

Advance Care Planning Resources

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

Aboriginal Health ACP Resources:

In your web browser search: 'FNHA Advance Care Planning'

Interior Health ACP Resources:

In your web browser search: 'Interior Health Advance Care Planning'

Interior Health MOST and Goals of Care

In your web browser search: 'Interior Health MOST and Goals of Care' (*MOST & Goals of Care Graphic*)

Provincial ACP Resources:

In your web browser search: 'Advance Care Planning BC' (*My Voice Booklet*)

National ACP Resources:

www.advancecareplanning.ca

www.livingmyculture.ca/culture/

Interior Health ACP Contact Info

For more information please email
advancecareplanning@interiorhealth.ca



Interior Health

Advance Care Planning Is For Everyone



Advance Care Planning 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 for the future.

Advance care planning (ACP) starts with you. It can begin at any stage of life and be revisited throughout your life journey. ACP is thinking about and writing down your wishes or instructions for personal and health care needs. It involves reflecting on spiritual, cultural, emotional and mental aspects of your well-being and how these topics guide your own advance care planning. These wishes or instructions are then written into an advance care plan.

Talk with your loved ones and health care team about the care or treatment you do or do not want to receive. Do not assume they know what you want if you are not able to speak for yourself.

Having conversations about ACP and end of life care may feel uncomfortable or awkward and may often be avoided. There may even be a fear of initiating the conversation. Talking with your loved ones about ACP should start long before there is a health crisis.

Together we can make these conversations easier. We can ensure that our own wishes, and those of the people who matter most to us are both understood, communicated and respected.

ACP Is For Everyone Graphic

The enclosed graphic represents the ACP process and possible stages of a person's health journey. The nautical theme of the graphic represents the beautiful and unique nature of British Columbia. Each wave represents 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 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.**

5 Steps of Advance Care Planning

The following 5 steps are part of Canada's national ACP framework and reflect the ACP process of repeated conversations, reflections and the revisiting of previous decisions based on changing needs and choices.



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 or making an audio/video recording. This recorded information becomes your Advance Care Plan.

Advance Care Planning (ACP)

What would matter to you if you could not speak for yourself on your journey?

Upon each new wave, revisit earlier ACP discussions and decisions

Advancing Illness

Worsening health



THINK and reflect on your health goals and priorities



By completing the 5 Steps of ACP, health care providers can better ensure that treatments and care align with your expressed wishes

TALK with a health care provider about future health changes and making decisions together

Chronic Illness or Injury Progression

Changing health



TALK with a health care provider about your goals and wishes



TALK with your SDM and loved ones about changing health and decisions



TALK with a doctor/nurse practitioner about Medical Orders for Scope of Treatment (MOST) and your Advance Directives

Health Event

New diagnosis or injury



LEARN about the illness or injury and possible future care needs



DECIDE who will be your SDM and **TALK** with them and your loved ones about your wishes



Review and update your goals and wishes, advance care plan, and Advance Directives

5 Steps of ACP

THINK

LEARN

DECIDE

TALK

RECORD

Thinking Ahead



THINK about your values and beliefs that impact the medical treatment you may or may not wish to receive



LEARN about Substitute Decision Makers (SDM), Enduring Power of Attorney, and Representation Agreements



RECORD your wishes in your advance care plan



TALK and **RECORD** your wishes that impact medical treatment, including organ donation

ACP is for Everyone



Reflecting Questions...

Here are some questions to consider as you explore ACP through the various waves 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?

Common ACP Documents in British Columbia

Below is a brief description of important documents related to ACP in the province of B.C. It is recommended to seek advice and guidance on the unique authority of each document and how they work together.

Review and decide which documents you need to complete to ensure your wishes and instructions are known and will be honoured. You may wish to seek legal guidance to be sure your completed documents meet legal requirements.

Advance Care Plan: A document(s) that records your specific 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: 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: 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.