

## Common Advance Care Planning Nomenclature

**Advance Care Planning** is when you talk with your family and friends (those with whom you have a relationship) about your wishes for future health care, while you are still able to make decisions for yourself. You talk about this with someone you trust and who knows you well. This person is called your substitute decision-maker, and he/she will make decisions for you when you are not able to (i.e., not capable) based on your wishes and the information you have provided them.

**Advance Care Plan** is a summary of your wishes or instructions about the kind of care you want or don't want. This plan is for a time when you can't speak for yourself. An advance care plan can be written down or you can tell your wishes to someone, such as your substitute decision-maker. If a health care provider asks your substitute decision-maker to make treatment decisions for you, this plan can help them do that. It is different from making plans for your finances, property, estate, will or funeral arrangements.

**Advance Directives or Living Wills:** An "advance care directive" or "living will" is a voluntary written document about your expressed wishes. It is to instruct and guide your SDM about your wishes for the personal and health care you would like to receive (or not). This is not a legally binding document in Ontario.

**Allow natural death** means providing you with care and support that focus on quality of life and do not prolong suffering during the dying process.

**Capable** (in medical and legal terms): To be capable of making personal care choices means that you can understand the information you need to make an informed decision about your health care. It also means that you understand what could happen as a result of that decision (e.g., risks/benefits of agreeing or not agreeing to different treatment possibilities).

**Cardiopulmonary resuscitation (CPR)** is the medical procedures (things that are done) that try to restart your heart and breathing when your heart and/or lungs stop working. CPR includes:

- Mouth-to-mouth breathing;
- Pumping on your chest;
- Electric shocks and medications that attempt to restart your heart; and
- Machines that breathe for you.

**Code status** is a term commonly used among health care providers. It means whether or not you want cardiopulmonary resuscitation.

**Expressed wishes** are your instructions about the medical interventions you would want your substitute decision maker and your health care providers to follow.

**Goals of Care Discussions** are conversations you have in the present about your values and priorities related to your current health status and treatment decisions. This means that you speak with your loved ones and your health care providers about your health and what is important to you when thinking about treatment(s).

**Health care provider** is a person licensed, certified, registered, or trained to provide health care in many different areas.

A **health care team** is made up of many different people who have knowledge, expertise and skills. They work together to provide the best possible care to meet your needs.

**Informed consent** is the permission you give to health care providers to receive medications / treatments or to allow medical tests or procedures to be done. Before you give verbal or written consent, health care providers must fully explain and make sure that you understand the tests or procedures. You also need to understand any benefits, risks and burdens of that medication, treatment, test or procedure and alternate options.

**Intubation** is a life-sustaining measure. It is when a breathing tube is put into your airway. The tube is then connected to a ventilator (machine) that will breathe for you.

**Life Sustaining Measures** are any interventions aimed at prolonging your life. Interventions may include medications, procedures (things that are done) and devices. These measures may be different for each person and situation. You will make decisions while talking with the physician(s) or nurse practitioner. These decisions will depend on the severity of your illness and your values and beliefs.

**Medical interventions** may include procedures (things that are done) or treatments (actions or medications) that align with your medical needs and your goals of care.

**Palliative Care** is an approach that focuses on relieving symptoms that you and your family say are troubling. This type of “whole person” care focuses on maintaining and improving your quality of life. The palliative care team works with you and your family to prevent and relieve symptoms such as pain and other physical symptoms. The team also supports the emotional and spiritual concerns of you and your family.

A palliative care approach works best when started early in your illness journey. Palliative care can be provided by your health care team in the following settings:

- Home;
- Inpatient;
- Outpatient;
- Family clinic; or
- A place you choose (retirement home, long term care, hospice, residential, etc.).

*Palliative care is not equal to end of life care. End of life care is part of palliative care.*

**Power of Attorney (POA) for Personal Care** is a witnessed signed legal document. In this document:

- You name a substitute decision maker;
- You give them the power to make decisions about all aspects of your personal care (when you are not capable), unless you specify otherwise;
- You outline their responsibilities to follow through with your wishes.

This includes decisions about your:

- Health care;
- Shelter;
- Clothing;
- Nutrition;
- Hygiene; and
- Personal safety.

This POA for personal care is only used if you become incapable of making a particular decision. You continue to make your own decisions until found incapable.\*

\*If you don't have POA for personal care there is a legal way that will decide who should be your SDM. *Outlined in Health Care Consent Act.*

The **provincial Do Not Resuscitate Confirmation Form** sets out your expressed wishes about resuscitation during transfer between home, hospital and healthcare facilities.

<http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ENV=WWE&NO=014-4519-45>

**Resuscitation** is medical interventions that are done with the goal of saving your life. You must talk with your health care provider about what you want or don't want done. (See Life Sustaining Measures).

**Resuscitation status** means cardiopulmonary resuscitation.

**Substitute Decision Maker (SDM)** is someone who can legally make decisions for you when you aren't able to make them for yourself (i.e., not capable). This is a person you trust and know very well. It's someone who will honour your values and wishes concerning your care. You can choose to appoint anyone who is willing and able to act on your behalf to be your substitute decision maker except:

- Someone who is paid to provide you with personal care;

- Your health care provider;
- Someone who is under the age of 16 years; or
- Someone who is mentally incapable. (This means they can't understand the information they need to make the decision or what may happen as a result of the decision).

**Symptom Directed Management** aims to identify your symptoms and pick treatments (actions or medications) for the best quality of life possible. This means that your care will be aimed at making your symptoms better. It will not treat the disease or condition that is causing your symptoms.

**Ventilation** – There are two main types of ventilation.

- a) Invasive mechanical ventilation is when a machine breathes for you. Intubation is needed for this.
- b) Non-invasive ventilation may be used instead of invasive mechanical ventilation. It is the use of a device to help your breathing, without intubation.

## References

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