Bucks County Health Improvement Partnership

Aria-Jefferson Health Bucks County • Bucks County Department of Health Bucks County Medical Society • Doylestown Health • Grand View Health Lower Bucks Hospital • St. Luke's Quakertown Hospital • St. Mary Medical Center

Advance Care Planning Documents

The documents included with this cover page:

- Reflection Guidelines, and
- Advance Directive

may be downloaded to give you a preview of the issues to be discussed in an Advance Care Planning conversation.

Bring the documents with you if you plan to attend a community information session, individual or group conversation, or attend the class at Bucks County Community College titled, “Making Healthcare Wishes Known.”

There is no charge for any of these services.

To schedule a conversation with a certified facilitator, please call one our Centers of Service for Advance Care Planning:

- Aria-Jefferson Health Bucks County Campus 215-949-5226
- Bristol Township Senior Center 215-785-6322
- Grand View Health 215-453-4152
- Pickering Manor 215-968-3878
- More Centers of Service planning to open soon

Your healthcare providers can’t honor your wishes unless they know what they are.

Thank you for taking this important step to make your wishes known!

Reflection Guidelines for Advance Care Planning

Reflect and define what an <u>acceptable quality of life</u> is for you

The following list of ideas (from real conversations) illustrates the types of statements people may make when describing what they feel are elements of an acceptable quality of life or a good day. Your definition may change over time and at any time. We urge you to reflect on your beliefs, values and goals, talk to family and friends, and to write in the space below your ideas for defining a good day, a day with an acceptable quality of life. Then copy your statement into the space provided on page 1 of your advance healthcare directive.

- *Know who I am, who I'm with, and where I am*
- *Verbally communicate and understand loved ones*
- *Be awake and able to communicate and follow directions*
- *Provide for my own care, feeding and dressing*
- *Live independently*
- *Live without intractable pain*
- *Play golf several times a week or play with my grandchildren*
- *Go shopping, even if it is only on the internet*
- *Solve crossword puzzles and read the newspaper or books*
- *Contribute to making someone else's life better or happier*
- *Maintain my current life which is meaningful to me*
- *Live to keep a promise made to a loved one*
- _____*, add your own ideas in your own words*
- _____

- *I want to stay alive as long as possible*
- *How I live my life is more important than how long I live*

To me an <u>acceptable quality of life</u> is when I can:

Reflect on things important for your comfort and peace of mind

This section may be a bit more difficult than the previous reflection. Many people find it difficult to talk about what they want at the end of life even when they know the end is inevitable. The items listed here are things that people have identified as important and are meant to get you thinking about what is important to you. Draft your thoughts in the box below and then copy your statement into the space provided on page 1 of the advance healthcare directive.

- *To spend my last days at home*
- *To have family and friends visit and hold my hand*
- *Not to be a burden physically, mentally or financially on my family*
- *To have someone read to me or hear my favorite music*
- *To permit my agent to continue life-sustaining treatment for up to ___ days (such as 30, 60 or other number of days) to satisfy religious values or to allow family members to gather… (be specific about days and purpose)*
- _____
- _____

Reflect on other instructions you want to convey to your agent

This section gives you the option to identify specific cultural, religious, and personal beliefs that you want your healthcare agent to follow. Again, the items listed here are intended to help you reflect on what additional instructions you want to leave for your healthcare agent. Draft your thoughts in the box below and then copy your statement into the space provided on page 2 of the advance healthcare directive.

- *Cultural beliefs such as opening a window so at death my soul can ascend to heaven*
- *Religious beliefs such as preferences about blood transfusions or pregnancy*
- *Personal beliefs such as preferring that others celebrate your life rather than mourn your death*
- _____
- _____

Advance Healthcare Directive

For _____ Date of birth: _____

Signed on _____, 20___

I, _____, of _____ County, Pennsylvania, make this Advance Healthcare Directive of my own free will. I ask that my family, loved ones and caregivers honor my wishes which are intended to lessen any burden placed on them and minimize any feelings of guilt.

My Healthcare Choices

If I ever lose my ability to communicate my wishes, my healthcare agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations that I may list here. I want my healthcare agent to make decisions that, in his or her best judgment, would best achieve the acceptable quality of life I have outlined below.

To me an acceptable quality of life is when I can: *(See Guidelines to help your reflection)*

If I reach a point where doctors are reasonably certain that I will not regain an acceptable quality of life as outlined above, I want to stop or withdraw all treatments that would only prolong my life. Treatments I would not want if I were to reach this point may include but are not limited to CPR (heart-lung resuscitation), tube feedings, IV hydration, respirator/ventilator (breathing machine), dialysis (kidney machine), and antibiotics. If I reach a point where efforts to prolong my life are stopped, then I want medical treatments and nursing care that will make me comfortable.

The following are important to me for comfort and peace of mind: *(If you don't write specific wishes, your physician and nurses will provide the best standard of care possible.)*

____ I consent to donate any organs or tissue if I am a candidate.

Other Instructions I want my healthcare agent to follow based on my moral, religious or ethical considerations:

My Healthcare Agent

If I am no longer able to make my own healthcare decisions, the person I choose as my healthcare agent is:

Name of agent: _____ Relationship: _____

If my agent is unable to serve for any reason then my choice for healthcare agent is: First alternate agent: _____ Relationship: _____

If my alternate agent is unable to serve for any reason then my choice for healthcare agent is:

Second alternate agent: _____ Relationship: _____

For current contact information, see attached page.

____ I do not want to appoint a healthcare agent at this time and direct my healthcare providers to follow my instructions for my acceptable quality of life.

Healthcare Agent's Powers

I want my healthcare agent to be able to do the following:

1. To authorize, withhold, or withdraw medical care and surgical procedures.
2. To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential, or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service, and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a Do Not Resuscitate (DNR) or Allow Natural Death (AND) order, including an out-of-hospital DNR or AND order, and sign any required documents and consents.

Effective immediately, I authorize all healthcare providers and insurers to disclose to my healthcare agent (personal representative), upon my healthcare agent's request, any information, including medical records, regarding my physical or mental health which may be private and protected by law.

Having carefully read this document, I have signed it on this _____ day of _____, 20___, revoking all previous healthcare directives, healthcare powers of attorney, living wills, and medical healthcare treatment instructions.

_____
Signature (Principal)

_____ _____
Witness Address

_____ _____
Witness Address

Please write the date this advance healthcare directive was signed on the top of page 1.

Notarization (optional)

On this _____ day of _____, 20___, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of Pennsylvania, the day and year first above written.

_____
Notary

Acknowledgment by Healthcare Agent (recommended)

I have read the above Advance Healthcare Directive and am named as the Healthcare Agent. I hereby acknowledge that when I act as Healthcare Agent, I shall act in good faith in the principal's best interests, make decisions consistent with the principal's choices, act only within the scope of authority granted to me, and resign if I find I am unable to honor the principal's choices.

Signature indicates agent's agreement with the acknowledgment statement.

Agent: _____ Date:_____

1st Alt: _____ Date:_____

2nd Alt:_____ Date:_____

Current Healthcare Agent Contact Information

Supplement to Advance Healthcare Directive

Current as of: _____, 20___

Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

First alternative Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Second alternative Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Recommended distribution of copies of your Advance Healthcare Directive:

- □ *Your agent(s), family members and loved ones*
- □ *Your primary care physician (and specialist if appropriate)*
- □ *Your hospital of choice*
- □ *Others who should know your choices, such as, your pastor or attorney*
- □ *Fill in the wallet card and keep it next to your insurance cards*
- □ *Carry Advance Healthcare Directive with you when you travel*
- □ *Consider putting copy in glove compartment in car and/or posting on refrigerator*