An Advance Care Planning Guide

For Alberta Healthcare Providers

JUNE 2026

Covenant Health
Palliative Institute

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https://redcap.link/y2orx68q

Introduction: Five key actions

Albertans are encouraged to engage in advance care planning by thinking about their values and goals, learning about their health, choosing an agent, sharing their wishes and recording them in a personal directive.

Alberta healthcare providers can use the **five key actions** below to facilitate this process. Although the actions are presented in sequence, not everyone will need to start at the beginning. Please apply this information within your scope of practice.

Advance care planning is a process that helps adults at any age or stage of health understand and share their values, goals and wishes for future care, so that treatment aligns with what matters most to them.

Engaging People in Advance Care Planning

FIVE KEY ACTIONS FOR HEALTH CARE PROVIDERS

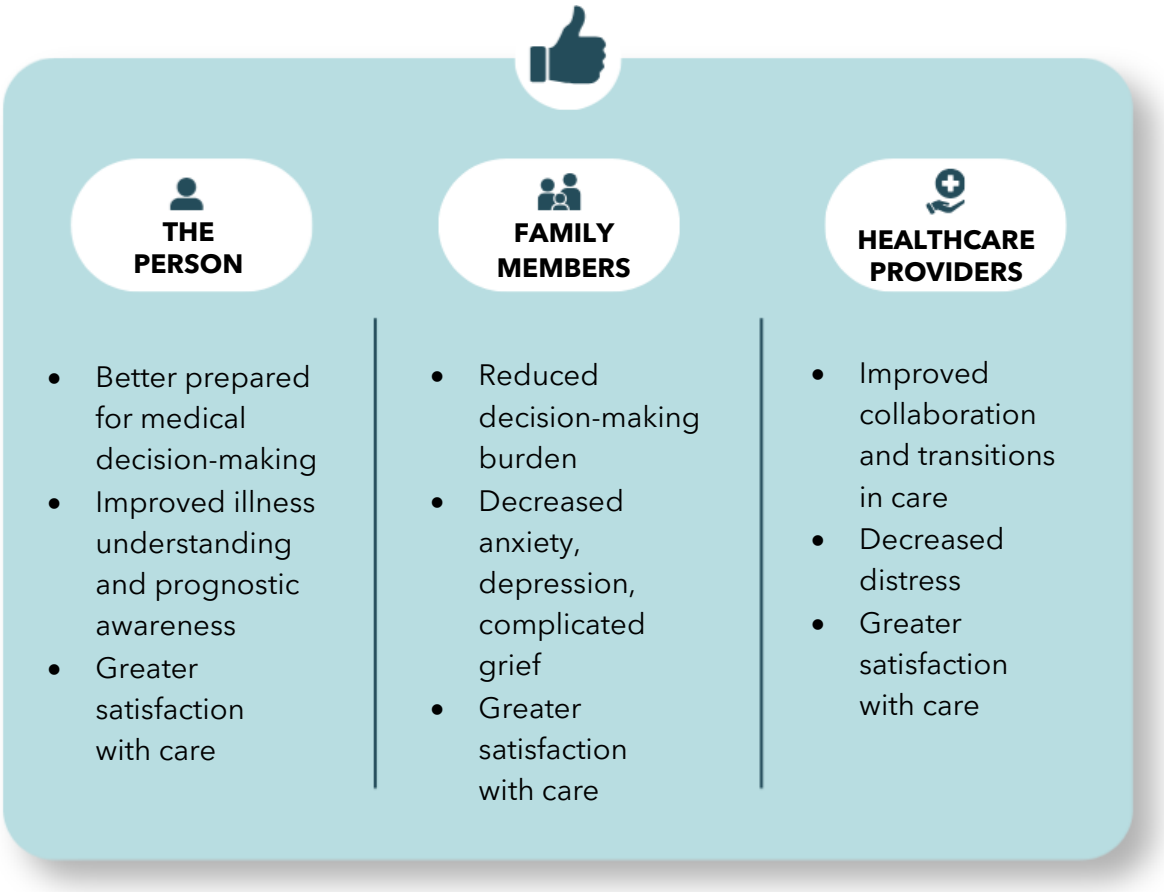
Action 1: Introduce and explain advance care planning

While it can be challenging to introduce advance care planning, it is best done before there is an urgent need for it. When people are prepared for future decision-making, outcomes are better, stress is reduced and healthcare providers report greater professional satisfaction.

This section includes:

Benefits of advance care planning

Advance care planning has many benefits for:



Getting started

People's readiness to engage in advance care planning will vary and conversations may happen over multiple visits. Use the Stages of Change model below to guide your approach.

PRECONTEMPLATIVE | NOT THINKING ABOUT IT

- Introduce and normalize the concept of advance care planning
- Highlight its importance using benefits that resonate with the individual
- Offer resources so they can learn more on their own time, at their own pace
- Reassure them that questions or concerns can be discussed in future visits

CONTEMPLATIVE | THINKING ABOUT ENGAGING

- Ask if they have questions or informational needs
- Offer resources to help them to identify their values, goals and wishes
- Explain the importance of appointing an agent(s) in a personal directive

PLANNING | COMMITTED TO ENGAGING SOON

- Discuss advance care planning resources with them
- Encourage appointment of an agent(s) in a personal directive
- Offer to facilitate an advance care planning conversation with them and their agent

ACTING | ENGAGED

- Facilitate an advance care planning conversation with them and their agent(s)
- Document the conversation
- Retain a copy of their personal directive
- Encourage them to use a Green Sleeve to store their documents

MAINTAINING | WILLING TO REVISIT

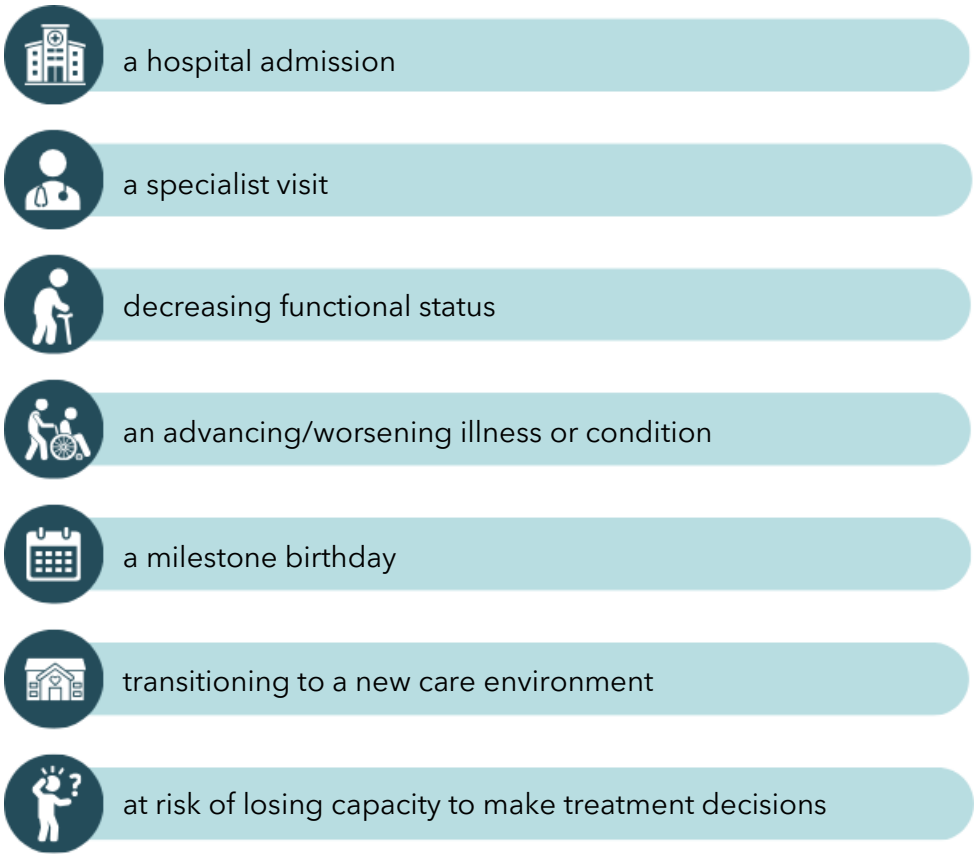
- Revisit over time and when health or life circumstances change
- Remind them to:
  - Update their personal directive as needed
  - Keep their agent(s) informed about changes
- Update your documentation and ensure they have up-to-date copies for their Green Sleeve

Adapted from: Bergman TD et al. The ACP-ASC model: A comprehensive behaviour change model for advance care planning based on the Stages of Change model. Palliative Medicine 2026 40(6): 868-878; and Westley C, Briggs LA. Using the Stages of Change model to improve communication about advance care planning. Nursing Forum 2004 39(3): 5-12.

When to talk about it

Watch for opportunities in regular encounters. Pay attention to cues and questions raised by the person. You may also wish to link it to routine clinical practices, such as an annual visit.

Also consider building the following triggers into your practice:



What if someone isn't interested?

That's okay. After you introduce the idea of advance care planning, listen to how they respond. Even if they don't want to talk about it now, they may be open to it in the future.

Keep in mind, a person may be the agent for someone else in their life, making this information relevant to them in another way.

Example conversation starters

HEALTHY ADULTS

"Before we finish up today, I've been asking people if they have ever heard of something called advance care planning. Can I tell you a bit about it?

Advance care planning prepares you and others to make important decisions about your care. Thinking and talking about what matters to you in advance can make future treatment decisions easier for you and the people close to you.

Would you be interested in learning more? I can offer you some resources to take home."

PEOPLE LIVING WITH ILLNESS

"Today we've talked about your [illness/condition]. Before we finish up today, I would like to take a step back to talk about something called advance care planning. Has anyone ever talked to you about this?

Advance care planning prepares you and others to make important decisions about your care. Thinking and talking about what matters to you in advance can make treatment decisions easier for you and the people close to you. It allows everyone to understand your goals and preferences and who you would like to make decisions for you if you're not able to make them yourself.

Can I offer you some resources to take home? We can discuss any questions you have at your next visit."

Action 2: Offer resources

Provide people with resources to start learning more about advance care planning on their own time, at their own pace. The following resources are designed for Albertans and reflect **provincial terminology and legislation**.

This section includes:

- Print resources
  - What Matters Most to You Brochure
  - My Wishes Alberta Workbook
  - Conversations Matter Guidebook
  - Green Sleeve Kit
- Online resources
  - Advance Care Planning | Covenant Palliative Institute
  - Advance Care Planning | Alberta Health Services
  - Personal Directive | Government of Alberta

Print resources

What Matters Most to You Brochure

Use this brochure to introduce advance care planning to people who are new to it.

Get the brochure

- English
- Français (French)
- Order free print copies

Note: To print as a double-sided brochure select "Print on both sides of page" and "Flip on short edge."

My Wishes Alberta Workbook

Offer this workbook to help people identify and share what is most important to them in their life, health and personal care.

Get the workbook

- English
- Français (French)
- العربية (Arabic)
- ਪੰਜਾਬੀ (Punjabi)
- Español (Spanish)
- Order free print copies

Conversations Matter Guidebook

Provide this guidebook to people who want comprehensive information about advance care planning, including an overview of Goals of Care Designations and Green Sleeves.

Get the guidebook

- English
- Français (French)
- العربية (Arabic)
- Niitsipowahssin (Blackfoot)
- Nêhiyawêwin (Cree)
- ਪੰਜਾਬੀ (Punjabi)
- 简体中文 (Simplified Chinese)
- Español (Spanish)
- 繁體中文 (Traditional Chinese)
- Tiếng Việt (Vietnamese)

Order print copies:

- Instructions for AHS staff
- Instructions for non-AHS staff

Green Sleeve Kit

This kit is essential for anyone with a serious illness. It includes the Conversations Matter guidebook, Goals of Care Designation Order form, Advance Care Planning/ Goals of Care Designation Tracking Record and a personal directive template.

Get the kit

Order print copies:

- Instructions for AHS staff
- Instructions for non-AHS staff

Online resources

For people interested in learning more online, recommend the following websites:

Advance Care Planning | Covenant Palliative Institute

Use this website to introduce advance care planning to people who are new to the topic or who want to access resources to help them take next steps.

Share the link: covenanthealth.ca/advance-care-planning

Advance Care Planning | Alberta Health Services

Share this website with people who want comprehensive information about advance care planning, including an overview of Goals of Care Designations. People can also register for education sessions and find instructions for ordering a Green Sleeve.

Share the link: conversationsmatter.ca

Personal Directive | Government of Alberta

Share this website with people who want more information about personal directives and how to create one.

Share the link: alberta.ca/personal-directive

Action 3: Encourage agent selection

The most important legal component of advance care planning is the careful selection and appointment of an agent(s) in a personal directive. As a healthcare provider you can help people understand the importance of selecting an agent who will honour their wishes.

This section includes:

- About personal directives
- Benefits of having a personal directive
- Qualities of a good agent
- If someone hasn't appointed an agent
- How to create a personal directive
- Example conversation starters
    - Healthy adults
    - People living with illness

About personal directives

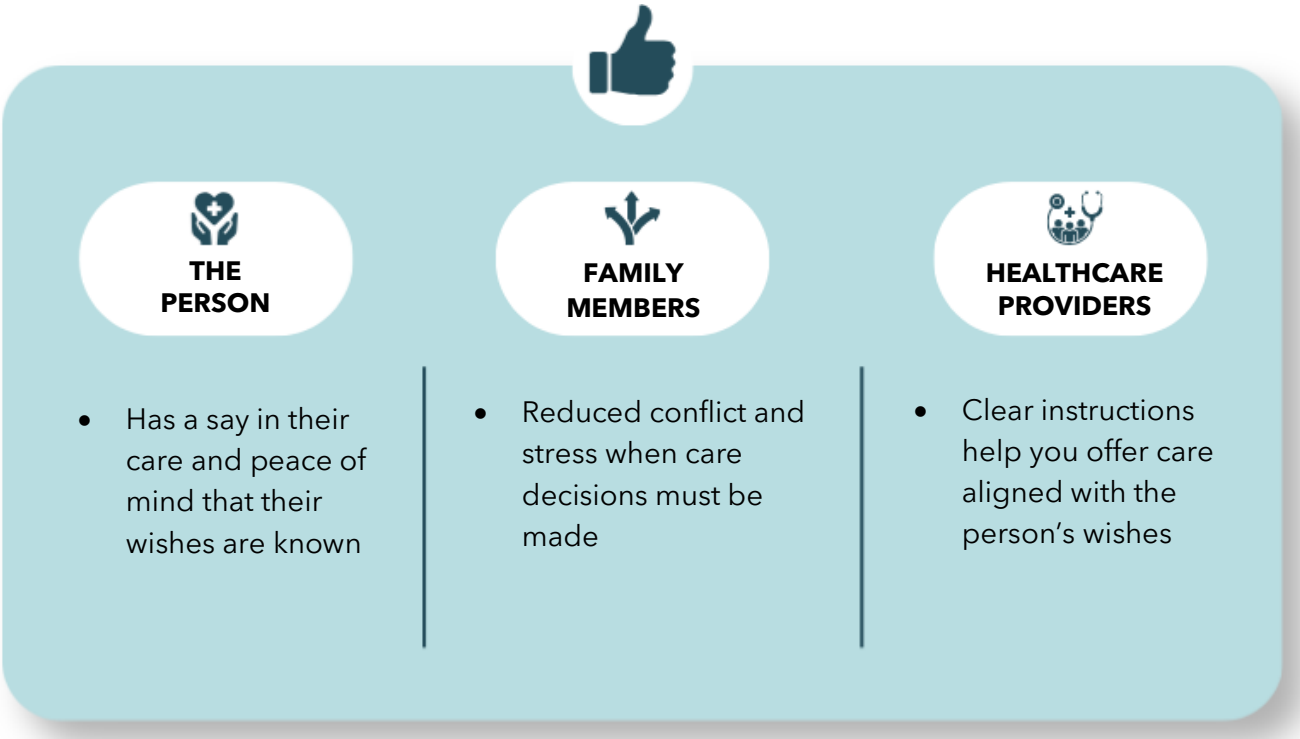
In Alberta, a **personal directive** is the legal document used to:

(i) outline a person's health and personal care instructions (e.g. medical treatments they would or would not want, where they would like to live)
(ii) name one or more people (called **agents**) to make care decisions for them if they become too sick or injured to make their own.

A personal directive must be written while a person has mental capacity. It only comes into effect if a decision is required and the person is found to lack the capacity to make that decision.

Benefits of having a personal directive

The benefits include:



Qualities of a good agent

An agent must be at least 18 years old and have decision-making capacity. You can help explain what qualities are important to consider when choosing an agent.

A good agent is someone who:

- The person **trusts** to make decisions based on their values, wishes and beliefs.
- Can make **difficult decisions** in stressful situations.
- Can **communicate** clearly and **collaborate** with the healthcare team.
- Is **willing** and **available** to be their agent - it is best to ask before naming them in the personal directive.

TIPS:

- It is a good idea to identify one or two alternate agents who can act if the preferred agent is unable to do so and to label them as "alternate".
- It is also a good idea for people to appoint someone to make financial decisions on their behalf by creating an enduring power of attorney.
- If a capable adult needs or wants help making personal, non-financial decisions, they can also authorize someone to assist them. This is called supported decision-making.

If someone hasn't appointed an agent

Encourage everyone over the age of 18 to have a personal directive. If someone doesn't have a personal directive and loses the ability to make their own decisions:

In the short term: You or other healthcare providers may lack clear guidance about how best to care for the person. You may need to rely on the person's nearest relative to make a one-time decision for them, and this may not be the person they would choose. This is called specific decision-making.

In the longer term: A family member or friend may have to go to court to become their guardian to make decisions on their behalf. This process can take considerable time and money.

How to create a personal directive

People can create a personal directive three ways:

- With a lawyer
- Using the personal directive template and instructions from Alberta's Office of the Public Guardian and Trustee (OPGT)
- On their own – to be legally valid, the document must be:
    - In writing
    - Dated
    - Signed by the maker
    - Signed by a witness

TIPS:

- The **Green Sleeve Kit** includes printed copies of the OPGT template and instructions.
- The **My Wishes Alberta Workbook** includes a link to these resources.
- Go to Action 2: Offer resources to get these resources.

Example conversation starters

HEALTHY ADULTS

"Now that you've become a parent/guardian, you may want to consider something called a personal directive. Have you heard of this before?

A personal directive is a legal document that outlines what's important to you and who you want to make care decisions for you if you become unable to do so. This person is called your agent. Having a personal directive can make difficult times easier for you and your family, especially when an unexpected event happens."

PEOPLE LIVING WITH ILLNESS

"When people are living with an illness or condition, it's important for them to think about what's important to them and who they would want to make care decisions for them if they become unable to do so. Have you given this some thought?

In Alberta, appointing this person(s) called your agent(s) is done through a legal document called a personal directive.

Sharing what's important to you now can help your agent(s) be prepared to make decisions on your behalf if you're not able to. It can create some peace of mind for you and reduce stress for your agent(s) and family. It can also help me and other healthcare providers give you the best possible care."

Action 4: Facilitate advance care planning conversations

Once a person is ready to engage, advance care planning conversations will help prepare them and their agent(s) to make decisions about health and personal care in the future. They will also enable you to offer care that aligns with their values and goals. Revisit these conversations over time and when health or life circumstances change.

This section includes:

Where to focus conversations by population

Advance care planning conversations can be considered for three distinct populations. For each, a slightly different approach is required.

Healthy adults

- Conversations will be more hypothetical and involve planning for unexpected events (e.g. trauma, pre-op for patients with good expected outcomes).

People living with illness

- Ensure people are aware of the overall nature of their illness or condition.
- Conversations will be an opportunity to focus on illness understanding and learning about living with the illness or condition.

People living with advanced illness

- Illness understanding and information become even more important because there is more information about the likely trajectory of the illness or condition and what decisions might be needed in the future.
- Conversations may be more specific and might involve wishes, beliefs and preferences about specific treatments (e.g. ICU admission, intubation, BiPAP, etc.).
- Conversations about end-of-life wishes become more important.

Conversation prompts

Questions to ask everyone

- Have you completed a personal directive and appointed an agent(s)?
- Who is your agent(s)? Do they know your wishes?
- Talk about the person's overall values and wishes:
    - What brings you joy and makes your life meaningful?
    - If you were to get very sick, what would matter most to you?
- What should I know about you as a person to give you the best possible care?

Additional questions for people living with illness

There are six additional questions to consider asking when facilitating an advance care planning conversation with someone who has an illness diagnosis.

TIP: Let people know in advance that you would like to talk about their values and treatment preferences and invite them to bring their agent, family member and/or friend to participate.

1. What do you know or understand about your health?

Talking about **illness understanding** is important. There is evidence that up to 70% of people with an incurable or progressive illness do not understand their prognosis.

2. What information do you need?

This is an opportunity to meet a person's **information needs**. It includes paying attention to health literacy, coping mechanisms and how much information the person wants.

3. What is most important to you going forward?

There is evidence that **values-based** conversations, rather than treatment-focused ones, are more likely to positively impact patient outcomes.

4. What concerns or worries do you have about your illness?

Talking about **worries and fears** is important. It offers a different way for people to express their values.

5. What would you be willing to go through for the possibility of more time?

Talking about **trade-offs** helps to explore the conditions under which a person would want treatments and what is most important to them.

6. What's most important to you when you are near the end of life?

People may have **specific wishes** about care settings, treatments or other things that would make death more meaningful or peaceful. Not everyone will be ready to talk about end of life.

These questions come from the *Serious Illness Conversation Guide*. For more information see the Resource library.

Discussing specific treatments

During advance care planning conversations, people may express preferences regarding specific treatments (e.g. feeding tubes, ventilators, etc.). When they do, explore why the person feels this way.

- Have they seen someone else have it?
- Do they worry that it will leave them in a state they wouldn't find acceptable?

Focus on identifying their underlying values and the context in which they might find a specific treatment acceptable or not.

For people who are in the latter stages of an illness, treatments as well as their benefits and burdens become less hypothetical. Conversations can become more focused and can help you and their agent(s) develop a clear understanding of their wishes.

Action 5: Document advance care planning conversations

Document advance care planning conversations when they happen and ensure people have up-to-date print copies of their documents to facilitate smoother transitions in care.

This section includes:

- Documentation for healthcare providers
  - Personal Directive
  - Goals of Care Designation Order (if applicable)
  - Advance Care Planning/Goals of Care Designation Tracking Record
- Documentation for patients

Documentation for healthcare providers

The following documents should be included in a person's health record to ensure you and other healthcare providers can provide care that's aligned with their wishes. Please follow the relevant policies and procedures in your setting.

Personal Directive

Encourage people to share a copy with you and file it in their health record.

IMPORTANT:

Healthcare providers have a **legal duty** to:

- Make reasonable efforts to obtain personal directives and to enact them if the person lacks the capacity to make a required decision.
- Once enacted, follow the instructions of the agent (informed by the personal directive) or, if there is no agent, follow relevant instructions in the personal directive.

Goals of Care Designation Order (if applicable)

It is important for individuals to have a Goals of Care Designation (GCD) order when full resuscitative care is not what they want or is not medically appropriate.

A GCD order is a medical order that is completed by a physician or nurse practitioner after relevant conversations with the person or their agent.

TIP: Use advance care planning conversations and personal directives to introduce and inform goals of care discussions and vice versa.

Advance Care Planning/Goals of Care Designation Tracking Record

All healthcare providers should use this form to document advance care planning and goals of care conversations when they happen.

For more information see the following sections of the Resource library:

- Healthcare policies and procedures
- Additional information for healthcare providers

Documentation for patients

Ensure people have **up-to-date print copies** of the following in their green plastic folder – i.e. Green Sleeve:

- Their personal directive
- Goals of Care Designation Order (if applicable)
- Advance Care Planning/Goals of Care Designation Tracking Record

TIP: Check out what to do when a patient brings in a Green Sleeve for tips on how to ensure a person's important advance care planning documents are used and updated by the healthcare team.

Encourage people to:

- Upload a copy of their personal directive to their MyHealth Alberta Account so it can be accessed via Connect Care.
- Periodically review and update their personal directive as needed.
- Bring their Green Sleeve to their medical appointments.
- Keep the Green Sleeve on their fridge where healthcare providers are trained to look for it in an emergency.

Resource library

This section includes all the resources referenced throughout this guide as well as additional resources on related topics.

Resources include:

- Advance care planning resources for the public
- Planning ahead: preparing legal documents in Alberta
- Provincial legislation
- Capacity assessments and enactment of personal directives
- Other types of substitute decision-making
- Healthcare policies and procedures
- Additional information for healthcare providers
- Resources to support conversations about serious illness
- Related academic articles

Advance care planning resources for the public

Advance Care Planning | Covenant Palliative Institute
- What Matters Most to You Brochure | English | Français (French)
- My Wishes Alberta Workbook

Advance Care Planning | Alberta Health Services
- Conversations Matter Guidebook
- Keep Advance Care Planning Documents in a Green Sleeve

MyHealth Alberta Account | MyHealth Alberta

Planning ahead: preparing legal documents in Alberta

Personal Directive | Government of Alberta – Health and personal planning
- Personal directive template and instructions

Supported Decision-Making | Government of Alberta
Enduring Power of Attorney | Government of Alberta – Financial planning
Wills in Alberta | Government of Alberta – Estate planning

Provincial legislation

Personal Directives Act, RSA 2000, c P-6
Personal Directives Regulation, Alta Reg 99/2008
Personal Directives (Ministerial) Regulation, Alta Reg 26/1998

Capacity assessments and enactment of personal directives

About Capacity Assessment | Government of Alberta
Forms Used to Assess Capacity | Government of Alberta
Personal and Financial Decision-Making: Toolkit for Frontline Staff | Alberta Health Services
Decision-Making Capacity Assessment | Covenant Health
Also see: Additional information for healthcare providers

Other types of substitute decision-making

Specific Decision-Making | Government of Alberta
Adult Guardianship | Government of Alberta
Trusteeship | Government of Alberta

Healthcare policies and procedures

Advance Care Planning and Goals of Care Designation Policy | Alberta Health Services
Advanced Care Planning and Goals of Care Designation Procedure | Alberta Health Services
Advance Care Planning and Goals of Care Designation Policy | Covenant Health
Advance Care Planning and Goals of Care Designation Procedure | Covenant Health
Policy on Advance Care Planning | Canadian Medical Association

Additional information for healthcare providers

Advance Care Planning/Goals of Care: Information for Health Professionals | Alberta Health Services
- Advance Care Planning/Goals of Care Designation E-Learning Module | Alberta Health Services
- Frequently Asked Questions | Alberta Health Services
- What to Do When a Patient Brings a Green Sleeve | Alberta Health Services

Advance Care Planning/Goals of Care Designation Connect Care Quick Start Guide | Alberta Health Services
Health Law FAQ: Personal Directives Manual | Alberta Health Services
Medical-Legal Resources on Advance Care Planning | Covenant Palliative Institute
Supporting Choice: A Practical Guide to Advance Care Planning with Supported Decision-Making for Healthcare Professionals | Advance Care Planning Canada

Resources to support conversations about serious illness

Serious Illness Conversation Guide | Alberta Health Services
Serious Illness Care Program: Reference Guide for Clinicians | Alberta Health Services
Serious Illness Conversation Guide (Revised) | Ariadne Labs
3 Questions to Ask Yourself that Make Conversations about Serious Illness Easier | Health Canada
5 Simple Phrases to Transform Conversations with Seriously Ill Patients | The Conversation Project
Illness Roadmaps | The Waiting Room Revolution

Videos:
Part 1: Serious Illness Communication | Ariadne Labs – 11:28 min
Part 2: The Serious Illness Conversation Guide | Ariadne Labs - 25:28 min
Part 3: Implementing Serious Illness Communication | Ariadne Labs - 10:35 min
Preparing or Deciding: Simplifying Serious Illness Communication - 4:50 min

Related academic articles

The ACP-ASC Model: A Comprehensive Behaviour Change Model for Advance Care Planning Based on the Stages of Change Model (2025)
Simplifying Serious Illness Communication: Preparing or Deciding (2024)
Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review (2021)
Overview of Systematic Reviews of Advance Care Planning: Summary of Evidence and Global Lessons (2018)
Defining Advance Care Planning for Adults: A Consensus Definition from a Multidisciplinary Delphi Panel (2017)