



# ELDERLY PATIENT CARE

PRA-BC CENTRALIZED ORIENTATION 2024

# OUTLINE

## Aging Safely

- Geriatric Assessment/Care-Planning/GOC
- Driving Safety

## What is Geriatric Depression?

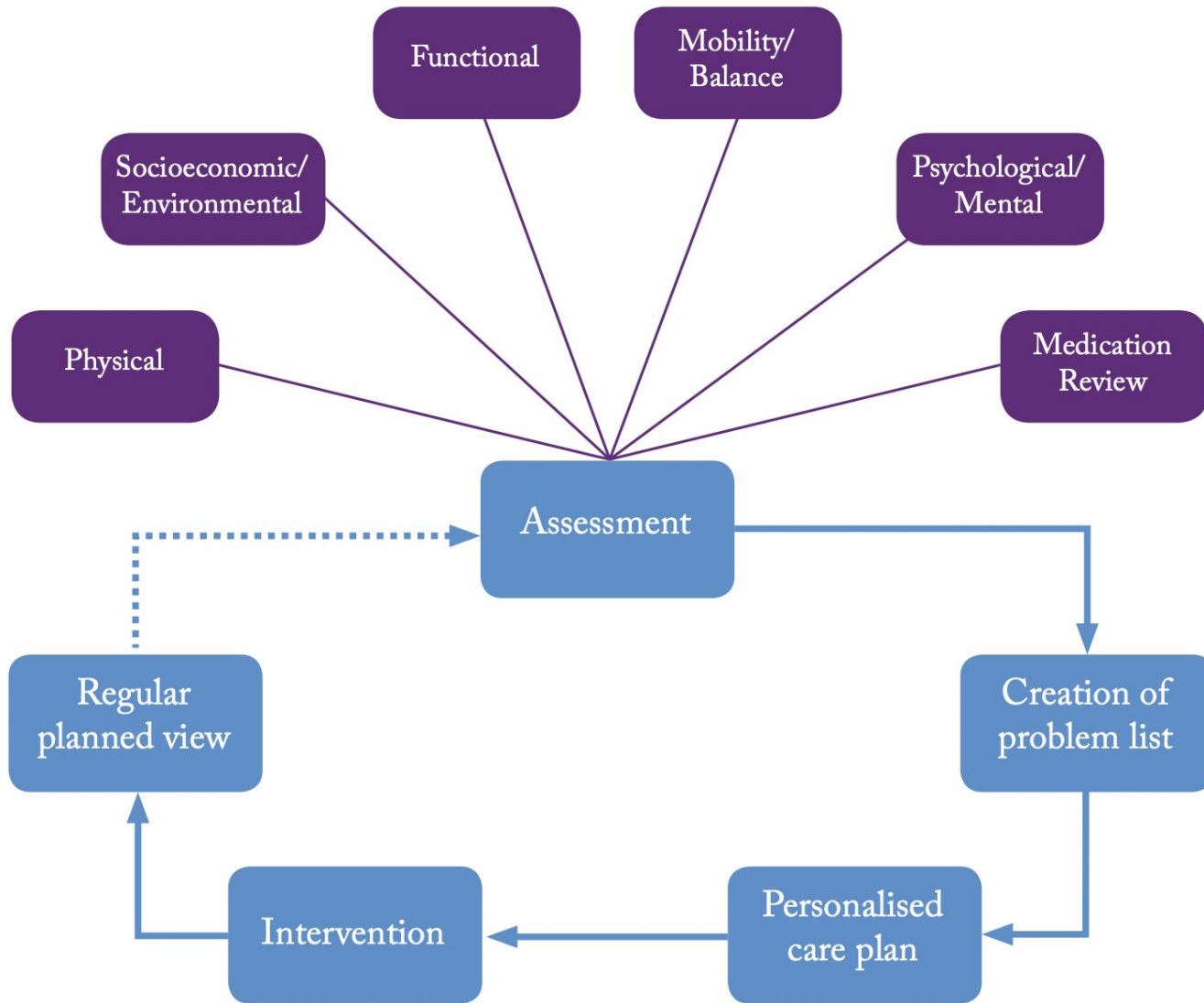
- Screening
- Diagnosis
- Treatment

## Capacity

- Capacity and Consent
- Mental Health Act
- Health Care and Care Facility Act
- Adult Guardianship Act
- Advanced Directives
- Substitute Decision Making
- Case Study

## Medical Assistance In Dying

# THE GERIATRIC ASSESSMENT



- [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  $\geq 12$  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
- Steadying self on walls
- Shuffling
- En bloc turning
- Not using assistive device properly

These changes may signify neurological problems that require further evaluation.

# MOOD/COGNITION

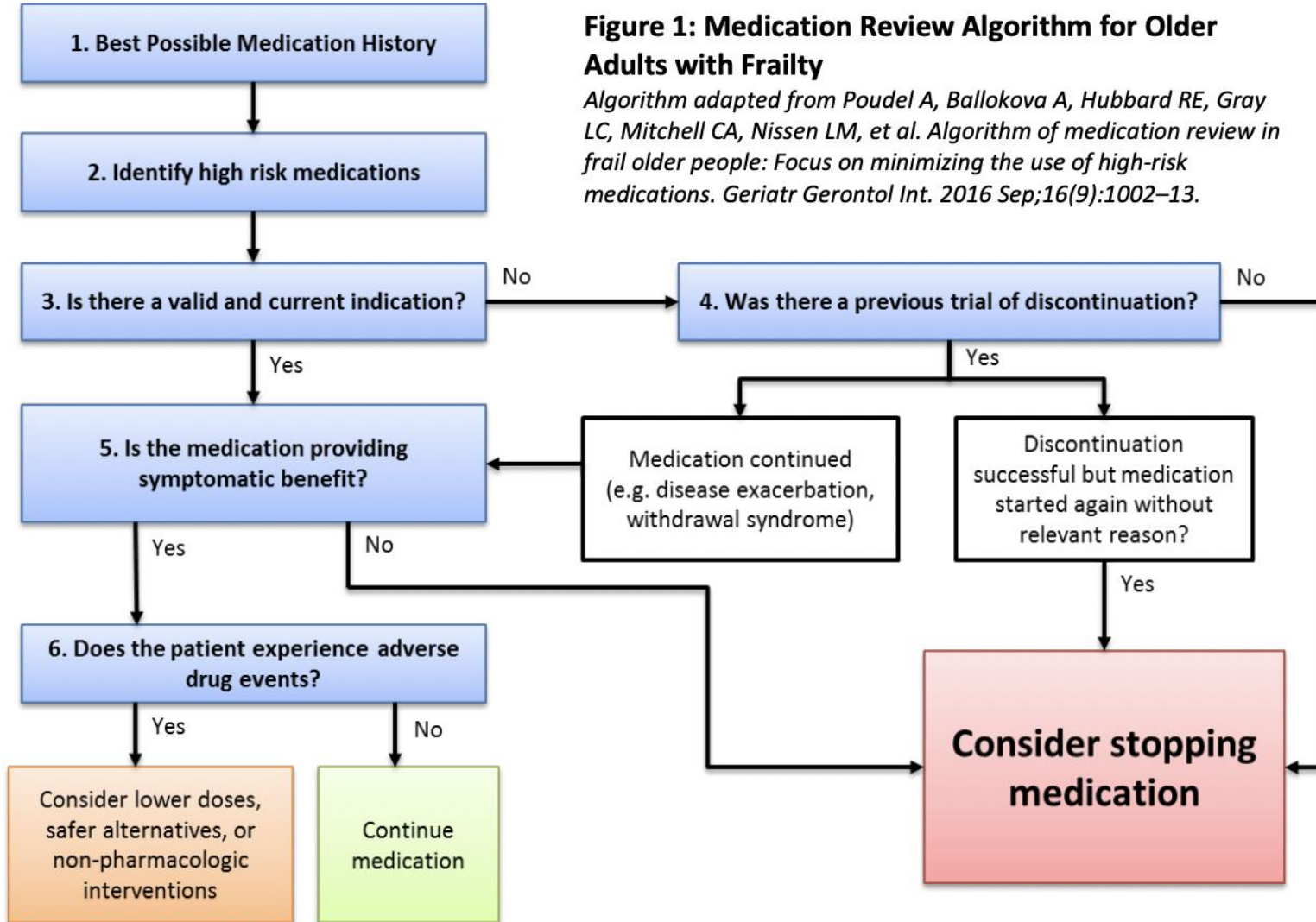
- Screen for depression – GDS
- Sleep
- Screen for cognitive changes – MOCA, MMSE
- Engage family/care-givers
- Capacity



# MEDICATION REVIEW

**Figure 1: Medication Review Algorithm for Older Adults with Frailty**

Algorithm adapted from Poudel A, Ballokova A, Hubbard RE, Gray LC, Mitchell CA, Nissen LM, et al. Algorithm of medication review in frail older people: Focus on minimizing the use of high-risk medications. *Geriatr Gerontol Int.* 2016 Sep;16(9):1002–13.

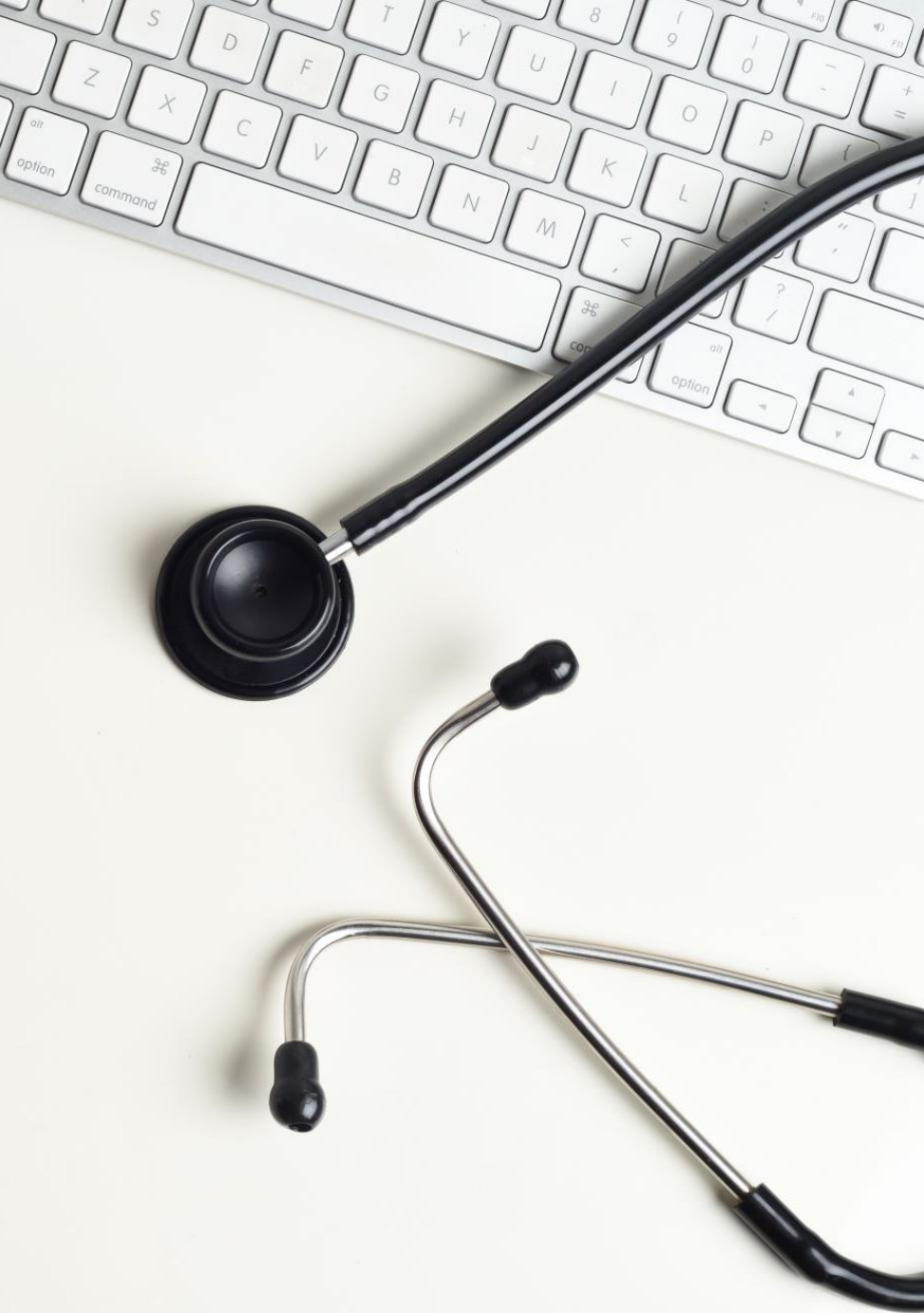


- [BC Frailty Guidelines - Medication Review](#)
- [Pharmanet Access](#)



# 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



### 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



## HOME AND COMMUNITY CARE SERVICES

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

## OLDER ADULTS MENTAL HEALTH AND SUBSTANCE USE

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



**SUPPORTING FRAIL SENIORS**  
IT TAKES a COMMUNITY

**Family Caregivers of British Columbia**

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

**CAREGIVER Rx**  
• with their permission

ASK CAREGIVERS are you OK?

Referral process involving health care provider

34% HAVE a CAREGIVER in DISTRESS

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

familycaregiversbc.ca

**211 British Columbia**

LIFE CAN BE HARD.

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

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

240 LANGUAGES

24/7

FREE

bc.211.ca

**Nidus** Protect and maintain your self-determination

NIDUS is an EXPERT on REPRESENTATION AGREEMENTS

Education, support and assistance with personal and health-care planning

THESE are my HEALTHCARE WISHES and PRIORITIES

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

- VDOFP: Navigating Resources for Frail Seniors:



# 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 \(MOST\)](#)



## NO CARDIOPULMONARY RESUSCITATION – MEDICAL ORDER

Capable patients may request that no cardiopulmonary resuscitation be started on their behalf. This should be done after discussions with their doctor or nurse practitioner. "No cardiopulmonary resuscitation" is defined as no cardiopulmonary resuscitation (no CPR) in the event of a respiratory and/or cardiac arrest.

This form is provided to you or your substitute decision maker to acknowledge that you have had a conversation with a physician or nurse practitioner about a No CPR Order, and understand that no CPR will be provided in circumstances where you can no longer make decisions for yourself. It instructs people such as first responders, paramedics and health care providers not to start CPR on your behalf whether you are at home, in the community or in a residential care facility. The personal information collected on this form assists the health professionals noted above to carry out your wishes. If you have any questions about the collection of this information contact **HealthLink BC at 8-1-1** or go to [www.gov.bc.ca/expectedhomedeath](http://www.gov.bc.ca/expectedhomedeath).

You or someone at your location should have the form available to show to emergency help if they come to your aid. It is desirable that you wear a MedicAlert\* No CPR bracelet or necklet to enable quick verification that you have a No CPR Order in place. To obtain a free No CPR bracelet/necklet, please:

1. Complete the form below
2. Fill out the MedicAlert Registration form which can be printed from: [https://www.medicalert.ca/nocpr/resources/MedicAlert\\_Application\\_BC\\_NO CPR.pdf](https://www.medicalert.ca/nocpr/resources/MedicAlert_Application_BC_NO CPR.pdf)
3. Mail both of the forms to: MedicAlert Foundation Canada, Morneau Shepell Centre II, 895 Don Mills Road, Suite 600, Toronto ON, M3C 1W3

If you change your wishes about your no CPR preference, then please inform your doctor, nurse practitioner or residential care facility nurse, tear up the No CPR form, and contact MedicAlert if you enrolled with them for a No CPR bracelet or necklet.

<b>PATIENT IDENTIFICATION</b>	Patient Last Name	Birthdate (YYYY / MM / DD)	
	Patient First and Middle Name(s)	Personal Health Number (PHN)	
	Patient Address	Telephone Number	
<b>WITNESSED BY THE PATIENT, OR BY THE PATIENT'S SUBSTITUTE DECISION MAKER (SDM) WHEN THE PATIENT IS INCAPABLE</b>	I, _____ (patient's name or patient's substitute decision maker if patient is incapable) have had a conversation with the undersigned physician/nurse practitioner about this No CPR Order in the event of cardiac or respiratory arrest. I understand that in the event of a cardiac or respiratory arrest, no cardiopulmonary resuscitation is to be undertaken.		
	Patient's Signature	Date Signed	
	Signature of the Patient's Substitute Decision Maker	Date Signed	
	Relationship of the Patient's Substitute Decision Maker to the Patient (e.g. representative, committee of person, or temporary substitute decision maker)		
<b>SECTION TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER</b>			
<b>STATUS OF MEDICAL ORDER</b>	The above identified patient has expressed wishes to not have CPR in the event of cardiac or respiratory arrest. I have discussed the patient's health status, life expectancy, and expressed wishes with the patient/patient's substitute decision maker. Based on this discussion, I order that in the event of a respiratory and/or cardiac arrest no cardiopulmonary resuscitation is to be undertaken. This order shall be in effect until cancelled or repealed.		Date
	<input type="checkbox"/> Patient (or SDM) agrees and has signed this form <input type="checkbox"/> Patient (or SDM) agrees but has declined signing this form		
<b>ATTENDING PHYSICIAN/NURSE PRACTITIONER</b>		<b>ALTERNATE PHYSICIAN/NURSE PRACTITIONER</b>	
Name of Attending Physician / Nurse Practitioner		Name (Print)	
License Number of Physician / Nurse Practitioner	Phone Number	Phone Number	
Address	Signature		

**COPY 1** – TO PATIENT; **COPY 2** – TO ATTENDING PHYSICIAN/NURSE PRACTITIONER; **COPY 3** – IF APPLICABLE, TO HOME & COMMUNITY CARE OR RESIDENTIAL CARE FACILITY

NO CPR FORM

## PATIENT/FAMILY INSTRUCTIONS

Looking at this form may be one of the most difficult things you have ever done. Many thoughts and emotions may surface. So often people try to ignore their mortality, yet we all know it is one of the facts of life: we all, one day, will die.

This form is a medical order that reflects your wishes about what you would like to have happen in the event you stop breathing or your heart stops beating. Take time to thoughtfully consider your wishes and ask your health care professionals what resuscitation would entail and any risks to quality and/or quantity of life that could accompany resuscitation if you decided to have it.

Whether you live at home or in a residential care facility, your care team will help you and/or your substitute decision maker to make choices and plans for end-of-life-care. If you have a life-limiting illness and are choosing to die at home, you will need to make additional plans. The steps you will need to consider are listed below.

If you are a family member who is asked to consider this document on behalf of your loved one, all of what is said above applies also. This can be a stressful decision. Remember to seek support from trusted family members, friends and/or a spiritual advisor if you have one and your health care team.

### IF YOU WANT TO DIE NATURALLY AT HOME, CONSIDER THESE STEPS

#### INDIVIDUAL / FAMILY

##### What to Do Ahead of Time

- Discuss the option of an in-home death with your physician/nurse practitioner and community nurse.
- Make a written plan with your physician/nurse practitioner and community nurse so you are clear about what will happen and so family, friends and others may support your decisions and respect your wishes and know what to do at the time of death. You need to write in your plan:
  - who will pronounce death, IF pronouncement is planned. Pronouncement is NOT necessary if a "Notification of Expected Home Death" form has been completed earlier by you and your doctor or nurse practitioner. The form can be found at [www.gov.bc.ca/expectedhomedeath](http://www.gov.bc.ca/expectedhomedeath).
  - how your physician/nurse practitioner can be reached;
  - what alternate arrangements have been made should your physician/nurse practitioner be unavailable or cannot be reached;
  - which funeral home will be called to transport the deceased.
- Make prearrangements with a funeral home. Such arrangements will normally involve selecting the funeral home and making plans with the funeral director for transportation of the deceased after death and the method of final disposition. For information on funeral homes in your area, you could contact the B.C. Funeral Association at 1-800-665-3899.
- Ensure that a copy of this form is easily available in your home. If you are away from your home for any reason, take the form with you so it's available should it be necessary.

#### FAMILY / FRIENDS

##### What to Do at the Time of Death

- DO NOT CALL 911, the ambulance, coroner, police, or fire department. Review your written plan for who to contact at the time of death.
- CALL family, friends, and the spiritual advisor, if any, you would like to have present.
- CALL the physician/nurse practitioner or community nurse to pronounce death IF a "Notification of Planned Home Death" form has NOT been completed, AND/OR pronouncement is planned.
  - If your physician/nurse practitioner or community nurse cannot be reached, CALL the backup physician/nurse practitioner or community nurse if prearranged.
- If a "Notification of Planned Home Death" form HAS been completed AND is in your home, call the funeral home after one hour or more has passed since your loved one's breathing has stopped.
  - You do NOT need to call a physician/nurse practitioner about completing a Medical Certificate of Death form. The funeral home can contact the physician or nurse practitioner to obtain a signed certificate within 48 hours, because the body cannot be released for burial or cremation without it.

People to Call	Name	Telephone Number
Phys/Nur. Practitioner		
Alternate Practitioner		
Community Nurse		
Funeral Home		
Spiritual Advisor		
Home Support Agency		
Hospice Program		
Family and Friends		

For more information, go to [www.gov.bc.ca/expectedhomedeath](http://www.gov.bc.ca/expectedhomedeath)

There are communities in British Columbia without physicians or nurse practitioners who live in the community and without a funeral home. It is essential that these situations be discussed by the patient and family and physician/nurse practitioner and an appropriate plan suitable for the community be made in advance.

PRINT

CLEAR FORM

# MOST FORM

<b>MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)</b> ADULTS, AGE 19 AND ABOVE	IDENTIFICATION LABEL								
<p><b>A</b> 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:</p> <p style="text-align: center;"><input type="checkbox"/> Attempt CPR and refer to Critical Care - _____</p> <p style="text-align: right;">Responsible Provider Signature (or delegate) _____ Date _____</p> <p style="text-align: right;">Physician's Printed Name _____</p>									
<p><b>OR</b></p>									
<p><b>B</b> I have had a discussion with patient and / or substitute decision maker:</p> <p><b>Patient/Resident:</b> <input type="checkbox"/> is at this time capable to make own medical decisions  <input type="checkbox"/> is NOT currently capable to make own medical decisions</p> <p><b>Patient / Resident / Substitute Decision Maker (SDM) consulted in development of Order / advised of Order:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;"> <input type="checkbox"/> Patient / Resident  <input type="checkbox"/> Representative  <input type="checkbox"/> Other (explain below)                      Explain: _____                 </td> <td style="width: 30%; border: none;"> <input type="checkbox"/> TSDM  <input type="checkbox"/> Personal Guardian  <input type="checkbox"/> None (explain below)                 </td> <td style="width: 40%; border: none;"> <input type="checkbox"/> Client / SDM disagrees with Order (see 2c, over)                 </td> </tr> <tr> <td style="border: none;">Printed name _____</td> <td style="border: none;">Date _____</td> <td style="border: none;"></td> </tr> </table> <p>Optional space for signature of Client or SDM aware of Order, intended for use in residential care. Order valid with or without signature.</p>		<input type="checkbox"/> Patient / Resident <input type="checkbox"/> Representative <input type="checkbox"/> Other (explain below) Explain: _____	<input type="checkbox"/> TSDM <input type="checkbox"/> Personal Guardian <input type="checkbox"/> None (explain below)	<input type="checkbox"/> Client / SDM disagrees with Order (see 2c, over)	Printed name _____	Date _____			
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Printed name _____	Date _____								
<p><b>SUPPORTING DOCUMENTATION:</b> Ask each patient / family if patient has expressed or documented wishes about future care</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> Previous DNACPR / MOST</td> <td style="width: 25%;"><input type="checkbox"/> VCH ACP Record</td> <td style="width: 25%;"><input type="checkbox"/> Representation Agreement</td> <td style="width: 25%;"><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Provincial No CPR</td> <td><input type="checkbox"/> Advance Directive</td> <td><input type="checkbox"/> Section 9</td> <td><input type="checkbox"/> Section 7</td> </tr> </table>		<input type="checkbox"/> Previous DNACPR / MOST	<input type="checkbox"/> VCH ACP Record	<input type="checkbox"/> Representation Agreement	<input type="checkbox"/> Other:	<input type="checkbox"/> Provincial No CPR	<input type="checkbox"/> Advance Directive	<input type="checkbox"/> Section 9	<input type="checkbox"/> Section 7
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<input type="checkbox"/> Provincial No CPR	<input type="checkbox"/> Advance Directive	<input type="checkbox"/> Section 9	<input type="checkbox"/> Section 7						
<p><b>IN THE EVENT OF SERIOUS ACUTE MEDICAL EVENT:</b></p> <p><input type="checkbox"/> Attempt Cardiopulmonary Resuscitation (CPR) In the event of acute medical event, maximum therapeutic effort.</p> <p style="text-align: center;"><b>OR</b></p> <p><input type="checkbox"/> Do Not Attempt Cardiopulmonary Resuscitation (DNACPR: No chest compressions or other direct means of restarting the heart), and:</p> <p><input type="checkbox"/> Option 1 (M1)* No CPR. Supportive care, symptom management, and comfort measures. Allow natural death.</p> <p><input type="checkbox"/> 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).</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> Option 4 (C1) No CPR. Maximum therapeutic effort as in Option 3 (M3) including referral to Critical Care but <b>not including</b> intubation and ventilation.</p> <p><input type="checkbox"/> Option 5 (C2) No CPR. Maximum therapeutic effort as in Option 4 (C1) including referral to Critical Care and <b>including</b> intubation and ventilation.</p>		<p><b>Specific comments on Order / Goals of Care to aid interpretation:</b></p>							
<p><b>DNACPR as detailed on this MOST will automatically be suspended</b> 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:</p> <p>Provider detailing circumstances of suspension of DNACPR / MOST _____</p>									



# WHAT DO THE LEVELS MEAN?

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

- 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



# *Frailty Roadmap for Families*

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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

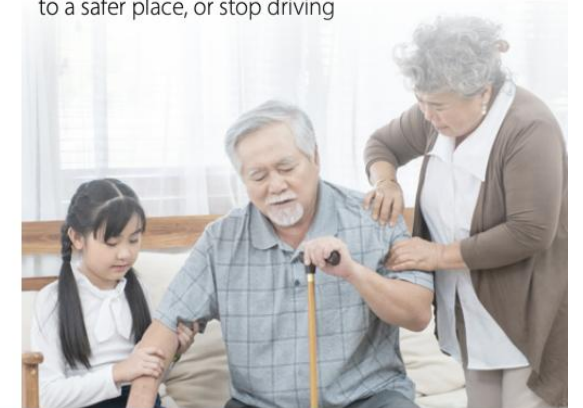
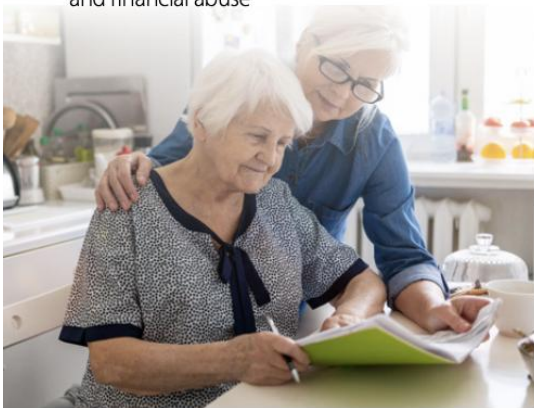
- Appoint a substitute decision maker or representative to speak for you if you are no longer able to speak for yourself
- With your doctor, consider the risks and benefits of proposed medical interventions or surgery. As we become more frail and medically complex, our risk of complications or poor recovery 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

## 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."

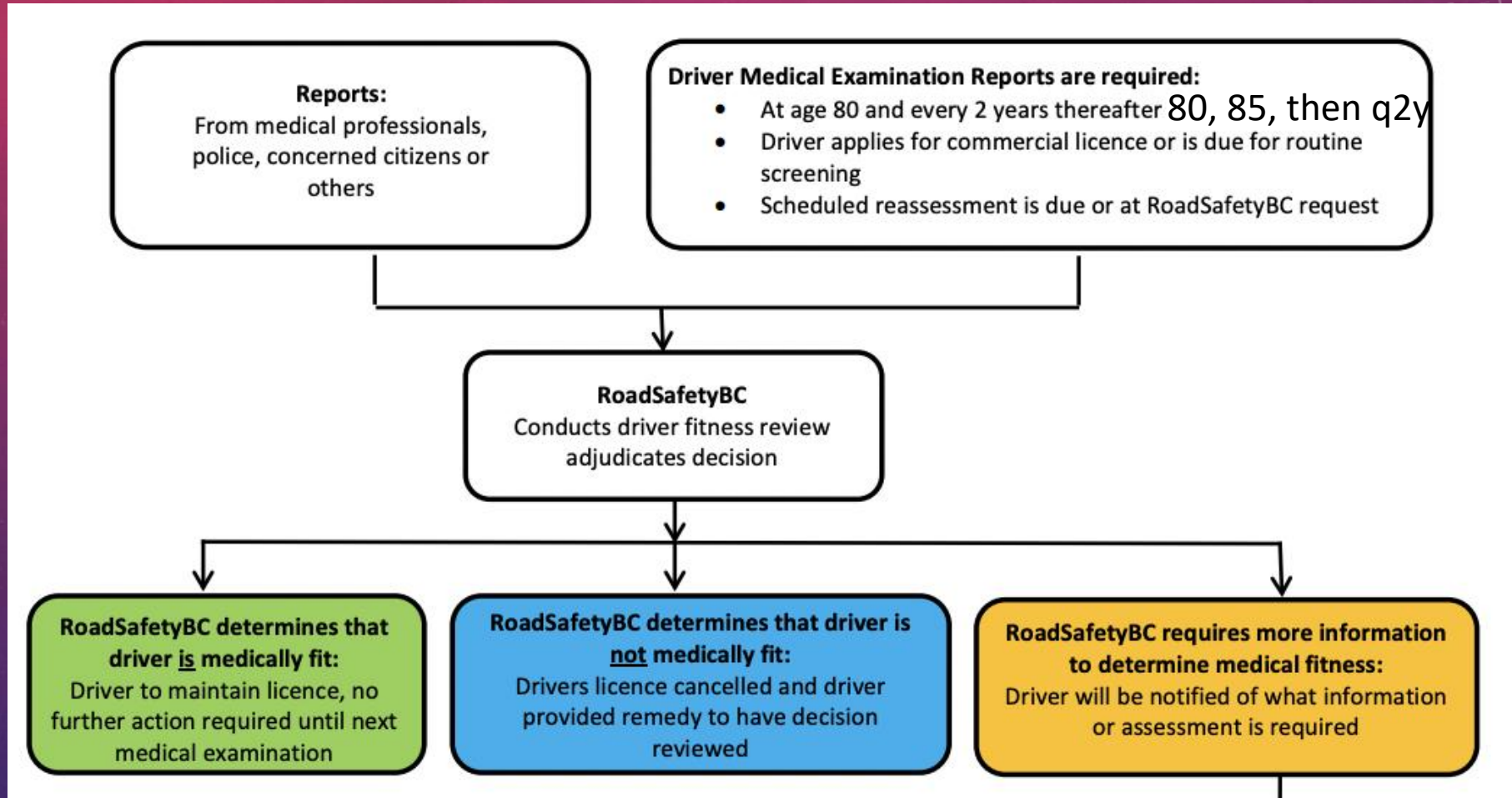
#### 6. Document your conversation

#### 7. Communicate with key clinicians

- [Serious Illness Conversation Guide Brochure](#)

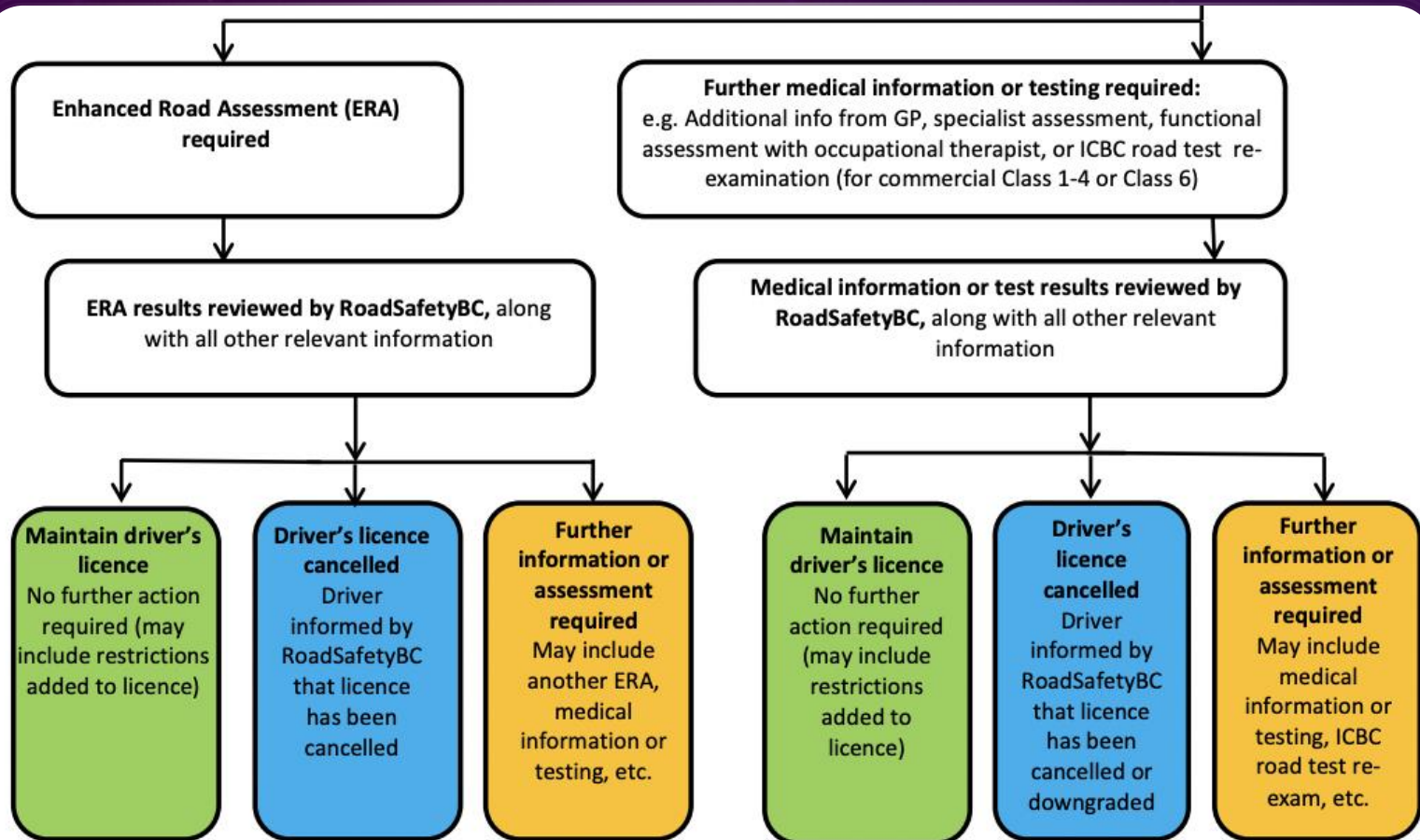


# DRIVER SAFETY





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

Any patient whose ability to drive safely you question.

<b>DO</b> report	<b>DON'T</b> report
<ul style="list-style-type: none"><li>✓ Conditions causing persistent functional impairment</li><li>✓ Conditions that cause episodic incapacitation</li><li>✓ Cognitive decline and dementia</li><li>✓ Cerebrovascular accident (CVA) with lasting deficits</li><li>✓ Uncontrolled psychiatric conditions impacting judgement</li><li>✓ Uncontrolled seizures</li><li>✓ Patients with diabetes experiencing frequent hypoglycemic events</li></ul>	<ul style="list-style-type: none"><li>✗ Temporary conditions</li><li>✗ Short-term after effects of surgery</li><li>✗ Fractures</li><li>✗ Concussions</li><li>✗ Eye surgery</li></ul>

# WHO TO REPORT

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



# HOW TO REPORT

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



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: <small>Stamp or sticker</small>
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: <small>(YYYY/MM/DD)</small>	Drivers Licence # (if known):	Professional Qualifications: <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/yrs.)
<input type="checkbox"/> <b>IN MY OPINION THIS PATIENT HAS A MEDICAL CONDITION THAT PUTS THE PUBLIC OR THEMSELVES AT RISK WHEN THEY DRIVE</b> (See: <a href="#">BC Medical Guidelines for Driving</a> ) (if undetermined, provide narrative information below and complete other areas as appropriate)		
<input type="checkbox"/> <b>THIS PATIENT CONTINUES TO DRIVE AFTER BEING WARNED OF THE DANGER (if known)</b>		
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:		
_____ _____ _____		
<b>Optional Recommendations:</b>		
<input type="checkbox"/> RECOMMEND <b>CANCELLATION</b> OF DRIVER'S LICENCE		
OR		
<input type="checkbox"/> RECOMMEND FURTHER <b>MEDICAL</b> 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)		
<b>Further Recommendations:</b>		
_____ _____ _____		
Date: _____		Signature: _____



## 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



# 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

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

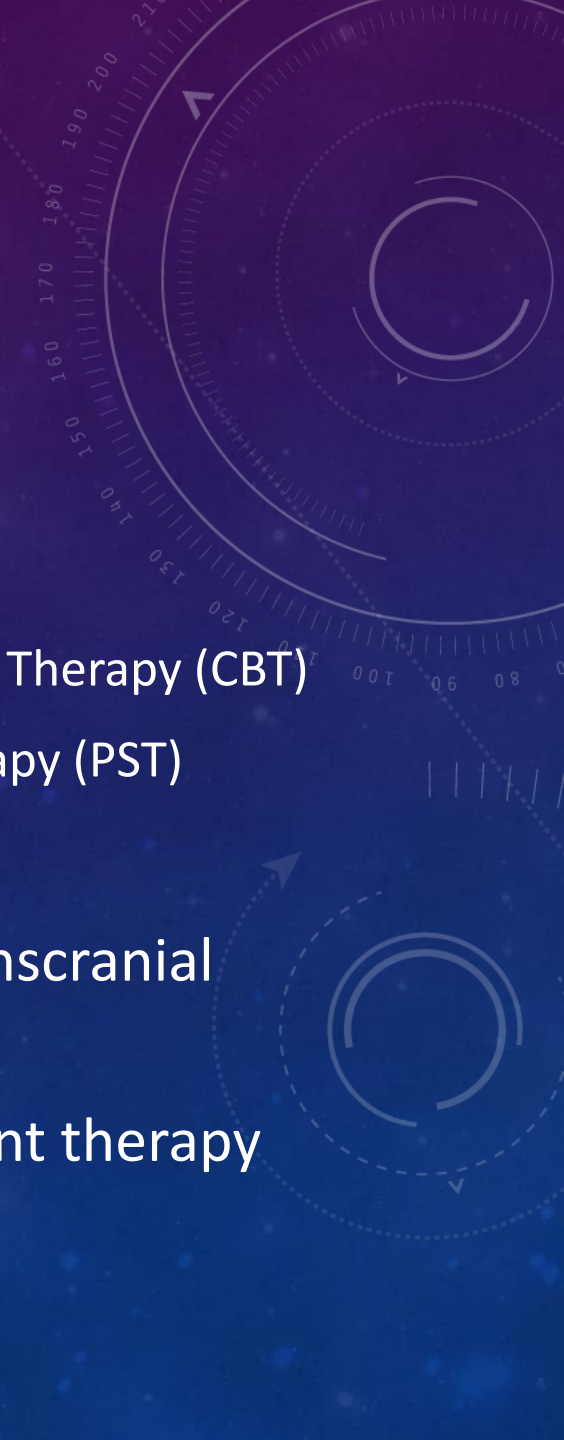
- A review of diagnostic criteria outlined in DSM-IV -TR or ICD 10 diagnostic manuals
- An estimate of severity, including the presence of psychotic or catatonic symptoms
- Risk assessment for suicide
- Personal and family history of mood disorder
- Review of medication use and substance use
- Review 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
- Cases
- 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



# 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

- 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**

# 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 (mature minor)

- 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



# 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 at 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

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="radio"/> Designated Facility <input type="radio"/> Other Site	Examination Date (DD/MM/YYYY)

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:  Check if summary continued on back of this page  Patient was given a copy of this form

<b>Examining Professional</b>	Name of Examining Physician or Nurse Practitioner (please print)		Signature of Physician or Nurse Practitioner	Date Signed (DD/MM/YYYY)
	<input type="radio"/> Physician <input type="radio"/> Nurse Practitioner	Phone Number		College ID Number

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)
Name of Designated Facility		Date Signed (DD/MM/YYYY)
		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, detention 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)

\_\_\_\_\_ 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

HLTH 3520 Rev. 2005/06/01

**PRINT** **CLEAR FOR**



# 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





# 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

# My Voice

Expressing My Wishes for Future Health Care Treatment

Advance Care Planning Guide



## Table of Contents

Introduction	2
Why is an Advance Care Plan Important?	3
Developing Your Advance Care Plan	5
Beliefs, Values and Wishes	5
Life Support and Life-Prolonging Medical Interventions	6
Advance Care Planning Options	8
Temporary Substitute Decision Maker (TSDM)	9
Representation Agreements	11
Advance Directive	14
A Representation Agreement and an Advance Directive	16
Enduring Power of Attorney	19
Changing or Cancelling Your Advance Care Plan	20
Definitions of Terms	22
Putting Your Papers in Order	25
<b>My Advance Care Plan</b>	
My Advance Care Plan - Summary	27
My Temporary Substitute Decision Maker (TSDM) List	28
My Beliefs, Values and Wishes	30
My Representative: Standard (RA 7) and Enhanced Agreements (RA 9)	32
Representation Agreement (Section 7)	34
Form 1: Certificate of Representative or Alternate Representative	40
Form 2: Certificate of Monitor	41
Form 3: Certificate of Person Signing for the Adult	42
Form 4: Certificate of Witnesses	43
Representation Agreement (Section 9)	44
My Advance Directive	50
Resources	52
Wallet Card	52

# ADVANCED DIRECTIVE MY VOICE: EXPRESSING MY WISHES FOR FUTURE HEALTH CARE TREATMENT

- Available in 11 languages
- Step by step guide through Advanced Care Planning
- <https://www2.gov.bc.ca/assets/gov/people/seniors/health-safety/pdf/myvoice-advancecareplanningguide.pdf>
- Video: <https://www.youtube.com/watch?v=5BD9yJJdhIQ>



## Personal Planning Options

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

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

\* = 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 to 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

## 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).



# CASE STUDY:

- **Background:**

Mr. Harold Thompson is an 86-year-old widower who lives alone in his small apartment with the help of home support. His health has been slowly declining over the past 2 years.
- **Medical history:**
  - Severe COPD (on home oxygen, several ER visits in past year)
  - Congestive heart failure (NYHA Class III)
  - Frailty (uses walker indoors, fatigues easily, unintentional 10 lb weight loss)
  - Mild cognitive impairment (forgets appointments, but still manages daily choices with help)
- **Social context:**
  - Widowed 10 years ago.
  - His daughter, Susan, visits daily and is the designated substitute decision maker (SDM). His son, Mark, lives in another city and visits occasionally.
  - Mr. Thompson has said things like, *“I’m tired of being in and out of the hospital. I just want to breathe easy at home.”*



# CASE STUDY

- **Current situation:**

Mr. Thompson was recently discharged from hospital after another COPD flare-up. At a follow-up clinic visit, his physician raises the importance of **advance care planning**.

- Susan feels ready to talk about planning for the future and wonders if her father should have a **Do Not Resuscitate (DNR) order** in place. Mark, however, insists that “Dad is a fighter” and thinks resuscitation or ICU care should always be tried. Mr. Thompson is somewhat conflicted—he doesn’t want more hospital trips but also worries about “giving up too soon.”

## QUESTIONS TO THINK ABOUT:

- **Capacity & Decision-Making**
  - How would you assess Mr. Thompson's ability to make decisions about his own care?
  - What role should Susan (his substitute decision maker) play at this stage?



## • **Advance Care Planning & Communication**

- How would you explore Mr. Thompson's values and wishes further?
- What strategies would help address the differences between Susan and Mark?





## • **DNR / Resuscitation Decisions**

- What information should be shared with the family about the likelihood and outcomes of CPR in someone with Mr. Thompson's level of frailty and illness?
- How do you explain what a DNR order means—and what it doesn't mean?



## • **Goals of Care**

- What are realistic goals of care for Mr. Thompson at this stage (e.g., life prolongation vs. comfort at home)?
- How do you translate his wishes into a care plan that guides health providers across settings (community, ER, hospital)?



QUESTIONS?



# 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

- Temporary exclusion for those with mental health as the sole diagnosis extended to Mar 17, 2027
- If death is determined to be NOT reasonably foreseeable (Bill C-7), 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?



# WORKING IN LONG TERM CARE

- Challenging, diverse, and impactful work of caring for the frail elderly
- Panel of ~5-30 residents in the interdisciplinary LTC home setting
- Flexible & part-time – augments well with clinic/hospital work
- LFP and FFS billing options
- Full & provisional licences accepted
- Opportunity to join the Long Term Care Initiative (LTCI):
  - Community of practice with mentorship, networking, and educational opportunities
  - Incentive payments for participation
  - After-hours Care Program to alleviate 24/7 care

Contact [ltc@vancouverdivision.com](mailto:ltc@vancouverdivision.com)





THANK YOU!!!

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