

# Advance Care Planning Definitions

**Advance Care Planning:** Advance care planning is making choices about what you would want if you were too sick to talk. The three steps are:

- Thinking about what is important to you
- Thinking about what kind of choices you might have to make
- Telling others what you would like by talking to them or writing an *advance directive*.

**Advance directive:** An advance directive is a written guide for family, friends and health care staff that says what care you want if you were too sick to talk. You can share what is important to you, including at the end of your life, and name a person you trust to make choices about your health care. An advance directive is for all adults who are 18 years and older and can be changed anytime.

An advance directive includes at least these two legal forms:

- Health Care Directive and/or Living Will
  - Durable Power of Attorney for Health Care (DPOA) and/or Health Care Agent
1. **Code status:** A medical order showing if a patient wants *cardiopulmonary resuscitation* (CPR) and other medical treatment. All patients will receive CPR and medical treatment to extend their life unless shown otherwise.
    - **CPR:** Emergency care to try to restart a patient's heart and breathing if they stop. This care may include pressing on a patient's chest, putting in a breathing tube to get oxygen into a patient's body, and/or electric shock and medicines.
    - **Full Code** means that a patient WANTS CPR and all other medical treatment to live as long as possible and agrees to go to a hospital, if needed.
    - **DNR:** A DNR (*do not resuscitate*) order tells medical staff that the patient does NOT want CPR if the patient's heart stops beating.
    - **DNR—full:** This order shows that a patient does NOT want CPR, but DOES WANT all other medical care, including a breathing machine if they have trouble breathing. This also means a patient agrees to get care in a hospital's intensive care unit if needed.
    - **DNR—selective:** This order is for a patient who does NOT want CPR or a breathing machine, but DOES WANT all other medical care, including a breathing mask like a BiPAP.
    - **DNR—comfort/comfort care:** This is when a patient decides to change the goal of their health care from strong treatment to live as long as possible, to getting care to make them comfortable. This does not include CPR or a breathing machine. This is also called comfort-focused care.

2. **Durable Power of Attorney for Health Care:** A durable power of attorney for health care is a legal form where a patient can name a person they trust to make health care decisions for them if he or she is too sick to talk. It is important for that person of trust to know what is important to the patient ahead of time. This form must be notarized OR witnessed by two people (only some people may witness).
3. **Goals of care:** This is a talk about what a patient cares about and how this shapes his or her health care.
4. **Health Care Agent/Proxy:** A person(s) a patient trusts who is named in a Durable Power of Attorney for Health Care form. The person makes choices about a patient's care if they are too sick to talk.
5. **Health Care Directive:** A legal form where a person states the kind of care they would want. It also guides health care staff and a health care agent when a patient is too sick to talk. This form must be notarized OR witnessed by two people (only some people may witness).
6. **Hospice:** Care to reduce a patient's symptoms and help them to be comfortable at the end of their life. For hospice, a doctor must think that a patient is likely to live six months or less. The patient also chooses to stop health care treatment to live longer. Hospice care is given by a team at home, (person's home, nursing home, adult family home) or even a hospice facility or hospital, depending on the patient's needs.
7. **Life-sustaining treatment:** Care to keep a patient alive by helping or taking the place of a body's functions. Some examples are CPR, a breathing machine, a feeding tube and kidney dialysis. Treatments like these may be used for a short time until a patient can recover and function on their own. They can also be used for a long time, even when there is no chance a patient will get better.
8. **Palliative Care:** A service for patients of any age with any kind of serious illness and at any stage of their illness. The goal of care is to ease a patient's symptoms and reduce the stress they may feel because of their illness. Unlike hospice care, palliative care can be given along with health care that is meant to cure an illness.
9. **Permanent unconscious condition:** When a patient is not likely to wake up from a coma or vegetative state and two doctors think there is little chance the patient will get better.
10. **Terminal condition:** When a doctor thinks a patient cannot be cured and is likely to die in a short time.
11. **"The Conversation":** A patient talks about their values and goals with loved ones to share thoughts about the kind of health care they would like to get if they are too ill to speak. Shape. This talk can help loved ones know the things the patient cares most about.

## 12. Other Advance Care Planning Tools:

- **Personal letter:** A personal letter that a person writes ahead of time about their wishes if they are dying or if they ever are in a coma they will not wake up from.
- **Other advance directives:** Valley Medical Center often uses the Washington State Medical Association (WSMA) advance directives. Patients can use any type of form they like, including Honoring Choices PNW, Prepare for Your Care, End of Life WA, Five Wishes, and many more.
- **Other tools:** Patients can use many tools to help start talking with their loved ones about what is important to them. Some include: Conversation Starter Kit, Health Care Agent/Proxy Kit, Prepare for Your Care, JoinCake, MyDirectives, U.S. Advance Care Plan Registry and many more.

13. **POLST** (Physician Orders for Life-Sustaining Treatment): A form that lists a patient's wishes for health care, including if they want CPR or a breathing machine. A POLST is usually for patients with a serious illness and must be filled out and signed with a doctor, nurse practitioner or physician assistant.

14. **Surrogate decision-maker:** If a patient has not completed a Durable Power of Attorney for Healthcare form, then Washington state law decides who can make health care choices for a patient when they are too sick to talk. The state list in order: 1) appointed guardian, 2) appointed Durable Power of Attorney for Healthcare, 3) spouse or registered domestic partner, 4) parents of the patient and 5) siblings of the patient, 6) adult grandchildren of the patient, 7) adult nieces and nephews of the patient, 8) adult aunts and uncles of the patient, 9) a close friend (with limitations and requirements) of the patient. If there is a group of relatives that include more than one person, then the whole group must agree to the health care decision.