

## Common ACP Documents in British Columbia

It is recommended to seek legal advice on the unique authority of each document, how they work together and to ensure the documents meet legal requirements.

**Advance Care Plan:** A document(s) that records your specific health care wishes and instructions.

**Advance Directive:** A legally binding document that states what health care you give consent or refusal to, in advance.

**Enduring Power of Attorney:** A legal document in which you appoint one or more persons to handle your financial and legal affairs. It is valid while you are capable of making your own decisions and remains valid if you become unable to do so.

### **Medical Orders Scope of Treatment (MOST):**

A MOST is a medical order, completed by your physician or nurse practitioner, to let your health care team know what level of care you wish to receive. Each Health Authority in B.C. has their own MOST form.

### **Representation Agreement Section 7:**

A legal document in which you appoint a representative to help make decisions on your behalf regarding personal care, health care, and may also include routine management of financial and legal affairs.

### **Representation Agreement Section 9:**

A legal document in which you appoint a representative to help make decisions on your behalf regarding personal care and health care, including living arrangements, participation in activities, and giving or refusing consent to life-preserving health care.

## Advance Care Planning Resources

Speak with your health care provider or visit [Interior Health's ACP](#) webpage to learn more and to access related documents.

Use the camera on your cell phone to scan the QR code below to go directly to Interior Health's ACP webpage.



### [My Advance Care Plan Workbook](#)

This workbook will guide you through the 5 steps of ACP with prompting questions to assist you in completing your advance care plan.

**Electronic version:** The workbook can be accessed and downloaded from Interior Health's ACP webpage.

**Printed version:** You can request a workbook by contacting your health care provider or local Interior Health [Home and Community Care office](#).



## Advance Care Planning Is For Everyone

Advance Care Planning is about thinking ahead, having discussions and writing down what's important to you so your loved ones and health care team know your values and wishes.



### Interior Health ACP Contact Info

For more information please email [advancecareplanning@interiorhealth.ca](mailto:advancecareplanning@interiorhealth.ca)

## What is Advance Care Planning?

Advance care planning (ACP) starts with you. It can begin at any stage of life and be revisited throughout your life journey. ACP is thinking about and writing down your wishes or instructions for personal, financial, and health care decisions.

It involves reflecting on physical, spiritual, cultural, emotional and mental aspects of your well-being and how they guide your advance care planning. These wishes or instructions are then written into an advance care plan.

Talk with your loved ones and health care team about the care or treatment you do or do not want to receive. Do not assume they know what you would want. It is also important to choose a Substitute Decision Maker (Representative) to speak on your behalf if you are unable to speak for yourself.

Having conversations about ACP and end of life care may feel uncomfortable or awkward and may often be avoided. There may even be a fear of initiating the conversation. Talking with your loved ones about ACP should start long before there is a health crisis.

Together we can make these conversations easier. We can ensure that our own wishes, and those of the people who matter most to us are both understood, communicated and respected.

## 5 Steps of ACP

The following 5 steps are part of Canada's national ACP framework to guide people through the process.



**THINK** about your values, beliefs, wishes and goals of care.



**LEARN** about your health, medical care options and the role of a Substitute Decision Maker (SDM).



**DECIDE** what health care you want to accept or refuse, and who will be your SDM.



**TALK** about your wishes with your loved ones, SDM and health care providers.



**RECORD** your wishes by writing them down in your own [My Advance Care Plan](#) workbook.

## Reflecting Questions...

Here are some questions to consider as you explore advance care planning.

**ACP Is For Everyone:** Have you ever had a conversation with someone about ACP?

**Thinking Ahead:** What makes your life meaningful? How would your beliefs and values impact your health care decisions? Have you written these down? Do you know what legal forms would be needed to communicate your wishes if you couldn't speak for yourself?

**Health Event:** If you received a new diagnosis or had a serious injury who would you talk with to learn more? Who would you trust to be your SDM and speak on your behalf? Have you recorded your goals of care?

**Chronic Illness or Injury Progression:** Have you noticed changes in your health? Have you spoken with your health care provider about them? Do these changes impact previous ACP decisions you've made?

**Advancing Illness:** With advancing illness, have your health goals and priorities changed? Have you shared these with your SDM? Does your Advance Care Plan or Advance Directive need to be updated? Have you spoken with your health care provider about MOST?

**End of Life:** What does 'a good death' mean to you? When you think about dying are there things you worry about? If you were nearing death, what would you want to make things most peaceful for you? Do you have any spiritual, cultural or religious beliefs that would affect your care at the end of life?