MY ADVANCE CARE PLAN

Advance Care Planning (ACP)

Advance care planning (ACP) is the process of thinking about, discussing, and writing down your wishes about the type of medical care and treatment you want to receive in the future. In particular, towards the end of your life or when you are not able to make your own decisions.

It's a good idea to think about advance care planning now, before you become seriously ill or injured. It's especially important to think about and discuss advance care planning if you have a terminal condition, are very frail, or have strong opinions about how and where you are treated at the end of your life.

My Advance Care Plan

You may wish to complete an advance care plan to document your preferences and wishes for health care at the end of your life. An advance care plan should be completed with the help of your GP or specialist, and be the result of your thoughts and discussions with your family and loved ones.

Your GP or specialist can explain to you the details of medical treatments for the very ill or injured, and talk you through the benefits and risks of these treatments. If you wish, they can lodge your advance care plan on your electronic record, to be shared with other clinicians if and when it's needed (for example, if you are seriously injured or unwell and in hospital).

It's very important that, if you make a plan, you give copies to your family and loved ones. You should also keep a copy somewhere that you and those who live with you know about, e.g. with your enduring power of attorney document, will, and other important documents.

Important: Your advance care plan will only be used if you are not capable of making your own decisions and speaking for yourself.

Next Steps

If you are thinking about advance care planning, you should take the following actions:

1. Read the Advance Care Planning Guide (see www.advancecareplanning.org.nz).
2. Spend some time thinking about what values and beliefs around end-of-life issues are important to you, and consider discussing this with your family and loved ones. Specific issues to consider include:
   - Do you have a strong preference about where you die?
   - Do you have any specific religious beliefs or spiritual issues?
   - What concerns or fears do you have regarding the end of your life?
   - Do you wish for your organs and/or tissues to be donated, if possible, when you die?
3. Read through both **Part A** and **Part B** of the following My Advance Care Plan to understand what information will be needed to complete a plan.
4. Fill out **Part A**, either by hand or using the electronic form (see the next page).
5. Make an appointment to discuss advance care planning with your GP or specialist.

   Note. It is important to let your practice know in advance that your appointment is for an ACP discussion. This will help to ensure that the appointment is long enough. It will also give your GP the chance to prepare before you arrive. Your ACP discussion with your GP might require more than one appointment. Advance care planning is relatively new to Canterbury, and not all general practice teams currently offer this service.

6. Consider making a will and appointing an enduring power of attorney.

Completing the Advance Care Plan

Complete as many of the sections in **Part A** as you can (four pages).

You should complete **Part B** of the plan with the help of a health professional because they have to sign that you are competent to make these decisions. Competency is a legal term meaning that you can fully understand the decisions you are making. If you don't get a health professional to sign the plan, other doctors might question your ability to make these decisions.

You will need to sign your Advance Care Plan when it is finished and you are happy with it. Once signed, saved and shared, you can keep a printed copy and share it with anyone you want to. You need to keep a record of who has copies, so that you can change all of the copies in the future if you want.

Options

Either:

- Print the Advance Care Plan, complete **Part A** by hand, and take it with you to your appointment with your GP or specialist.

Or:

- Complete **Part A** of the electronic form (see below) and save it to your computer. Either print the finished document and take it with you, email it to your GP or specialist, or save it to a portable drive (e.g. pen drive, CD or DVD) and take it with you. Remember that email is not totally secure.

Using the Electronic Form

This electronic form is to help you get started writing your Advance Care Plan. It is not the final plan to be shared with others.

You should download the form to your computer before filling it out. You can also save the form to your computer as many times as you like as you fill it out.

The form is designed to be used with Adobe Reader. If you don't have Adobe Reader, or need to update your version, go to http://get.adobe.com/reader/ to install a free copy.

If you need more room than the boxes on the form provide, then the best option is to print out the form and complete a handwritten copy.

MY ADVANCE CARE PLAN

Part A

Name | Date of Birth | or NHI

I have had the chance to think about the health care I want, including towards the end of my life, and this plan represents my wishes. I would like the health professionals caring for me, and my family/whanau and friends to know these things when I can no longer speak for myself. For further information, see www.healthinfo.org.nz/Advance-care-planning-ACP.htm.

I am aware that this plan must be made by me, not for me. I can change or cancel it at any time, and am aware that it needs to be kept up to date.

I am aware that Part B should be written in conjunction with a trusted health professional.

I understand that within the Canterbury Region this plan can be made available to all health professionals who are involved, or become involved, in my care.

☐ I have **not** appointed an Enduring Power of Attorney for personal care and welfare.

☐ My appointed Enduring Power of Attorney for personal care and welfare is:

First Name(s) | Last Name

Relationship

Address

Home Phone | Daytime Phone | Mobile

Remember to save the form

MY ADVANCE CARE PLAN

Part A

☐ I would like the following people contacted by health professionals when decisions are made about my care / treatment. These people know me well and understand what is important to me:

First Name(s)

Last Name

Relationship

Phone

Address

First Name(s)

Last Name

Relationship

Phone

Address

First Name(s)

Last Name

Relationship

Phone

Address

☐ I **have** made a Will

☐ I have **not** made a Will

Remember to save the form

MY ADVANCE CARE PLAN

Part A

I am currently receiving care and treatment for the following health condition(s):
(State "not applicable" if your health status is good)

I expect that the following things may occur in the future with respect to my health:

If decisions about my health care are required and I can no longer tell you myself, I would like people to know:

The following things are important to me and make my life meaningful:
(Include people, pets, personal values, spiritual issues, religious beliefs, and anything else that is important)

The following things worry or concern me:
(Include family concerns, hopes and fears, emotional issues and anything else you want)

I would like my family and friends to know and remember these things:

Remember to save the form

MY ADVANCE CARE PLAN

Part A

I understand that when I am dying my comfort and dignity will always be looked after.

In addition: (Please choose all that apply)

- ☐ I would like food and drink to be offered for as long as I can manage them without distress
- ☐ I would like treatments, including medications, not adding to my comfort to be stopped
- ☐ I would like my family and friends to be with me
- ☐ I would like to have my spiritual and / or religious beliefs attended to

Comments:

My preferred place of care when I am dying is (please choose one):

- ☐ home / place of residence
- ☐ hospice / residential care facility
- ☐ hospital
- ☐ no preference

Comments:

If my organs and / or tissues could be made available or donated for transplantation:

- ☐ I **would** wish this to happen
- ☐ I would **not** wish this to happen
- ☐ I am happy for my family / friends as listed on pages 1 and 2 to make the decision

Comments:

Remember to save the form

MY ADVANCE CARE PLAN

Part B

This section should be completed with the help of a health professional. For advice on completing this section, see www.healthinfo.org.nz/Advance-care-planning-ACP.htm.

If I am seriously ill or have a potentially life-threatening illness or injury and am unable to make decisions for myself, the following best describes my preferences. I understand this does not require health professionals to provide treatments which will not be of benefit.
(Please choose **only one** of the numbered options)

☐ 1. I wish my treatment to be aimed at preserving and prolonging my life. I would accept **all** available treatments and hospital admission.

If required and appropriate, I would want cardio-pulmonary resuscitation to be attempted:

Yes

No

Comments:

☐ 2. I wish to receive tests and treatments aimed at improving my comfort and providing a quality of life that I would find acceptable. I understand that these treatments may also prolong my life although this is not the main priority for my care. Since the focus of care is quality of life, I understand that cardio-pulmonary resuscitation will not be attempted.
(please choose one of the two options below)

I am happy to be admitted to hospital where this is necessary to achieve the best outcome.

I prefer to be treated in my home / place of residence and not be admitted to hospital unless it is necessary for my comfort. I accept that this will limit the type of treatments I can receive.

☐ 3. I would like to receive only those treatments which look after my comfort and dignity. I do not wish to receive any treatment aimed at prolonging my life. I understand this means that cardiopulmonary resuscitation will not be attempted. Provided my comfort and dignity can be adequately looked after I would like to remain in my preferred place of care.

☐ 4. I wish the health professionals caring for me to make decisions on my behalf taking account of what matters to me and, where possible, in close consultation with the individuals I have listed on pages 1 and 2.

☐ 5. None of these options accurately represents my wishes
(see Specific Treatment and Care Preferences below).

MY ADVANCE CARE PLAN

Part B

Specific Treatment and Care Preferences:

I have completed this section with the help of a health professional who has provided guidance as to the types of treatments that might be considered in my situation and the likely benefits they will provide as well as potential risks. If I have left this section blank, it is because I have no preferences.

Examples of circumstances include persistent vegetative state, cardiac arrest, worsening of heart failure, advancing incurable cancer, etc. Goal of Care refers to the overall aim of treatment. Examples include recovery, independence, comfort, allowing natural death, etc.

In the following circumstance:	I would like the **goal of care** to be:	I would **accept** the following treatment:	I would wish to **refuse or stop** the following treatment:
(example) Cardiac Arrest	to allow natural death	comfort measures	Cardiopulmonary resuscitation

MY ADVANCE CARE PLAN

SIGNATURES

1. I understand that this is a record of my preferences to guide the health professionals caring for me in providing appropriate care for me.
2. I understand that it will only be used when I am unable to make decisions for myself.
3. I understand that my wishes will be taken into account but cannot require health professionals to provide treatments that will not benefit me or are not available or are currently unlawful.
4. I understand that my decision to refuse specific treatments will ordinarily be followed.
5. I acknowledge that this record will be held in an electronic format and made available to other healthcare providers for the purposes of treating me. I understand that I can opt out of this by selecting opt out:

❑ Tick to opt out

Name _____

Address _____

Home Phone _____ Mobile _____

Signature _____ Date _____

We have discussed this plan and I as a health professional believe this person is competent to make these plans for the future and is making these choices voluntarily and based on adequate information.

First name _____ Last name _____

Designation _____

Facility / Organisation _____

Address _____

Phone _____

Signature _____ Date _____