Who Will Speak for You?

Advanced Care Planning Kit
British Columbia Edition
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### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>About End of Life Planning Canada</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td><strong>PART 1 – Advance Directive</strong></td>
<td>5</td>
</tr>
<tr>
<td>Consider Your Personal Values</td>
<td>6</td>
</tr>
<tr>
<td>Consider These Medical Situations</td>
<td>7</td>
</tr>
<tr>
<td>About the Advance Directive Form</td>
<td>13</td>
</tr>
<tr>
<td>Your Advance Directive</td>
<td>14</td>
</tr>
<tr>
<td><strong>PART 2 – About the Representation Agreement</strong></td>
<td>17</td>
</tr>
<tr>
<td>Types of Representation Agreements: RA7 and RA9</td>
<td>19</td>
</tr>
<tr>
<td>Representation Agreement RA9 Form</td>
<td>20</td>
</tr>
<tr>
<td>Temporary Substitute Decision Makers TSDM's</td>
<td>22</td>
</tr>
<tr>
<td>Power of Attorney and Enduring Power of Attorney</td>
<td>23</td>
</tr>
<tr>
<td><strong>APPENDICES</strong></td>
<td></td>
</tr>
<tr>
<td>1. Your Charter Rights as a Patient</td>
<td>24</td>
</tr>
<tr>
<td>2. Glossary of Medical Terms</td>
<td>26</td>
</tr>
<tr>
<td>3. About Cardiopulmonary Resuscitation (CPR)</td>
<td>28</td>
</tr>
<tr>
<td>4. No CPR Medical Order</td>
<td>29</td>
</tr>
<tr>
<td>5. Levels of Care/ Medical Orders for Scope of Treatment (MOST)</td>
<td>32</td>
</tr>
<tr>
<td>6. Frequently Asked Questions</td>
<td>35</td>
</tr>
<tr>
<td>7. Further Resources Frequently Asked Questions</td>
<td>37</td>
</tr>
</tbody>
</table>

*With special thanks to Connie Jorsvik, BScN, Health Navigator, Patient Pathways, ACP Administrator DWDC and Dr. Sue Hughson, Director DWDC*

**Disclaimer:** 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.
ABOUT END OF LIFE PLANNING CANADA

Our Mission
End of Life Planning Canada is a national charitable organization. Our mission is to help Canadians to navigate the end-of-life experience with confidence and dignity.

Our Mandate
We promote research and provide information, education and support to help individuals and their families to plan for a gentle and dignified death, and to navigate the health care system with confidence that their rights and preferences will be respected to the very end.

We offer a broad program of information, education and support about health care rights and options at the end of life. We:

- Encourage Canadians to think about their wishes for end-of-life care, to understand their options for achieving those wishes, and to make their preferences known to their families, caregivers and health care providers in the event they should become unable to speak for themselves in the future.
- Educate Canadians about legal rights and options at the end of life, to promote informed decision-making and improve the quality of their interactions with the health care system.
- Offer personal, confidential support to individuals and/or their families who wish to discuss end-of-life rights, options and preferences in a safe and compassionate place.
- Provide resource materials such as patient rights booklets and advance care planning kits tailored to each province and territory, and conduct seminars, discussion groups and workshops to offer practical advice on how to plan for a gentle and dignified death.

Funding
End of Life Planning Canada is funded by donations from individuals, foundations and corporations that support the work that we do. Many of our services are provided by volunteers. To donate, please go to elplanning.ca.

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INTRODUCTION

This Advance Care Planning Kit invites you to think about and express your wishes for health care and treatment at the end of life. The kit is intended to provoke thinking, conversation and planning, and to encourage communication between you, your family and your health care providers.

The kit guides you through the process of considering your personal values and asks you to imagine medical situations that could happen to you. It walks you through the steps of drafting an Advance Directive and making a Representation Agreement which includes naming who will be your Representative; this is the person authorized to speak for you if you are unable to speak for yourself.

The kit contains information on medical interventions such as CPR that may be used in end-of-life situations, and explains Medical Orders for Scope of Treatment (MOST) and No CPR order. The kit also includes a glossary of terms, a summary of your legal rights as a patient, answers to some frequently asked questions, and a section on further resources.

The best time to think about your preferences for future medical care is when you are well and able. Of course it is hard to imagine how you may feel when you are not well. We offer various scenarios to help you to plan for the future, while reminding you that you can always change your mind. Advance care planning is the best way to ensure that your wishes are known to your family, your caregivers and health care providers. By doing it now, you ease the future burden of decisions that might have to be made, under difficult circumstances, by those who love and care for you.
PART 1

Advance Directive

What is an Advance Directive?
An Advance Directive is most often a document, written while you are well and able to make decisions, in which you state your wishes for medical or non-medical care, just in case you become unable to speak for yourself at some time in the future.

Why should you have an Advance Directive?
In a medical emergency or in any other circumstance that leaves you unable to communicate, for example if you have a stroke or if you are in a coma, your Advance Directive will assert your right to choose what you want or do not want in the way of medical treatment and care. It will help those responsible for your care to decide on your treatment. It will help your family to understand and support the decisions that you would have made yourself.

There is no legal requirement for you to have an Advance Directive. Only you can create it – no one else can do it for you. But if you do not have an Advance Directive, others may not know your wishes and you may be subjected to aggressive or life-prolonging medical interventions that you would not want. On the other hand, you may have a specific medical condition for which you do want all available treatment.

Start the process now of creating your Advance Directive by thinking about your personal values and the everyday pleasures that make life worth living.
CONSIDER YOUR PERSONAL VALUES

1. Think through a day in your life and consider what you enjoy most, what you look forward to, and what makes your life livable and workable. What gives your life purpose and meaning? Here are some topics to get you thinking:
   - Independence, autonomy
   - Work
   - Time for yourself
   - Friends and colleagues
   - Hobbies
   - Holidays
   - Birthdays and celebrations
   - Travel
   - Family
   - Food
   - Sports
   - Exercise
   - Reading
   - Music
   - Television, movies
   - Keeping a journal or diary

2. Which of the following do you fear most near the end of life? Rank these items from 1 to 10. Think of other concerns that you may have.
   - Losing your mobility
   - Being in pain
   - Being incontinent
   - Being alone
   - Losing the ability to think, being confused most of the time
   - Being a burden on loved ones
   - Being dependent on others for everyday activities like eating and bathing
   - Being in hospital
   - Losing your sight or hearing

3. If you could plan them today, imagine what the last days of your life would be like:
   - Where would you be?
   - What would you be doing?
   - Who would be with you?
   - What would you eat if you were able to eat?
   - Would you want the comfort of spiritual support from a member of the clergy or someone who shares your religious beliefs?
   - Are there people to whom you would want to write a letter or record an audio or video message, perhaps to be read, heard, or watched in the future?

4. How do you want to be remembered? If you were to write your own obituary or epitaph, what would it say?

5. What other personal values come to mind?
CONSIDER THESE MEDICAL SITUATIONS – Copy 1

Imagine various critical conditions and think about the treatment you would accept or refuse in each case. The answers will help to make things clear in your own mind so that you are better prepared for discussions with family, caregivers and physicians.

We have included in this kit two (2) copies of Consider These Medical Conditions.

- Complete Copy 1.
- Give Copy 2 to someone close to you, preferably your substitute decision maker. Ask them to answer the questions as though they were you.
- Compare your answers to theirs. Note and discuss differences. It is important for those closest to you to understand your values and your wishes for end-of-life care.

1. You are seriously ill with cancer but your mind is still sharp. Physicians recommend chemotherapy. They explain that this treatment often has severe side effects such as pain, vomiting, and weakness. Are you willing to endure these side effects if the chances of regaining your current health are less than 25 per cent?

   [ ] Yes
   [ ] Yes, on a trial basis
   [ ] No
   [ ] I am uncertain

   Note: It is your legal right to refuse or discontinue treatment. Read more about this Charter Right in Appendix 1.

2. You are seriously ill with terminal cancer but your mind is still sharp. Physicians offer chemotherapy to ‘buy time,’ giving you an 80% chance of an additional six months. Do you want this treatment even though it may have severe side effects?

   [ ] Yes
   [ ] Yes, on a trial basis
   [ ] No
   [ ] I would request medical assistance in dying
   [ ] I am uncertain
3. You have advanced Alzheimer’s disease, which has progressed to the point that you can no longer feed or toilet yourself and you no longer recognize your family, but you are not in pain. Do you want to be spoon-fed or tube-fed?
   [ ] Yes
   [ ] Yes, spoon-fed only
   [ ] Yes, spoon-fed or tube-fed on a trial basis
   [ ] No
   [ ] I am uncertain
   
   Note: It is your legal right to refuse food or drink.
   Read more about this Charter Right in Appendix 1.

4. You have advanced Alzheimer’s disease and no longer recognize your family. You have been hospitalized twice in the past year for pneumonia, which was cured by massive doses of antibiotics. You develop pneumonia once more. Do you want aggressive treatment in hospital again, or do you prefer to be kept comfortable at home until death occurs naturally?
   [ ] I want aggressive treatment, including antibiotics, to keep me alive
   [ ] I do not want treatment to keep me alive. I want comfort care at home
   [ ] I am uncertain

5. You have long-standing diabetes and your mind is still sharp. Last year you developed gangrene and lost one leg to this disease. You have now developed gangrene in your other leg and amputation has been recommended.
   [ ] I want the surgery to amputate my second leg if this will keep me alive
   [ ] I do not want the surgery. I want comfort care only, even though I may die
   [ ] I would request medical assistance in dying
   [ ] I am uncertain

6. You are physically very weak but your mind is sharp. You need help with most daily activities, such as dressing, bathing, eating, and going to the toilet. You develop a severe kidney infection. Dialysis is available to you. If left untreated, the infection will likely lead to organ failure that will cause your death within weeks or months.
   [ ] I want dialysis to keep me alive
   [ ] I do not want to start dialysis. I want comfort care until I die naturally
   [ ] I would request medical assistance in dying
   [ ] I am uncertain
Consider These Medical Situations – Copy 1... continued

7. You have congestive heart failure. You are always short of breath. Your swollen ankles make walking difficult. But your mind is still sharp and you enjoy time with family and friends. One day you have a severe heart attack and your heart stops beating. Do you want 911 called and CPR started?
   [ ] Yes
   [ ] No
   [ ] I am uncertain
   *Note: learn more about CPR and what you can expect in Appendix 3.*

8. You are terminally ill with a condition that causes great pain. Do you want to be sedated even to the point of unconsciousness if necessary to control your pain? This is called palliative sedation. Your physician can control the level of sedation to give you occasional hours of lucidity.
   [ ] Yes
   [ ] Yes, on a trial basis
   [ ] No
   [ ] I would request medical assistance in dying
   [ ] I am uncertain

9. You are in a permanent coma and your body is kept alive by artificial means such as mechanical breathing and tube feeding. Physicians say you will never recover because your brain has been severely damaged. But there are a few documented cases where people have recovered from a persistent vegetative state. Do you want to be kept alive in this way just in case you may someday recover?
   [ ] Yes
   [ ] No
   [ ] I am uncertain

10. Would you allow yourself to be temporarily placed on life support if your heart, kidneys or other body parts could be used in transplant operations to save other lives after you have died?
    [ ] Yes
    [ ] No
    [ ] I am uncertain

*Note: To be considered an organ donor you should register with BC Transplant’s Organ Donation Registry and ideally discuss your wishes with your family and your Representative.*
CONSIDER THESE MEDICAL SITUATIONS – Copy 2

Pretend you are the person who is asking you to answer these questions. Imagine various critical conditions and think about the treatment that you think that person would accept or refuse in each case. Compare your answers to theirs. Note the differences, talk about them. This will help you to understand their values and wishes for medical care at the end of life.

1. You are seriously ill with cancer but your mind is still sharp. Physicians recommend chemotherapy. They explain that this treatment often has severe side effects such as pain, vomiting, and weakness. Are you willing to endure these side effects if the chances of regaining your current health are less than 25 per cent?
   [ ] Yes
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   [ ] Yes, spoon-fed or tube-fed on a trial basis
   [ ] No
   [ ] I am uncertain
   
   Note: It is your legal right to refuse food or drink. Read more about this Charter Right in Appendix 1.
CONSIDER THESE MEDICAL SITUATIONS – Copy 2... continued

4. You have advanced Alzheimer’s disease and no longer recognize your family. You have been hospitalized twice in the past year for pneumonia which was cured by massive doses of antibiotics. You develop pneumonia once more. Do you want aggressive treatment in hospital again, or do you prefer to be kept comfortable at home until death occurs naturally?

[ ] I want aggressive treatment, including antibiotics, to keep me alive
[ ] I do not want treatment to keep me alive. I want comfort care at home
[ ] I am uncertain

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[ ] Yes
[ ] No
[ ] I am uncertain

Note: learn more about CPR and what you can expect in Appendix 3
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[ ] No
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[ ] I am uncertain

9. You are in a permanent coma and your body is kept alive by artificial means such as mechanical breathing and tube feeding. Physicians say you will never recover because your brain has been severely damaged. But there are a few documented cases where people have recovered from a persistent vegetative state. Do you want to be kept alive in this way just in case you may someday recover?

[ ] Yes
[ ] No
[ ] I am uncertain

10. Would you allow yourself to be temporarily placed on life support if your heart, kidneys or other body parts could be used in transplant operations to save other lives after you have died?

[ ] Yes
[ ] No
[ ] I am uncertain

Note: To be considered an organ donor you should register with BC Transplant’s Organ Donation Registry and ideally discuss your wishes with your family and your Representative.
ABOUT THE ADVANCE DIRECTIVE FORM

Turn to page 14 and read the Advance Directive form from start to finish before filling it out.

There are extra spaces for you to fill in circumstances are not covered. For example, you may have a hereditary condition you want to add.

Pay particular attention to item 4 that pertains to the “choice to prolong” and “choice not to prolong.”

Signing and making copies

1. Make copies of the form before you sign and date it so that each copy has your original signature. Give a copy to the person(s) who will be making decisions on your behalf if you are unable to speak for yourself. Keep a record of the people to whom you provide copies so that if you change your Advance Directive, you can provide them with your new wishes and eliminate possible future confusion.

2. Talk to your physician and ask that your Advance Directive and Representative Agreement be entered in your medical records. Keep a copy where it can easily be found in an emergency situation. Emergency personnel are trained to look for these documents on your refrigerator. Leave a note in a prominent place – perhaps attached to the fridge with a magnet – indicating where to find your directive and whom to call in an emergency. Suggested additional locations for copies of your Advance Directive include inside a zip lock bag in your freezer since it’s fireproof and waterproof.

3. Do not store your directive in a locked safety deposit box. It needs to be quickly accessible in case of an emergency.

You can always change your mind

Review your Advance Directive whenever your situation changes in a major way, or every year or two. If you do not make any changes, sign the Directive again with the new date in the space at the top of the form.

Review your Advance Directive if you move to a new address, if your spouse dies, if you get separated/divorced/remarried, or in the case of any other major life event.

If your medical condition has changed or if you have reconsidered some of your decisions, start over with a new form. You can download it from the ELPC website or request a new form by mail.

Be sure to tell everyone involved in your care if you change your Directive.
YOUR ADVANCE DIRECTIVE

We advise you to regularly review your Advance Directive. If you do not make changes, sign it again with the new date in the space below.

Signature ___________________________________________ Date________________

Signature ___________________________________________ Date________________

Signature ___________________________________________ Date________________

Signature ___________________________________________ Date________________

Signature ___________________________________________ Date________________

Signature ___________________________________________ Date________________

I, _________________________________________________, revoke any and all previous Advance Directives written by me.

If a time comes when I lack the capacity to give directions for my health care, this statement shall stand as an expression of my wishes and directions.

Choose one by putting a check mark in the appropriate space.

1. If I am sedated and unable to communicate, I would like the sedation lifted so that I can rationally consider my situation and decide for myself to accept or refuse a particular therapy.
   [ ] Yes [ ] No

When answering 2, 3, and 4 below, strike out conditions that you do not wish to be considered and add any that you do.

2. Should I be in any of the following circumstances, I direct that I be given only such care as will keep me comfortable and pain free until natural death occurs:
   a) [ ] An acute life-threatening illness of an irreversible nature
   b) [ ] Chronic debilitating suffering of a permanent nature
   c) [ ] Advanced dementia
   d) _________________________________________________________________
   e) _________________________________________________________________
Your Advance Directive... continued

3. In the circumstances set out in condition 2 above, if life-sustaining treatments have been started and they are the only treatments keeping me alive, I want them stopped. I specifically refuse the following life support treatments:
   
   a) [ ] Electrical, mechanical, or other artificial stimulation of my heart (CPR)
   b) [ ] Respiration or ventilator
   c) [ ] Artificial feeding such as G-tube, NG tube, or central intravenous line
   d) [ ] Being hand-fed should I no longer be able to feed myself
   e) [ ] Artificial hydration by intravenous line
   f) [ ] Antibiotics
   g) [ ] Transfer to an intensive care unit or similar facility
   h) _______________________________________________________________________
   i) _______________________________________________________________________
   j) _______________________________________________________________________

If you do not wish to have your life prolonged under the conditions set down in 1, 2, and 3 above, you must strike out 4 completely.

If you wish to have your life prolonged and request all applicable treatments, you must completely strike out 1, 2, and 3 above, leaving only the instructions in section 4.

4. [ ] I specifically direct that my life be prolonged and that I be provided all life-sustaining treatments applicable to my medical condition.

Note: While this directive puts your caregivers in charge of all treatment choices, you can always change your mind. For example, you can start treatments and then discontinue them.

I have other wishes:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Your Advance Directive... continued

5. I would prefer to be cared for and to die:
   [ ] at home
   [ ] in a hospice or palliative care unit

6. If my healthcare provider will not follow this Advance Directive, I ask that my care be transferred to a healthcare provider who will respect my legal rights.

7. If I am in a hospital or a resident in a healthcare or long-term care facility that will not follow this Advance Directive, I ask that I be transferred to another hospital or care facility.

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document, please indicate them below:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature: ________________________________ Date: __________

Print Name: __________________________________________

I have distributed this Advance Directive to the following people. This is a reminder to myself to keep these people informed of any changes. I am aware that outdated or defunct copies of this ACD may create confusion if left in circulation.

Name and phone number
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
About the Representation Agreement

What does it mean to have a Representation Agreement (RA)?
Making someone your Representative for personal care and health care transfers to this person the authority to help you make decisions on your own behalf about your personal care and your medical treatment if you need assistance to make decisions, or if you are not able to make your wishes known. The person you name in your Representation Agreement is your Representative. The Representative has access to the same information as you do if authorized by you, or when you are incapable of making your own decisions.

Why should I have a Representative?
If you are unable to communicate your wishes, your previously expressed wishes must be respected as written in your Advance Directive or as expressed orally or in any other manner. But even if you have written an Advance Directive, your medical condition may not be specifically addressed in your directive. Your Representative is authorized to make decisions on your behalf based on his or her understanding of the decisions you would have made if you were able to do so.

Having a Representation Agreement is the only way you can appoint someone to act on your behalf for your health care and personal care matters. Your Representative also has the authority to make arrangements for your personal care, such as where you will live, special dietary or clothing needs, and additional help to assist you in daily living should the need arise. Your Representative is concerned with all aspects of your future personal care as well as your medical care.

Who can I appoint?
Your Representative must be mentally capable and readily available to be contacted and legally able to have access to you. It should be someone who knows you well, who will respect your religious beliefs or spiritual values, and whom you trust to carry out your wishes.

You may not appoint as your Representative anyone who provides you with healthcare or support services for compensation, unless that person is also your spouse, partner or relative.
About the Representation Agreement... *continued*

**Talking with your Representative**

Sharing the statements and choices you make about your life and medical situations with your Representative will generate a discussion of your values and wishes. By comparing the answers your Representative or substitute decision maker has given to your own answers, you will see if she or he understands the wishes you have expressed for your future personal care and medical treatment, and is willing to take the responsibility to act on your wishes.

**Before completing the Representation Agreement form**

The form is a legal document. Read it all the way through. When you are clear about its use, complete the form and have it witnessed. You must satisfy yourself that your Representative understands the wishes you have expressed and is willing to act on your behalf.
Two types of Representation Agreements

A Representation Agreement (RA) is a legal document in BC used ONLY when you are alive, to authorize one or more people you trust to be your Representative, to help you manage your affairs and, if necessary, to make decisions on your behalf in case of illness, injury, or disability. A RA is the only way YOU can APPOINT someone to assist you or act on your behalf and to relay your wishes for your health care and personal care matters. It can also cover financial affairs. ~Bell Alliance LLP

**RA Section 7**

The RA Section 7 allows you to name a person to make routine financial management decisions, personal care decisions and some health care decisions. It does not allow the person to refuse life support or life-prolonging medical interventions for you. It can be ‘split’ into 2 agreements – one for financial and one for personal and health. The RA 7 is not appropriate if you own property or have major investments.

- **Personal Care:** Collect your mail, water your plants, clean out your fridge, look after your pets...
- **Financial Assistance:** Make sure your rent and bills are paid.
- **Health Care:** Help you make health care decisions or speak on your behalf when you are unable.

An RA7 names three people; a Representative, an Alternate Representative, and a Monitor. Your Alternate can only speak for you if the Representative cannot be reached (out-of-country or incapacitated). The Monitor is there to prevent abuse of power or position.

Note that many local financial institutions do not know about RA7’s. Tell them to treat it as a Power of Attorney and send it to their head office for verification.

For the RA 7 form we recommend that you contact Nidus for assistance in completing the form [http://www.nidus.ca/](http://www.nidus.ca/)

**RA Section 9**

The RA9 allows you to name a person to make personal care decisions and some health care decisions, *including* decisions to accept or refuse life support or life-prolonging medical
interventions for you. It does not allow for financial management. If you have property or investments an Enduring Power of Attorney (EPA) should be considered.

**Financial Assistance:** Not allowed. EPA needed for financial matters.
**Personal Care:** Collect your mail, water your plants, clean out your fridge, look after your pets...
**Health Care:** Help you make health care decisions or speak on your behalf when you are unable, including end-of-life decisions.

You need at least one person and two are recommended: one as the Representative and the other as the Alternate. As in the RA7, the Alternate can only speak for you if the Representative is unavailable.

---

**Who needs a copy of your RA?**

1. Your Representative
2. Alternate Representative
3. Monitor (for RA7 only).
   - Note: A hard copy MUST be presented by your Representative along with ID at the hospital, even if the RA is on-file with NIDUS.
4. Your doctor (they should scan your original to your file)
5. In the case of an RA7, your financial institutions will take a scan of the original.

---

**RA Section 9 FORM**

There are a number of Representation Agreement Section 9 forms available. **We recommend that you use the form from Nidus.** Click on the link below to open the form, or visit www.nidus.ca

[http://www.nidus.ca/PDFs/Nidus_Form_RA9.pdf](http://www.nidus.ca/PDFs/Nidus_Form_RA9.pdf)
Temporary Substitute Decision Makers (TDSM)

If you are not able to make decisions on your own behalf and you do not have a Representation Agreement, then a Temporary Substitute Decision Maker or substitute decision maker will be authorized to make decisions for you. The TSDM is determined by their relationship to you and where they rank in this hierarchy:

1. Spouse (can be common-law and/or same gender)
2. Adult Children (equally ranked)
3. Parent (equally ranked)
4. Siblings
5. Grandparent
6. Grandchild
7. Anyone else related by birth or adoption
8. A person immediately related by marriage
   - Unless any of these people have not been in contact with you for 12 months or more and/or there is conflict between you.

If the person you want to make decisions for you is ranked first on this list, and they are readily available to act on your behalf, then you do not need an RA. It is very important that your SDM knows your wishes for future care and they should have a copy of your Advance Directive and/or MOST.
Power of Attorney (PA) and Enduring Power of Attorney (EPA)

You can use these documents to appoint one or more people to be your “attorney” to handle your financial and legal affairs. (Attorney does not mean lawyer; most people appoint a spouse, family member or friend in a POA or an EPA.)

The Enduring Power of Attorney applies to financial and legal affairs only, not to health care or personal care. You may want an EPA if you own property or if you have investments or money that needs to be managed.

A PA is in effect only when you are mentally capable; it immediately ends when you become mentally incapable.

An EPA is in effect when you are mentally incapable (which includes many situations while in hospital); it can also be in effect when you are mentally capable.

You can restrict your attorney’s authority to specific dates or tasks. You will likely want an EPA to be as broad as possible because it is for when you are incapable.

You can do a simple EPA without an Attorney or Notary Public (see Resources) but you should strongly consider the services of an Estate Lawyer or Notary Public if you have property or investments.

Remember, the PA and EPA can only cover financial and legal affairs. Neither of them can cover health care or personal care matters.
APPENDIX 1. YOUR CHARTER RIGHTS AS A PATIENT

Healthcare laws and regulations vary slightly by province and territory but all Canadians generally share the following rights and options:

The right to be fully informed of all treatment options. This is also known as the ‘right of informed consent.’ Your physician is required to inform you of the risks and benefits of each treatment option as well as the probabilities of success.

The right to recognition of a substitute decision maker. You have the right to appoint a substitute decision maker - someone who can represent you if and when you can no longer make your own medical decisions. Your substitute decision maker can speak for you with the same authority as if you were speaking for yourself.

The right to recognition of an Advance Directive. Healthcare providers are required to follow your wishes for treatment, provided they are appropriate to your medical condition and are clearly outlined in a valid Advance Directive. The Directives you prepare may include a Do Not Resuscitate Order. Such forms are legally binding in provinces that offer them, so long as the documentation is filled out properly, signed by your physician, and kept up to date.

The right to a second opinion. It is your right to consult with another physician for any reason. Most people just want the reassurance of another viewpoint and an opportunity to speak with someone who will help them to decide on the best course of treatment.

The right to pain and symptom management. You have the right to refuse medication, but neither the Charter of Rights and Freedoms nor healthcare legislation grant you the right to demand medication. However, terminally ill persons can typically expect a vigorous pain management regimen, even if it may hasten the dying process.

The right to refuse treatment. You have the right to refuse any treatment, even if refusal might hasten your death. You also have the right to discontinue any treatment that has already started. Ethically and legally, there is no distinction between discontinuing treatment and refusing it in the first place.

The right to refuse food and drink. In Canada, nutrition and hydration by tube is considered medical treatment. You have the right to refuse or stop such treatment. You also have the right to refuse food and/or drink, and the right to refuse to be fed or given drinks by others. This option is referred to as Voluntary Stopping of Eating and Drinking (VSED) and is supported by many palliative care providers.

The right to end your own life. It is legal to end your own life in Canada and has been since suicide was removed from the Criminal Code in 1972.
Appendix 1. Your Charter Rights as a Patient... continued

The right to request an assisted death (MAID). On June 17, 2016, medical assistance in dying (MAID) became legal under some circumstances in Canada. If you are suffering from a grievous and irremediable medical condition, and natural death is reasonably foreseeable, you can talk to your doctor or nurse practitioner about your options for treatment and care which may include medical assistance in dying.

To initiate the MAID process, you must have an assessment by a physician, and a second independent assessment by another physician. Once you have been determined to meet the criteria for MAID, you must then have two independent witnesses to your request.

There are two types of MAID. The first is an injected medication that causes the immediate or rapid death of the patient. The second is where the clinician provides a lethal dose of medication that the consenting patient takes themselves, either immediately, or at another time.
Allow natural death: when death is about to occur from natural causes, do not delay the moment of death with medical interventions.

Antibiotics: drugs commonly used to treat infections. Some infections can be life-threatening for a grievously ill person. Examples would be pneumonia or an infection in the blood or brain.

Artificial nutrition: feeding by a method other than by mouth if the person is unable to swallow. Several methods may be used:
- Nasogastric Tube (NG tube): a tube inserted through the nose and into the stomach.
- Gastrostomy tube (G-tube or PEG tube): a tube inserted into the stomach for the long term administration of food, fluids and medications.

Artificial hydration: provides fluids via a small tube inserted into a vein (venous catheter or IV). Terminal patients who wish to voluntarily stop eating and drinking (VSED) and simply receive comfort care, should also request to discontinue artificial hydration by IV, as hydration prolongs the dying process.

Cardiopulmonary resuscitation (CPR): interventions that may include manual compressions to the chest, an electric charge to restart the heart, drug therapies, or a ventilator to assist in breathing. CPR can be life-saving, but the success rate for critically ill persons is extremely low. Read more about CPR in Appendix 3.

Cerebrovascular accident: see Stroke

Chronic debilitating suffering of a permanent nature: ongoing distress arising from a medical condition for which there is no cure. Examples would be Parkinson’s disease or severe diabetes.

Coma: a profound state of unconsciousness in which a person cannot be awakened by pain, light, sound or vigorous stimulation.

Comfort care: services that contribute to physical and mental ease and wellbeing, often provided for a dying person when further medical intervention has been judged inappropriate or is unwanted. See also Palliative care.

Dementia: a chronic or persistent disorder of a person’s mental processes caused by brain disease or injury and marked by memory disorders, personality changes and impaired reasoning. Alzheimer’s disease is the most common cause of dementia.
Appendix 2. Glossary of Medical Terms... continued

**Do Not Resuscitate (DNR):** means that you do not wish to undergo cardiopulmonary resuscitation (CPR) or advanced cardiac life support if your heart stops beating or you stop breathing. The form or medical order that states this is the **No CPR Order**, written either in hospital or on a legal form, to withhold CPR or advanced cardiac life support. If you are in hospital such an order may be on your chart or in a MOST order, but if you are anywhere else, the order must be shown to first responders to avoid being resuscitated. Read more about No CPR Order in Appendix 4.

**Heart failure:** a condition in which the heart is unable to pump sufficiently to maintain blood flow to meet the body’s needs; also known as congestive heart failure.

**Hospice:** from the word “hospitality,” the modern concept of hospice is a place and/or a service providing palliative care for terminally ill people in hospitals, long-term care homes or in their own home. Such care generally provides pain management and other comfort care but not medical interventions to prolong life.

**Intensive care unit (ICU):** a hospital unit with specialized staff providing constant monitoring and support for the care of those who are critically ill or injured. Also referred to as the critical care unit.

**Life support or life-sustaining treatment:** replaces or supports critical bodily functions such as breathing, cardiac function, nutrition and hydration. Such measures keep the person alive but do not cure the underlying problem. Life support may be used temporarily for a treatable condition.

**Medical Assistance in Dying (MAID):** also known as physician assisted dying. An individual can request medical assistance in dying where a physician or nurse practitioner, at an individual’s request: (a) administers a substance that causes an individual’s death; or (b) prescribes a substance for an individual to self-administer to cause their own death.

**Mechanical breathing:** used to support or replace the function of the lungs. A ventilator or respirator forces air into the lungs via a tube inserted into the person’s nose or mouth and into the trachea. In certain conditions, the tube is inserted through a small hole at the front of the throat.

**No CPR Order:** this is the only way to ensure that you are not resuscitated at home, in the community or in a Residential Care facility. For more information, see Appendix 4.
Appendix 2. Glossary of Medical Terms... continued

Palliative care: therapies given in any setting to provide comfort and to alleviate pain and distressing symptoms in order to relieve suffering and improve the quality of living and dying for those faced with a life-threatening illness or medical condition.

Personal care: includes health care, nutrition, shelter, clothing, hygiene or safety. Includes both treatment and personal assistance services.

Personal support worker services: hired services providing assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of daily living but does not include treatment.

Stroke, also called a cerebrovascular accident: a sudden disabling attack or loss of consciousness caused by an interruption in the flow of blood to the brain, especially through thrombosis (blood clot).

Terminal illness: a medical condition which has progressed to the point where death may be expected within weeks or months.

Treatment: any sort of procedure or action done for a health-related purpose, whether the treatment be therapeutic, preventative, palliative, diagnostic, cosmetic, etc.

Vegetative state: said of a person who is alive but comatose and without apparent brain activity or responsiveness. A person in a persistent vegetative state is completely unresponsive to psychological and physical stimuli, displays no sign of higher brain function and is being kept alive only by medical intervention.
APPENDIX 3. ABOUT CARDIOPULMONARY RESUSCITATION (CPR)

Cardiopulmonary resuscitation (CPR) is a medical procedure used to restart someone’s heartbeat and breathing when the heart and/or lungs stop working. CPR can be successful in emergency situations when the person is otherwise healthy. Imagine a young basketball player who collapses on the court, for example, and who is helped by CPR.

CPR is frequently performed on TV amid a flurry of people and machines; there are celebratory “high fives” all around when CPR is successful. This is a performance, which in real life is more fiction than fact. Only about 4-16% of CPR procedures done outside of hospital are successful.1

If someone suffers from severe illness, advanced old age or a terminal disease, the odds of a good outcome from CPR is extremely low while the odds of suffering are overwhelming. A frail person who has not been breathing even for three minutes will have brain damage. What’s more, during CPR ribs may be fractured, lungs punctured or the person may slip into a vegetative state and live that way for months.

This is why it is so important to make your wishes about CPR known in advance to your Representative, your substitute decision maker, your family, and your healthcare providers. CPR is an emergency procedure for which time is of the essence. If you wish to be resuscitated in the event of a cardiac incident, call 911 and first-line responders will automatically start that process when they arrive.

But remember that you have the right to refuse CPR. If you do not want to be resuscitated but need other help, 911 responders will do whatever else they can but must be shown a No CPR Order when they arrive. Read more about this forms in Appendix 4.

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APPENDIX 4. NO CPR ORDER

A No CPR Order signed by your doctor or nurse practitioner is the only way to ensure that you are not resuscitated at home, in the community, or in a Residential Care facility.

First Responders are obligated under law to begin and continue resuscitation unless they find a signed No CPR Order and/or a MedicAlert bracelet or necklet. MedicAlert requires a No CPR Order signed by your doctor before they will issue a bracelet or necklet.

The No CPR Order form is available for download at
http://www2.gov.bc.ca/assets/gov/health/forms/302fil.pdf
To be valid it must be signed by your doctor or nurse practitioner.

Where to keep your No CPR Order
All First Responders (firefighters, paramedics) are trained to look for a MedicAlert bracelet. If you do not have one they will look for medical papers on the refrigerator (in a GreenSleeve), or a note on the refrigerator stating where the papers are (Example: freezer, by front door, in top drawer of desk)

In Hospital
It is important to note that the No CPR Order does not automatically apply in acute care hospitals. In this situation the doctor needs to write a MOST order which happens after they consult with you. In the case of an in-hospital cardiac arrest, CPR is to only be initiated when the cardiac arrest is witnessed. This means that CPR will only be started if a healthcare professional is with you and witnesses you stop breathing and your heart stopping and/or you are on a heart monitor (i.e., only critical care units).

Do all healthcare professionals know about ACP, Advance Directives, & MOST?
GreenSleeves are now mandatory at the front of every patient chart in some health authorities but they are still rarely used, except on units where end-of-life is a common topic (dialysis, cardiac, elder medical units, palliative, hospice). Social Workers are all trained. RNs are often well trained. Hospitalists should all have this training. Family physicians and Specialists will likely not have had this training.

Will healthcare professionals talk to me about ACP, Advance Directives, and Levels of Care?

Never assume the health professionals know about ACP. Be assertive about bringing it up...

They are waiting for you to bring it up.
Appendix 4. No CPR Order, Sample Form

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NO CARDIOPULMONARY RESUSCITATION – MEDICAL ORDER

Capable patients may request that no cardiopulmonary resuscitation be started on their behalf. This should be done after discussions with their doctor or nurse practitioner. “No cardiopulmonary resuscitation” is defined as no cardiopulmonary resuscitation (no CPR) in the event of a respiratory and/or cardiac arrest.

This form is provided to you or your substitute decision maker to acknowledge that you have had a conversation with a physician or nurse practitioner about a No CPR Order, and understand that no CPR will be provided in circumstances where you can no longer make decisions for yourself. It instructs people such as first responders, paramedics and health care providers not to start CPR on your behalf whether you are at home, in the community or in a residential care facility. The personal information collected on this form assists the health professionals noted above to carry out your wishes. If you have any questions about the collection of this information contact HealthLink BC at 8-1-1 or go to www.gov.bc.ca/expecteddeath.

You or someone at your location should have the form available to show to emergency help if they are called to come to your aid. It is desirable that you wear a MedicAlert® or CPR bracelet or necklace to enable quick verification that you have a No CPR Order in place. To obtain a free No CPR bracelet/necklet, please call 1-800-668-1997, or visit the website at www.medicalert.ca/noCPR. If you change your wishes about this matter, then please inform your doctor, nurse practitioner or residential care facility nurse, and MedicAlert and tear up the form.

<table>
<thead>
<tr>
<th>PATIENT IDENTIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Last Name</td>
</tr>
<tr>
<td>Birthdate (YYYY-MM-DD)</td>
</tr>
<tr>
<td>Patient First and Middle Name(s)</td>
</tr>
<tr>
<td>Personal Health Number (PIN)</td>
</tr>
<tr>
<td>Patient Address</td>
</tr>
<tr>
<td>Telephone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WITNESSED BY THE PATIENT, OR BY THE PATIENT'S SUBSTITUTE DECISION MAKER (SDM) WHEN THE PATIENT IS INCAPABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I, [patient’s name or patient’s substitute decision maker] if patient is incapable, have had a conversation with the undersigned physician/nurse practitioner about this No CPR Order in the event of cardiac or respiratory arrest. I understand that in the event of a cardiac or respiratory arrest, no cardiopulmonary resuscitation is to be undertaken.</td>
</tr>
<tr>
<td>Patient’s Signature</td>
</tr>
<tr>
<td>Date Signed</td>
</tr>
<tr>
<td>Signature of the Patient’s Substitute Decision Maker</td>
</tr>
<tr>
<td>Date Signed</td>
</tr>
<tr>
<td>Relationship of the Patient’s Substitute Decision Maker to the Patient (e.g., representatives, committee of person, or temporary substitute decision maker)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER</th>
</tr>
</thead>
<tbody>
<tr>
<td>The above identified patient has expressed wishes to not have CPR in the event of cardiac or respiratory arrest. I have discussed the patient's health status, life expectancy, and expressed wishes with the patient/patient's substitute decision maker. Based on this discussion, I order that in the event of a respiratory and/or cardiac arrest no cardiopulmonary resuscitation is to be undertaken. This order shall be in effect until cancelled or repealed.</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ATTENDING PHYSICIAN/NURSE PRACTITIONER</th>
<th>ALTERNATE PHYSICIAN/NURSE PRACTITIONER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Name (Print)</td>
</tr>
<tr>
<td>License Number of Physician / Nurse Practitioner</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Phone Number</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Address</td>
<td>Signature</td>
</tr>
</tbody>
</table>

COPY 1: TO PATIENT. COPY 2: TO ATTENDING PHYSICIAN/NURSE PRACTITIONER. COPY 3: IF APPLICABLE TO HOME & COMMUNITY CARE OR RESIDENTIAL CARE FACILITY

This form can be found at www2.gov.bc.ca/assets/gov/health/forms/30268.pdf
```
Appendix 4. No CPR Order, Sample Form.

**PATIENT/FAMILY INSTRUCTIONS**

Looking at this form may be one of the most difficult things you have ever done. Many thoughts and emotions may surface. So often people try to ignore their mortality, yet we all know it is one of the facts of life: we all, one day, will die.

This form is a medical order that reflects your wishes about what you would like to have happen in the event you stop breathing or your heart stops beating. Take time to thoughtfully consider your wishes and ask your health care professionals what resuscitation would entail and any risks to quality and/or quantity of life that could accompany resuscitation if you decided to have it.

Whether you live at home or in a residential care facility, your care team will help you and/or your substitute decision maker to make choices and plans for end-of-life care. If you have a life-limiting illness and are choosing to die at home, you will need to make additional plans. The steps you will need to consider are listed below.

If you are a family member who is asked to consider this document on behalf of your loved one, all of what is said above applies also. This can be a stressful decision. Remember to seek support from trusted family members, friends and/or a spiritual advisor if you have one and your health care team.

**IF YOU WANT TO DIE NATURALLY AT HOME, CONSIDER THESE STEPS**

**INDIVIDUAL / FAMILY**

What to Do Ahead of Time

- Discuss the option of an in-home death with your physician/nurse practitioner and community nurse.
- Make a written plan with your physician/nurse practitioner and community nurse so you are sure about what will happen and so family, friends and others may support your decisions and respect your wishes and know what to do at the time of death. You need to write in your plan:
  - who will pronounce death, if pronouncement is planned. Pronouncement is NOT necessary if a "Notification of Expected Home Death" form has been completed earlier by you and your doctor or nurse practitioner. The form can be found at [www.gov.bc.ca/expectedhomedeath](http://www.gov.bc.ca/expectedhomedeath).
  - how your physician/nurse practitioner can be reached;
  - what alternate arrangements have been made should your physician/nurse practitioner be unavailable or cannot be reached;
  - which funeral home will be called to transport the deceased.
- Make prearrangements with a funeral home. Such arrangements will normally involve selecting the funeral home and making plans with the funeral director for transportation of the deceased after death and the method of final disposition. For information on funeral homes in your area, you could contact the B.C. Funeral Association at 1-800-665-3699.
- Ensure that a copy of this form is easily available in your home. If you are away from your home for any reason, take the form with you so it’s available should it be necessary.

**FAMILY / FRIENDS**

What to Do at the Time of Death

- DO NOT CALL 911, the ambulance, coroner, police, or fire department. Review your written plan for who to contact at the time of death.
- CALL family, friends, and the spiritual advisor, if any, you would like to have present.
- CALL the physician/nurse practitioner or community nurse to pronounce death if a “Notification of Planned Home Death” form has not been completed, AND/OR pronouncement is planned.
  - If your physician/nurse practitioner or community nurse cannot be reached, CALL the backup physician/nurse practitioner or community nurse if prearranged.
- If a “Notification of Planned Home Death” form HAS been completed AND is in your home, call the funeral home after one hour or more has passed since your loved one's breathing has stopped.
  - You do NOT need to call a physician/nurse practitioner about completing a Medical Certificate of Death form. The funeral home can contact the physician or nurse practitioner to obtain a signed certificate within 48 hours, because the body cannot be released for burial or cremation without it.

<table>
<thead>
<tr>
<th>People to Call</th>
<th>Name</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/Nurse Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alternate Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Nurse</td>
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<td></td>
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<tr>
<td>Funeral Home</td>
<td></td>
<td></td>
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<tr>
<td>Spiritual Advisor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Support Agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family and Friends</td>
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</tbody>
</table>

For more information, go to [www.gov.bc.ca/expectedhomedeath](http://www.gov.bc.ca/expectedhomedeath)

There are communities in British Columbia without physicians or nurse practitioners who live in the community and without a funeral home. It is essential that these situations be discussed by the patient and family and physician/nurse practitioner and an appropriate plan suitable for the community be made in advance.
APPENDIX 5. LEVELS OF CARE/MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

Levels of Care, also known as MOST, is a medical order that identifies one of six designations for scope of treatment. These designations provide direction on adult resuscitation status, critical care and medical interventions.

MOST has been adopted by all BC Health Authorities and is used in all hospitals and care facilities. It is a standardized form that expresses your wishes for ongoing treatment and care and is kept in your medical file. It covers many of the same issues as your Advance Directive but the information is distilled into a standardized form allowing health care providers to know exactly what categories of care you wish to receive.

If you have an Advance Directive, it should be converted to MOST. You should ask for confirmation that this has been done.

If you have a life-limiting or life-ending illness/disease, MOST should be discussed with you. The most appropriate person to initially discuss ACP and MOST with is a hospital social worker since they are all trained.

The Level of Care/MOST orders (along with the rest of your ACP) will be scanned into the computer for instant retrieval at all future admissions. You will be given a copy of your Levels of Care/ MOST orders to add to your ACP file at home.

(See more on the MOST designations on the following page)
Appendix 5. MOST destinations... continued

<table>
<thead>
<tr>
<th>Code Status and MOST Designations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom Control</td>
</tr>
<tr>
<td>-----------------------------------</td>
</tr>
<tr>
<td>DNR M1</td>
</tr>
<tr>
<td>DNR M2</td>
</tr>
<tr>
<td>DNR M3</td>
</tr>
<tr>
<td>DNR C1</td>
</tr>
<tr>
<td>DNR C2</td>
</tr>
<tr>
<td>CPR C2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DNR M1</th>
<th>Goal: Allow natural death with supportive care, symptom management and the provision of care. Transfer to higher level of care if patients comfort needs are not met in current location.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DNR M2</td>
<td>Goal: Treat readily reversible problems &amp; sustain life if possible within the capacity of current location of care.</td>
</tr>
<tr>
<td>DNR M3</td>
<td>Goal: Sustain life &amp; reverse medical problems. Transfer to acute care for investigations and treatment, including surgery as required. This does NOT include critical care interventions.</td>
</tr>
<tr>
<td>DNR C1</td>
<td>Goal: Reverse medical problems or sustain life, with transfer to acute care AND assessment for critical care interventions, WITHOUT intubation. Non-invasive ventilation may be offered.</td>
</tr>
<tr>
<td>DNR C2</td>
<td>Goal: Reverse medical problems or sustain life, with transfer to acute care AND assessment for critical care interventions, including intubation. However, resuscitation is not ordered (DNR).</td>
</tr>
<tr>
<td>CPR C2</td>
<td>Goal: CPR efforts, including chest compressions, defibrillation &amp; intubation for patients with a WITNESSED cardiac arrest.</td>
</tr>
</tbody>
</table>

- Generally, “M1” designations are at home, palliative/hospice or Residential Care.
- Generally, “M2 & M3” designations are Residential Care.
- Generally, “C” designations are in acute care hospitals.
Appendix 5. MOST form... continued

This form is used to notify of the patient’s will in regards to CPR and the different care levels. It is offered through the End of Life Care Program.
APPENDIX 6. FREQUENTLY ASKED QUESTIONS

Q: Can someone else create an Advance Directive on my behalf?
No. But if you are unable to write, your directive may be given orally. If someone else is writing on your behalf, his/her signature must be witnessed in your presence.

Q: What if I have a written Advance Directive in which I refuse a certain treatment, and then change my mind when I am in hospital?
You can change your mind at any time. Any instructions you give orally will override previously written instructions provided you are competent when you express the new instructions.

Q: I am just not comfortable imagining all these medical conditions you describe. Why can’t I simply say I don’t want my dying to be prolonged?
You may certainly do so. Many people do. However, if you do not set down specific instructions, a general Advance Directive is open to interpretation—and you may be treated in ways you would not want.

Q: What happens if I don’t have a Representation Agreement? Does that mean I have no substitute decision maker?
Everyone has a substitute decision maker. If you have not named a specific person as your Representative, then your substitute decision maker is determined by the following hierarchy*:

1. Spouse (can be common-law and/or same gender)
2. Adult Children (equally ranked)
3. Parent (equally ranked)
4. Siblings
5. Grandparent
6. Grandchild
7. Anyone else related by birth or adoption
8. A person immediately related by marriage

Unless any of these people have not been in contact with your for 12 months or more and/or there is conflict between you.

* If the Consent and Capacity Board has previously appointed a Representative for you, then that person rather than any other is your substitute decision maker.
Appendix 6. Frequently Asked Questions... continued

Q: My son has my Representation Agreement. If he moves out of the country, can he delegate one of my two daughters to act instead?

No, your son cannot decide this for you. You would have to make out a new Representation Agreement for Personal Care naming one of your daughters as your substitute decision maker. To prevent such a situation, name each of your two daughters as your second and third choice, and appoint them to act independently rather than jointly.

Q: I have two sons and I want to give them equal rights to make decisions for me. Why should I not appoint them to act jointly?

If appointed jointly, they have to agree on every decision before any action can be taken, and situations may arise where they disagree on your care. A better solution would be to appoint one son as your Representative and the other as your second choice if the first is not able to make decisions for you.

Q: My brother and I are not on very good terms, but I have no other relatives, so he is my substitute decision maker. What happens if he goes against the wishes in my Advance Directive and makes other decisions for me?

If your physician or anyone else who has a copy of your Advance Directive sees that your wishes are not being followed, they can apply to the Consent and Capacity Board to have your brother ordered to comply with your directive, or to request that the Board itself act on your behalf.

Q: My husband has a serious heart condition. He has had several medical procedures and numerous hospital stays for complications. He has told me that if he has another heart attack he wants to be left alone and I am not to call 911. I don’t want to take responsibility for this decision. What should I do?

To ensure that your husband is not resuscitated against his will, he should ask his physician to complete and sign a DNR Confirmation Order or MOST. Your husband should keep the form where it is easily found in an emergency. In this way, the decision is his own and not your responsibility. You will find full details of what this document is, what it means, and how you can obtain it in Appendix 3.
APPENDIX 7. FURTHER RESOURCES

INCAPACITY PLANNING

GOVERNMENT OF BC FORMS AND DOCUMENTS, INCLUDING:

- Representation Agreement (Section 9) Form
- Representation Agreement (Section 7) Form
- Representation Agreement Regulation
- Enduring Power of Attorney Form
- Health Care (Consent) and Care Facility (Admission) Act
- Mental Health Act

MY VOICE: EXPRESSING MY WISHES FOR FUTURE HEALTH CARE TREATMENT IN BC (PDF OF WORKBOOK)

HTTP://WWW.HEALTH.GOV.BC.CA/LIBRARY/PUBLICATIONS/YEAR/2013/MYVOICE-ADVANCECAREPLANNINGGUIDE.PDF

ADVANCE DIRECTIVES

SPEAK UP! INCLUDES VIDEO ON THE 5 STEPS OF ADVANCE CARE PLANNING

HTTP://WWW.ADVANCECAREPLANNING.CA/

DYING WITH DIGNITY: ADVANCE CARE DIRECTIVE

HTTP://WWW.DYINGWITHDIGNITY.CA/DOWNLOAD_YOUR_ADVANCE_CARE_PLANNING_KIT

FRASER HEALTH AUTHORITY – ADVANCE CARE PLANNING: INCLUDES VIDEOS IN A NUMBER OF LANGUAGES

HTTP://WWW.FRASERHEALTH.CA/HEALTH-INFO/HEALTH-TOPICS/ADVANCE-CARE-PLANNING/ADVANCE-CARE-PLANNING

VANCOUVER COASTAL HEALTH HTTP://WWW.VCH.CA/YOUR-HEALTH/HEALTH-TOPICS/ADVANCE-CARE-PLANNING/

NIDUS.CA

GENERAL INFORMATION: HTTP://WWW.NIDUS.CA/
Appendix 7. FURTHER RESOURCES...continued

**Registry** [https://registry.nidus.ca/](https://registry.nidus.ca/)

**Representation Agreements (for capable adults)** [http://www.nidus.ca/?page_id=6308](http://www.nidus.ca/?page_id=6308)

**Power of Attorney:** [http://www.nidus.ca/PDFs/Nidus_Info_POA-EPA_Differences.pdf](http://www.nidus.ca/PDFs/Nidus_Info_POA-EPA_Differences.pdf)

**Revoking Agreements:**

[http://www.nidus.ca/PDFs/Nidus_Info_Making_Changes_to_RA.pdf](http://www.nidus.ca/PDFs/Nidus_Info_Making_Changes_to_RA.pdf)

**Health Care Consent – Your rights under the law:**

[http://www.nidus.ca/PDFs/Nidus_Info_HCC_Your_Rights_and_the_Law.pdf](http://www.nidus.ca/PDFs/Nidus_Info_HCC_Your_Rights_and_the_Law.pdf)

**Refusing Health Care – What are My Rights**

[http://www.nidus.ca/PDFs/Nidus_Info_RefusingHealthCare.pdf](http://www.nidus.ca/PDFs/Nidus_Info_RefusingHealthCare.pdf)

**HealthLink BC:**

**No CPR Order:** [http://www.healthlinkbc.ca/healthfeatures/no_cpr.html](http://www.healthlinkbc.ca/healthfeatures/no_cpr.html)

**Medical Alert Bracelets BC:** [https://www.medicalert.ca/nocpr/](https://www.medicalert.ca/nocpr/)

**Medical Assistance in Dying**


**Fraser Health Authority:** No department or guidelines currently available (as of October 2016)

**Dying with Dignity Canada:** [http://www.dyingwithdignity.ca/find_support](http://www.dyingwithdignity.ca/find_support)

**Hemlock Society:** [http://hemlockaid.ca/](http://hemlockaid.ca/)