

Please provide as much detail as possible. Fax this form and other supporting document(s) to **(250) 952-6888** OR mail to: ROADSafetyBC, PO BOX 9254, STN PROV GOVT, VICTORIA, BC V8W 9J2. To ensure expediency, please send documents to RoadSafetyBC only once.

If you are a medical professional, you may call: **250-953-8612**, Monday to Friday 8:30am-4:30pm to speak directly with a Registered Nurse Case Manager.

PATIENT INFORMATION		CLINICIAN INFORMATION	
Name:		Name: Stamp or sticker	
Address:		Phone #:	
City:	Postal Code:	Provide a secure and confidential fax number if you wish to obtain confirmation this report has been received: Fax #:	
DOB:	Drivers Licence # (if known):	Professional Qualifications:	
(YYYY/MM/DD)		<input type="checkbox"/> Family Physician <input type="checkbox"/> Specialist Physician <input type="checkbox"/> Psychologist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Optometrist <input type="checkbox"/> Other _____	How long has patient been under your care? _____ (months/yr.)
<input type="checkbox"/> IN MY OPINION THIS PATIENT HAS A MEDICAL CONDITION THAT PUTS THE PUBLIC OR THEMSELVES AT RISK WHEN THEY DRIVE (See: BC Medical Guidelines for Driving) (If undetermined, provide narrative information below and complete other areas as appropriate)			
<input type="checkbox"/> THIS PATIENT CONTINUES TO DRIVE AFTER BEING WARNED OF THE DANGER (if known)			
The RoadSafetyBC assessment and action depends on the description of the medical impairment, please provide as much detail as possible: i.e.: dates, prognosis, compliance, and if the condition is likely to improve. Attach any relevant documents.			
Impairments: <input type="checkbox"/> Cognitive <input type="checkbox"/> Vision/Sensory <input type="checkbox"/> Motor <input type="checkbox"/> Risk of Sudden Incapacitation <input type="checkbox"/> Other			
Cognitive Impairment: Screening scores (i.e.: MMSE _____ MOCA _____ Trails B _____ OTHER _____)			
Severity of cognitive decline: (scale on back) <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Details of medical condition or functional impairment impacting driving including, if relevant, level of insight and judgement: _____ _____ _____			
Optional Recommendations: <input type="checkbox"/> RECOMMEND CANCELLATION OF DRIVER'S LICENCE OR <input type="checkbox"/> RECOMMEND FURTHER MEDICAL ASSESSMENT (i.e.: Drivers Medical, vision testing, specialist). Please specify below. <input type="checkbox"/> RECOMMEND DRIVING ASSESSMENT (i.e.: ICBC on-road assessment or Functional Driving Evaluation)			
Further Recommendations: _____ _____ _____			
Date: _____		Signature: _____	
Ministry of Public Safety and Solicitor General MV2351 (20180413)	RoadSafetyBC www.gov.bc.ca/roadsafetybc	PO Box 9254 Stn Prov Gov Victoria BC V8W 9J2	Telephone: (250) 387-7747 Facsimile: (250) 952-6888
Page 1 of 2			

WHAT TO TELL YOUR PATIENT

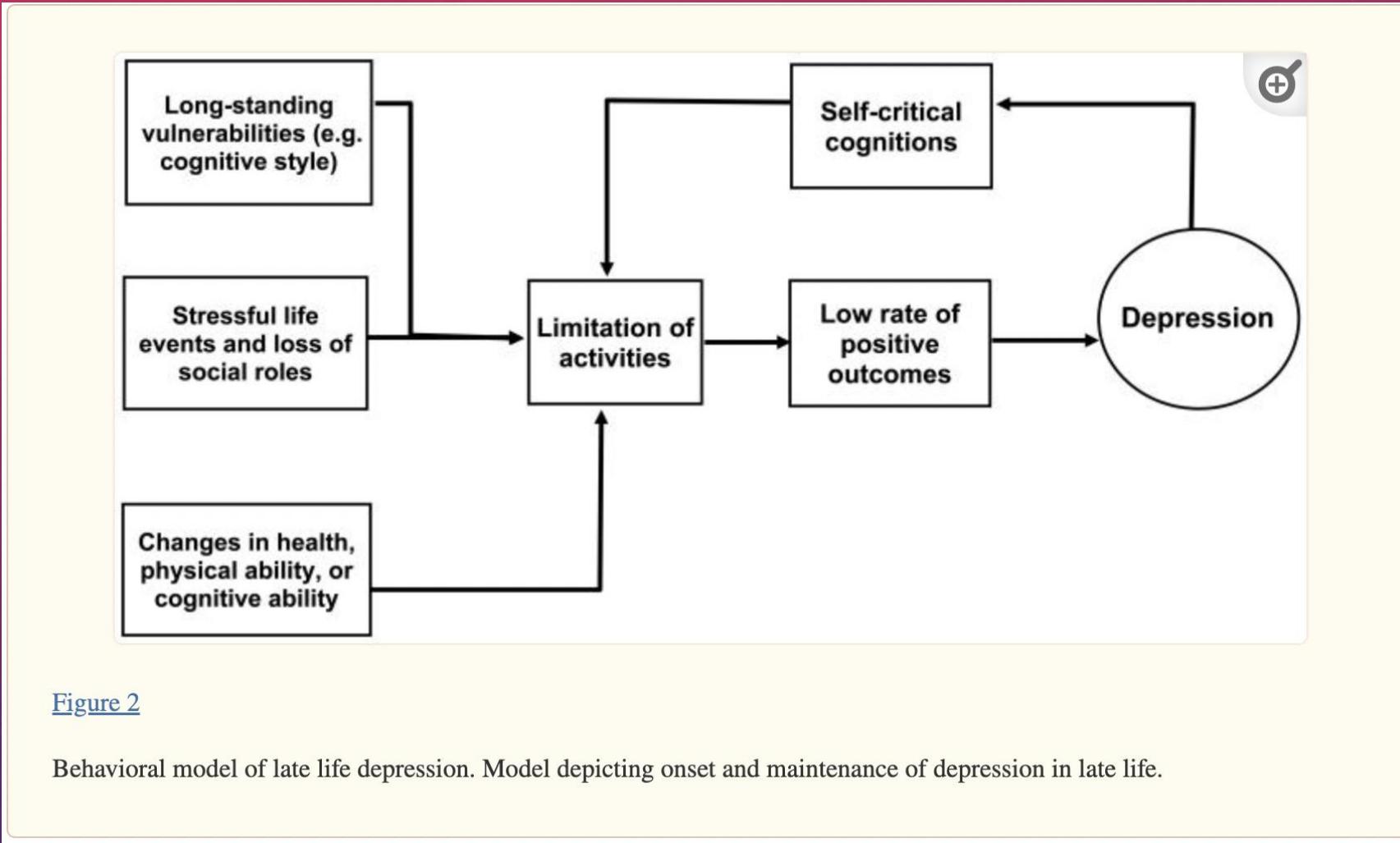
- Their condition is a safety concern to themselves and others
- Discuss alternatives to driving (transit, Handydart, taxis)
 - Resource for alternate transportation for seniors [here](#)
- License can be exchanged for a free BC Identification card
- ALL licensing decisions are made by RoadSafetyBC – can call directly to discuss
 - They will receive a letter in writing regarding the decision



QUESTIONS?

GERIATRIC DEPRESSION

- 20% >65y.o live with a mental illness
 - 80-90% of LTC residents have mental health and/or cognitive impairment
- Less likely to endorse affective symptoms, more likely to display cognitive changes, somatic symptoms, loss of interest
- Risk factors: genetic vulnerability, cognitive diathesis, age-related neurobiological changes, stressful events, insomnia
- Protective factors: higher education and socioeconomic status, engagement in valued activities, religious/spiritual involvement
- Prodromal phase of dementia



<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2852580/>

BIOLOGICAL RISK FACTORS

- Frequently occur in the context of medical illness – cardiac, cerebrovascular, neurological, infection, malignancy
- Endocrine dysregulation – hypo/hyperthyroidism
- Medications – betablockers, CNS medications, CCBs, Digoxin, corticosteroids, hormones, anti-Parkinson agents, benzodiazepines, etc
- Low levels of Vit B12, ratio of omega 6 to omega 3 FA
- Vascular factors – sleep disturbance, psychomotor change, decreased energy
- Neuroanatomical factors – psychomotor change, concentration disturbance
- Inflammatory factors – appetite and sleep disturbance, loss of energy, concentration disturbance, thoughts of death

NEUROCOGNITIVE DISORDERS

- Significant co-morbidity with late-onset depression and dementia
- Cognitive impairment with major depression may not be completely reversible when depression is treated
- Depression with cognitive impairment - -> 40% develop Alzheimer's Dementia within 3-5y
- Co-morbidity with Parkinson's Disease – increased functional impairment (increased motor disturbance)
- Depression-executive dysfunction syndrome
- Co-morbid anxiety results in more treatment resistant depression – increased rates of somatic symptoms, disability, suicide, faster cognitive decline

PROTECTIVE FACTORS

- Resources – health, cognitive function, socioeconomic status
- Resiliency – life experiences have taught psychological strategies to manage stressors
 - Emotional regulation – “Putting into perspective”
 - Positive self- concept
- Meaningful engagement – social activities, health, work, religion



SUICIDE

- Suicide in older adults is more likely to be associated with depression than any other age group
- 3-4x higher risk for males than women, significantly increases for men and decreases for women in midlife
- Risk factors – physical illnesses (including incontinence), certain personality characteristics, ETOH abuse
- More likely to use lethal means in late life
- Higher level of intent and planning, less likely to verbalize suicidal thoughts
- More likely to visit a physician shortly before death – 70% visited a primary care physician within a month

SCREENING:

CANADIAN GUIDELINES ON PREVENTION,
ASSESSMENT AND TREATMENT OF DEPRESSION
AMONG OLDER ADULTS

We recommend targeted screening of those elderly at higher risk for depression due to the following situations:

- Recently bereaved with unusual symptoms (e.g., active suicidal ideation, guilt not related to the deceased, psychomotor retardation, mood congruent delusions, marked functional impairment after 2 months of the loss, reaction that seems out of proportion with the loss)
- Bereaved individuals, 3 to 6 months after the loss
- Socially isolated
- Persistent complaints of memory difficulties
- Chronic disabling illness
- Recent major physical illness (e.g., within 3 months)
- Persistent sleep difficulties
- Significant somatic concerns or recent onset anxiety
- Refusal to eat or neglect of personal care
- Recurrent or prolonged hospitalization
- Diagnosis of dementia, Parkinson disease or stroke
- Recent placement in a nursing/Long Term Care (LTC) home **[B]**

GERIATRIC DEPRESSION SCALE (GDS)

- Patients without significant cognitive impairment

GDS-5/15 Geriatric Depression Scale

Each of these are a yes/no question – the depressed answers are noted in parentheses below.

- A. Are you basically satisfied with your life? (No)
- B. Do you often get bored? (Yes)
- C. Do you often feel helpless? (Yes)
- D. Do you prefer to stay at home, rather than going out and doing new things? (Yes)
- E. Do you feel pretty worthless the way you are now? (Yes)

SCORE FROM FIRST 5 QUESTIONS: _____

If 2 or more, please give remaining 10 questions.

- F. Have you dropped many of your activities and interests? (Yes)
- G. Do you feel your life is empty? (Yes)
- H. Are you in good spirits most of the time? (No)
- I. Are you afraid something bad is going to happen to you? (Yes)
- J. Do you feel happy most of the time? (Yes)
- K. Do you feel you have more problems with memory than most? (Yes)
- L. Do you think it is wonderful to be alive now? (No)
- M. Do you feel full of energy? (No)
- N. Do you feel that your situation is hopeless? (Yes)
- O. Do you think most people are better off than you? (Yes)

SCORE FROM ALL 15 QUESTIONS: _____

CORNELL SCALE FOR DEPRESSION IN DEMENTIA

- Patients with moderate to severe cognitive impairment

Depression: Cornell Scale for Depression in Dementia

Resident: _____ Room #: _____ Date: _____

Scoring system: a = unable to evaluate 0 = absent 1 = mild or intermittent 2 = severe

Mood-related Signs	a	0	1	2
Anxiety: anxious expression, ruminations, worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sadness: sad expression, sad voice, tearfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of reactivity to pleasant events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability: easily annoyed, short-tempered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Disturbance	a	0	1	2
Agitation: restlessness, hand wringing, hair pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retardation: slow movement, slow speech or slow reactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple physical complaints (Score 0 if GI symptoms only.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest: less involved in usual activities (Score only if change occurred acutely, e.g., in less than one month.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Signs	a	0	1	2
Appetite loss: eating less than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss (Score 2 if greater than 5 lbs. in one month.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack of energy: fatigues easily, unable to sustain activities (Score only if change occurred acutely, e.g., in less than one month.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclic Functions	a	0	1	2
Diurnal variation of mood: symptoms worse in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty falling asleep: later than usual for this individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple awakenings during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early morning awakening: earlier than usual for this individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ideational Disturbance	a	0	1	2
Suicide: feels life is not worth living, has suicidal wishes, makes suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor self-esteem: self-blame, self-depreciation, feelings of failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pessimism: anticipation of the worst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood-congruent delusions: delusions of poverty, illness or loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Score: _____

Notes/Current medications: _____

Assessor: _____

See Reverse for Directions

Following a positive screen for depression, a complete bio-psycho-social assessment should be conducted, including:

- A review of diagnostic criteria outlined in DSM-IV -TR or ICD 10 diagnostic manuals
- An estimate of severity, including the presence of psychotic or catatonic symptoms
- Risk assessment for suicide
- Personal and family history of mood disorder
- Review of medication use and substance use
- Review of current stresses and life situation
- Level of functioning and/or disability
- Family situation, social integration/support and personal strengths
- Mental status examination, including assessment of cognitive functions
- Physical examination and laboratory investigations looking for evidence of medical problems that could contribute to or mimic depressive symptoms **[D]**

ASSESSMENT



TREATMENT

- Psychotherapy
 - Cognitive Behavioural Therapy (CBT)
 - Problem Solving Therapy (PST)
- SSRIs/SNRIs
- rTMS – Repetitive Transcranial Stimulation
- ECT – Electroconvulsant therapy

SSRI/SNRI

- First line – **Sertraline or Duloxetine**
 - Second line – Citalopram/Escitalopram – risk of long QTc
- Screen for hyponatremia and repeat serum Na in 2-4 weeks after initiation (esp. of on diuretics or hx of hypoNa+)
- Patients should be seen every 1-2 weeks initially (in-person or virtually)
 - Supportive psychosocial interventions and monitoring for worsening of depression, agitation, and suicide risk
- If improvement has occurred but recovery not complete– continue 4 more weeks of mono-therapy or augment OR switch to another antidepressant
- Should be treated for a minimum of 1 year at optimum dose – remission
- LTC – reviewed monthly/care conference
- Reasons to refer: Psychotic depression, Bipolar disorder, Depression with suicidal ideation

PREVENTION

- Social Prescribing – reduced depressive symptoms
- Interventions focusing on reducing social isolation and/or loneliness – reminiscence therapy, physical exercise programs, videoconferences with family, horticultural therapy, gender-based social groups
- Encourage patient with low levels of physical activity to become more active – protective effect
- Hope and positive thinking



QUESTIONS?

CAPACITY AND CONSENT

- What is Consent?
- What is Capacity?
- BC Mental Health Act
- Health Care (Consent) and Care Facility (Admissions) Act
- Adult Guardianship Act (AGA)
- Advanced Care Planning
 - POA
 - Representation Agreements
- MAID

CONSENT

- 1 **Be related to a treatment or treatment plan**
- 2 **Be informed** (the nature of treatment, risks, side effects, expected benefits, alternatives, likely consequences of refusing are discussed)
- 3 **Be voluntary** (not under coercion, or under duress)
- 4 **Not be obtained through fraud or misrepresentation** (by the physician)

- Informed consent – process of getting permission from a patient before conducting a healthcare intervention
- Must be done by a health practitioner who has knowledge of the intervention/treatment
- Patient must be capable

1

Nature of the treatment

2

Expected benefits of the treatment

3

Material risks of the treatment

4

Material side effects of the treatment

5

Alternative courses of action (i.e - alternate treatments including non-pharmacological)

6

Likely consequences of *not* having the treatment

7

Likely consequences of *having* the treatment

HOW TO OBTAIN CONSENT

- Material Risks or side-effects:
 - Probable or likely to occur
 - Possible if they carry serious consequences
 - Those which a reasonable person in the patient's circumstances would want to know in order to make a decision

WHEN IS CONSENT NOT NECESSARY?

- **SPECIFIC TO BRITISH COLUMBIA:**
 - When urgent or emergency health care is required , the adult is incapable (impaired, unconscious) and there is no committee, representative, advance directive or substitute decision maker
 - Involuntary psychiatric treatment is needed under the Mental Health Act
 - Preliminary examinations such as triage or assessment in the emergency department

CAPACITY

- The ability to understand and appreciate the consequences of a treatment
- Can fluctuate and is specific to the treatment offered
- <6 y.o. is NOT capable, 6-13y.o. has partial capacity, >13y.o. capable but with variability

- 1 An individual is capable until proven otherwise
- 2 Capacity can fluctuate (i.e. - someone may be capable at one time regarding a treatment and incapable at another)
- 3 Capacity is task-specific (i.e. - capacity for finances is different than capacity for admission to a long-term care facility)
- 4 Capacity is treatment-specific (i.e. - antipsychotics vs. mood stabilizers, diabetes management vs. chemotherapy for cancer, neurosurgery for brain cancer vs. acetaminophen for a headache)
- 5 Capacity is functional (i.e. - just because someone is diagnosed with a mental disorder does not mean they are incapable)
- 6 Disagreement or refusal with medical recommendations does not equate to incapacity
- 7 Acquiescing to treatment does not prove capacity
- 8 The best interests of the person are not relevant to the question of determining capacity

Assessing an Adult's Ability to Seek/Refuse Support and Assistance

All Incapability Assessments Have a Common Process

Assessment of Cognitive Function plus Assessment for Executive Dysfunction

- Assessment is focused on the adult's ability to make a specific decision and *does not* imply a global finding of incapacity
- To make a decision, an individual must be able to receive, assimilate, and integrate relevant information, evaluate benefits and risks, and understand the implications of a decision (Cooney, L.M., et al, 2004)
- To be capable the adult must also be able to carry out the decision

Assessment of Cognitive Function

Tools: MMSE or 3MS* (Modified Mini Mental State Exam) and Clock Drawing *included in your package.

- Assesses memory & orientation; screens other cognitive processes including construction, abstract thinking (3MS), sequencing, visual-motor processing.
- <24/30 (MMSE) & <78/100 (3MS) indicates dementia, however, with vascular disease, head injury, & other processes a score of 100% may have significant deficits in executive (frontal) cognitive functioning rendering the adult incapable of following through to seek support and assistance.
- Administering this screening tool is a useful clinical interview tactic to evaluate the adult's thinking and approach to problem solving.
- If short-term memory is impaired the adult cannot evaluate day-to-day events or remember they decided to ask for help.
- For complex cases, Neuropsychological testing may be necessary to clarify cognitive and executive function disabilities.

Assessment for Executive Dysfunction

Executive Cognitive Processes include:

- planning
- active problem solving
- anticipation of an intended action
- initiation of activity
- ability to carry out a decision
- inhibition of inappropriate behaviour
- capacity to monitor the effectiveness of one's behaviour

- Self-report by an adult with suspected Cognitive and Executive Dysfunction must be validated by reliable collateral.
- Adults with Executive Dysfunction have problems in judgment and in trusting appropriate people for assistance.
- Adults with Executive Dysfunction may be influenced by individuals who might take advantage of them.
- Intact Executive Function is instrumental to the adult being able to seek support and assistance.

Referrals to community teams may be required for further assessment:

- Ability to initiate, organize, and carry out Instrumental and Basic Activities of Daily living (IADL/BADL) * see attached Lawton & Brody IADL that can serve as an interview tool or be given to the caregiver to complete and report back.
- Any change from baseline functioning is abnormal and indicates underlying physical, cognitive, or psychiatric illness is present.
- Determine areas of self-deficit that are not being provided for in the existing living environment.

Self-Neglect

- Occurs when an adult's actual performance in IADL/BADL is deficient, putting them at risk: they lack insight, and do not have, or refuse, appropriate help to maintain health, safety and (their usual) quality of life.

Assessing an Adult's Ability to Seek/Refuse Support and Assistance

Medical Workup and Medication Assessment

Rule out treatable aspects of Cognitive and Executive Dysfunction

(See Conclusions from Canadian Consensus Conference on Dementia (CCCD); CMAJ 1999;160)

- Medication over/under use may negatively influence cognition and function
- Assess for use of alcohol, narcotic or other substance use that can influence cognition and function, including over-the-counter medications
- Recommended Basic Laboratory Tests:
 - CBC & Diff.
 - Electrolytes
 - FBS
 - TSH
 - Calcium
 - Syphilis Serology (HIV Serology if indicated)

If Neglect/Poor Nutrition is suspected: Ask the adult:

- Have you lost weight in the past 6 months without trying to lose weight?
- Have you been eating less than usual for more than a week?

If yes to both questions refer to dietitian for a full nutrition assessment.

CT/other computerized head scanning to rule-out/confirm diagnosis if not already completed (see CCCD; CMAJ 1999;160)

re:port Who to Call

Vancouver Coastal Health has designated responders to address concerns related to abuse, neglect and self-neglect of vulnerable adults.

If you have concerns that a vulnerable adult is being abused, is living at risk due to neglect or self-neglect, or is having difficulty accessing support and assistance on their own, call one of the following in your area.

- Adult Protection Social Worker
- Hospital/Unit Social Worker
- Mental Health Therapist
- Continuing Care Case Manager
- Program Manager/Practice Consultant
- Licensing Officer

Document on the adult's file the date, any action taken, and who you called to report your concerns.

For more information and a list of designated responders please visit our website:
www.vchreact.ca

If you still require direction call:
1-877-REACT-99 (1-877-732-2899)



BC MENTAL HEALTH ACT

- Provides physicians with the legal authority to admit and detain patients with a mental health disorder in a designated facility
- Form 4 (physician medical certificate), Police Intervention (Section 28), Order from a Judge (Form 10)
- Criteria to be admitted involuntarily:
 - Suffering from an apparent mental disorder that impairs their ability to act appropriately
 - Requires psychiatric treatment
 - Requires care and supervision in a designated facility for the person's own protection or the protection of others
 - Is it not suitable as a voluntary patient

FORM 4.1

- Must be completed by a licensed physician (can not be a resident)
- Second Form 4 (4.2) must be completed within 48h → continues the involuntary admission for one calendar month

Zoom in



BRITISH COLUMBIA
Ministry of
Health

Patient label area (optional)

FORM 4.1
FIRST MEDICAL CERTIFICATE (INVOLUNTARY ADMISSION)
[Mental Health Act sections 22, 28, 29 and 42, R.S.B.C. 1996, c. 288]
HLTH 3504.1 2022/12/06

SECTION 1 - All fields required to be completed.

First and Last Name of Person Examined (please print)	Personal Health Number (if available)
Name and Address of Examination Site	
<input type="checkbox"/> Designated Facility <input type="checkbox"/> Examination Date (DD/MM/YYYY) <input type="checkbox"/> Other Site	

I have examined the person named above on the date noted above. I have determined that the person meets the requirements for involuntary admission under the Mental Health Act of British Columbia and I have set out the reasons for my determination below.

1. I have formed the opinion that the person **has a disorder of the mind that requires treatment and seriously impairs the person's ability to react appropriately to their environment or associate with others**. The reasons for my opinion are as follows:

2. I have formed the opinion that the person **requires treatment in or through a designated facility**. The reasons that I have formed this opinion are as follows:

3. I have formed the opinion that the person **requires care, supervision and control in or through a designated facility to prevent their substantial mental or physical deterioration or for the protection of the person or for the protection of others**. The reasons that I have formed this opinion are as follows:

4. I have formed the opinion that the person **cannot suitably be admitted as a voluntary patient**. The reasons that I have formed this opinion are as follows:

Signed below by:

Examining Professional	Name of Examining Physician or Nurse Practitioner (please print)		<input type="checkbox"/> Check if summary continued on back of this page <input type="checkbox"/> Patient was given a copy of this form
<input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner	Phone Number	College ID Number	Date Signed (DD/MM/YYYY)
			Time Signed 24HR HH:MM

Yes No This person was brought to me by a police officer or constable under section 28 of the Act.

SECTION 2 - To be completed in a designated facility by someone other than the examining professional who completed Section 1

Note: In the case of a certificate relating to a person detained in a correctional centre or youth custody centre, Section 2 does not require completion.

I, the Mental Health Act Director or delegate, confirm that I have reviewed Section 1 of this form, and that it sets out the information required by section 22(3) of the Mental Health Act to involuntarily admit the person who was examined to the designated facility named below.

Name of MHA Director of Designated Facility or Delegate (please print)	Signature of Mental Health Act Director or Delegate of Designated Facility
Involuntary Admission Date (Date & Time Signed)	
<input type="checkbox"/> Date Signed (DD/MM/YYYY) <input type="checkbox"/> Time Signed 24HR HH:MM	

Note: When a Form 4.1 (First Medical Certificate) is completed outside of a designated facility, it is valid for up to 14 days from the date of medical assessment and authorizes apprehension, detainment and transportation to a designated facility. Involuntary admission begins when the Mental Health Act (MHA) Director or delegate of a designated facility completes Section 2 of Form 4.1 and lasts up to 48 hours. A Form 4.2 must be completed during this time to extend involuntary admission for up to one month. If a Form 4.2 is not completed within that time, a new Form 4.1 is required to restart involuntary admission. Form 5 must be completed to initiate involuntary treatment. Immediately upon involuntary admission, attempts must be made to help the person understand their rights under the MHA by completing Form 13.

EXTENDED LEAVE (FORM 20)

- Allows an involuntary patient to live in the community while still being legally an admitted involuntary patient (still certified)
- Requires ongoing treatment, supervision, care and support
- Can be recalled to facility

FORM 20
MENTAL HEALTH ACT
[Section 37, R.S.B.C. 1996, c. 288]

LEAVE AUTHORIZATION

_____ is released on leave from _____
first and last name of patient (please print)

_____ is _____
name of designated facility (please print) date (dd / mm / yyyy)

The above-named patient's medical certificate expires on _____
date (dd / mm / yyyy).

CONDITIONS OF LEAVE (must be completed)

Note: if above space is insufficient, continue on back of form

It is my opinion that appropriate supports exist in the community to meet the conditions of leave.

I hereby authorize the physician named below, who has agreed to do so, to assume the following responsibilities:

clinical care of the patient
 completion of renewal certificate
 renewal and modification of conditions of leave
 recall from leave
 discharge of the patient

_____ physician's name (please print) _____ phone number

_____ physician's address

_____ director's signature

_____ date signed (dd / mm / yyyy)

I confirm that the conditions of my leave have been explained to me.

_____ signature of patient

PRINT **CLEAR FORM**

HEALTH CARE (CONSENT) AND CARE FACILITY (ADMISSIONS) ACT

- Before an adult is admitted into a care facility, it is required by law that consent is obtained for their admission
 - Includes long-term care, hospice, facility licensed for the treatment of mental health and substance use or another licensed facility for adults
- Given by an adult who is going into the facility unless they have been assessed and determined to be incapable of giving or refusing consent → then consent from substitute
- Consent must be informed, voluntary, specific and given by a capable adult
- Conducted by physician, NP, RN, psychologist, OT or social worker



ADULT GUARDIANSHIP ACT

- Law that protects adults who are incapable of managing their personal or financial affairs as a result of self-neglect or abuse by others
- States every adult is presumed to be capable of managing his or her own affairs, but if they require support should be provided in least restrictive manner
- Emergency Assistance (Section 59) allows for urgent action by a designated agency (i.e Health Authority) if there is **IMMINENT RISK** and the follows:
 - The adult is apparently abused or neglected
 - It is necessary to act without delay in order to preserve the adult's life, prevent serious physical or mental harm, protect the adult's property from significant loss or damage
 - The adult is apparently incapable of giving or refusing consent
- Support and Assistance provisions
- Statutory Property Guardianship – PGT
- An adult **MUST** agree to an assessment of incapacity – if they refuse can as PGT to assess

ADVANTAGES OF THE AGA

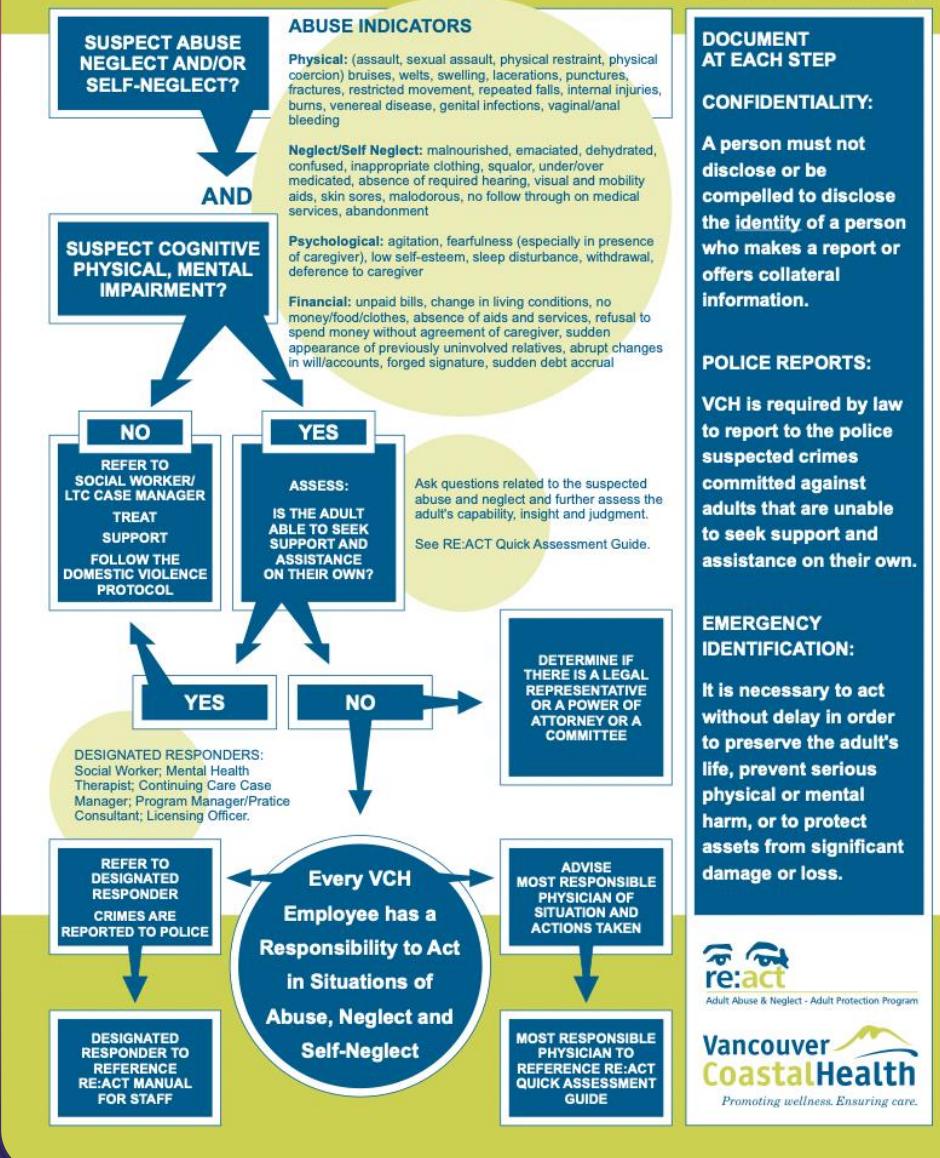
- Provides authority to investigate
- Mandates a response to abuse, not just self-neglect
- May take place at an adult's "safe place" – not necessarily a psychiatric facility
- Includes provisions to provide emergency health care, not just psychiatric treatment
- Not reliant on physician assessment in the last 14 days
- Presumption of capability and principles allow for least intrusive interventions
- Protection of assets is an important aspect



Adult Abuse and Neglect

Re:act Response Flow Chart

For Vancouver Coastal Health



- ReACT Adult Protection Program

ADVANCED CARE PLANNING

- Advanced Directive
- Power of Attorney (POA)
 - General – ends when person is incapable
 - Enduring – continues to be active if person becomes incapable
- Representation agreements
 - Section 7
 - Section 9
- Recommended to get BOTH a POA and Representation agreement to ensure that all needs are addressed

Personal Planning Options

Adapted from: Public Guardian Trustee of British Columbia (2019): It's Your Choice Personal Planning Tools

	Financial Affairs	Legal Affairs	Personal Care	Healthcare	Facility Admission
Enduring Power of Attorney (EPOA)	Yes	Yes	No	No	No
Representation Agreement for Routine Management of Financial Affairs (Financial RA7)	Yes*	Yes*	No	No	No
Representation Agreement for Personal and Health Care Decisions (Personal/Health Care RA7)	No	No	Yes [†]	Yes [†]	No
Representation Agreement for Personal and Health Care Decisions (Personal/Health Care RA9)	No	No	Yes	Yes	Yes
Advance Directive for Health Care (Advance Directive)	No	No	No	Yes	No
Nomination of a Committee of Estate	Yes	Yes	No	No	No
Nomination of a Committee of Person	No	No	Yes	Yes	Yes

* = Note that a Financial RA7 is more limited than an EPOA, † = Note that a Personal/Health Care RA7 is more limited than an RA9

REPRESENTATION VS. COMMITTEE

- Representation Agreement 9
 - Must be established when adult is **FULLY CAPABLE**
 - Broader powers, authorize to do anything necessary in relation to personal care and health **INCLUDING** end-of-life decisions
- Representation Agreement 7
 - Can be established when adult has **LOST SOME CAPACITY**
 - Limited scope – authorize to make decisions on adults behalf or help to make decisions for personal care and minor health matters as well as day-to-day financial affairs and instructing legal council
- Committee
 - Patient is already deemed **INCAPABLE** but requires a person or body to be appointed for either financial decision or health decision making
 - Court appointed (much more involved expensive process)

TEMPORARY SUBSTITUTE DECISION MAKERS

- Must be at least 19, willing, capable , have no dispute with the adult and have been in contact with the adult in the last year

http://nidus.ca/PDFs/Nidus_Role&ScopeAuthorityTSDM-BC.pdf

Who can be selected as your TSDM?

A potential TSDM must be selected in the following order:

- 1) Your spouse (legally married or in a marriage-like relationship). There is no minimum time you must have been together.

If there is no spouse who qualifies, the provider will continue down the list to find someone who is related to you by birth or adoption:

- 2) An adult child (if more than one, only one is selected, birth order does not matter);
- 3) A parent;
- 4) A sibling;
- 5) A grandparent;
- 6) A grandchild;
- 7) Other relative.

If no one related by birth or adoption is available or qualified, the provider will look for:

- 8) A close friend (defined in the legislation as an adult who has a long-term, close personal relationship involving frequent personal contact with you, but who does not receive compensation for providing personal care or health care to you);
- 9) A person who is immediately related to you by marriage (an in-law).

MEDICAL ASSISTANCE IN DYING (MAID)

- Eligible for health services funded by a province or territory, or the federal government
- At least 18 years old and mentally competent
- Have a grievous and irremediable medical condition (+ previously death in foreseeable future)
- Make a voluntary request for medical assistance in dying
 - Request cannot be the result of outside pressure or influence
- Give informed consent to receive Medical Assistance in Dying
- New Legislation passed for patients who have mental illness as the sole diagnosis → expansion of the law delayed to 2027

MAID

- To be considered as having a grievous and irremediable medical condition, must meet **all** of the following criteria:
 - have a serious illness, disease or disability
 - be in an advanced state of decline that **cannot** be reversed
 - experience unbearable physical or mental suffering from illness, disease, disability or state of decline that **cannot** be relieved under conditions that are considered acceptable
- Must be able to give informed consent both:
 - At the time of request
 - Immediately before receiving medical assistance in dying, unless special circumstances apply
- Can withdraw consent at any time and in any way

MAID

- Written request signed by an independent witness
 - If patient is unable to sign, can be requested on patient's behalf by another adult who DOES NOT benefit from death
- Medical assessment done by 2 independent assessors (physician or nurse practitioner)
- Immediately before receiving medical assistance in dying a patient must:
 - be given the opportunity to withdraw consent
 - affirm consent
- Waiver of consent must be done in advance if loss of capacity is a future concern

MAID

- If death is determined to be NOT reasonably foreseeable, additional safeguards must be met:
 - One of the 2 medical assessors must have expertise in the medical condition that is causing unbearable suffering or must consult with another practitioner with expertise
 - Patient must be informed of available means to relieve suffering and be offered consultations with professionals who provide services like palliative care, counselling services or mental health/disability support services
 - Patient and practitioner must have discussed reasonable and available means to relieve suffering and all agree that they were seriously considered
 - Eligibility assessment must take a minimum of 90 days, unless there is an immediate risk of loss of capacity
 - Immediately before MAID, patient must be given an opportunity to withdraw request and must give express consent



QUESTIONS?

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THANK YOU!!!

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