Glossary

Advance Care Planning – A process allowing individuals to make medical decisions about their future end-of-life care in advance.

Advance Directive – A written statement that directs healthcare providers concerning consent or refusal of treatment when the individual patient does not possess decision making capacity.

Autonomy – Having the ability to function independently.

Competency/Capacity – An individual is able to understand the consequences of his or her actions.

DNR or DNAR – "Do Not Resuscitate"; "Do Not Attempt Resuscitation"-Written as an order after the patient has been consulted by his or her physician regarding his or her diagnosis and prognosis and that this decision be documented on the record. You may see this term move toward a newer term, **AND**; **A**llow **N**atural **D**eath

EOL - end-of-life

Health Care Agent–a competent patient appoints a surrogate or proxy to make health care decisions on behalf of oneself in the event that they become incompetent/unable to do so themselves. **Also known as *Durable Power of Attorney for Health Care; Medical Power of Attorney (MPOA*); *Health Care Proxy*; *Health Care Surrogate*.**

Living Will – Instructional directive that allows a competent adult to give directions for future care in the event that an individual becomes incapacitated due to illness, or for any reason, can no longer make decisions.

Patient Self-Determination Act – Established in 1991; Requires hospitals, nursing homes, health maintenance organizations (HMOs) and home health care agencies receiving Medicare and Medicaid funds to: have written policies and procedures concerning adult patients and their ability to provide informed consent and refusal of treatment, inform patients of their right to make decisions concerning treatment or nontreatment, never discriminate, comply with state laws concerning directives and provide educational programs on the law and Advance Directives.

Physician Orders for Scope of Treatment (POST) – A physician's order form addressing specific treatment options at end-of- life. Must accompany the patient throughout the healthcare system. Also known as *POLST* or *MOLST* in other states.