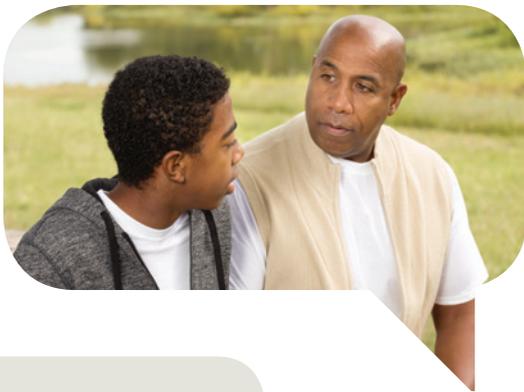




UNDERSTANDING GOALS OF CARE AND ADVANCE CARE PLANNING

IT'S ABOUT CONVERSATIONS

YOUR GUIDE FOR MAKING HEALTHCARE DECISIONS



What is Advance Care Planning?

Advance Care Planning is a way to help you think about, talk about and document your wishes for health care. It is a process that can assist you in making healthcare decisions now and for the future.

What are the benefits?

If there is a time when you are unable to speak for yourself, it is important that your loved ones and your cancer care team understand your wishes for health care.

None of us know what tomorrow might bring, or can predict our future health. Planning today can ensure that your wishes are known, no matter what the future holds.

Advance Care Planning may bring comfort and peace of mind to you, your loved ones, and to those who may have to make healthcare decisions on your behalf.

Who is it for?

Everyone. We can all benefit from Advance Care Planning. If an unexpected event or change in your health occurs and you are unable to make decisions about your health care, planning in advance ensures your wishes will be known.

When is a good time to start?

Now. It is important to begin Advance Care Planning conversations before you face a crisis or become seriously ill.

"I want my loved ones to know my feelings about my future health care. That way, if they're faced with making decisions on my behalf they'll have peace of mind."

Imagine that without warning, you are seriously injured in a car crash. Your heartbeat and breathing can only continue with artificial support. Your doctors believe it is unlikely you will recover.

Imagine your ability to make your own decisions is gone. You cannot feed yourself and no longer know who you are or who your loved ones are. You will never regain your ability to communicate meaningfully with others and your condition will become worse over time.

Imagine you are living with cancer and it is getting worse despite treatment.

Will your loved ones and cancer care team know your wishes?

How do I begin?

THINK

LEARN

DECIDE

TALK

DOCUMENT

“It is helpful to think about your goals regarding prolonging life and quality of life and what you want your loved ones to know.”

STEP 1

THINK about your values and wishes.

Do you have personal beliefs that influence your healthcare wishes?

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

Where would you want to be cared for?

Have you had past experiences with family or friends where healthcare decisions had to be made?

What did you learn from that experience?

When you think about death, what do you worry about?

When you are nearing death, are there things you would wish for or not wish for?

THINK

LEARN

DECIDE

TALK

DOCUMENT



STEP 2

LEARN

about your
own health.

If you have an existing medical condition such as cancer, it's important to talk to your doctor or other healthcare providers. You can ask about what you might expect to experience in the future as a result of your medical condition (prognosis).

You can learn about the possible medical treatments for your condition and what to expect from these treatments. You can understand the types of healthcare decisions you may need to make.

While we can never predict exactly what life will bring, your cancer care team can talk to you generally about what other patients with your condition have experienced.

STEP 3

DECIDE who will make decisions and speak on your behalf.

Unexpected or sudden medical events can leave us unable to communicate our wishes. Other medical conditions can slowly take away our ability to communicate or make decisions about our health care. This is why another important step in the Advance Care Planning Process is to choose someone who can speak for you in the event you are unable to make medical decisions for yourself. The person should be your Substitute Decision Maker.

A Substitute Decision Maker can be anyone you choose, such as a family member or close friend. It is very important to discuss your values and wishes with the person you are considering to be your Substitute Decision Maker.

You can have more than one Substitute Decision Maker in the event one cannot be reached in case of emergency. Substitute Decision Makers can be listed in order, and you can decide if they can act alone, or come to a decision together.

Some of the things you may want to consider:

Do I trust this person to make healthcare decisions with my cancer care team based on my values and wishes?

Are they able to communicate clearly?

Would they be able to make difficult decisions in stressful situations?

Is this person willing and available to speak for me if I were unable to make healthcare decisions for myself?



THINK

LEARN

DECIDE

TALK

DOCUMENT



"I spoke with my son about my advance care plan. At first he wasn't keen. He tried to tell me I was needlessly worrying, and that I am fit and healthy. I know he gets upset thinking of a time when I won't be here.

I explained that I intend to stay well, but in case something happens and I can't speak for myself, I want him to be comfortable making medical decisions with my doctors. I was able to tell him what I value about my health and what my priorities are if I get very sick or when I'm dying. But, more importantly I know he won't feel burdened or worried about making the right decisions for me, because now he knows the kinds of things that I value in my health.

Later, I called the rest of my family. I wanted to make sure they knew my son was my Decision Maker and what we'd talked about. I don't want any misunderstandings when I'm sick."

STEP 4

TALK. Communicate your wishes and values about health care.



Likely the most important part of advance care planning is the conversations that you have over time with your designated agent, loved ones and healthcare team. Talking about your health with loved ones may be difficult, but understanding your wishes in advance will help them later on. It will help make an already stressful and uncertain time less difficult.

THINK

LEARN

DECIDE

TALK

DOCUMENT

STEP 5

DOCUMENT in a Personal Directive.

In Manitoba, anyone over the age of 16 can write a Health Care Directive. You have the right to accept or refuse medical treatment at anytime.

Where should I keep my Health Care Directive?

It is wise to make several copies of your Health Care Directive to ensure that the document can be found easily when it is needed.

You should keep one copy at home. If you have an *Emergency Response Information Kit (ERIK)* place it in there. If you don't have an ERIK kit, you can talk to your doctor. A copy of the ERIK form is at the back of this book.

The next step in Advance Care Planning is to document your plan. In Manitoba the legal document is called a Health Care Directive. In a Health Care Directive, you choose a Substitute Decision Maker – that is the person who can collaborate with your cancer care team if you are unable to do so.

Your Substitute Decision Maker makes healthcare decisions on your behalf in keeping with your wishes.

You can also write down any other information about your wishes and values related to health care in your Health Care Directive.

Your Substitute Decision Maker should have a copy. Keep a copy in your file at your primary care provider's office as well as your cancer care team's office. Take a copy with you when you travel. Bring a copy with you when being admitted to hospital, and prior to surgery.

Is this legally binding?

Your family, friends and health care providers are required to follow your wishes that you have expressed in your Health Care Directive. These wishes will

The Health Care Directive only comes into effect if there is ever a time that you are unable to make decisions about your health care. It can be helpful for reducing conflict or distress and bringing comfort to those who are close to you. It clearly states who your Substitute Decision Maker is and can provide guidance about your wishes.

Your Health Care Directive can, and should be reviewed any time you have a change in your health circumstances or your wishes and values. If you would like more information about Health Care Directives, you can contact your local Regional Health Authority.

be honoured by a court of law unless they are not accepted health care practices.

I have someone who is my Power of Attorney, and helps me with my banking. Isn't that the same thing?

No, a Power of Attorney is not the same thing as being a Substitute Decision Maker for healthcare decisions. A power of attorney cannot make health care decisions for you. A Power of Attorney looks after financial issues only.

Understanding the Goals of Care Designations

What are Goals of Care Designations?

Goals of Care Designations are instructions that guide your care team about the general focus of your care, and where you might wish to receive care. A doctor or nurse documents your Goals of Care after speaking with you and/or your Substitute Decision Maker.

Why are Goals of Care Designations important for me?

By knowing and following your Goals of Care Designations, healthcare providers care for you in a way that is timely, medically appropriate, and meets your personal values and wishes. They also provide an organized way for care teams to communicate about your care.

Goals of Care Designations are created just for you and your situation. They can change if your circumstances change or you want to change something you had decided earlier.

“Talk to your cancer care team about which Goal of Care Designation best reflects your health circumstances, and your wishes and values.”

There are three general approaches to care, or Goals of Care Designations:



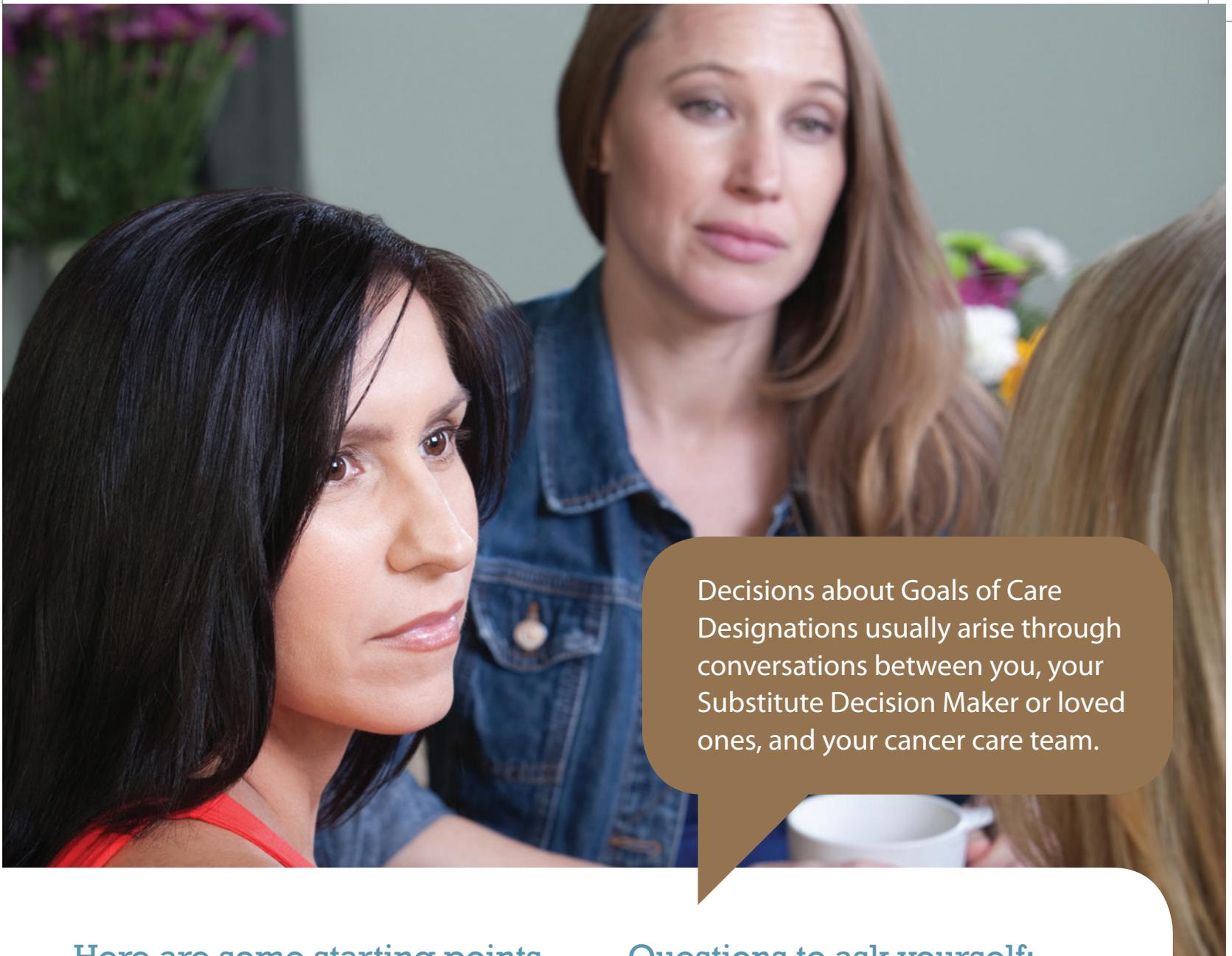
Resuscitative Care - The focus is to prolong or preserve life using any medical or surgical means including, if needed, resuscitation (trying to restart the heart after it has stopped) and admission to Intensive Care.



Medical Care - Medical tests and interventions are used to cure or manage an illness as well as possible but don't use resuscitative or life support measures. This is appropriate when resuscitative and life support measures won't work or when the person chooses not to receive such treatments. Medical care can be provided in many locations, depending on the person's wishes and values as well as medical appropriateness.



Comfort Care - In this approach to care, the aim of medical tests and interventions are for optimal symptom control and maintenance of function when cure or control of an underlying condition is no longer possible or desired. Transfer to a hospital may occur in order to better understand or control symptoms.



Decisions about Goals of Care Designations usually arise through conversations between you, your Substitute Decision Maker or loved ones, and your cancer care team.

Here are some starting points for your own conversations:

My wish is to use all medical therapies including resuscitation and artificial life-sustaining treatments in intensive care, to keep me alive if it all possible. (R)

Length of life is most important to me regardless of my recovery or changes in the quality of my life. (R)

My wish is for full medical care but without the use of resuscitation or artificial life-sustaining intensive treatments, if these are either unlikely to prolong my life or restore me to a certain quality of life. (M)

My wish is for health care to focus on my comfort and alleviate suffering. I would like medical care that focuses only on my quality of life. I would like to avoid being kept alive by medical treatments, resuscitation or artificial life-sustaining intensive treatments. (C)

Questions to ask yourself:

I am accepting of treatments that try to fix problems but if I'm not getting better or going to achieve a certain quality of life, would I want to switch to focusing only on my comfort and allowing natural death to occur?

Is it important for me to discuss what I mean by quality of life?

Under what circumstances would I want to avoid being kept alive by medical treatments, resuscitation or intensive care?

What kind of changes to my health or life in the future might affect my wishes?

When are Goals of Care Designations Discussed or Changed?

Your cancer care team will approach you to discuss the goals for your care:

- Anytime before starting a treatment plan
- Whenever there is a big change in your health status
- At your request
- At the request of your loved ones or Substitute Decision Maker
- At the request of your cancer care team

In most cases, you, your Substitute Decision Maker, your loved ones and cancer care team will agree about the Goals of Care Designation that is most appropriate for you. However, if there is a time when reaching an agreement is hard to do, ask your health care provider on next steps.



Health Care Directive

Please type or print legibly



This is the Health Care Directive of:

Name _____

Address _____ City _____

Province _____ Postal Code _____ Telephone () _____

Part 1 – Designation of a Health Care Proxy

You may name one or more persons who will have the power to make decisions about your medical treatment when you lack the ability to make those decisions yourself. If you do not wish to name a proxy, you may skip this part.

I hereby designate the following person(s) as my Health Care Proxy:

Proxy 1

Name _____

Address _____

City _____

Province _____ Postal Code _____

Telephone () _____

Proxy 2

Name _____

Address _____

City _____

Province _____ Postal Code _____

Telephone () _____

*(Check one choice **only**.) For an explanation of “consecutively” and “jointly” please see the reverse side of this form).*

If I have named more than one proxy,

I wish them to act:

consecutively OR **jointly**

My Health Care Proxy may make medical decisions on my behalf when I lack the capacity to do so for myself *(check one choice **only**):*

With no restrictions

With restrictions as follows:

Part 2 – Treatment Instructions

In this part, you may set out your instructions concerning medical treatment that you do or do not wish to receive and the circumstances in which you do or do not wish to receive that treatment. **REMEMBER** – your instructions can only be carried out if they are set out clearly and precisely. If you do not wish to provide any treatment instructions, you may skip this part.

Part 3 – Signature and Date

You must sign and date this Health Care Directive. No witness is required.

Signature _____

Date _____

If you are unable to sign yourself, a substitute may sign on your behalf. The substitute must sign in your presence and in the presence of a witness. The proxy or the proxy's spouse cannot be the substitute or witness.

Name of substitute: _____

Address _____

Signature _____

Date _____

Name of witness: _____

Address _____

Signature _____

Date _____

Health Care Directives in Manitoba

What is the purpose of a Health Care Directive?

As a Manitoba citizen you have the right to accept or refuse medical treatment at any time. The *Health Care Directives Act* allows you to express your wishes about the amount and type of health care and treatment you want to receive should you become unable to speak or otherwise communicate this yourself. It also allows you to give another person the power to make medical decisions for you should you ever be unable to make them yourself.

Why should I fill out a form?

Due to accident or illness, you may become unable to say or show what treatment you would like, and under what conditions. If you have signed a directive, those close to you and the health care professionals treating you are relieved of the burden of guessing what your wishes might be.

How do I make a Health Care Directive?

The Manitoba government has prepared a form for your convenience (see reverse). The form serves as a guide for providing the appropriate information. However, **any paper that is signed, dated and provides the same information may be used.** A directive may be made by anyone capable of making a health care decision and understanding the consequences of that decision.

Who do I talk to about these decisions?

It is strongly recommended you talk to your doctor before completing the directive. This will ensure your instructions are clear and easily understood by those who provide treatment. Your choices should then be clearly typed or printed.

What is a proxy?

A proxy is someone you choose and name in your directive to act for you in the event you are not able to make such judgments and speak on your own behalf. Because it is not possible to anticipate every set of circumstances, your proxy has the power to make health care decisions for you based on what you have told your proxy about your wishes and the information in your directive.

Who do I choose as my proxy?

The choices you make in a directive are very personal. The person(s) you choose to represent you should be close friends or relatives who are willing to accept this responsibility. You should discuss your wishes openly and in detail with them. It is wise to name more than one proxy in case one is not available when needed.

If you designate two proxies, you must decide how you want them to work, either independently or together as a team. If you decide the two proxies should act **jointly**, they will act together on your behalf. If you decide they should work **consecutively**, the second proxy will be contacted if the first is not available or is unwilling to make the required decision at the required time.

It is important to make sure that your proxy (or proxies) understand(s) what is expected and is willing to speak and act for you.

Can I change my mind about my directive?

A Health Care Directive should be a record of your current wishes. If at any time you wish to change the content or the proxies you have listed, all copies of your old directive should be destroyed and a new directive written.

What is the effect of a Health Care Directive?

The wishes you express in your directive are binding on your friends, relatives and health care professionals (unless they are not consistent with accepted health care practices) and will be honoured by the courts. However, health care professionals treating you are not obliged to search for or ask about a signed directive. It is important to be sure that family, friends, your doctor and your proxy know you have a directive and know where it can be found.

For more information contact:
your regional health authority

Emergency Response Information Kit – Health Information Form Trousse d'information pour les situations d'urgence – <i>Formulaire d'information sur la santé</i> (Please print and keep information updated / <i>S.V.P. imprimer et mettre à jour régulièrement</i>)		
Personal Information		<i>Renseignements personnels</i>
First Name / <i>Prénom</i>	Middle Name / <i>Autres noms</i>	Last Name / <i>Nom de famille</i>
Address (Street, Apt. #, Box #, Civic # / <i>Adresse (rue, app, C.P., n° mun)</i>)		<input type="checkbox"/> Male / <i>Homme</i> <input type="checkbox"/> Female / <i>Femme</i>
City or Town / <i>Ville ou Village</i>	Province / <i>Province</i>	Postal Code / <i>Code postal</i>
Phone # / <i>N° de téléphone</i>	Birth Date (dd/mm/yyyy) / <i>Date de naissance (jj/mm/aaaa)</i>	
Manitoba Health Registration # / <i>N° d'immatriculation Santé Manitoba (6#)</i>	Personal Health ID # / <i>N° d'identification personnelle (9#)</i>	
Other Medical Plan & No./ <i>Autre nom et n° d'assurance santé (eg. Blue Cross/Croix bleue)</i>		
Contacts		<i>Contacts</i>
Family Doctor(s) / <i>Médecin(s) de famille</i>		Phone # / <i>N° de téléphone</i>
First Emergency Contact Person / <i>Première personne contact en cas d'urgence</i>		
Address / <i>Adresse</i>		
Phone (home & work) / <i>N° de tél. (maison et travail)</i>		Relationship / <i>Lien de parenté</i>
Second Emergency Contact Persons / <i>Deuxième personne contact en cas d'urgence</i>		
Address / <i>Adresse</i>		
Phone (home & work) / <i>N° de tél. (maison et travail)</i>		Relationship / <i>Lien de parenté</i>
Medical History		<i>Antécédents médicaux</i>
Do you have / <i>Souffrez-vous</i> <input type="checkbox"/> heart disease / <i>d'une maladie de coeur</i> <input type="checkbox"/> diabetes / <i>de diabète</i> <input type="checkbox"/> high blood pressure / <i>d'hypertension artérielle</i> <input type="checkbox"/> breathing problems / <i>d'une maladie pulmonaire</i> <input type="checkbox"/> other medical concerns (provide detail below) / <i>autres problèmes médicaux (précisez ci-bas)</i>		
Past Medical History (illnesses, surgeries) / <i>Antécédents médicaux (maladies, chirurgies)</i>		
Allergies / <i>Allergies</i>		(over / <i>verso</i>)



If you would like to obtain a wallet card identifying contact information for your Substitute Decision Maker, in the event of a medical emergency, ask your cancer care team.

Advance Care Planning Checklist

- I have thought about my values and beliefs and personal goals as they relate to my health care
- I have spoken to my cancer care team about my current health and what future healthcare decisions I might need to make
- I have chosen a Substitute Decision Maker to whom I have spoken about my wishes
- I have discussed my healthcare treatment wishes with my family and/or key support people
- My doctors and I have spoken together about my Goals and Care Designation
- I have completed a Health Care Directive and given copies to my Substitute Decision Maker, cancer care team, primary care provider, and local hospital
- I have also received the following resources to help me plan my care:
 - the bookmark with wallet card
 - a copy of my Health Care Directive
 - a copy of my Goals Of Care Designation
- I will bring a copy of my Health Care Directive and Goals of Care Designation to the hospital or cancer care facility or other health care appointments whenever I go



For more information, please contact your
cancer care team or visit:

www.advancecareplanningincancer.ca

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