

ADVANCE CARE PLANNING

CONVERSATIONS
MATTER

GOALS OF CARE
DESIGNATIONS

First Fasten Your Own Seatbelt: Doing Your *Own* Personal Directive

Welcome!



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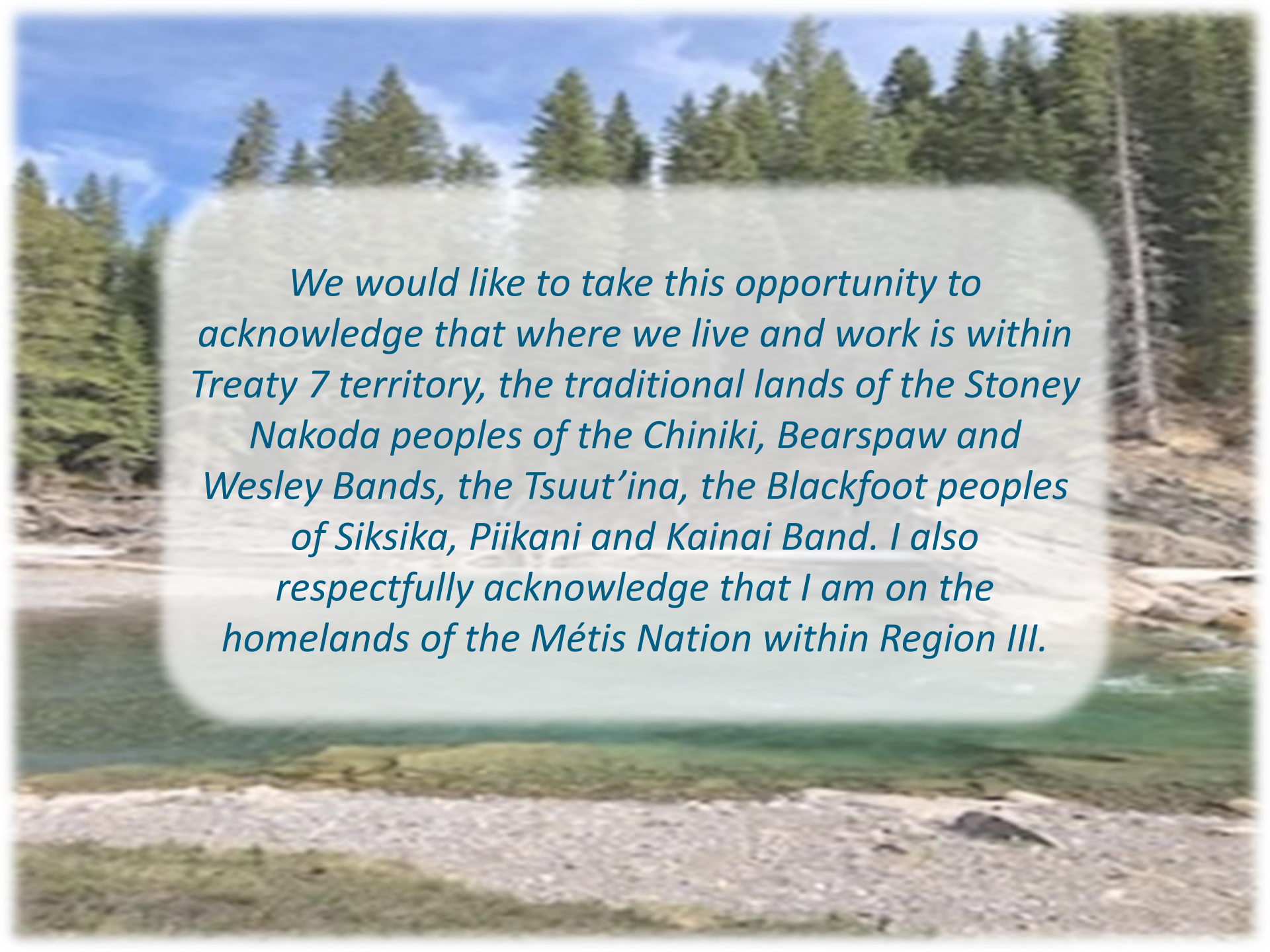
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Virtual Housekeeping

- Please Mute.
 - Address questions at the end.
 - Office of the Public Guardian – Personal Directive form :
 - [Office of the Public Guardian and Trustee \(OPGT\) | Alberta.ca](#)
 - [Personal directive | Alberta.ca](#)
-

A scenic landscape featuring a river in the foreground, a dense forest of evergreen trees in the middle ground, and mountains in the background under a clear blue sky. The text is overlaid on a semi-transparent white rounded rectangle in the center of the image.

We would like to take this opportunity to acknowledge that where we live and work is within Treaty 7 territory, the traditional lands of the Stoney Nakoda peoples of the Chiniki, Bearspaw and Wesley Bands, the Tsuut'ina, the Blackfoot peoples of Siksika, Piikani and Kainai Band. I also respectfully acknowledge that I am on the homelands of the Métis Nation within Region III.

National Advance Care Planning Day April 16th

Advance Care Planning Day

April 16 | #ifnotyouwho

Learn more at advancecareplanning.ca/acpday



If not you, **who?**
Si pas vous, **qui?**

La journée nationale
de la planification
préalable des soins

16 avril | #sipasvousqui

Apprenez-en plus à planificationprealable.ca/journeepps

Today's topics

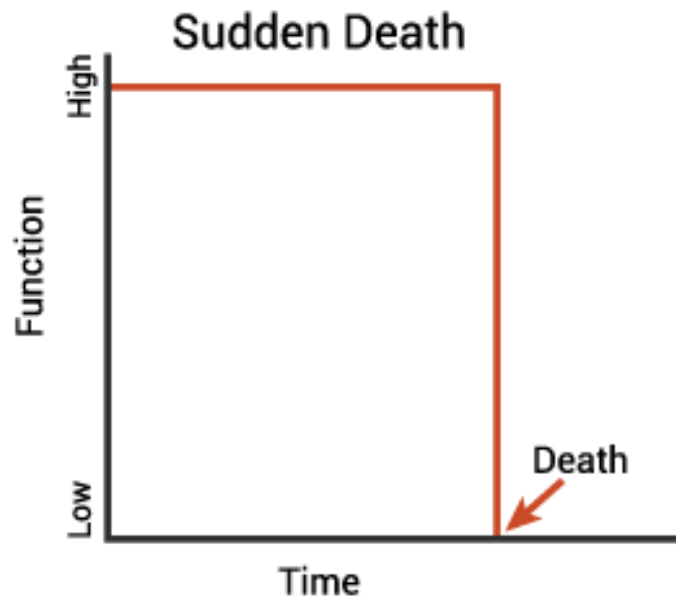
- Advance Care Planning Process
 - Writing your own Personal Directive
 - Resources
-

What is Advance Care Planning?

1. Thinking about and sharing your wishes for healthcare with people close to you.
 2. Choosing someone to make healthcare decisions for you if you become unable (“Agent”).
 3. Writing this information in a Personal Directive.
-

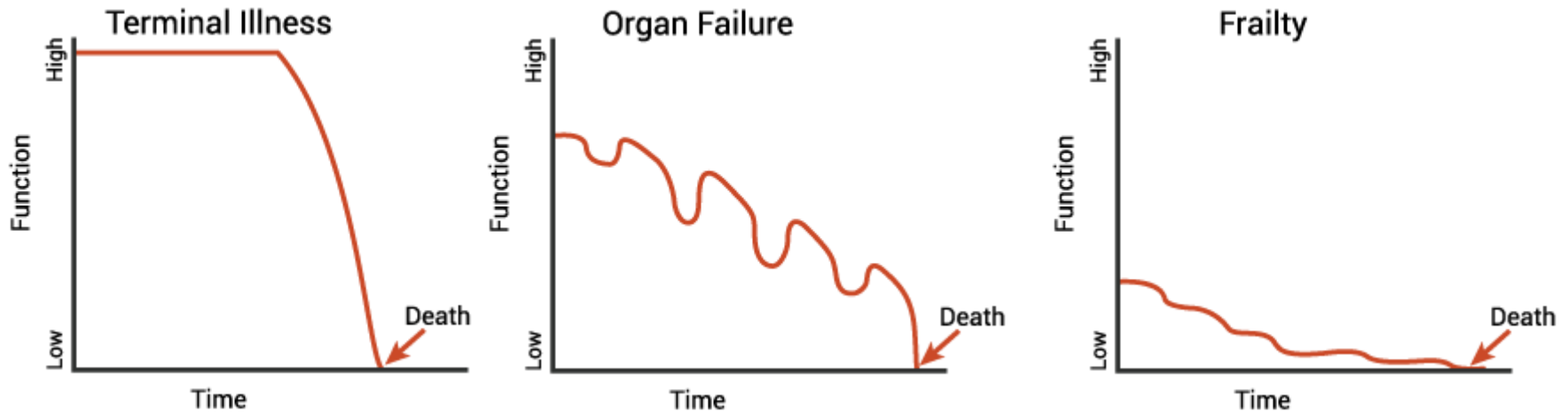
Why Is This Important?

Where we used to be:



- Full functioning until sudden death – no ongoing decline.
- Medicine could do very little in terms of curing illness
- This was the normal trajectory of aging/death!

Where we are now:



- Aging/death characterized by long period of decline of function before death.
- Today, these 3 trajectories account for 85% of all deaths – likely more in the older population.

Advance Care Planning Process

1. **Think** about your wishes and values
 2. **Learn** about your own health
 3. **Choose** someone to make decisions and speak on your behalf
 4. **Communicate** your wishes and values about health care
 5. **Document** in a Personal Directive
-

What is a Personal Directive?

The legal document that allows you to:

- Appoint someone you trust (your “Agent”) to make **healthcare** and **personal** (non-financial) decisions if you can’t
- Write down healthcare wishes/instructions you would want known if you couldn’t speak for yourself.

Completely different than a Will or Enduring Power of Attorney!



Important to Know

- Your Personal Directive only comes into effect **IF** you become unable to make your own personal/healthcare decisions.
 - Your Agent doesn't automatically get decision making power if you lose capacity
 - Personal Directive needs to be 'activated' or brought into effect first.
 - Specific process and paperwork to do this.

What Do I Do With My Personal Directive?

- Keep original in a safe place
- Copies for:
 - Your Green Sleeve
 - Your agent
 - Your family
 - Your healthcare providers



Writing *Your Own* Personal Directive




Writing a Personal Directive

- Can be written with or without a lawyer.
 - No standard format for Personal Directives
 - Must be in writing (handwritten or typed)
 - Signed, Dated, Witnessed = legal.
 - Check your documents
-

Personal Directive Template

AB Office of Public Guardian & Trustee

 **Personal Directive**

Protected A (when completed)

I, _____, make this Personal Directive.
name of maker

This Personal Directive takes effect with respect to personal matters that relate to me when it is determined, in accordance with the *Personal Directives Act*, that I do not have capacity to make personal decisions with respect to those matters.

I have placed my initials next to the provisions in this document that form part of my Personal Directive.

1. Revocation of previous personal directive

Not Applicable

Initials _____ I revoke all previous personal directives made by me.

2. Designation of agent

Option One

Initials _____ I designate the following as my agent(s)

OR

Option Two

Initials _____ I designate the Public Guardian as my agent.

I have consulted with the Public Guardian and the Public Guardian is satisfied that no other person is able and willing to act as my agent. The Public Guardian has agreed to be my agent.

OR

Option Three

Initials _____ I do not wish to designate an agent, but provide the following information and instructions to be followed by a service provider who intends to provide personal services to me.

- **Not** mandatory to use this form.
- User-friendly, has instruction sheet.
- Provided by AHS to patients in Green Sleeves.

Personal Directives – 4 main elements

- Revocation of previous Personal Directives
 - Designating (choosing) an agent
 - Healthcare wishes/Instructions (optional)
 - Witnesses/Signatures
-

Revocation of Previous Personal Directives

- Important!
- Voids any other Personal Directives you have written.
- If wanting to change your Personal Directive at a later date, best to do a new one and revoke all others.

Designating an Agent

- Age >18, with mental capacity to make decisions
- Doesn't have to be spouse or even a family member.
- Consider:
 - Someone who you trust
 - Someone who knows your wishes
 - Someone who can be contacted
 - Someone who can communicate well
 - Someone who can make decisions under stress.



Multiple Agents

- You can have more than one agent.
- How you write the names matters!

Mary Smith and
Bob Jones

Mary Smith or
Bob Jones

Mary Smith (Primary)
Bob Smith (Alternate)



Your Agent:

- Should have a copy of your personal directive
 - Should know where the original is
 - Should know you have picked them (and agrees)
 - Is *legally obligated* to follow your wishes if speaking for you.
-

Healthcare Wishes

- Consider writing Quality of Life Statements
 - *What is most important in your life?*
 - *What does ‘quality of life’ mean to you?*
 - *What could you not live without?*
 - *What does poor quality of life mean to you?*
 - *Are there any situations where you would not want life prolonged?*
- Can be more specific
 - Diagnosis specific
 - End-of-Life wishes



Special Considerations

- Medical Assistance in Dying
 - Agent cannot initiate
- Organ Donation
 - Discuss with your family



Witnesses and Signatures

- **Your Personal Directive isn't legal until it is signed, dated, and witnessed.**



- Your witness:
 - Must be age 18 or older.
 - Should initial where you have initialled.
 - Needs to watch you sign/date your Personal Directive
 - Needs to sign/date the Personal Directive in front of you.

Who Can NOT Witness?

- Anyone you listed as an agent
- The spouse/partner of your agent
- Your spouse/partner
- As a healthcare provider, can I witness a Personal Directive?
 - If you transcribed the Personal Directive – NO
 - Otherwise YES but...chart well to protect yourself!



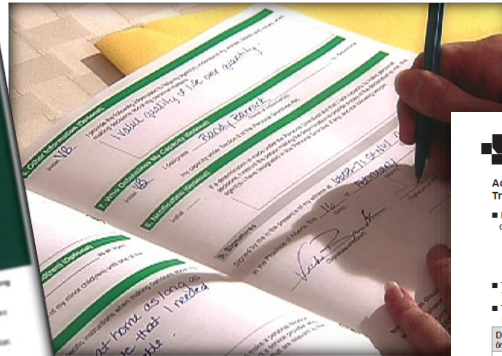
Personal Directive - Takeaways

- Your Personal Directive should be the result of the Advance Care Planning Process (5 Steps).
 - Your Personal Directive is a gift for your agent, loved ones, and healthcare team.
 - If you haven't already – start having advance care planning conversations and write a Personal Directive.
-

The Green Sleeve – "Health Passport"



Green Sleeve



Personal Directive
(copy)

Alberta Health Services

Advance Care Planning/Goals of Care Designation Tracking Record

Purpose: to document the content of Advance Care Planning (ACP) conversations and/or decisions.

Benefits:

- Assists healthcare providers in being aware of previous conversations underlying the current GCD order.
- Gives clues about where to pick up the conversation if decisions are made.
- The ACP/GCD Tracking Record is a continuous record that goes into the patient's medical chart and progress notes may be necessary to ensure it is kept.
- The original form is kept in the patient's Green Sleeve. When the patient is discharged from hospital, a copy remains with the sending facility.

Date (yyyy-Mon-dd)	Site	Attendees	Conversation Summary

10110/Rev(2019-06) Learn more - www.conversationsmatter.ca Page 1 of 1 (Side A)

ACP/GCD Tracking Record

Alberta Health Services

Goals of Care Designation (GCD) Order

Date (yyyy-Mon-dd) _____ Time (hh:mm) _____

Goals of Care Designation Order

To order a Goals of Care Designation for this patient, check the appropriate Goals of Care Designation below and write your initials on the line below it. (See reverse side for detailed definitions)

Check R1 R2 R3 M1 M2 C1 C2

Initials ▶ _____

Check here if this GCD Order is an interim Order awaiting the outcome of a Dispute Resolution Process. Document further details on the ACP/GCD Tracking Record.

Specify here if there are specific clarifications to this GCD Order. Document these clarifications on the ACP/GCD Tracking Record as well.

Patient's location of care where this GCD Order was ordered (Home, or clinic or facility name)

Indicate which of the following apply regarding involvement of the Patient or alternate decision-maker (ADM)

This GCD has been ordered after relevant conversation with the patient.
 This GCD has been ordered after relevant conversation with the alternate decision-maker (ADM), or others. (Names of formally appointed or informal ADM's should be noted on the ACP/GCD Tracking Record)
 This is an interim GCD Order prior to conversation with patient or ADM.

History/Current Status of GCD Order

Indicate one of the following

This is the first GCD Order I am aware of for this patient.
 This GCD Order is a revision from the most recent prior GCD (See ACP/GCD Tracking Record for details of previous GCD Order).
 This GCD Order is unchanged from the most recent prior GCD.

Name of Physician/Designated Most Responsible Health Practitioner who has ordered this GCD _____ Discipline _____

Signature _____ Date (yyyy-Mon-dd) _____

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GCD
Order Form

AHS Conversations Matter Guidebook



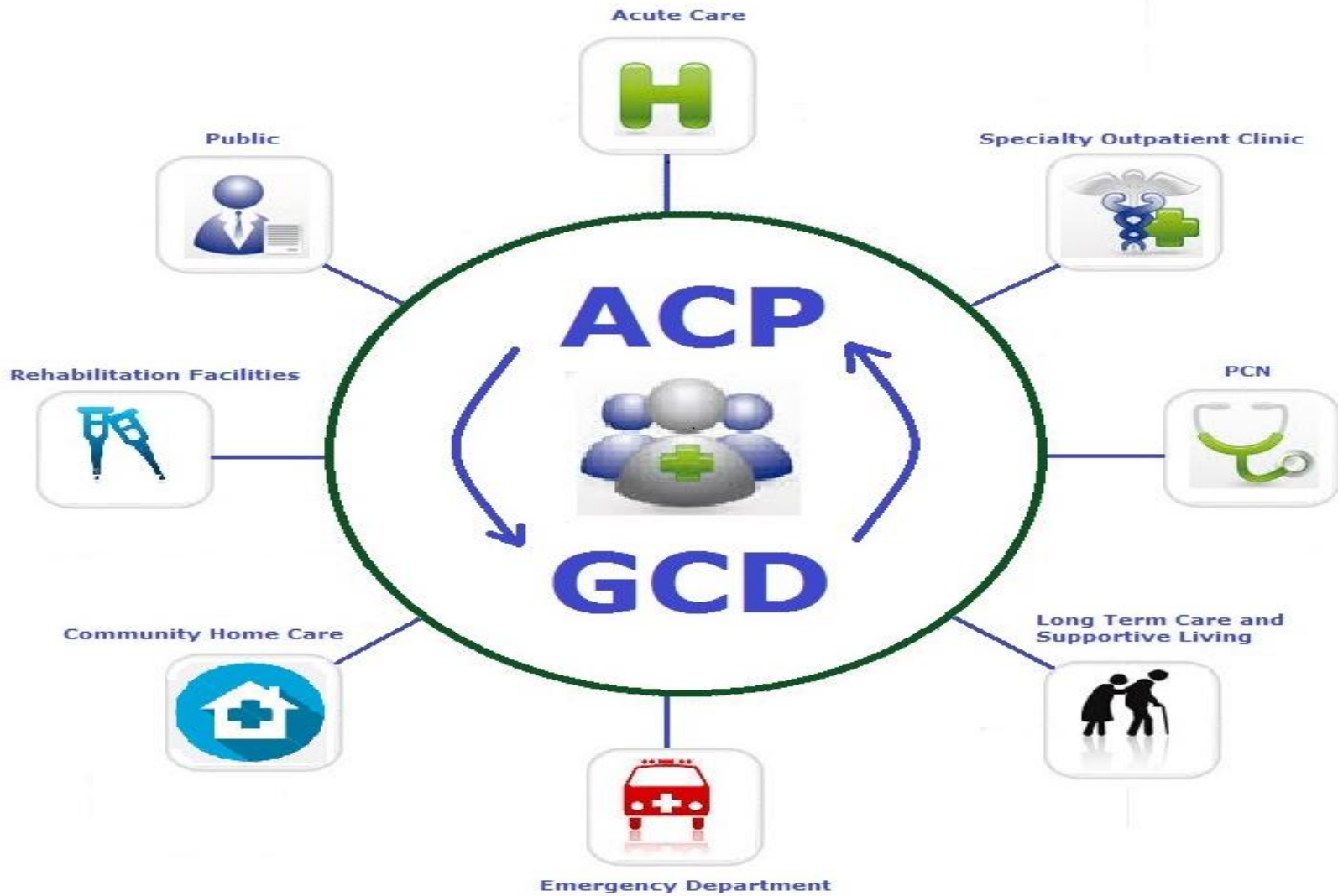
 Alberta Health
Services

Includes:

- 5 step ACP process
- GCD explanation
- Green Sleeve use
- Available in 7 languages

Available at

www.conversationsmatter.ca



If You Want to Know More

Advance Care Planning Goals of Care Education

3hr facilitated ACP/GCD course available via ZOOM

- e-mail calgaryconversations.matter@ahs.ca

On-Line ACP/GCD e-module

- www.conversationsmatter.ca

ACP/GCD Clinical Knowledge Topic and FAQ

- www.conversationsmatter.ca
-

Resources

Alberta's Office of the Public Guardian and Trustee:

For anything about Personal Directives (enacting, capacity, complaints, forms etc)

www.humanservices.alberta.ca/guardianship-trusteeship.html

AHS's Conversations Matter Website:

Healthcare Provider and Public resources. Level 1 Policy & Procedure, Forms, FAQ, Clinical resources, e-module, videos, Guidebook

www.ConversationsMatter.ca

Patient/Public Resources

Home > Information For > Patients & Families > Advance Care Planning

Advance Care Planning

Making sure your voice is heard when you cannot speak for yourself



Are you prepared in the time of COVID-19?

All Albertans should prepare for a possible scenario where they may be unable to make their own medical decisions, especially if they are older or have chronic or serious illness.

If you became seriously ill from [COVID-19](#), would your family, caregivers and healthcare providers know how you would want to be cared for? Who would speak for you if you were too sick to speak for yourself?

Learn more about [advance care planning](#).

Advance Care Planning

A way to help you think about, talk about and document wishes for health care in the event that you become incapable of consenting to or refusing treatment or other care.

You may never need your advance care plan - but if you do, you'll be glad that it's there and that you have had these conversations, to make sure that your voice is heard when you cannot speak for yourself.

Goals of Care Designation

Patients & Families >

Health Professionals >

Public Education Sessions

Looking for a course to explain advance care planning, Personal Directives, and goals of care?

More >

Contact Us

Have a Question?

conversationsmatter@ahs.ca

How

WWW.C

Advance Care Planning / Goals of Care

These two things are connected

Advisory

- [COVID-19 information](#)
- [ACP/GCD Specific COVID-19 Resources](#)



What Matters to You?

April 16th is [Advance Care Planning \(ACP\)](#) day across Canada. Alberta Health Services Advance Care Planning and the What Matters to You? initiative have partnered to encourage patients, families and staff to talk about what is important to them.



Having a What Matters to You? conversation is a great starter for more in-depth conversation about your future healthcare wishes in the event of injury or serious illness. Check out the [WMTY website](#) for more information.

Although Advance Care Planning conversations don't always result in determining a Goals of Care Designation they are useful building blocks to conversations.

Advance Care Planning is a way to help you think about talk about and document wishes for health care.

Goals of Care Designation is a medical order used to describe and communicate the general aim or focus of care including the preferred location of that care.



Conversations Matter

It's about decisions and how we care for each other

Advance Care Planning

Making sure your voice is heard when you



Are you prepared in the event that you become incapable of consenting to care? All Albertans should have a conversation about what they are older or have a chronic illness.

If you become seriously ill, you may need to be cared for by healthcare providers. Who will speak for yourself? Who will be your caregiver and health care decision maker?

Learn more about advance care planning.

Advance Care Planning is a way to help you think about, talk about and document your wishes for health care in the event that you become incapable of consenting to care.

You may never need your advance care plan - but if you do, you will have had these conversations, to make sure that your voice is heard when you need it.

Goals of Care Designation is a medical order used to describe and communicate the general aim or focus of care including the preferred location of that care.

Although advance care planning conversations don't always result in determining a Goals of Care Designation, they make sure your voice is heard when you care for someone else.



Medical Care

Focuses on medical tests and interventions to cure or manage a person's illness, but does not use resuscitative or life support measures.

Comfort Care

Focuses on relieving pain and suffering, and providing emotional and spiritual support. No life support measures are used.

Quick Reference

- [Conversations Matter](#)
 - [Interactive Guide](#) (available via AHS App)
- [Personal Decision Making](#)
- [Personal Directive](#)
- [Office of the Public Guardian and Trustee](#)
- [Speak UP](#)

Featured

Quality Improvement Project

Advance Care Planning and Goals of Care Designations (ACP/GCD) is fundamental to patient and family centered care. All teams are encouraged to continually evaluate and improve their ACP/GCD practices to help patients and families receive more, better and earlier ACP/GCD conversations. This information will help you conduct a targeted program specific quality improvement project.

- [Quality Improvement Project](#)

Contact

New to ACP GCD?

Policy / Forms / OI

Tools & Resources

Pediatrics

Supplies

General Information

- [Frequently Asked Questions](#)
- [Clinical Knowledge Topic - Advance Care Planning Goals of Care Designations, All Ages - All Locations](#)

Micro Learnings

- [Goals of Care Designation Categories](#) (sound required)
- [Advance Care Planning Documents](#) (sound required)

E Learning Modules

Target audience: frontline physicians, nurses, allied health care workers, health care aides, social workers and unit clerks or anyone wanting to learn more about advance care planning in Alberta.

Four learning topics target specific aspects of the policy

1. Advance Care Planning Basics
2. Documents and Workflow
3. Goals of Care Designations (Adult, Pediatric and EMS case scenarios)
4. Personal Directives

Upon entering the course, you will select a learning path most relevant to your role and care setting.

ACP/GCD Team

- Education:
 - Advance Care Planning process and facilitation
 - Personal Directives
 - GCD interpretation
 - Goals of Care conversations
 - Green Sleeve education
- QI/Process Improvement support

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Some Questions?



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