



A Guide to Advance Care Planning

Your Health Care Decisions Are Important



Advance Care Planning is a process that helps you decide what care you would want or not want if you have a health crisis and are not able to make decisions or speak for yourself.

The best time to complete the process is while you are well and not in a health crisis. This gives you time to consider carefully what matters most to you, and the treatment decisions you make. This guide will walk you through the process of completing your advance care plan, step by step.

Give The Gift

Making your wishes known is a gift to yourself and one you can give to your family now. We have developed this guide to help you begin the process.

There are five key steps to completing your Advance Care Plan:

- 1 Think-** think about what matters to you.
- 2 Talk-** Talk about your wishes with your family, friends, and health care provider(s).
- 3 Put it in Writing-** Document your choices and decisions in a legal form so it will be ready when needed.
- 4 Share-** Share your advance Directives with your family, friends, and health care providers.
- 5 Review-** Review your documents periodically, at least once a year.



STEP 1- Think

Designing the gift of Advance Care Planning is important. Give yourself plenty of time to think through what you would prefer to have happen (or not happen) if you need medical care. You may find it helpful to write down your thoughts. Think about what is important to you. You can talk with family, friends, your health care provider, pastor/clergy, or others. They may be able to help you think about your choices and what matters most to you.

Quality of Life:

What gives your life value, meaning, and purpose? What does "quality of life" mean to you?

How would not being able to walk, talk, eat, think normally or take care of your own daily needs impact your life?

What would you be willing to give up or tolerate to keep what matters most to you?

Is quality of life more important to you than how long you live? Or do you want to live as long as possible, no matter what?

Health Care Experiences:

Think about good or bad health experiences you know about. How have those experiences influenced your choices for future health care?

Has anyone close to you died? Do you think their death was a "good" death or "bad" death? Why?

Do you have any medical problems or conditions? Do you expect them to get worse? Will your medical problems change your quality of life? If so, how?

Are you having medical treatments for your problem/condition? Are you thinking about having any new medical treatment(s)? Will this affect your quality of life? If so, how?

End of Life Care:

Think about medical treatments near the end of your life. Are there circumstances when you would want additional efforts (mechanical assistance) with your breathing, eating and hydration?

Would you want CPR if you had terminal illness?

Are there treatments you know you would want?

Are there treatments you know you would NOT want?

Can you imagine a time you would want to stop having treatments just to keep you alive longer and only use *comfort measures* to keep you as comfortable as possible during the time you have left?

Where would you prefer to spend your last few months, weeks, or days? In your home? Hospice? Hospital?

Someone to Speak For You:

Who would you want to speak on your behalf about health care decisions if you could not communicate for yourself? Would they be able to make decisions based on what you want?

Have you told this person what you would want? Have you told anyone?

How much do you want your family or other loved ones to be involved in your health care? Some? A lot? Not at all? Are there people you do not want to make decisions for you?

Final Wishes:

What do you want to do or say before die?

Do you want your organs donated after you die? Have you discussed this with your family or loved ones?

Would you prefer to be buried or cremated? Do you have instructions about what should happen to your body after you die?



STEP 2- Talk

Now that you have thought about your end-of-life care choices and what matters most to you, you may be ready to share your thoughts with:

- your family
- those closest to you
- your health care providers
- anyone who is likely to be involved in your future health decisions

This can be a hard conversation to start.

Many people are afraid about how their family or loved ones might react.

It is important to remember this is probably something you will discuss more than on time. The more you talk about your choices for care at the end of life, the more comfortable you and your family become. So keep talking.

Here are some ideas for starting your conversation:

"There's something I've been thinking about for a while that I want to share. I really need you to listen carefully."

"Did you hear what happened with _____? That got me thinking, and I want to make sure you know what my preferences for care are, in case you ever have to speak for me."

"I have been thinking about my own future health care choices if I were not able to communicate what I wanted. Have you thought about what you would want?"

"It would have been so much better for _____ if they/we had known what he/she wanted at the end of life. I know what my health care choices would be. Have you thought about yours?"

You have now completed a very important step in the Advance Care Planning process. You have had the difficult, and sometimes very emotional, conversation about you end of life care choices. Now you will want to complete the process by putting it in writing.



STEP 3- Put it in Writing

Now you need to record your choices in an Advance Directive document or form. By taking this set, you give your loved ones and your medical team the information they need to be able to honor your choices.

There are different kinds of Advance Directors. Here are a few examples:

Name of Document	Important Information
Health Care Power of Attorney	Must be signed in front of two witnesses and a notary.
Living Will	Must be signed in front of two witnesses and a notary.
Advance Instructions for Mental Health Treatment	Must be signed in front of two witnesses and a notary.
Medical Orders for the Scope of Treatment (MOST)	A doctor's order that you and your doctor sign. Keep it with you at all times.
Portable Do Not Resuscitate (DNR) Order	A signed doctor's order that should be kept with you at all times.

How to get the forms you need:

Healthcare Power of Attorney and Living Will (combined)

Attached you will find a document called *A Practical Form for All Adults*. This form combines the two most common types of Advance Directives (*Healthcare Power of Attorney and Living Will*) into one document. Using the *Practical Form for All Adults* document, fill it in, and then sign it when you are in front of two witnesses and a notary. You may want to discuss this document with your attorney.

Advance Instruction for Mental Health Treatment

Visit the North Carolina Secretary of State website to download a form. www.sosnc.gov/ahcdr.

MOST Form

If you would like a MOST form, talk with your doctor. Only a doctor, Nurse Practitioner or Physician Assistant can fill out this form. This doctor's order is typically completed when a person has an advanced illness or life-limiting condition with a life expectancy of one year or less. This form is bright pink and designed to be easily seen.

Portable DNR

A Do Not Resuscitate form informs health care professionals that you do not desire to be revived in any manner if your heart stops. This includes CPR, shock or intubation. This form is bright yellow and designed to be easily seen. It should be posted somewhere near the patient so health care providers will spot it immediately. Your doctor must sign the DNR for it to be valid. Copies of the form are not valid-only the original form is honored.



STEP 4- Share

Now that you have completed your Advance Directive, you need to share copies of your signed documents with your health care provider(s) and your family or those closest to you. Be sure to talk about your choices with them. Some families can do this in one conversation; others may need more. There is no right or wrong way to have these discussions.

Who should get a copy of your Advance Directives?

- **Family and/or Health Care Power of Attorney:** Share a copy of your documents with your family and/or designated Health Care Power of Attorney(s).
- Make sure you give copies of your completed documents to anyone likely to play a role in your future health care. That could include family or loved ones, friends, attorney or clergy.
- **Health Care Providers:** Take a copy to your next appointment with your healthcare provider. Review and discuss your healthcare choices.
- **UNC Health Wayne:** Hospitals are required to ask about Advance Directives during the admission process and will request a copy of your documents to scan into your health record (Chart). That way, it will be available to the physicians and medical staff who are providing your care. UNC Health Wayne wants to be the hospital of your choice, but wherever you choose for hospital services, prepare to provide a copy of your Advance Directives upon each admission to ensure that the most recent version can be put into your chart.
- **Register on Websites:** Consider uploading your documents to the North Carolina registry and/or the Federal registry so they are available to other health care providers and institutions if needed.
 - North Carolina registry: www.sosnc.gov (there may be a fee)
 - Federal registry: www.uslivingwillregistry.com (there may be a fee)

Other things to consider about your Advanced Directives

- **Original Documents:** Keep your original documents in a safe place. Make sure you can get the documents quickly if you need them.
- **Copies:** Keep a copy of your Advance Directives in a place that is easy to get to. When you travel, take a copy with you so the Advance Directives will be available to emergency personnel or your health care providers.
- **Keep a List:** Keep a list of everyone who received a copy of your Advance Directives so you will know who to notify if you make any changes to your documents.
-



STEP 5- Review Your Decisions

Review your Advance Directive documents at least once a year, and any time your health condition changes. Your thoughts, perspectives, and viewpoints can change over time.

- **What you want now:** It is important to make sure these documents reflect your current preferences about end-of-life choices and any changes in your health.
- **Any big changes since the last review?** A good guideline is to re-examine your Advance Directive when there are major changes in your life such as marriage, birth of a child, significant illness, declining health, divorce, death of a family member, etc., or at least once a year.

Reminders About Witnesses And Notary ***Your witnesses cannot be:***

- Related to you by blood or marriage
- Your heir or named in your will
- Have a claim against you or against your estate
- Your doctor or other health care provider
- An employee of the hospital where you are a patient or a long-term care home or adult care home where you live

A Notary Public must witness and notarize all signatures. Notaries are available in many places in Wayne County, including most credit unions. Some other places to obtain this service include: tax firms, bail

An Advance Directive For North Carolina

A Practical Form for All Adults

NOTE: *UNC Health Care honors the right of patients to communicate health care wishes using advance – including this form – when they are completed correctly and meet the standards of North Carolina law. While it is not a requirement, you may wish to consult an attorney before signing any document that affects your legal rights.*

Introduction

This form allows you to express your wishes for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form has three parts. You may complete Part A only, or Part B only, or both Parts A and B. To make this advance directive legally effective, you must complete Part C of this form. Please keep all five pages of this form together and include all five pages of the form in any copies you may share with your loved ones or health care providers.

This form complies with North Carolina law (in NCGS § 32A-15 through 32A-27 and § 90-320 through 90-322).

Part A: Health Care Power of Attorney

1. **What is a health care power of attorney?** A health care power of attorney is a legal document in which you name another person, called a “health care agent,” to make health care decisions for you when you are not able to make those decisions for yourself.
2. **Who can be a health care agent?** Any competent person who is at least 18 years old and who is not your paid health care provider may be your health care agent.
3. **How should you choose your health care agent?** You should choose your health care agent very carefully, because that person will have broad authority to make decisions about your health care. A good health care agent is someone who knows you well, is available to represent you when needed, and is willing to honor your wishes. It is very important to talk with your health care agent about your goals and wishes for your future health care, so that he or she will know what care you want.
4. **What decisions can your health care agent make?** Unless you limit the power of your health care agent in Section 2 of Part A of this form, your health care agent can make all health care decisions for you, including:
 - starting or stopping life-prolonging measures

- decisions about mental health treatment
 - choosing your doctors and facilities
 - reviewing and sharing your medical information
 - autopsies and disposition of your body after death
5. **Can your health care agent donate your organs and tissues after your death?** Yes, if you choose to give your health care agent this power on the form. To do this, you must initial the statement in Section 3 of Part A.
 6. **When will this health care power of attorney be effective?** This document will become effective if your doctor determines that you have lost the ability to make your own health care decisions.
 7. **How can you revoke this health care power of attorney?** If you are competent, you may revoke this health care power of attorney in any way that makes clear your desire to revoke it. For example, you may destroy this document, write “void” across this document, tell your doctor that you are revoking the document, or complete a new health care power of attorney.
 8. **Who makes health care decisions for me if I don’t name a health care agent and I am not able to make my own decisions?** If you do not have a health care agent, NC law requires health care providers to look to the following individuals, in the order listed below: legal guardian; an attorney-in-fact under a general power of attorney (POA) if that POA includes the right to make health care decisions; a husband or wife; a majority of your parents and adult children; a majority of your adult brothers and sisters; or an individual who has an established relationship with you, who is acting in good faith and who can convey your wishes. If there is no one, the law allows your doctor to make decisions for you as long as another doctor agrees with those decisions.

Part B: Living Will

1. **What is a living will?** In North Carolina, a living will lets you state your desire not to receive life-prolonging measures in any or all of the following situations:
 - You have a condition that is incurable that will result in your death within a short period of time.
 - You are unconscious, and your doctors are confident that you cannot regain consciousness.
 - You have advanced dementia or other substantial and irreversible loss of mental function.
2. **What are life-prolonging measures?** Life-prolonging measures are medical treatments that would only serve to postpone death, including breathing machines, kidney dialysis, antibiotics, tube feeding (artificial nutrition and hydration), and similar forms of treatment.
3. **Can life-prolonging measures be withheld or stopped without a living will?** Yes, in certain circumstances. If you are able to express your wishes, you may refuse life-prolonging measures. If you are not able to express your wishes, then permission must be obtained from those individuals who are making decisions on your behalf.
4. **What if you want to receive tube feeding (artificial nutrition and hydration)?** You may express your wish to receive tube feeding in all circumstances. To do this, you must initial the statement in Section 2 of Part B.

5. **How can you revoke this living will?** You may revoke this living will by clearly stating or writing in any clear manner that you wish to do so. For example, you may destroy the document, write “void” across the document, tell your doctor that you are revoking the document, or complete a new living will.

Part C: Completing this Document

To make this advance directive legally effective, all three sections of Part C of the document must be completed.

1. Wait until two witnesses and a notary public are present, then sign and date the document.
2. Two witnesses must sign and date the document in Section 2 of Part C. These witnesses cannot be:
 - related to you by blood or marriage,
 - your heir, or a person named to receive a portion of your estate in your will,
 - someone who has a claim against you or against your estate, or
 - your doctor, other health care provider, or an employee of a hospital in which you are a patient, or an employee of the nursing home or adult care home where you live.
3. A notary public must witness these signatures and notarize the document in Section 3 of Part C.

Part A: Health Care Power of Attorney (Choosing a Health Care Agent)

If you do not wish to appoint a health care agent, strike through this entire part and initial here

My name is: _____

My birth date is: __ / __ / _____ /

(Please Print)

1. The person I choose as my health care agent is:

first name	middle name	last name	
------------	-------------	-----------	--

street address	city	state	zip code
----------------	------	-------	----------

home phone	work phone	cell phone	e-mail address
------------	------------	------------	----------------

If this person is unable or unwilling to serve as my health care agent, my next choice is:

first name	middle name	last name
------------	-------------	-----------

street address	city	state	zip code
----------------	------	-------	----------

home phone	work phone	cell phone	e-mail address
------------	------------	------------	----------------

2. Special Instructions:

NOTE: In this section, you may include **any special instructions** you want your health care agent to follow, or **any limitations** you want to put on the decisions your health care agent can make, including decisions about tube feeding, other life-prolonging treatments, mental health treatments, autopsy, disposition of your body after death, and organ donation.

If you do not have any special instructions for your health care agent, or any limitations you want to put on your agent's authority, please draw a line through this section.

3. Organ Donation:

____ (initial) My health care agent may donate my organs, tissues, or parts after my death.

(Please note: if you do not initial above, your health care agent will not be able to donate your organs or parts.)

Part B: Living Will

If you do not wish to prepare a living will, strike through this entire part and initial here _____ .

My name is: _____

My birth date is: ____/____/____

(Please Print)

1. **If I am unable to make or communicate health care decisions, I desire that my life not be prolonged by life-prolonging measures in the following situations** (you may initial any or all of these choices):

____ (initial) I have a condition that cannot be cured and that will result in my death within a relatively short period of time.

____ (initial) I become unconscious and my doctors determine that, to a high degree of medical certainty, I will never regain my consciousness.

____ (initial) I suffer from advanced dementia or any other condition which results in the substantial loss of my ability to think, and my doctors determine that, to a high degree of medical certainty, this is not going to get better.

2. **(initial) Even though I do not want my life prolonged by other life-prolonging measures in the situations I have initialed in section 1 above, I DO want to receive tube feeding in those situations** (initial here only if you **DO** want tube feeding in those situations).

3. **I wish to be made as comfortable as possible.** I want my health care providers to keep me as clean, comfortable, and free of pain as possible, even though this care may hasten my death.
4. **My health care providers may rely on this living will to withhold or discontinue life-prolonging measures in the situations I have initialed above.**
5. **If I have appointed a health care agent in Part A of this advance directive or a similar document, and that health care agent gives instructions that differ from the desires expressed in this living will, then:** (NOTE: initial **ONLY ONE** of the two choices below):
- ____ (initial) **Follow this living will.** My health care agent cannot make decisions that are different from what I have stated in this living will.
- ____ (initial) **Follow health care agent:** My health care agent has the authority to make decisions that are different from what I have indicated in this living will.

Part C: Completing this Document (wait until two witnesses and a notary public are present before you sign!)

1. Your Signature

I am mentally alert and competent, and I am fully informed about the contents of this document.

Date: _____

Signature: _____

2. Signatures of Witnesses

I hereby state that the person named above, _____, being of sound mind, signed (or directed another to sign on the person's behalf) the foregoing document in my presence. I am not related to the person by blood or marriage, and I would not be entitled to any portion of the estate of the person under any existing will or codicil of the person or as an heir under the law, if the person died on this date without a will. I am not the person's attending physician. I am not a licensed health care provider or mental health treatment provider who is (1) an employee of the person's attending physician or mental health treatment provider, (2) an employee of the health facility in which the person is a patient, or (3) an employee of a nursing home or any adult care home where the person resides. I do not have any claim against the person or the estate of the person.

Date: _____ Signature of Witness: _____

Date: _____ Signature of Witness: _____

3. Notarization

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by

_____ (type/print name of signer)

_____ (type/print name of witness)

_____ (type/print name of witness)

Date: _____

(Official Seal)

Signature of Notary Public

, Notary Public

Printed or typed name

My commission expires: _____