Ontario Renal Network

Ontario Palliative Care Network

Person-Centred Decision-Making

Resource for healthcare providers

Advanced chronic kidney disease (CKD) is a serious illness. It is important to consider how treatment decisions (e.g., starting dialysis) align with a patient's wishes, values, and beliefs for their care.

In Ontario, Advance Care Planning, Goals of Care, and Treatment Decisions & Informed Consent are situated along a Person-Centred Decision-Making continuum, as pictured in the diagram below.

Goals of Care (GOC) Conversations
Current care

Discussions between a provider and a capable patient (or the incapable patient's Substitute Decision Maker [SDM]) that focus on:

- Ensuring the patient understands the serious (incurable and progressive) nature of their illness, and
- Helping the healthcare provider to understand the patient's values and the goals they have for their care.

The discussion is focused on the **current** clinical context.

Outcome: Patient and healthcare providers have a shared understanding of the patient's goals for their care. These goals are then used to support treatment decisions and informed consent.

How do I have a goc conversation?

1. **Illness understanding:** Confirm the patient's understanding of their diagnosis and prognosis.
2. **Elicit values and define goals:**
   - Explore the patient's past experiences, hopes, values and priorities;
   - Discuss the patient's perception of quality of life; and
   - Ask the patient to describe the goals they have for their future care.
3. **Questions:** Allow questions and resolve outstanding concerns.
4. **Document:** Document the identified GOC. Use these goals to inform the development of a **Plan of Treatment** with the patient. Provide the Plan of Treatment to the patient and/or their SDM.
5. **Revisit:** Revisit this discussion regularly, especially if the patient's health status changes. Update the GOC and Plan of Treatment accordingly.

Advance Care Planning (ACP) Conversations
Future care

ACP involves the patient (while capable):

- Confirming their future Substitute Decision Maker by accepting the automatic SDM or assigning a Power of Attorney for Personal Care (POAPC), and
- Discussing their wishes, values, and beliefs with their SDM.

Outcome: Patient has shared their wishes and values with their SDM to prepare their SDM for future decision-making.

Treatment Decisions & Informed Consent
Current treatment

Informed and contextualized treatment decisions are made by the patient (or their Substitute Decision Maker if incapable).

Consent requires providing the patient with information about the nature of treatment, benefits, risks, side effects, alternative courses of action, and likely consequences of not receiving treatment.

The conversation is focused on the **current** clinical (treatment oriented) context.

Outcome: Treatment decision(s) (e.g., code status) through Shared Decision-Making.

For more tips on how to facilitate Goals of Care conversations with a patient (or SDM), please see: ***Approaches to Goals of Care Conversations: Resource for healthcare providers***

1. *Speak Up Ontario. Just ask: a conversation guide for goals of care discussions [internet]. Canadian Researchers at the End of Life Network. [undated; cited [2017 September]. Available from: http://www.advancecareplanning.ca/wp-content/uploads/2015/09/acp_just_ask_booklet-rev-july20_final-web2.pdf.*

For more information about the Ontario Renal Network please visit **ontariorenalnetwork.ca**

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