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ADVANCE CARE PLANNING INFORMATION SHEET

Advance Care Planning is a voluntary process of discussing and writing down future health care wishes in advance. What you write down in your Advance Care Plan only comes into effect if and when you become unwell and are unable to communicate those wishes for yourself.

If you become seriously unwell, information in your Advance Care Plan will guide your family and doctor when making medical treatment decisions on your behalf. Advance Care Planning conversations are an important aspect of planning and these conversations can include your family/whānau, health professionals, friends, carers, lawyer, kaumatua, minister.

The conversations give you the opportunity to develop and express your preference based on:

- your personal beliefs
- a better understanding of your current and likely future health
- treatment and options available.

Advance Care planning is about deciding what you do and do not want, not about withholding treatment. It's about making sure that everyone has a clear understanding of your wishes and preferences.

Advance Care Planning can include:

Documenting your Advance Care Plan

Advance Care Planning is about thinking, talking and planning. The outcome of this process is an Advance Care Plan where you write down what is important to you.

The National Advance Care Planning Co-Operative has developed several resources, including "My Advance Care Plan", where you can write your individual plan. These resources are available through your General Practice team or MidCentral hospital clinician or access through the website: www.advancecareplanning.org.nz.

It is recommended you take your "My Advance Care Plan" form to your Doctor or Registered Nurse for further discussion, as the final page provides for specific treatment and care preferences.

(Please note that you will need to book an appointment with your general practitioner or practice nurse, for which there may be a cost).

Enduring Power of Attorney (EPOA)

An Enduring Power of Attorney is a legal document that allows you to appoint another person (your attorney) to make decisions on your behalf, but only if you are not able to make or communicate these yourself. (A doctor must certify that you are not mentally capable of making an informed decision before the attorney can be enacted).

You can appoint an attorney to manage your property and an attorney to make decisions about your care and welfare. This may be the same person.

When selecting someone to be your attorney it is important to choose someone 18 years or older, whom you trust, who knows you well, who is willing to respect your views and values, who will be a good advocate for you and who is able to make decisions under circumstances that may be difficult or stressful.

Advance Directive

An Advance Directive is an instruction on what medical care or treatment you do or do not want in specific future circumstances.

An Advance Directive may be a stand-alone document or part of an Advance Care Plan. An advance directive cannot be made by someone else on your behalf.

Storing Your Advance Care Plan

It is important that others have access to your Advance Care Plan if you are unable to communicate for yourself in the future. It is recommended you keep your original Advance Care plan in a safe place that your family/ whānau are aware of. It's a good idea to give a copy to others eg your general practitioner team, lawyer.

You may also want to send a copy of your Advance Care Plan to the hospital, so that if you are ever admitted to hospital the health professionals are aware you have an Advance Care Plan.

There are also wallet size cards available through your general practice or Palmerston North hospital, that you can carry in your wallet or purse, identifying you have an Advance Care Plan and who to contact in an emergency.

Changing or Cancelling Advance Care Plan Documents

You might want to change or cancel your advance care planning documentation in the future if there is a change in your personal or medical circumstances. For example, the person that you appointed may no longer be the best person for that role, or your goals for medical treatment may have changed.

Make sure you let your EPOA, family and your doctors know if you change your plan and provide them with copies of your new document, so they can be kept up to date with your life changes and health status.

How to do Advance Care Planning

1) Think about your beliefs, values and goals for what is important in your life.
2) Talk to your family and friends about your wishes for health care in the future.
3) Talk to your General Practitioner, hospital doctor or other health professionals and find out more about your illness and what may occur in the future.
4) If you wish, chose a person to be Enduring Power of Attorney, and discuss your beliefs, values, goals and your wishes regarding medical treatment with them. Ensure they understand your viewpoint.
5) Write your choices and wishes in an Advance Care Plan.
6) If possible, give copies of your document to relevant people (in case they need them in the future). This may include your EPOA, family, friends, doctor, hospital, lawyer.

These are the documents you are likely to see as you make your way through the Advance Care Planning process. If you have any further questions after reading this information sheet, please don't hesitate to contact your health professional for more information.