College of Registered Nurses of Nova Scotia

Guidelines to Assist Registered Nurses with the Personal Directives Act

Background

Since the government of Nova Scotia announced its plan to proclaim the *Personal Directives Act* on April 1, 2010, the College has been receiving numerous calls from registered nurses and nursing employers, especially from those in the long-term care sector. The majority of questions have related to the issues of assessing capacity and the role of registered nurses in implementing their responsibilities under the new legislation.

The *Personal Directives Act* enables an individual (i.e., of the age of majority or a mature minor) to appoint a substitute decision maker for matters of personal care in the event the person becomes incapable of making such decisions. The Act allows a "*person with capacity*" to make a personal directive for himself/herself which can set out specific instructions or an expression of his/her values, beliefs and wishes about the future personal-care decisions to be made on his/her behalf. The Act also enables the individual to authorize a person to "*act as a delegate*" to make decisions concerning his/her personal care should s/he no longer be able to do so.

Personal directives would *only* go into effect when a person lacks the capacity to make a personal care decision and would have *no* validity when a person still has such capacity. A personal directive must be signed, dated and witnessed (there are criteria as to who can become a delegate and who can sign as a witness).

"Personal care" is defined as including, but not limited to, "health care, nutrition, hydration, shelter, residence, clothing, hygiene, safety, comfort, recreation, social activities, support services and any other personal matter that is prescribed in the regulations". In the event that a person has not made a personal directive naming a delegate or setting out relevant instructions in his/her personal directive, the Act enables the appointment of a '*statutory decision-maker*' for decisions pertaining to health care, long-term care placement, and home care services.

A personal directive is intended to address issues of personal care, as distinct from financial issues. In Nova Scotia, the only way to appoint a person to act on behalf of another person in regard to financial matters (outside the Court appointment of a guardian) is through the use of an Enduring Power of Attorney. However, the *Personal Directives Act* does allow for an Enduring Power of Attorney to be combined with a personal directive in a single document which could then address both personal care and financial issues [Sec.23].

A personal directive made outside the province will be honoured in Nova Scotia provided that the document was made in the form required by the legislation of the jurisdiction where the document was created or the jurisdiction where the client resided [Sec.24].

Capacity Assessment

For the purposes of the Act "*capacity*" is defined as "the ability to understand information that is relevant to the making of a personal-care decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of a decision" [Sec. 2 (a)]. Capacity refers to a person's capability to engage in a particular undertaking or transaction and implies that a person may have various levels of abilities depending on the nature of the decision-making required. The common law presumption of a person having capacity to consent is to assume the person *has* capacity unless there is information to suggest otherwise.

Decisions that are associated with greater risk to a person require a higher level of capacity. In other words, at any given time a person may have the capacity to make some decisions (e.g. whether or not to have a flu shot) and not others (e.g. decide on having a high-risk surgery).

Currently, registered nurses and other healthcare professionals must ensure that clients have given informed consent for any service they are providing and this remains the same under the *Personal Directives Act*. Before providing a health treatment, including a nursing service, practitioners would continue to be responsible for assessing the capacity of a client to consent to that specific treatment e.g. to have breakfast, have a morning bath, take prescribed medications, have a dressing done, start intravenous therapy, etc. At the most basic level, capacity assessment in relation to the provision of healthcare services refers to the ability of a client to consent to day-to-day services. This basic capacity assessment falls within the scope of practice of many healthcare providers, including registered nurses.

If a nurse suspects that a client does not have capacity, then the next step could be to seek the opinion of the substitute decision maker. If there is a question or disagreement about capacity, then a physician's opinion should be sought. The trigger for the physician review of capacity is when the registered nurse is unable to determine capacity to consent using the knowledge and tools commensurate with his/her education, standards, and scope of practice. As the parameters for a physician assessment may vary depending on the employment setting (e.g., home care, hospitals, or continuing care, employers/institutions) must develop clear policies and procedures on who can initiate physician capacity assessments.

The Act allows for a capacity assessment or reassessment of a client named in the personal directive to be requested by a delegate, statutory decision maker, nearest relative, health care provider, person in charge of a home care services provider, or person in charge of a continuing care home in which a client resides [Sec. 10(2)]. Clients may also request a reassessment of capacity if they feel that their status has changed.

In rare situations where a person has made a personal directive and there is a reasonable basis to believe that the person lacks capacity to make the decision to leave the province, the police may be contacted to prevent the person from leaving until a capacity assessment can be completed [Sec. 11(1)].

In summary, if the client has capacity, the registered nurse obtains consent for the service or treatment from the client. If client capacity to consent to treatment is in question (i.e., when you have moved beyond the presumption of capacity), the following guidelines apply:

1. If the client does not have capacity, determine whether or not a personal directive exists, and if so, follow the instructions or wishes in the directive. If no personal directive exists, and therefore no delegate has been named, determine and seek out the statutory decision maker.
2. If client capacity cannot be determined, or there is disagreement, request physician assessment.

Role and Accountabilities of Registered Nurses

According to the *Personal Directives Act,* healthcare providers include licensed/registered health professionals under provincial legislation – this includes registered nurses.

As a registered nurse, you should:

- Determine, as part of your ongoing client assessment, if your client has the capacity to make decisions about his/her daily care (again, assume that a person has capacity to consent unless there is information or evidence to suggest otherwise).
- Ask whether or not the client has a personal directive.
- Review the client's personal directive, if one exists, to determine the client's wishes for his/her care and whether a delegate has been named.
- Ensure that decisions are made by the delegate if one has been named.
- Inform the physician and/or appropriate person as defined by agency policy if there is a sudden change in the client's level of capacity or you question your client's ability to understand information relevant to a care decision and/or the consequences of such a decision.
- Follow agency policy in terms of contacting a statutory decision maker if there is no personal directive with clear relevant instructions, or a delegate has not been named. Statutory decision makers are the nearest relative (see definition for priority) or a public trustee when there is no available relative. Registered nurses should advocate for the creation of agency policy where none exists. The College suggests that employers provide education and support to registered nurses to assist them in implementing their responsibilities under the *Personal Directives Act.*

  Please note: the term "substitute decision maker" is not defined in the *Personal Directives Act* but is a generic umbrella term sometimes used to describe either a delegate named in a personal directive or a statutory decision maker.

Definitions

Delegate: a person authorized under a personal directive to make, on a client's behalf, decisions regarding the client's personal care.

Statutory decision maker: the nearest relative or the public trustee authorized under Section 14 of the *Personal Directives Act.*

Nearest relative: defined in the *Personal Directives Act* (in order of priority): spouse, child, parent, person standing *in loco parentis* ("in the place of a parent"), sibling, grandparent, grandchild, aunt or uncle, niece or nephew, other relative.

Mature minor: a person under the age of majority who, for purposes of consent to treatment or refusal of treatment, can demonstrate an appreciation for the nature and consequences of his/her decision whether or not to consent to a particular treatment.

Healthcare: defined in the *Personal Directives Regulations* as any examination, procedure, service or treatment that is done for a therapeutic, preventative, palliative, diagnostic or other health-related purpose and includes a course of health care or care plan.

Personal Directives Act http://www.gov.ns.ca/legislature/legc/bills/60th_2nd/3rd_read/b163.htm

Personal Directives Regulations http://www.gov.ns.ca/just/regulations/regs/pdpersdir.htm