Advance Care Planning Discussion Guide for Individual

**Introduction of Advance Care Planning, Ask for permission**

I would like to speak with you about Advance Care Planning and the importance of Advance Care Planning discussions as it relates to your future treatment goals. Is that alright?

**Evaluate the Understanding of Advance Care Planning**

Do you know what Advance Care planning is?

**Explain Advance Care Planning and the Benefits**

Advance Care Planning is a process that enables individuals to make plans about their future health care. It allows individuals to take part and be in charge of their health care plan.

Advance Care Planning Involves:

- Knowing possible future treatment plans and how they align with your values and beliefs
- Determining your treatment plan goals that align with your values and beliefs
- Sharing your decisions with your physicians and families/friends
- Completing an Advance Directive for future treatment plans

Everyone over the age of 18-years-old should have advance care planning documentation and conversations.

**Four Steps of the Health Care Power of Attorney (HCPOA) document**

There are many legal Advance Care Planning Documents available in South Carolina. The Health Care Power of Attorney (HCPOA) document is one of them. This document does not have to be notarized. The HCPOA document allows you to make 4 important decisions. This document only comes into effect if, and only if, you are unable to make decisions for yourself.

- The first decision you will have to make is determining “who do you want to appoint as your health care agent”. The agent’s responsibility is to advocate for the treatments/goals you would want for yourself.
- The second decision you will need to make is about organ donation.

The third and fourth decisions pertain to a situation where your life expectancy is limited or you are permanently unconscious.

- The third decision you will need to make is whether you desire to have life-sustaining treatment, such as a breathing machine or chest compressions, if your heart or breathing stops and you will not have a meaningful recovery.
- The final decision you will have to make is whether you would like artificial nutrition and hydration, for example, a feeding tube or IV fluids.
Inquire About Goals/Values/ Fears/ Strengths/ Critical Abilities / Family Awareness

I think it would be helpful for me to understand what is most important to you:

1.) Would you mind sharing any cultural, family, religious, spiritual, or personal beliefs that might help you choose the care you want or do not want?

2.) What are your worries/fears/concerns about your future health?

3.) What brings you strength during difficult times?

4.) What abilities are so critical to your life that you can’t imagine living without them?

5.) How much does your family know about your values and wishes?

Summarize the conversation (overall goals) and Recommend the Plan

Keeping in mind the values you shared with me and your current health, I recommend that we complete/update your Advance Care Planning Document. This will help to make sure that your treatment plans reflect what is most important to you.

How does that sound?

Reassure Commitment

“[I/our medical team] will be with you to help you.”

Respond to Emotion appropriately

Non-verbal

- Provide Tissues and Utilize Silence
- Appropriate Physical Reassurance (ex. hand on shoulder)
- Active Listening and Consistent Eye Contact

Verbal (Name Emotion)

- “It would be fine for someone in your situation to feel [sad/angry/frustrated.]”
- “I cannot imagine how hard it is for you [to lose your independence.]”
- (Name Emotion) “I sense how upset you are feeling about ----”
- (Name Emotion) “It sounds like you are worried that the illness might shorten your life.”