Advance Care Planning Workbook

Health PEI
One Island Health System

Advance Care Planning Workbook

What is Advance Care Planning?

Advance Care Planning is a process to help you think about and share your thoughts and wishes about your future health care. It helps you to make decisions about your future health care and identify who will communicate your wishes if you are unable to communicate yourself. Advance Care Planning involves having conversations with your health care team to understand your health condition and the care options that are available to you.

This workbook will help you through the Advance Care Planning process. It includes:

- Questions to help you think about the values and beliefs that influence your choice of health care options;
- Definitions of medical terms you will need to know to make informed decisions about your health care options; and
- Other information that may be useful in communicating with your health care team and your family.

Why should I make an Advance Care Plan?

You should make an Advance Care Plan to ensure that your wishes and values are known in the event that you need to receive medical care and are not able to communicate on your own behalf. If you do not have an Advance Care Plan in place, you may receive treatment that is not consistent with your values and preferences.

Having an Advance Care Plan may bring comfort, peace of mind and certainty to you, your family and anyone who may have to communicate your health care wishes on your behalf.

When should I make an Advance Care Plan?

Now. An Advance Care Plan should be made in advance of a crisis or illness that may impair your ability to communicate with your health care team. If you wait too long to complete your Advance Care Plan, you risk not being able to tell your health care team the care you want to have or refuse.

Think About Your Values and Beliefs

In order to think about the values and beliefs that you want reflected in your Advance Care Plan, think about the following questions and write down your thoughts:

What are your values, wishes and goals for your health care?

Do you have personal beliefs that influence your health care goals?

Are there conditions under which you do or do not want a certain treatment?

Where would you want to live and receive care?

Have you had experiences with family or friends receiving certain treatments that have influenced your health care goals?

When you are nearing death, are there things that you are worried about or would wish?

When you are nearing death, are there things that you would like family and friends to know?

Is there someone who you want to speak or make decisions on your behalf when you are no longer capable of communicating for yourself?

Learn About Your Own Health

It is important to talk to your health care providers about any health conditions you may have, how the health conditions will affect you in the future and treatment options that are available. This will help you to understand the health care decisions that you may need to make, and to communicate your future health care wishes to your family and friends.

CPR and Goals of Care

Cardiopulmonary resuscitation (CPR) – This includes medical procedures used to try to restart a person's heart and breathing when the heart and/or lungs stop working. This may include mouth-to-mouth breathing, chest compressions, electric shock and machines that breathe for the individual. CPR's effectiveness depends on the previous health of the person, the cause of the heart stoppage and the speed with which CPR is given after the heart and/or lungs stop working.

People who have many chronic health problems and are elderly are unlikely to benefit from CPR. When someone with many chronic health problems has a heart stoppage, it is usually part of a complex process. Many parts of the body are already affected by disease and a heart stoppage is often the final step in progressive deterioration leading to death.

Comfort care – This approach to care involves medical care for symptom control, maintenance of quality of life and comfort where cure or control of an underlying condition is no longer possible or desired. An individual receiving comfort care has decided that he or she does not want to receive CPR if their heart or lungs stop working.

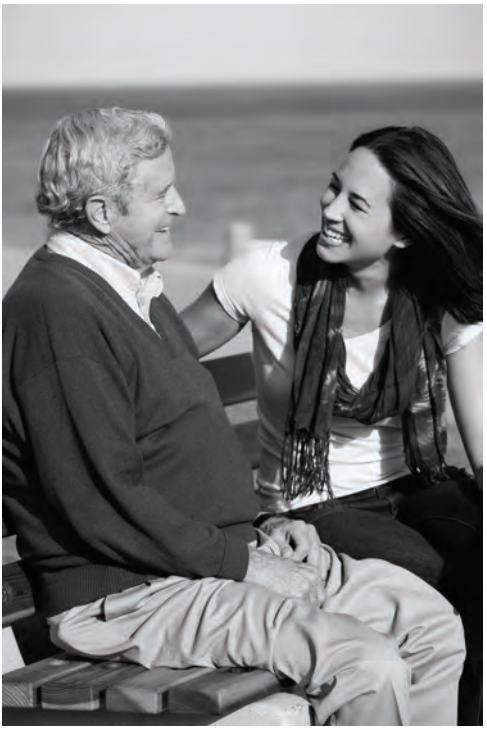
Medical Care and Interventions – This approach to care involves medical care to treat and control illness and symptoms. An individual receiving medical care has decided that he or she does not want to receive CPR if their heart or lungs stop working.

Medical Care and Interventions, including resuscitation – This approach to care involves medical care to treat and control illness and symptoms. An individual receiving this type of care has instructed the health care team that he or she wishes to receive CPR if their heart or lungs stop working.

Communicate Your Values and Beliefs

How can I make my future health care wishes known?

- Talk to your family, friends and health care team about your health care wishes.



Talking with your family, friends and health care team about your health care wishes will let them know what care you are willing to accept or would refuse. It may also reduce the anxiety that family and friends may feel.

Talking to your family members and friends may also give them greater confidence to communicate your wishes to the health care team if you are unable to do so.

Write a Health Care Directive

Writing a Health Care Directive is a legal document (also called a "Living Will") that allows you to identify the health care options that you accept or refuse in your future medical treatment. You can also name one or more individuals as a "proxy" who will have legal authority to provide or withhold consent to medical treatment on your behalf in accordance with your instructions and values.

Health Care Directives

It is strongly recommended that you speak to your health care team before completing a Health Care Directive. This will help ensure that your instructions are clear and understood by those who provide treatment.

A Health Care Directive can be written with or without the assistance of a lawyer. If you decide to have a lawyer help you write your Health Care Directive, we recommend that you speak to the lawyer after you have completed an Advance Care Plan with your health care team. The Advance Care Plan will help your lawyer to understand the Goals of Care that you have identified to your health care team, and help ensure that the Health Care Directive is consistent with those Goals of Care.

The following may be helpful in understanding and completing a Health Care Directive:

"Health Care Directives", Community Legal Information Association of PEI

(Available at ***www.cliapei.ca*** or (902)-892-0853 or 1-800-240-9798)

"Prince Edward Island Health Care Directive Form" (Available at ***www.cliapei.ca***)

Communicate and update your instructions

Your wishes for health care treatment may change over time or in response to your health condition. It is important that you talk to your family, friends and members of the health care team about any changes that you wish to make in your Advance Care Plan so that they can ensure that you receive appropriate care. You can change your Advance Care Plan as long as you are able to make your own decisions about your health care. Your health care team members will also reconfirm your wishes with you if your health situation changes.

Questions?

How can I start making my Advance Care Plan?

You can start by thinking about what your values and beliefs are with regard to future health care treatment and writing them down. You should also communicate those values and beliefs to your friends, family and health care providers.

Who do I speak to regarding an Advance Care Plan?

You can speak to your friends, family, lawyer and health care providers. If you are being admitted to a public long-term care facility, your health care providers will ask you about making an Advance Care Plan to ensure that they understand your goals of care.

Should I be speaking to anyone about an Advance Care Plan if I'm not sure what types of future health care I want?

Yes. Having a conversation about Advance Care Planning may help you determine what your goals are for your future health care.

Do I need to make an Advance Care Plan?

No. It is recommended to make an Advance Care Plan so that your health care providers and substitute decision maker(s) know your preferences for health care treatment.

Do I need to have a Health Care Directive?

No. However, you may wish to have a Health Care Directive to appoint someone to make health care decisions on your behalf in the event that you become incapable of providing or refusing your consent for health care treatment. You can also use a Health Care Directive to direct your substitute decision maker with respect to the types of treatment that you consent or refuse to consent to.

Who can assist me in making a Health Care Directive?

There is no restriction on who can help you make a Health Care Directive. We recommend that you speak to a lawyer or other person who has appropriate knowledge about Health Care Directives before you make a Health Care Directive.

What is the difference between an Advance Care Plan and a Health Care Directive?

An Advance Care Plan is a record of your health care preferences that is made while you are capable of providing consent to health care treatment. An Advance Care Plan does not provide authority for any treatment, nor does it authorize anyone to act as your substitute decision maker.

A Health Care Directive is a legal instrument, similar to a will or power of attorney, that is made while you are capable of providing consent to health care treatment. In your Health Care Directive, you can appoint a substitute decision maker and specify medical procedures for which you provide consent or refuse consent. A Health Care Directive comes into effect when you lose capacity to provide consent to health care treatment. Consent provided in a Health Care Directive does provide authority for treatment.

What happens if I make an Advance Care Plan but change my mind in the future?

You can change your mind at anytime. If you do change your mind, you should advise your friends, family and health care providers so that they know what your new goals of care are.

This resource was adapted from the Winnipeg Regional Health Authority –

"Advance Care Planning: Have a Say in Your Health Care"

Notes

CANADA

Design and Printing: Communications PEI
2013

13HPE41-36850