Respecting Choices®
PERSON-CENTERED CARE

Glossary of Terms

Term	Definition
Advance Care Planning	An ongoing process of person-centered communication that includes understanding, reflection, and discussion about future healthcare decisions. The goals of advance care planning are to • Provide qualified assistance in making informed healthcare decisions; • Create plans that represent an individual's goals, values, and preferences • Prepare a designated healthcare agent to follow these preferences • Develop strategies to communicate these plans to those who need to know (e.g., healthcare agents, providers, and others) • Assist healthcare providers to thoughtfully use such plans when needed Advance care planning is for all adults and children with life-limiting conditions. It's planning ahead in case you had a sudden unexpected event (such as a car accident), or sudden illness that left you unable to communicate and make your own healthcare decisions. In that case, a person close to you would need to make decisions for you. This can be difficult when there has been no discussion. Advance care planning is a conversation between you and the person you choose (who we refer to as a healthcare agent) to make healthcare decisions for you if needed. These conversations help you talk to your agent about your goals and values, and how you would want him/her to make decisions on your behalf.
Advance Directive	Any plan, written or oral, that communicates an individual's goals, values, and preferences for future medical treatment. An advance directive is a broad term that encompasses a variety of written forms, such as living will, power of attorney for healthcare, or a combination of these documents.
Activation of the Power of Attorney for Healthcare	Refers to the time when the authority of a designated healthcare agent begins, which is determined when an individual has been assessed to have lost his/her decision-making capacity. The terms of this assessment are outlined in state statutes.
Allow natural death	Alternative language used by some to refer to not wanting cardiopulmonary resuscitation (CPR) attempted and prefer to focus on maximizing comfort while allowing death to occur.

Cardiopulmonary Resuscitation (CPR)	Emergency procedures used to attempt to restart heartbeat and breathing, which can include blowing into the mouth, pushing on the chest, inserting a breathing tube into the windpipe, giving medications into the vein, and electric shock.
Comfort care	Care and treatment for the relief of pain and symptoms in order to maximize comfort and to promote a peaceful environment without the use of intubation, artificial nutrition/hydration and re-hospitalization (unless indicated for comfort). Treatment includes medication, oxygen, positioning, mouth and skin care, and other strategies that promote relaxation.
Decision making capacity	The ability to make one's own decisions includes four components: (1) the ability to understand that one has authority—that there is a choice to be made, (2) the ability to understand information (the elements of informed consent), (3) the ability to communicate a decision and associated rationale, and (4) the ability to make a decision consistent with one's values and goals that remains consistent over time—or to be able to explain why one's values have changed.
Do Not Resuscitate (DNR) or Do Not Attempt Resuscitation (DNAR)	An order by a physician that CPR is not to be performed if the heartbeat and breathing stops. The DNR order is communicated to bedside caregivers, emergency medical technicians, first responders, and/or emergency staff to provide clear direction for circumstances in which the heartbeat or breathing stops.
Guardianship	A person appointed by a judge to make another person (the Ward)'s personal decisions, including consenting to or refusing medical treatment. To appoint a legal guardian, the judge first determines that the person in question is legally incompetent. The legal guardian's authority could be limited to financial decisions, to personal decisions, or to both.
Healthcare agent	The person chosen by an individual to make healthcare decisions in the event that the individual cannot communicate and make his/her own decisions. A healthcare agent is legally appointed in a document called a Power of Attorney for Healthcare. The specific, legal name for a healthcare agent varies by state, region, and country, and could include such equivalent terms as healthcare proxy, medical power of attorney, personal representative, patient advocate, and surrogate decision maker, among others.
Feeding tube	A tube inserted into a person's stomach through the nose, mouth, abdominal wall or alternate route to provide nutrition and/or hydration. It is used when individuals are unable to take adequate amounts of food and water by mouth.
Hospice Care	A service delivery system that provides comprehensive medical, psychosocial, nursing, social service, spiritual, and bereavement care for an individuals who have a limited life expectancy and their families.
Life-sustaining	Medical treatment or procedures that serve to effectively prolong life

treatment	including, but not limited to, CPR, mechanical ventilation, medications, blood transfusions, medically administered nutrition and hydration, dialysis, and external mechanical or technological devices (e.g., defibrillators, left ventricular assist devices). These interventions are not life-sustaining when it becomes clear that their use will not prolong life.
Long-term care	A variety of healthcare, personal care, and social services delivered over a sustained period of time. There are a variety of venues where long-term care is provided, such as in nursing homes, residential care facilities, and private homes.
Palliative care	Specialized medical care for people with serious or advanced illness that provides comprehensive strategies for the relief of pain and symptoms. The goal is to promote quality of life for the individual and their family.
Person-centered care	Healthcare that creates a partnership between providers, individuals, and their families to provide education and support for the facilitation of making healthcare decisions and participating in care.
Permanently unconscious	A lasting and indefinite condition in which an individual is unaware of him/herself or their environment. The diagnosis is determined by defined neurological assessment by a qualified physician.
Persistent vegetative state (PVS)	An irreversible condition diagnosed by defined neurological assessment that identifies a complete loss of key brain functions, such a consciousness and cognition, but the heartbeat and breathing is preserved. Individuals in this state continue to have sleep/wake cycles.
POLST (Physician's Orders for Life-Sustaining Treatment) Paradigm Program	A program that is designed to assist individuals who we would not be surprised if they died in the next year— those with serious illness and advanced frailty—in making and communicating decisions regarding goals of care for treating complications from serious illness. The POLST paradigm program results in the documentation of an individual's healthcare decisions as medical orders that can be followed throughout the healthcare spectrum. The POLST paradigm program is a component of the Respecting Choices Last Steps ACP program.
Statement of Treatment Preference form	A disease-specific , planning document (a type of advance directive) for individuals with serious and advanced illness who are at risk for complications. It identifies goals of care in selected "bad outcome" situations that serve to guide clinical decision making when appropriate. The Statement of Treatment Preference form is a component of the Respecting Choices Next Steps ACP program.
Trial of intervention	A plan to assess whether or not a specific treatment or intervention will result in achieving an individual's goals. These person-centered goals may include improvement in function, recovery from a complication, or a decrease in pain and symptoms. This plan may also include time frames, such as a two-week period of assessment