My Advance Care Plan

This Advance Care Plan Belongs To: _____

I have reviewed and updated **My Advance Care Plan** on the following dates:		

Interior Health

810375 Apr 3-24

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Land Acknowledgement

Interior Health recognizes and acknowledges the traditional, ancestral, and unceded territories of the Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, Syilx, and Tŝilhqot'in Nations where we live, learn, collaborate and work together.

What is Advance Care Planning?

Advance care planning (ACP) starts with you; it is about thinking ahead, discussing and writing down what's important to you so your loved ones and health care team can honour your wishes if you are unable to speak for yourself. It can begin at any stage of life and can be revisited throughout your life journey.

My Advance Care Plan Workbook Instructions

This **My Advance Care Plan** workbook is yours; it will guide you through the 5 steps of ACP with prompting questions to assist you in completing your own advance care plan.

Take your time going through the workbook; it does not need to be completed all at once. You may need to do some research, talk with others or seek some advice before completing a specific step. Remember, the information you write today, can be changed as your life circumstances change.

Share a copy, or portions of this workbook, and/or its location with a trusted loved one, ideally your Substitute Decision Maker (see page 11), and/or your health care provider (e.g. doctor, clinic nurse, social worker). You can also keep it with your Greensleeve (see page 16).

Please download this workbook and save it to your computer before you type in your answers. This workbook is also available in hardcopy. You can request one by contacting your local Home and Community Care office.

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5 Steps of Advance Care Planning

The following 5 steps are part of Canada's national ACP framework to guide people through the ACP process.

THINK about your values, beliefs, wishes and goals of care.

LEARN about your health, medical care options and the role of a Substitute Decision Maker (SDM).

DECIDE what health care you want to accept or refuse, and who will be your SDM.

TALK about your wishes with your loved ones, SDM and health care providers.

RECORD your wishes by writing them down in this workbook. Keep all your ACP documents together and let your SDM know where they can be found. This recorded information becomes your Advance Care Plan.

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Common ACP Documents in British Columbia

Below is a brief description of important documents related to ACP in the province of B.C. Review and decide which documents you need to complete to ensure your wishes and instructions are known and will be honoured. It is recommended to seek legal advice to review the unique authority of each document and ensure all legal requirements are met.

Advance Care Plan: A document(s) that records your specific personal and health care wishes and instructions.

Advance Directive: A legally binding document that states what health care you give consent or refusal to, in advance.

Enduring Power of Attorney: A legal document in which you appoint one or more persons to handle your financial and legal affairs. It is valid while you are capable of making your own decisions and remains valid if you become unable to make your own decisions.

Medical Orders Scope of Treatment (MOST): A MOST is a medical order, completed by your physician or nurse practitioner, to let your health care team know what level of care you wish to receive. Each Health Authority in B.C. has their own MOST form.

Representation Agreement Section 7 (Rep 7): A legal document in which you appoint a representative to help make decisions on your behalf regarding personal care, health care and may also include routine management of financial and legal affairs.

Representation Agreement Section 9 (Rep 9): A legal document in which you appoint a representative to help make decisions on your behalf regarding personal care or health care, including living arrangements, participation in activities, and giving or refusing consent to life preserving health care.

Will: A will is a legal document that you complete that provides direction on what to do with your property and belongings, any care needs of dependents, e.g. minor children, other dependents, pets, and other wishes and instructions for after you die.

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ACP Is For Everyone Graphic

The graphic below represents the ACP process and possible stages of a person's health journey. The nautical theme reflects the beautiful and unique nature of British Columbia with each wave representing progressive changes in a person's health condition: *Thinking Ahead, Health Event, Chronic Illness or Injury Progression, Advancing Illness, and End of Life*.

The ebb and flow of water can be reflective of one's own health journey, as well as their comfort with embracing aspects of ACP. The waves have various icons that speak to one of the recurring **5 Steps of ACP: Think, Learn, Decide, Talk and Record**.

Reflecting Questions...

Here are some questions to consider as you explore ACP through the various waves and identify where you currently imagine yourself being on the graphic.

ACP Is For Everyone: Are you like the people on the shore who are just starting to think about ACP? Have you ever had a conversation with someone about ACP?

Thinking Ahead: What makes your life meaningful? How would your beliefs and values impact your health care decisions? Have you written these down? Do you know what legal forms would be needed to communicate your wishes if you couldn't speak for yourself?

Health Event: If you received a new diagnosis or had a serious injury who would you talk with to learn more? Who would you trust to be your Substitute Decision Maker (SDM) and speak on your behalf? Have you recorded your goals of care?

Chronic Illness or Injury Progression: Have you noticed changes in your health? Have you spoken with your health care provider about them? Do these changes impact previous ACP decisions you've made? If so, have you talked with your SDM and loved ones about these decisions?

Advancing Illness: With advancing illness, have your health goals and priorities changed? Have you shared these with your SDM? Does your Advance Care Plan or Advance Directive need to be updated? Have you spoken with your health care provider about MOST? Would you want all available care to prolong your life?

End of Life: What does a good death mean to you? When you think about dying are there things you worry about? If you were nearing death, what would you want to make things most peaceful for you? Do you have any spiritual, cultural or religious beliefs that would affect your care at the end of life?

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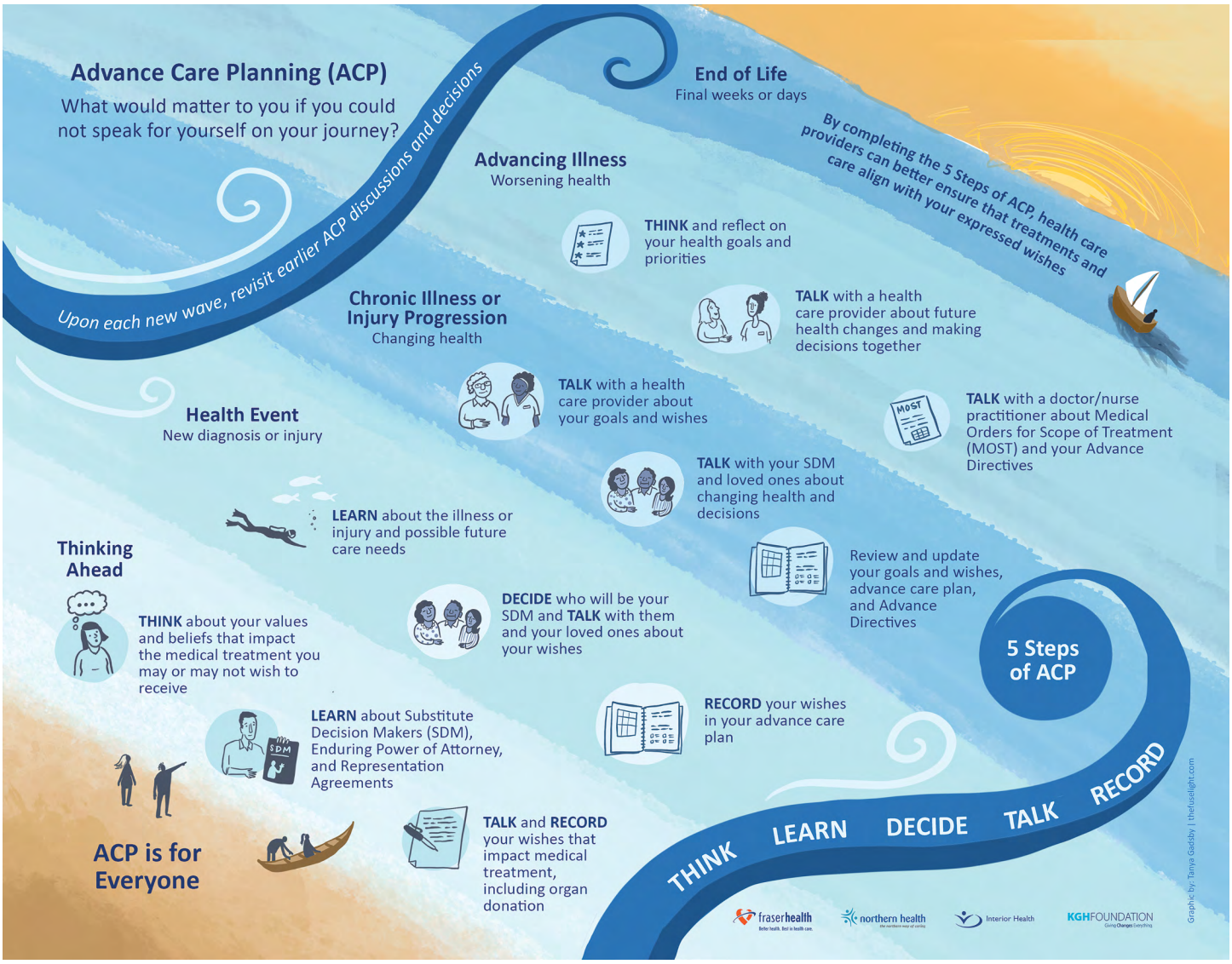

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Step 1: **Think**

Thinking about what is important to you can help you make decisions related to your health. Think about your values, beliefs, wishes and what type of care you may or may not want to receive. Taking time to identify what matters most to you can help guide and understand your feelings, behaviours and choices.

What makes my life meaningful?

Values are based on our personal ethics and/or ideals that help guide our decision-making process. Some values influence our lives more than others. A core value is a belief or personal priority so deeply held that it would cause you to make a life-changing decision. Select your top five core values or fill in your own. Some of the unselected values may still be very important to you, but they may not be a core value that guides all you do.

- ☐ Authenticity
- ☐ Autonomy
- ☐ Balance
- ☐ Compassion
- ☐ Community
- ☐ Courage
- ☐ Fairness
- ☐ Faith
- ☐ Family
- ☐ Friendships
- ☐ Fun
- ☐ Growth
- ☐ Happiness
- ☐ Honesty
- ☐ Humour
- ☐ Inner Harmony
- ☐ Integrity
- ☐ Kindness
- ☐ Knowledge
- ☐ Love
- ☐ Loyalty
- ☐ Openness
- ☐ Optimism
- ☐ Recognition
- ☐ Religion
- ☐ Reputation
- ☐ Respect
- ☐ Spirituality
- ☐ Stability
- ☐ Trust
- ☐ _____
- ☐ _____
- ☐ _____

Three things I hope to do before I die:

1. _____
2. _____
3. _____

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I would find certain health situations difficult to live with, e.g. loss of memory, constant pain, not being able to speak, being bedridden, etc.

To me, “quality of life” means...

If I were nearing death, what would I want to make the end more peaceful for me? (e.g. location, chosen family, friends or pets nearby, music, spiritual practices, etc.)

Think about who you would trust to make decisions on your behalf if you couldn’t speak for yourself. Think about how you would like to approach this topic.

Ask yourself, ‘Who knows me really well? Who can I talk with about what matters most to me and my health care wishes?” See page 11 for more information on Substitute Decision Makers.

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Step 2: **Learn**

Learn about your health, medical care options and the role of a Substitute Decision Maker (SDM). Planning early gives you the time you need to carefully identify your choices, needs and preferences, as well as time to complete important legal documents.

What are my current health concerns and questions?

Regarding my condition and treatment, I'd like to know (select a circle along the scale)...

○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○

Only the basics — All the details

I have a current MOST (Medical Orders for Scope of Treatment)

○ Yes ○ No ○ Don't Know ☐ I need to learn more about MOST

I would like to learn about the following medical interventions: (check all that apply)

- ☐ CPR (Cardio-pulmonary resuscitation)
- ☐ Tube feeding
- ☐ Intubation
- ☐ Defibrillation
- ☐ Life support machines
- ☐ Dialysis
- ☐ Organ transplant/donation
- ☐ Blood transfusion
- ☐ Artificial hydration and nutrition
- ☐ _____
- ☐ _____
- ☐ _____

I need to learn about: (check all that apply)

- ☐ Advance Directive
- ☐ A Will
- ☐ Enduring Power of Attorney
- ☐ Substitute Decision Makers
- ☐ Representation Agreement section 7
- ☐ Representation Agreement section 9
- ☐ _____
- ☐ _____
- ☐ _____

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Step 3: **Decide**

Decide what health care you may want to accept or refuse, and who you would choose to speak for you if you couldn't speak for yourself. Remember your decisions may change over time. If they do, be sure to update your **My Advance Care Plan**.

How do I usually make health care decisions?

☐ By myself ☐ With others ☐ Others decide for me ☐ _____

When it comes to sharing information about my health with others (select a circle along the scale)...

○ . . . . . ○ . . . . . ○ . . . . . ○ . . . . . ○

I don't want those close to me to know all the details about my health

I am comfortable with those close to me knowing all the details about my health

Here are my reflections about medical interventions I may or may not want (consider the interventions listed in Step 2).

If I wasn't able to speak for myself, I would want the people I trust to follow all my wishes or do what they think is best in the moment based on the information available at the time. (select a circle along the scale)?

○ . . . . . ○ . . . . . ○ . . . . . ○ . . . . . ○

I want them to do exactly what I've said, even if it makes them uncomfortable

I want them to do what they believe is best for me, even if it's different from what I've said

If I am diagnosed with a serious illness that could shorten my life, I would prefer (select a circle along the scale)...

○ . . . . . ○ . . . . . ○ . . . . . ○ . . . . . ○

Not to know how quickly it is progressing or the best estimation for how long I have to live

To understand how quickly it is progressing and the best estimation for how long I have to live

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If I was seriously ill or near the end of my life, how much medical treatment would I feel was right for me (select a circle along the scale)?

○ . . . . . ○ . . . . . ○ . . . . . ○ . . . . . ○

I would want to try every available treatment to extend my life, even if it's uncomfortable

I would not want to try treatments that impact my quality of life in order to extend my life

Where would I prefer to be toward the end of life (select a circle along the scale)?

○ . . . . . ○ . . . . . ○ . . . . . ○ . . . . . ○

I strongly prefer to spend my last few weeks or days in a hospice or hospice-like environment

I strongly prefer to spend my last few weeks or days at home

After my death I want to be:

- ☐ Cremated
- ☐ Buried
- ☐ I would like my remains to be placed: _____

I have made the following decision regarding organ donation:

- ☐ Yes, I want to donate my organs with no restrictions
- ☐ Yes, I want to donate my organs but with some restrictions _____
- ☐ No, I do not want to donate my organs
- ☐ I need more information to make a decision.

BC Transplant (http://www.transplant.bc.ca/organ-donation/register-as-an-organ-donor)

People legally appointed to make health care decisions on behalf of others who are not capable of making their own decisions are called Substitute Decision Makers (SDMs). A SDM is appointed by completing a Rep 7 or Rep 9 Agreement (see page 4). A Temporary Substitute Decision Maker (TSDM) is chosen by the health care team if you have not completed a Rep 7 or Rep 9, or if your SDM is unavailable.

The TSDM is chosen from an ordered list that is determined by B.C. law. A TSDM must be 19 or older, be able to understand and make an informed-decision, have no dispute with you, and have been in contact with you in the past year.

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In the absence of a completed Rep 7 or Rep 9 Agreement, or if the SDM is unavailable, the health care provider will contact the individuals in the exact order below:

1. Your spouse (married or common-law)
2. An adult child (19 or older, birth order doesn't matter)
3. A parent
4. A sibling (birth order doesn't matter)
5. A grandparent
6. A grandchild (birth order doesn't matter)
7. Anyone else related to you by birth or adoption
8. A close friend
9. A person immediately related to you by marriage.

Even if you have appointed a SDM it is advisable to complete the ***My Temporary Substitute Decision Maker List*** *on page 17 to ensure contact information is available for the health care team.*

A person lower down on the list may only be chosen as your TSDM if all the people above them do not qualify or are not available. If you know that you want someone lower on the list to make your health care decisions, then you should legally name that person as your representative using a Rep 7 or Rep 9 form (see Step 2).

I've decided who my Substitute Decision Maker is for the Representation Agreement.

☐ Yes: Name _____ Phone _____

☐ No

Check the appropriate box below for legal documents that express your wishes and guide your loved ones and health care team to support you.

	Complete	Incomplete	Not Applicable
Advance Directive	☐	☐	☐
A Will	☐	☐	☐
Enduring Power of Attorney	☐	☐	☐
MOST (Medical Orders Scope of Treatment)	☐	☐	☐
Representation Agreement section 7	☐	☐	☐
Representation Agreement section 9	☐	☐	☐

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Step 4: **Talk**

As shown in the ground-breaking Advance Care Planning Video Love is Not Enough, we can't assume that our loved ones know what matters most to us if we don't talk with them about it.

Having early, important conversations with loved ones and health care providers helps them make the right decisions for you if you are unable to speak for yourself. These conversations can help you feel less anxious and more in control of your health and well-being.

These are not one-time only conversations. As your health, wishes and life circumstances may change over time it is important to keep talking! As you prepare to have these conversations here are a few tips for getting started.

When talking with a loved one, choose a time that won't feel rushed or be interrupted. Select a place that is comfortable for you; it may be at the kitchen table, at a restaurant or during a walk.

Here are a few tips to help you prepare for the conversation:

- You can consider having a practice conversation so you feel as prepared as possible to have a "real" conversation.
- You don't have to talk about everything or talk to everyone in the first conversation. In fact, we suggest you keep talking over time!
- Be patient. Some people are nervous or may need time to get ready to talk.
- Every time you start a conversation it helps you come closer to making your wishes fully known. Keep trying.
- You don't have to lead the whole conversation; it's important to also listen to what the other person says so they can ask questions and you can build trust and understanding.
- Nothing you say is permanent. You can always change your mind as life's circumstances change over time.
- You may find out during these conversations that you and your loved ones disagree. It is natural to have some disagreement, and is important to know ahead of time so that you can be clear about your wishes.

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Here are a few conversation starters that the organization Advance Care Planning Canada has suggested:

Be Straight Forward: I need your help with something...

Knowledge Share: I was at a workshop today and I would like to share what I learned.

Reflection: I was thinking about what happened to _____ and it made me realize...

Proactive Planning: Right now, I'm healthy, but I want to think ahead and be prepared if something unexpected should happen ...and how we might want to handle that situation.

What Matters Most: I think it's really important that people who matter to me know what's important to me about my health care and my quality of life.

In The Moment: Right now. I'm living with _____ illness, and I expect _____ . Is this what you understand too?

Clarification: I want to make sure you understand and could honour my wishes.

Thinking Ahead: I want you to be prepared if you had to make decisions on my behalf.

When talking with a health care provider, ask for an extended appointment so there is enough time to discuss your advance care plan. You may find it useful to come to the appointment with a list of questions that will help inform your decisions. You may need to schedule more than one appointment with your health care provider.

What questions do I have for my health care provider?

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Who do I want to talk with about **My Advance Care Plan**? Who needs to know what matters to me regarding my health care? Check all that apply:

- ☐ Parent(s)
- ☐ Spouse/partner
- ☐ Chosen family member(s)
- ☐ Adult child/children
- ☐ Faith leader (minister, priest, rabbi, imam, etc.)
- ☐ Trusted friend(s)
- ☐ Doctor(s)
- ☐ Nurse practitioner/nurse(s)
- ☐ Social worker
- ☐ _____
- ☐ _____
- ☐ _____

What are the most important things I want to share during my conversations?

Here is a list of some other things you may want to talk about.

- Do you have any worries about your health?
- What do you need to address to feel more prepared (e.g. finances, property, legal documents, relationships, living arrangements, social media accounts, etc.)?
- Do you have any fears, concerns, or mistrust about where or how you receive health care?
- Who do you want (or not want) to be involved in your health care?
- When you look ahead to the future, are there important events or dates you hope to be present for?
- Are there kinds of treatment you would want or not want (e.g. resuscitation attempts, ventilation, feeding tube)?

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Step 5: **Record**

This step highlights the importance of recording your thoughts, reflections and decisions. Take a moment to congratulate yourself on working to complete your own **My Advance Care Plan**!!

This workbook, along with related documents (see page 12), should be kept together in a safe place. You can save them electronically on your computer or store printed copies in your home, or both.

Remember to share all, or portions of, your **My Advance Care Plan** workbook with people who need to know your wishes, or tell them where they can find it in your home. It's important to update your **My Advance Care Plan** if your health or life circumstances change.

What is a Greensleeve?

A Greensleeve is a green, plastic folder that can hold your important Advance Care Planning documents. It is best to keep your Greensleeve on, in or around your refrigerator as this is where paramedics are trained to look if they are called to an emergency. The Greensleeve is meant to be taken with you to clinic appointments or hospital visits so that health care providers know your wishes, advance directive and/or goals of care.

You can obtain a Greensleeve by asking a health care provider at a Home and Community Care office, or by emailing advancecareplanning@interiorhealth.ca and providing your mailing address.

Some important papers you may wish to keep in or with your Greensleeve are:

- **My Advance Care Plan**
- Representation Agreement(s)
- Copy of your Medical Order for Scope of Treatment (MOST)
- Advance Directive

If your advance care planning documents do not all fit in your Greensleeve, it is recommended that they be kept together.

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My Temporary Substitute Decision Maker List

	Name	Phone
Spouse (includes married or common-law)		
Adult Children (birth order does not matter)		
Parents		
Siblings (birth order does not matter)		
Grandparents		
Grandchildren		
Anyone else related to me by birth or adoption		
Close Friends		
Person(s) related by marriage		

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Additional Notes

You may wish to write down other thoughts, questions or wishes you may have regarding your advance care plan documents, including any steps you need to take to complete a Will.

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Advance Care Planning Resources

Speak with your Physician or Nurse Practitioner, call your local Interior Health Community Care Office or visit the following websites to learn more about ACP.

Government of BC: Wills and Estate Planning Information

Indigenous Health ACP Resources

Interior Health ACP Resources

Interior Health MOST and Goals of Care

BC Transplant

Advance Care Planning Canada

Living My Culture

Interior Health ACP Contact Info

For more information please email advancecareplanning@interiorhealth.ca

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