

Speak Up

Start the conversation
about end-of-life care



Advance Care Planning Workbook Nova Scotia Edition

It's about conversations.
It's about decisions.
It's how we care for each other.

www.advancecareplanning.ca
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For more information about advance care planning, please visit our website at:

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NOVA SCOTIA Hospice Palliative Care ASSOCIATION

The Nova Scotia Hospice Palliative Care Association is the provincial voice for hospice palliative care in Nova Scotia. The association works to bring awareness to end-of-life issues facing Nova Scotians through education, public engagement and partnerships. The Association is secretariat, chair and founding member of the Quality End of Life Care Coalition of Nova Scotia, a group of 22 health and community organizations that believe all Nova Scotians have a right to quality end of life care, which allows them to die with dignity, free from pain, surrounded by loved ones in a setting of their choice.

The information provided within this workbook is included as a public service and for general reference only. Every effort is made to ensure the accuracy of the information found here. However, this information is not considered legal, medical or financial advice and does not replace the specific medical, legal or financial advice that you might receive or the need for such advice. If you have questions about your health or about medical issues, speak with a health care professional. If you have questions about your or someone else's legal rights, speak with a lawyer or contact a community legal clinic.



Making an Advance Care Plan

Speak Up

Start the conversation
about end-of-life care

Advance Care Planning is a process of reflection and communication. It is a time for you to reflect on your values and wishes, and to let others know what kind of health and personal care you would want in the future if you become incapable of consenting to or refusing treatment or other care.

This workbook will provide an introduction to advance care planning and provide some tips on how to begin the process of thinking and talking about your wishes should you not be able to speak for yourself. In Nova Scotia, the Personal Directives Act sets out the law around how you determine how your personal care decisions, including health care decisions are made. It also describes how you can name a person to make decisions for you if you are incapable of doing so — commonly referred to as a substitute decision maker. In Nova Scotia the legal term for this person is a ‘delegate’. A Personal Directive is a written document that expresses your wishes. The following pages will relate the advance care planning process to Nova Scotia and provide some information on relevant tools and resources.

Advance Care Planning means having discussions with family and friends, especially your future Substitute Decision Maker(s)/Delegate. A Substitute Decision Maker/Delegate is the person or people who will provide consent or refusal of consent for care and treatments for you if you are not mentally capable to do so for yourself. Advance Care Planning can include choosing a Substitute Decision Maker as well as expressing your wishes about care that you want or may not want.

It can include discussions with your health care providers to ensure that you have accurate medical information on which to make decisions (consents) or to express wishes about future care and treatment. It can also include writing down your wishes, and may even involve talking with legal professionals.

It is a way to give those who will be required to provide consent for your medical treatment and care the confidence to make decisions on your behalf when you are mentally incapable to do that for yourself.

You may never need your advance care plan – but if you do, you will be glad that you have had these conversations. It is a way to make sure that your voice is heard when you cannot speak for yourself.

Why plan for end-of-life care?

Life can take many twists and turns. **Imagine:**

- One day, without any warning, you find yourself in a hospital with a life-threatening illness. You are unable to speak for yourself – you do not recognize your family or friends. Your doctors do not feel that you will leave the hospital alive. Do you want to be kept alive using machines? Does anyone know your wishes? Who will make decisions for you?

OR

- Your father is becoming frailer as he ages. His condition seems to change every day, and he's been making regular trips to the hospital. What would happen if he couldn't make decisions for himself during the next hospital visit? Would you be able to make them for him? Would you know what to say?

OR

- You are at the beginning stages of Alzheimer's and you know that at some point you will not be able to recognize people or make your own decisions. How will you make your wishes known? Who will make decisions about your care and treatment when you are no longer mentally capable of doing so yourself?

We are living longer, but eventually we all will die. And, the way we die is changing. Today, most people die from a chronic illness. They live with these illnesses for several years before death. If you are in that situation, during these years you may experience significant periods of illness which may require decisions to be made. For example, if you are diagnosed with heart disease, you may want to think about what might happen should you have a heart attack, what your options for treatment might be, and what that might mean for your quality of life.

An Advance Care Plan is more than a document outlining your wishes for care at the end of life – it is also a conversation that you have with the person or people who will act for you if you cannot speak for yourself. It means thinking about what is important to you and what you value. It means talking to your loved ones about these things. Reflecting on your values and having these conversations will help you, your loved ones and anyone that will act as your Substitute Decision Maker/Delegate talk to health care professionals about difficult decisions that may have to be made about your care at the end of life or when you are seriously ill and cannot speak for yourself.

Having these conversations and making a plan are ways to give your Substitute Decision Maker(s)/Delegate the confidence to make decisions on your behalf. It is how we care for each other.

Advance Care Planning is a process, not just a document. Results of the process can include the naming of a Substitute Decision Maker/Delegate, writing a personal directive or both.

Remember, this plan will only be used if you are not capable of speaking for yourself. You can also change it at any time as long as you are mentally capable.

The choices you make at the end of life – for yourself and others – are important. Make sure that your voice is heard and respected. Think about what you would want and start the conversation with others about your end-of-life care.

Let's get started: Making an advance care plan



Advance Care Planning includes conversations that you have with close family and friends about your values and beliefs as well as the medical procedures that you want and do not want at the end of life. It is also about the experiences and people that you want around you at the end of life. Thinking about and discussing your values and beliefs can make it easier to make health care and personal care decisions when necessary.

How to begin:

1. Think about what is right for you

Begin by reflecting on your values, beliefs and understanding about end-of-life care or specific medical procedures, such as drug therapies, cardiopulmonary resuscitation (CPR) or dialysis. Think about any situations that you may have experienced with others and how it made you feel. You should also speak with your health care providers to ensure you have accurate information about your own health condition in order to express wishes about medical procedures that you may or may not want.

Ask yourself:

- If possible, would I prefer to die at home, in a hospital or in a long term care facility?
- What might change my mind about my choice?
- Do I want or not want certain medical interventions (e.g., resuscitation or feeding tubes) if I am unlikely to survive or live independently?
- Why would I want or not want these procedures?
- Do I have any fears about dying (e.g., I'll be in pain, I won't be able to breathe)?
- Is there someone that I can talk to about these fears, such as my doctor?
- What would be meaningful for me at the time of my death (e.g., family/friends nearby, music playing or pictures)?

2. Learn about end-of-life care options and procedures

Some individuals want to prolong life as long as possible using medical interventions. Others would not want to be hooked up to machines at the end of life if there is no chance of recovery.

This document includes terms and phrases often used at end of life and other times of significant illness. It will be helpful to review these terms as a first step in thinking about what is right for you.

3. Decide who will make medical decisions on your behalf should you become incapable of doing so¹

Think carefully about who you feel would understand, honour and follow your wishes, and would be most capable of making medical decisions on your behalf as your Substitute Decision Maker. This may be a spouse, an adult child, a trusted family member or a good friend. Your Substitute Decision Maker should be someone who knows you very well and who you can trust. They must be willing to respect your views and values and act on your wishes, not their own. And they should be able to make difficult decisions in stressful situations.

Before you choose someone, you need to understand what the law says about what you must do to appoint someone as your Substitute Decision Maker. You also need to know what happens if you do not appoint someone to act for you through that legal process.

In Nova Scotia, the Personal Directives Act provides a framework for choosing a Substitute Decision Maker, known as a Delegate, and for completing a written document outlining your health and personal care wishes. This document is called a Personal Directive.

What do you need to know about the law in Nova Scotia regarding advance care planning and Substitute Decision Makers?

The following pages will explain how advance care planning is done in Nova Scotia, according to the law. It will give you some points to consider when thinking about your wishes and identifying who might speak on your behalf if you cannot speak for yourself. You can find more information at www.novascotia.ca/just/pda.

The law that governs advance care planning in Nova Scotia is the Nova Scotia Personal Directives Act. It allows you to set out instructions or general principles about how your health and personal care decisions will be made. It also explains how a substitute decision maker is identified and chosen, as well as his/her roles and responsibilities.

In Nova Scotia you can prepare a Personal Directive. Your Personal Directive may:

- Name your Substitute Decision Maker.
- Provide written instructions about your wishes for care.
- Do both of these things.

¹ This information was adapted from the Nova Scotia Department of Justice. www.novascotia.ca/just/pda

In Nova Scotia anyone who is capable of understanding written information and the outcomes of their choices can make a Personal Directive. (Including mature minors). If you do not prepare a Personal Directive that names your Substitute Decision Maker, the law determines who that will be. Here is how it works.

Named Delegate

If you name your Substitute Decision Maker in your Personal Directive – that is, the person you identify as being able to make health and personal care decisions for you, this person is known as your Named Delegate. Named Delegate is the term used in the Personal Directives Act, however this person is often referred to as simply a Delegate. For the purposes of this workbook Named Delegate and Delegate mean the same thing. This person will make decisions on your behalf if you become incapable of doing so. Personal care decisions include decisions about nutrition, hydration, shelter, clothing, hygiene, comfort, recreation, support services, health care and placement.

Your Substitute Decision Maker/Named Delegate must follow any instructions you may have written in your personal directive. There are some exceptions to this. If you express a different wish to your Delegate after you have written your personal directive, they must follow that. Or, if medical advances or technologies change that may cause you to express something different, or circumstances change and had you known them you may have expressed a different wish, your Delegate must consider these changes.

If you do not have any written instructions, your Delegate must make a decision they believe you would have wanted based on what they know about your values and beliefs and any other wishes. If your Delegate does not know what you have wanted, they must act in your best interest.

You can only name one person to be your Delegate. However, you can delegate different kinds of decisions to different people. For example you can designate your spouse to make health care decisions for you, but you can designate your sister to make the decision regarding nursing home placement or personal care decisions. You can also instruct your Delegate to consult family members or friends before making a decision. If you wish, you can also designate someone to act as an alternate for your Named Delegate, in case your Named Delegate cannot be reached or is no longer capable of making decisions for you.

Your Delegate can be anyone you wish, a neighbour, friend, relative spouse etc. However, they must be over the age of 19. This person should know you well, be willing and able to make complex decisions on your behalf and be able to be contacted.

Statutory Decision Maker

If you become incapable of making decisions for yourself and you have not named a Delegate to make decisions for you, and you do not have a written personal directive in place, the Personal Directives Act provides a Substitute Decision Maker for you. This person will be known as a Statutory Decision Maker. The Act sets out a hierarchy of relatives that will be asked to make decisions for you. They can make decisions in relation to three areas: health care, placement in a continuing care home and home care services. They must make decisions based on knowledge of your wishes, your values and/or verbal instructions. If they do not know your wishes, they must base the decisions on your best interest.

Let's get started:

Making an advance care plan (continued)



Start the conversation
about end-of-life care

If you need a Statutory Decision Maker, your health care providers will follow the list of relatives in the hierarchy until they find an adult who has been in contact with you over the last year and is willing to make decisions for you. The list is as follows:

- Anyone designated as your legal guardian by the courts
- Spouse
- Child
- Parent
- Person who stands in the place of a parent
- Sibling
- Grandparent
- Aunt or Uncle
- Niece or Nephew
- Other relative
- Public Trustee (public government organization)

If you do not wish to name anyone to make decisions for you, but want to set out certain instructions for health care providers to use, you can write down the instructions and/or talk to your health care providers. However, it is very difficult to write instructions that are specific to every situation. If your instructions are unclear or not applicable to a specific situation then your health care providers would turn to your Statutory Decision Maker.

There is a sample Personal Directive form provided at the end of this Workbook along with more detailed instructions regarding developing a Personal Directive and naming a Delegate.

More information can also be found at the Nova Scotia Department of Justice Website at www.novascotia.ca/just/pda.

More information on advance care planning and other end-of-life issues relevant to Nova Scotia can also be found at the Nova Scotia Hospice Palliative Care Association website at www.nshpca.ca.

For the National Speak Up Campaign materials and for more information about other provincial and territorial guidelines please visit the Speak Up website www.advancecareplanning.ca.

4. Begin the Conversation

Now that you have information about Personal Directives and Substitute Decision Makers/Delegates in Nova Scotia, it's time to have a conversation with those who may make decisions for you, your family, and, if needed, appropriate health care professionals. It is important to know that making a Personal Directive is one part of the planning process. Having conversations and ensuring those closest to you know your wishes, values and beliefs regarding your health and quality of life is critical and will help shape your Personal Directive and help others make decisions for you.

Your future Delegates or Statutory Decision Makers may find the conversation difficult, or they may be relieved to know exactly what kind of care you would like to receive. If you do decide to put written instructions in a Personal Directive, make sure that your future Delegates have a copy of your document, and that they can understand it, honour it and feel comfortable making medical and other personal care decisions on your behalf.

Instructions on completing a written directive are included at the end of this booklet and reviewed on page 13.

Do not forget to tell others too, such as your doctor, other health care professionals involved in your care, your lawyer, and other family members or friends. Let your doctor know who you have appointed to be your future Delegate and that you have shared your wishes, goals and values with them. You may wish to provide your Personal Directive to your doctor or request that the information be noted in your medical record. This is important so that if you become mentally incapable, your doctor can discuss your wishes about health care with your delegate or if relevant, the person appointed as Statutory Decision Maker.

Having trouble talking? Our website has some great tips for starting the conversation. Visit www.advancecareplanning.ca to learn more.

Locally, the website of the Nova Scotia Hospice Palliative Care Association also provides links to resources to help begin the conversation, please go to www.nshpca.ca

Let's get started:
Making an advance care plan (continued)

5. Document your wishes

In Nova Scotia, written documentation of your health and personal care wishes is known as a Personal Directive. Personal Directives can consist of simply naming a Delegate who will make decisions for you, or you may wish to provide instructions about relevant health and personal care scenarios that are important to you. These written instructions can be very detailed or they can speak more broadly to your wishes and values regarding your health, personal care and quality of life.

This Workbook includes the Nova Scotia Personal Directive sample form for you to use. It was developed by the Nova Scotia Department of Justice. It is found on page 21. It includes some instructions to help you fill it out. (You do not have to use this form to write your Personal Directive, it was developed as a guide. You can write your instructions on any piece of paper, as long as it is signed dated and witnessed appropriately. You also do not need a lawyer to write a personal directive, although you may wish to consult one depending on your personal circumstances. For more information, please see: "How to Write a Personal Directive" on page 13 of this booklet.)

NOTES

Questions you may have

These questions have been adapted from the Personal Directive page of Nova Scotia Department of Justice website: www.novascotia.ca/just/pda.

When is your Personal Directive/Advanced Care Plan used?

Your plan is only used if you are mentally incapable of making your own health care decisions (e.g., you are in a coma or your illness has impaired your ability to communicate your decisions). Your Substitute Decision Maker(s)/Delegates can use it to guide your care, advocate for your wishes, and consent or refuse consent to treatment on your behalf.

What if I change my mind?

Our lives – and the people around us – change over time. You will want to review your advance care plan/personal directive regularly to be sure it still reflects your wishes and that you are comfortable with your choice of Substitute Decision Maker/Delegate. Remember, it will only be used if you cannot speak for yourself.

In Nova Scotia, the Personal Directives Act sets out how to make changes/revoke your Personal Directive. Changes or the intention to change should be made in writing, dated and witnessed and all previous copies destroyed. See details in “How to Make A Personal Directive” on page 13 of this booklet or the forms attached to the end of this document for more information.

What happens in an emergency if I cannot communicate and the hospital does not know who my Substitute Decision Maker/Delegate is?

If you have written instructions that health care providers are able to access, they will make decisions based on that information. If written instructions are not available and there is time to do so, health care providers will attempt to locate a relative or neighbour who can direct them to who your named delegate may be. If there is no information and a relative cannot be located, health care providers may contact the public trustee.

If it is an emergency situation and time is a concern, the health care providers will proceed with providing treatment. To avoid this situation, you may want to have a card in your wallet indicating you have a Personal Directive and/or that you have named a Delegate, and include his/her contact information.

It is also important to make sure your family doctor has a copy of any written instructions, or any documents naming a Delegate in case s/he is contacted.



Questions you may have (continued)

What if my Substitute Decision Maker/Delegate is not able or willing to make decisions for me?

In Nova Scotia, you have the option to name an alternate individual as your named Delegate. The alternate would be asked to assume the role of your decision maker if your Named Delegate is unable to do so.

I have a “Living Will.” Is that not good enough?

In Nova Scotia, the law does not mention any document called a Living Will, although it is commonly thought of as any document in writing in which you list your wishes about medical treatments you may or may not want. Therefore, a living will can be incorporated into your Personal Directive as your instructions about your care. According to the Personal Directives Act in Nova Scotia, a document that is signed, dated and witnessed according to the requirements of the Act will be a legal document and must be honoured. For more details on what these requirements are, please see “How to Write A Personal Directive” on page 13 of this booklet.

My family will know what to do. Why do I have to write it down?

Writing down your wishes helps to ensure your wishes are clear for everyone. You may believe that they know what to do, but they may not. For example, you may have said something like “pull the plug if I’m a vegetable,” but you need to be clear about what that really means to **you**. Your family may also have questions about the wishes that you have made. Writing down those wishes may help the conversation.

However you do not need to write down your wishes for those wishes to be followed by your Substitute Decision Maker/Delegate because you can choose to provide wishes only orally. In Nova Scotia, you do not have to write down your wishes in a Personal Directive. If you choose, you can simply write down who you are naming as a delegate to make health care personal care decisions for you. However, it is important you discuss your wishes with that person.

These types of documents are only for old people, right?

You cannot predict how and when you will die. If you are an adult, you should have an Advance Care Plan. You can change your plan as often as you like and as your life changes. But do not just write it down. The most important thing to do is to have a conversation with the person or people who will be asked to give or refuse consent to treatment when you are unable.

What other documents should I consider preparing?

An Enduring Power of Attorney allows you to appoint someone to look after your money, property and financial affairs when you are not mentally capable of making financial and property decisions, or if you wish them to assist you with your financial affairs when you are still capable. It is only in effect when you are alive.

A Will that allows you to set out how you want your personal, property and financial assets handled after you die. A Will takes effect when you die.

How to write a Personal Directive²

The Nova Scotia government has provided sample Personal Directive forms for you to use if you want.

- There is a short form if you just want to name a Delegate. Naming a Delegate Only in a Personal Directive: Information and Sample Short Form. (Found at <http://novascotia.ca/just/pda/>)
- There is a longer form that you can use to write your Personal Directive and Name your Delegate – Making a Personal Directive Information and Sample Form. (Included in this Workbook on page 21).
- You may find it helpful to read the sample forms and the accompanying instructions for completing them because they highlight issues you should think about when writing a Personal Directive.

You do not have to use either form, as long as your Personal Directive meets a number of criteria. Your Personal Directive is valid under the Personal Directives Act if:

- You are capable of understanding the nature and effect of the Personal Directive when you complete it.
- It is in writing and dated.
- You sign it in the presence of a witness, and your witness signs it.
- If you are physically unable to sign, but are mentally capable, another person can sign for you in the presence of both you and the witness. The person who signs for you cannot be your Delegate or their spouse.

The following people may NOT sign as witnesses to your Personal Directive:

- A person you named as your Delegate.
- The spouse of your delegate. A spouse includes married, common law and registered domestic partners.
- A person who signs the Personal Directive on your behalf.
- The spouse of a person who signs the Personal Directive on your behalf. A spouse includes married, common law and registered domestic partners.

You do not need a lawyer to write a Personal Directive, but you may wish to speak with a lawyer when you are discussing other planning tools such as an Enduring Power of Attorney and a Will.

What to do with a personal directive once it is signed:

- Keep the original at home in a special place and tell people where it is. Make sure the place is easily accessible. You may want to consider storing it in places such as a freezer, fridge, kitchen cupboard, so people can find it easily in an emergency.
- Give a copy to your delegate.
- Give copies to other trusted family members and friends.
- Give a copy to your physician and other people who will be providing care to you.
- If you are traveling, take a copy with you. Many provinces and U.S. states will honour your wishes. Some will follow the rules in place in their province or U.S. state. If you plan to travel, you should check the procedure in that location.
- If you are admitted to a hospital or a continuing care home, take a copy with you.
- List the people who have copies of your Personal Directive and keep this list with your Personal Directive. If you change or cancel your Personal Directive, let these people know.

² Adapted from: Personal Directives in Nova Scotia <http://novascotia.ca/just/pda/>

How to write a Personal Directive

Changing your Personal Directive:

If you want to change or cancel (revoke) your Personal Directive, you should destroy all copies of the old Personal Directive to avoid any confusion and make a new Personal Directive.

You can also declare your intention to cancel your Personal Directive in writing, signed and witnessed.

Keeping a list of who has copies of your Personal Directive will help you make sure that everyone has copies of your most current wishes. It is a good idea to review your Personal Directive every year, whenever you or your delegate have a significant change in health, or when you experience a significant event in your life such as the death of a loved one, a marriage or a divorce.

If you write some new wishes, date and sign the paper. The most current wishes made while you were still capable will be followed. The most current wishes override anything you previously put in your Personal Directive.

A sample form is provided at the end of this book, as well as instructions on how to complete it. You can fill out the sections relevant to you or simply complete the section(s) identifying your delegates. You can fill out the form and tear it out. There is also a shorter “Naming a Delegate” only form at www.novascotia.ca/just/pda. You can also write your own document, provided it meets the conditions above.

If you would like more information on the advance care planning process in general and useful links go to www.adcancecareplanning.ca or www.nshpca.ca.

These are some definitions of terms that are commonly used in health and personal care. These can help you understand your options.

Personal Care Terms

Clothing relates to decisions about what you want to wear. For example, you may want to wear clothing that has religious or cultural significance, or you may want to look a certain way.

Comfort Measures or Comfort Care focuses on care not cure. Some examples of comfort measures are: nursing care, medication for managing symptoms including pain, oxygen for shortness of breath, fluids for dehydration except by intravenous therapy, mouth care, positioning, warmth, emotional and spiritual support, and other measures to relieve pain and suffering. Comfort measures do not include treatment aimed at cure of the illness.

Continuing Care services are provided to eligible Nova Scotians who need care. Care can be provided on a long or short-term basis and include: Home Care, Long-Term Care, Home Oxygen Services, Aboriginal Continuing Care, Caregiver Benefit, HELP-Bed Loan, Supportive Care, Specialized Equipment Program and Respite. For more information visit <http://novascotia.ca/dhw/ccs>.

Continuing care homes are homes under the authority of the Departments of Health or Community Services (for example, nursing homes and group homes).

Nutrition relates to the food or drink you may wish to have. You may want to receive a certain type of diet (for example, vegetarian); you may want to receive food consistent with your cultural or religious beliefs (for example, Kosher or Halal). Nutrition can become a health care issue (for example, if you become diabetic).

Shelter is about where you live. You may wish to indicate your preferences about where you would like to live, especially if you cannot be cared for at home. Do you prefer a specific continuing care home? Do you prefer a geographical location?

Support services means services that help a person with daily activities such as housekeeping, preparing meals, laundry, toileting, dressing, feeding, mobility and transportation (for example, for grocery shopping and going to appointments).

² Adapted from the National Speak Up Workbook and the information provided by the Nova Scotia Department of Justice:
<http://novascotia.ca/just/pda/>

Health Conditions

Stroke is a potentially life threatening event in which parts of the brain are deprived of blood carrying oxygen. Strokes are commonly caused by either blockage of a blood vessel (usually in the form of a clot) or by breaking of a blood vessel that results in bleeding in or around the brain. The impact of a stroke on you physically and mentally can range from mild to severe. Stroke may affect your ability to walk resulting in the need for a cane, or a wheelchair or confinement to bed or a chair. Depending on the part of the brain affected, stroke may affect your ability to communicate (e.g., speaking and/or understanding.) You may have the supports at home to meet your needs or you may need to live in a continuing care home. How well you recover from a stroke will depend on many factors.

Dementia is a term used to describe the symptoms of many illnesses that cause a loss of memory, judgment, ability to think clearly, recognize people and communicate, as well as changes in behaviour and mood. These symptoms may be temporary and related to another condition, or they may gradually get worse over time. Symptoms can range from mild to severe.

You might be forgetful at times but able to have meaningful conversations; you might sometimes not recognize your family and friends, but usually be able to carry on conversations; you might not recognize your family and friends and be unable to have a conversation. In the most advanced stages of dementia you will need 24 hour care.

The most common form of dementia is Alzheimer's Disease.

Permanent coma is a state of unconsciousness where there is no reasonable expectation of regaining consciousness. You would need to be in bed and receive nourishment through a feeding tube. You would need 24 hour care.

Health Interventions and other Health Care Terms

Allow natural death refers to decisions NOT to have any treatment or procedure that will delay the moment of death. It applies only when death is about to happen from natural causes.

Antibiotics are drugs that may be provided to treat an infection. For example, a person with a terminal illness (such as bone cancer) may develop pneumonia. Left untreated, it can lead to death. A person may choose to die of pneumonia rather than the terminal illness.

Blood transfusions are where blood is infused into your body through an intravenous line (a needle in your vein).

Chemotherapy is a term used specifically to refer to drugs given to treat cancer. Defibrillation is where the heart is given an electric shock. Sometimes this is used as part of CPR to start the heart. Other times it is used to make an irregular heart beat become regular.

End-of-life care refers to health care provided at the end of a person's life. This type of care focuses on you living the way you choose during your last days or weeks and providing comfort measures until the time of death.

Health care professional is a person licensed, certified or registered in their province/territory to provide health care (e.g., a doctor, nurse or social worker).

Informed consent refers to the permission you give to health care providers that allows medical investigations and/or treatments. Health care providers are required to offer you, and you are entitled to receive, detailed explanations of the investigations/treatments and their risks, benefits and side effects; alternatives to these options; and what would likely happen if you refuse the options. Health care providers must also answer any questions you have about the treatments and the information must be provided before you give verbal consent or sign a consent form.

Intravenous therapy (IV) means that a needle is inserted into a vein, usually in your hand, arm or foot. This needle is connected to a tube that can carry fluids and medications directly into your blood stream.

Intubation is where a tube is inserted down your airway so that you can breathe. If you are unable to breath on your own, intubation may result in the use of a ventilator or breathing machine. Some people may want to be resuscitated, but may not want to be intubated. A definition of 'resuscitation' is included below.

Kidney dialysis cleans the blood of toxins by machine (hemodialysis) or by fluid passed through the abdomen (peritoneal dialysis). It is needed when the person's kidneys are not working.

Life support with medical interventions refers to medical or surgical procedures such as tube feeding, breathing machines, kidney dialysis, some medications and CPR. All of these use artificial means to restore and/or continue life. Without them, you would die.

Life limiting illness refers to an incurable medical condition caused by injury or disease.

Palliative care is the way we care for people who have a life limiting illness. It focuses on providing good quality of life. In other words, keeping you as comfortable and free of pain or other symptoms as possible. Palliative care may involve medicines, treatments, physical care, psychological/social services and

spiritual support, both for you and for those who are helping to care for you. Palliative care can be provided anywhere, at any stage of any illness along with care and treatment aimed at cure or prolonging life.

Radiation is a concentrated x-ray beam directed at a certain spot (e.g., a cancerous growth).

Resuscitation (cardiopulmonary resuscitation [CPR]) is used to re-start the heart if it stops beating. It includes chest compression, drugs, electric shocks and artificial breathing. Television shows give the impression that CPR is highly successful, when in actual fact, survival rates are about 0–20% depending on the person's condition.

Substitute Decision Maker (SDM) is a person(s) who provides consent or refusal of consent for treatment or withdrawal of treatment on behalf of another person when that person is mentally incapable to make decisions about treatment. The Substitute Decision Maker(s) is required to make decisions for you following any wishes you expressed about your care when you were mentally capable. If your Substitute Decision Maker does not know your wishes applicable to the treatment decision to be made, he or she is required to act in your best interests) In Nova Scotia your substitute decision maker is referred to as a Delegate or Statutory Decision Maker. More details are provided on page 6.

Surgery could include minor surgery (such as having wisdom teeth removed or feeding tube inserted) or major surgery (such as having a gall bladder removed). Symptoms are signs that you are unwell (e.g., pain, vomiting, loss of appetite or high fever).

Terminal illness means an incurable medical condition caused by injury or disease. These are conditions that, even with life support, would end in death within weeks or months. If life support is used, the dying process takes longer.

Tube feeding gives liquid nutrition through a tube into your body. A person who cannot eat or drink needs a feeding tube to get nourishment. The tube is inserted into the stomach either through the nose or a small hole cut into the abdomen. A ventilator is a machine that helps people breathe when they cannot breathe on their own.

My Advance Care Plan:

My wishes for care at the end of Life

There are some circumstances when an injury or illness cannot be reversed or cured. In some cases medical procedures, called **interventions**, will only prolong life and delay death. These procedures could include mechanical ventilation, tube feeding, intravenous fluids or other treatments (see our Word List on pages 15-18 of this workbook for more information). It is important to think about your wishes should you have a life limiting condition that cannot be reversed or cured. Would you want to be treated with these types of medical procedures?

It is important to remember that when you are in pain or experiencing unpleasant symptoms such as dizziness or nausea, health care providers will always offer you medicine and treatment to relieve those symptoms.

If the doctor finds that you have a condition that is incurable, and you reach the point where you no longer want treatment or care that will prolong your life, there is medical treatment and nursing care available to you to provide comfort. For example, if you choose you may receive:

- Surgery to control pain (such as the repair of a broken hip)
- Antibiotics as needed to relieve symptoms of infection
- Pain-relieving medicine
- Medication to ease breathing difficulties

You may also have other wishes related to your care at the end of life – such as specific spiritual rituals you may want to have performed or to have music playing. You can use the questions below to document your wishes for care.

Consider answering the following questions to help guide you and your Substitute Decision Maker/Delegate in discussions. Jot down the answers to these questions and then include them in your Personal Directive. Remember that you can change your mind at any time - just be sure that you communicate any changes to your Substitute Decision Maker/Delegate and update your Personal Directive.

1. What do I value most in terms of my mental and physical health? (For example, being able to live independently, being able to recognize others, being able to communicate with others.)

2. What would make prolonging life **unacceptable** for me? (For example, not being able to communicate with those around me, being kept alive with machines but with no chance of recovery, not having control of my bodily functions.)

3. When I think about death, I worry about certain things happening. (For example, struggling to breathe, being in pain, being alone, losing my dignity.)

4. If I were nearing death, what would I want to make the end more peaceful for me? (For example, family and friends nearby, dying at home, having spiritual rituals performed.)

5. Do I have any spiritual or religious beliefs that would affect my care at the end of life? (For example, certain beliefs about the use of certain medical procedures.)

6. Other wishes and thoughts. (Write down anything that would help others understand and support you at the end of life.)

Making Your Personal Directive Sample Form⁴

You can use this form to name your Delegate and write your Personal Directive. If you wish to name your Delegate only you can do so on this form and leave the other sections blank. Or, you can use the short form found at <http://novascotia.ca/just/pda/>

Remember you can also write your own document, provided it meets the conditions outlined in Pages 13-15 of this booklet.

Instructions for Completing a Personal Directive Sample Form

Name

I, _____, make this Personal Directive.
Name of Maker

Print your name here. You are the maker of this Personal Directive and will be referred to as the maker for the rest of the form.

To make a valid Personal Directive you must be capable of understanding the nature and effect of your Personal Directive. That means that you understand what you have put in your Personal Directive and the consequences of your choices. There is no age requirement for writing a Personal Directive.

1. Consultation when assessing capacity(optional)

Your Personal Directive only takes effect when you are not capable of making your own care decision (when you are not able to understand the nature of the decision to be made and the consequences of your choice). Your health care provider will determine whether you demonstrate an understanding of the proposed care, the risks and benefits, the alternatives, etc. This happens every time services are provided to a patient/client and is part of obtaining informed consent.

Determining capacity can be complex and sometimes it may be helpful for the health care provider to speak with someone who knows you well. You may identify someone by name (for example, Jane Smith), title or position (for example, my parish priest) with whom you would like your health care provider to speak.

2. Revoking (Cancelling) Other Personal Directives (optional)

If you have never written a Personal Directive before, go to section 3.

Section 2 allows you to revoke (cancel) previous Personal Directives.

The Personal Directives Act allows you to have more than one Personal Directive so long as they deal with different types of decisions. For this reason, there are two options for revoking or cancelling previous Personal Directives. This section allows you to:

- (1) revoke all previous Personal Directives or
- (2) revoke only certain previous Personal Directives, allowing the other(s) to remain in effect. Enter the date and a brief description of the previous Personal Directive(s) that is being revoked.

Initial the appropriate option to indicate you agree with this revocation. Initial beside only one of the options.

It is a good idea to review your Personal Directive every year, whenever you or your delegate have a significant change in your health, or when you experience a significant event in your life such as the death of a loved one, a marriage or a divorce.

⁴ Source: Personal Directives in Nova Scotia <http://novascotia.ca/just/pda/>

3. Authorization to Act as Delegate (optional)

A delegate is someone you name to make personal care decisions (including health care decisions) for you when you are not capable to make these decisions. The delegate must be at least 19 years old (unless they are your spouse). They do not have to live in Nova Scotia as long as they can be contacted.

There are two options under section 3. Choose only one of the options if you decide to complete this section.

- (1) You may name one person to act as your delegate and make any personal care decision that you are not capable to make.

You may choose to name an alternate delegate to make decisions when the delegate named before is unable or unwilling to make a decision. If you choose not to name an alternate delegate, it is advisable to place a line through the space provided for naming an alternate delegate.

- (2) You may choose different people to act as your delegates for different decisions. Each person named will be able to make decisions only for the type of decisions identified in your Personal Directive.

You may choose to name an alternate delegate to make decisions when each delegate named before is unable or unwilling to make a decision. If you choose not to name an alternate delegate, it is advisable that you place a line through the space provided for naming an alternate delegate.

Your delegate should be someone who:

- knows you very well
- is trustworthy
- is willing to respect your views and values
- is able to make difficult decisions in stressful circumstances and who you trust to speak for you

Sometimes a spouse or family member is the best choice. Sometimes they may not be the best choice because they may be too emotionally involved. Only you know what is best for your particular circumstances. Talk over your wishes with your delegate(s) and make sure they will respect your wishes, even if your wishes conflict with your delegate's wishes.

If your delegate does not know your wishes, they will make decisions based on your values and beliefs. If they don't know your values and beliefs, they will make decisions that are in your best interests. When deciding what is in your best interests, the delegate needs to consider whether consenting or refusing consent will improve or deteriorate your condition; whether it is the least restrictive option; and what are the risks and benefits of consenting or refusing to consent.

If you decide not to name a delegate and you do not provide specific instructions under section 5 of the sample form about the decision to be made, a person authorized under the Personal Directives Act may be asked to make the decision on your behalf. These people

are called statutory decision-makers and they may only make decisions about your health care, placement in a continuing care home, and home care services. The people in the list below are potential “statutory decision-makers”. A care provider will start at the top and work their way down the list until they find an adult who has been in contact with you over the previous year and is willing to make the decision.

- spouse (includes married, common law, registered domestic partners)
- child
- parent
- person who stands in the place of a parent
- sibling
- grandparent
- grandchild
- aunt or uncle
- niece or nephew
- other relative

If there is no one from that list available or willing to make the decision, the Public Trustee’s office will be contacted. A stranger may not be the person you wish to make your decisions.

Your statutory decision-maker will make decisions based on your values and beliefs. If they don’t know your values and beliefs, they will make decisions that are in your best interests. When deciding what is in your best interests, the statutory decision-maker needs to consider whether consenting or refusing consent will improve or deteriorate your condition; whether it is the least restrictive option; and what are the risks and benefits of consenting or refusing to consent.

If you choose to name a delegate, go to section 5.

If you choose not to name a delegate, go to section 4.

4. No Delegate Authorized (optional)

You may decide that you do not want to name a delegate but you do want your care providers to follow specific instructions. By completing section 4, you are telling care providers that your instructions should speak for themselves and the care providers can rely on them without needing to get the consent of another person. You will write down your instructions in the next section of the sample form (section 5). Talk about your instructions with your care providers, including health care providers, to ensure your instructions reflect your wishes and to ensure they understand what you want.

It is important to know that it is very difficult to write down instructions that cover every situation. If your instructions are not relevant to the decision to be made or if they are not clear, the care provider may need to talk with a statutory decision-maker and ask them to make the decision on your behalf. In these circumstances, the statutory decision-maker would be guided by what you wrote down and make the decision they think you would have wanted.

5. Specific Instructions (optional)

You may write down specific instructions that you want your delegate to follow, or if you have not named a delegate, that you want your care providers to follow. For example, you may decide to write down instructions about a medical treatment you would or would not want in certain circumstances. For instructions relating to health care, you should talk with your health care provider so they can provide you with accurate information about health conditions and treatment options. It is important to be informed before you decide what instructions to write down. At the end of these Instructions for Completing a Personal Directive (Long Form), there is a list of words that relate to personal care choices (including health care). These may help you think about some of the possible choices you may want to consider.

When you write down your instructions, it is very important that you express them clearly and identify the situations where you expect the instructions to be followed. Your delegate or care providers can only follow instructions that are clear (everyone would agree on what you mean) and that apply to your circumstances at the time the decision is made. Some examples of what you might want to express in this section include:

- My faith affiliation is such that I would not want a blood transfusion under any circumstances
- If I have a severe stroke [see information that follows these Instructions] and cannot maintain an acceptable quality of life [you need to say what ‘acceptable quality of life’ means to you here or in section 6] I do not want anyone to attempt to or continue to resuscitate me if I have no pulse and am not breathing
- If I can give a family member an organ and still maintain an acceptable quality of life [you need to say what ‘acceptable quality of life’ means to you here or in section 6] then I want to donate the organ while I am still alive

Remember that you can fill out both section 5 (specific instructions) and section 6 (other information). If your instructions are unclear or do not apply to the situation, your delegate or statutory decision-maker will make decisions based on your values and beliefs. If they don’t know your values and beliefs, they will make decisions they believe are in your best interests.

6. Other Information (optional)

You may write down general information that you think will help your delegate or statutory decision-maker when it comes time to make personal care decisions (including health care) on your behalf. You can write down specific instructions (under section 5) and general information under this section of the Personal Directive.

It is impossible to anticipate every situation. It may be most useful if you express your basic personal values and beliefs about your life and future care and leave the specific decisions up to your delegate or statutory decision-maker. You should think about your religious beliefs, cultural preferences or other information that will help guide your delegate or statutory decision-maker when they make decisions for you in the future. What you write down should reflect YOUR personal values, beliefs and wishes, and should identify what is important to YOU. Talk to your delegate and loved ones about this. Some examples of what you might want to express in your Personal Directive include:

- what you would consider to be an acceptable quality of life (think about such things as:
*recognize family and friends *communicate *feed myself *take care of myself
*be conscious and aware of my surroundings and people *live in my own home
*breathe on my own without assistance from a ventilator)
- your views about admission to a continuing care home if necessary
- whether you prefer to stay at home as long as this does not cause undue stress on your family and caregivers
- your values and beliefs about sexual activity
- your values and beliefs about what you eat
- your preferences around social activities
- whether you want everything possible done to maintain life
- whether your religious beliefs are important to you and because of this you have certain wishes
- if you are nearing death, what you would want or not want to happen
- whether you would want to die at home if possible

Your wishes will be respected as long as they apply to the situation and they are possible to comply with. For example, it may not be possible to comply with your wish to never live in a continuing care home if your physical care needs become too much for your family and home care services. Current administrative processes will be followed consistently whether you are making the decision yourself or if the preference is expressed in a Personal Directive.

Health care decisions are complex and it is helpful to think of them in two general contexts:

- (1) situations where you have a condition that you will recover from and
- (2) situations where you have a condition that is life threatening or irreversible and unacceptable to you.

You may want to list your health care wishes under these two general contexts. For example, you may want to say something like:

“If I have a condition that is reversible or where I can achieve an acceptable quality of life [and you have described what ‘acceptable quality of life’ means to you], I want the following: e.g., all necessary health care including life saving treatment; or all necessary health care except...”

“If I have a condition that will cause me to die soon or a condition (including substantial brain damage or brain disease) where there is little reasonable hope that I will regain a quality of life acceptable to me [and you have described what ‘acceptable quality of life’ means to you], I want the following: e.g., resuscitation; comfort measures only; specific treatments if recommended by my health care providers e.g., antibiotics, kidney dialysis; transfer to a hospital if necessary; all necessary health care to prolong my life...”

At the end of these Instructions there are descriptions of some of the more common health conditions and treatments that many people think about when planning for their future health care decisions and making their Personal Directive. Talk to your health care provider about your current health condition and future treatment options.

7. Instructions about Statutory Decision-makers (optional)

You may decide that you do not want to name a delegate and that you are comfortable with having your nearest relative act as your statutory decision-maker, but there is a relative(s) in the following list that you would NOT want to make decisions for you. If so, you can put that information in your Personal Directive.

- spouse (includes married, common law, registered domestic partners)
- child
- parent
- person who stands in the place of a parent
- sibling
- grandparent
- grandchild
- aunt or uncle
- niece or nephew
- other relative

8. Consultation when Delegate Making Decision (optional)

If you fill out this section, you must name a delegate.

Sometimes there may be more than one person that you want to be involved in making a decision about your personal care (including health care). Where you name a delegate, only your delegate can make the decision on your behalf, but you can direct your delegate to talk with certain people (e.g., family, friends, spiritual advisor) before making a final decision. This can be helpful to inform your delegate and help them make the decision on your behalf.

9. Notification (optional)

You can decide if you want certain people told, or not told, when your Personal Directive becomes effective (when a care provider has determined that you are not capable of making a personal care decision (including health care)). When this happens your care provider will look to your Personal Directive to see who should make the decision for you or to see if you have provided instructions about the decision.

You should list the people you want to be told when you have been determined to be incapable of making a personal care decision. You may want to list people who are close to you and who will support you. This may include your family, spiritual advisor, Power of Attorney that you have appointed, lawyer and others. It is helpful to list their contact information.

There may be people who you do not want to be involved in your life when you become incapable of making personal care decisions. You should list their names.

10. Compensation for Personal Care Services (optional)

If you want to name as your delegate the person who provides you with personal care services for pay, then you must specifically authorize the details of your payment agreement in your Personal Directive. It is advisable that you speak with a lawyer if you want to complete this section.

11. Remuneration for Delegate (optional)

Generally, delegates can only be reimbursed for reasonable out-of-pocket costs associated with being a delegate, but they cannot be paid for taking on the role of a delegate. However, if you want to pay your delegate for acting as your delegate, then you must specifically set out the details of this payment in your Personal Directive. It is advisable that you speak with a lawyer if you want to complete this section.

12. Signatures (mandatory)

If your Personal Directive is not signed and witnessed properly, it will not be valid.

You must sign and date the Personal Directive in the presence of a witness. If you are physically unable to sign the Personal Directive but you are mentally capable, you can direct another person to sign for you in front of you and the witness. The person who signs for you can't be your delegate or their spouse.

Who witnesses your signature is important. The following persons may NOT witness the signing of a Personal Directive:

- A person you named as your delegate.
- The spouse of your delegate. A spouse includes married, common law (partners living together for 1 year or more) and registered domestic partners.
- A person who signs the Personal Directive on your behalf.
- The spouse of a person who signs the Personal Directive on behalf of the maker. A spouse includes married, common law (partners living together for 1 year or more) and registered domestic partners.

Suggestions for after you complete your Personal Directive

- Keep the original at home in a special place and tell trusted family and friends where it is.
- Give a copy to:
 - your delegate
 - trusted family members and friends
 - your physician and other people who will be providing care to you.
- Take a copy with you:
 - If you are traveling. Many provinces and U.S. states will honour your wishes. Some will follow the rules in place in their province or U.S. state. If you plan to travel you should check the procedure in that location.
 - If you are admitted to a hospital or continuing care home.
- List the people you have given copies of your Personal Directive to and keep this list with your Personal Directive. If you change or cancel your Personal Directive, let these people know.

Copies of my Personal Directive have been given to:

Name	Relationship	Contact Info

Note: This information is provided to help you understand the Personal Directives Act. It is not legal advice or medical advice. Consult a professional if you need help to understand your options and the implications of your choices.

I, _____, make this Personal Directive.
Name of Maker

This Personal Directive is made pursuant to the Personal Directives Act and takes effect if I am not capable of making a decision regarding my personal care.

I have placed my initials and my witness has placed his/her initials next to the sections in this document that I want to be part of my Personal Directive.

1. Consultation when assessing capacity (optional)

Witness' Initials

Your Initials

The person making the assessment of my capacity is to consult with the following person when making the assessment.

Name: _____
Print Name, Title or Position of Individual

Address: _____
Street Address

City/Town Province

Phone: _____ Email: _____
Home Business

2. Revoking (Cancelling) Other Directions (optional)

Witness' Initials

Your Initials

I revoke (cancel) all previous instructions, personal directives, and authorizations, including those made pursuant to the Medical Consent Act.

OR

Witness' Initials

Your Initials

I revoke (cancel) only the following instructions, personal directives or authorizations:

Date: _____

Description:

3. Authorization to Act as Delegate (optional)

Witness' Your
Initials Initials

I authorize the following person to act as my delegate to make personal care decisions on my behalf for all personal matters, of a non-financial nature, that relate to me.

Name: _____
Print Name of Delegate

Address: _____
Street Address

City/Town Province

Phone: _____ Email: _____
Home Business

If my delegate is unable, unwilling or unavailable to make a personal care decision, I authorize the following person to act as my alternate delegate.

Name: _____
Print Name of Alternate Delegate

Address: _____
Street Address

City/Town Province

Phone: _____ Email: _____
Home Business

OR

Witness' Your
Initials Initials

I want to authorize more than one delegate to make different personal care decisions on my behalf. I authorize the following individuals to act as my delegates and alternate delegates (if the delegate is unable, unwilling or unavailable to make a personal care decision) to make personal care decisions on my behalf for all the following personal care matters, of a non-financial nature, that relate to me:

health care

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

home care services

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

accommodation,
including placement
in a continuing-care
home

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

with whom I may
live and associate

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

participation in
social activities

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

participation in
educational activities

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

participation in
employment activities

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

other personal care
matters as follows:

Name of Delegate and contact information

Name of Alternate Delegate
and contact information

4. No Delegate Authorized (optional)

I **DO NOT** wish to authorize a delegate, but have provided instructions in section 5
for persons who intend to provide personal care services to me.

Witness'
Initials

Your
Initials

5. Specific Instructions (optional)

I instruct my delegate(s) to carry out the following specific instructions when
making decisions about my personal care:

additional page attached? ☐ Yes ☐ No

Witness' Initials

Your Initials

If I have not designated a delegate(s), or if my delegate(s) and alternate delegate(s) are unable, unwilling or unavailable to make a personal care decision, I instruct all persons who intend to provide personal care services to me to follow the following instructions that are relevant to the decisions to be made:

additional page attached? ☐ Yes ☐ No

6. Other Information (optional)

Witness' Initials

Your Initials

I provide the following information to help my delegate(s) or statutory decision-maker understand my values, beliefs and wishes when making decisions about my personal care:

additional page attached? ☐ Yes ☐ No

7. Instructions about Statutory Decision-makers (optional)

Witness' Initials

Your Initials

I **DO NOT** wish to authorize a delegate and am comfortable with a relative authorized under section 14 of the Personal Directives Act making decisions on my behalf about health care, home care and placement in a continuing care home, except I **DO NOT** want the following relative(s) making decisions on my behalf:

Name	Relationship
------	--------------

8. Consultation when Delegate Making Decisions (optional)

Witness' Initials

Your Initials

My delegate(s) is to consult with the following person(s) when making decisions about my personal care.

Name: _____
Print Name of Delegate

Address: _____
Street Address

City/Town Province

Phone: _____ Email: _____
Home Business

9. Notification (optional)

Witness' Initials

Your Initials

If it is determined that I lack capacity to make a personal care decision,
I instruct the person making the determination to notify me, the delegate(s)
I have authorized in this Personal Directive, if any, and the following people:

Witness' Initials

Your Initials

If is determined that I lack capacity to make a personal care decision,
the following people are not to be notified of the determination:

10. Compensation for Personal Care Services (optional)

Witness' Initials

Your Initials

My delegate, _____, is authorized to
Name of Delegate
receive compensation for providing me with personal care services on the following terms:

11. Remuneration for Delegate (optional)

Witness' Your
Initials Initials

My delegate, _____, is authorized

Name of Delegate

to receive remuneration for exercising his/her authority under this personal directive on the following terms:

12. Signatures (mandatory)

Signed by me in the presence of my witness at _____, in the Province of

Location

Nova Scotia, this _____ day of _____, _____.

Day

Month

Year

Printed Name of Witness

Printed Name of Maker

Relationship to Maker

Signature of Maker in the presence of the Witness

Signature of Witness in the presence of the Maker

Street Address

Street Address

City/Town

City/Town

Province

Province

Home Phone Number

Business Phone Number

Home Phone Number

Business Phone Number

Email

Email

OR (where Maker physically unable to sign)

Signed on behalf of the Maker, _____, in the presence of the
Name of Maker

Maker **and** in the presence of the witness at _____, in the Province of
Location

Nova Scotia, this _____ day of _____, _____.
Day Month Year

Print Name of Person signing on behalf of Maker

Print Name of Witness

Relationship to Maker

Signature of Person signing on behalf of Maker
in the presence of the Maker

Signature of Witness in the presence of the Maker

Street Address

Street Address

City/Town

City/Town

Province

Province

Home Phone Number Business Phone Number

Home Phone Number Business Phone Number

Email

Email

My Advance Care Plan: **My other planning documents**

In addition to this Advance Care Plan, I have also completed the following documents:
(check all that apply, and note the location of each document)

<input type="checkbox"/> Enduring Power of Attorney	Location: _____
<input type="checkbox"/> Will	Location: _____
<input type="checkbox"/> Organ Donation	Location: _____
<input type="checkbox"/> Other (e.g. specific bequests)	
Name of Document: _____	Location: _____
Name of Document: _____	Location: _____

Now that you've made your plan...

Speak Up

Start the conversation
about end-of-life care

Congratulations on beginning the process!

Now that you've made your plan, it's time to tell others about it.

Continue the conversation about end-of-life care.

Talk to your future Substitute Decision Maker/Delegate about your plan and your wishes. They may have questions about your wishes about future care or want more details about what you have written in your plan. That conversation can give them the information and confidence to make decisions about your care during a difficult time.

Talk to your family members and friends – they need to know your wishes if you cannot communicate for yourself. Share your conversation and wishes with your doctor and health care providers as you see fit. Talking now will help reduce any anxiety and will help them better understand and honour your wishes at the end of life.

The choices you make at the end of life – for yourself and others – are important. Make sure that your voice is heard.

For more information about advance care planning, please visit:
www.advancecareplanning.ca
www.nshpca.ca



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