Ongoing Conversations and Documentation on one of the conversations and Documentation

Code Status

Serious Illness/ End of Life planning

Goals of Care - Medical, Surgical, Nursing, Rehabilitation, etc.

Advance Care Planning & Identifying a Substitute Decision Maker

HEALTH CARE PLANNING FRAMEWORK

The Substitute Decision Maker(s) and/or Support Person should be involved in all health care planning

Healthy Adults

Health event or Diagnosed with Illness

Prognostic indicators identify increased risk of dying

Ongoing Decline entering Final weeks to days of life or meet triggers

Advance Care Planning (ACP)

Identify Substitute
Decision Maker (SDM)

Reflect on values, wishes, beliefs, and health preferences

Consider organ donation

Consider housing and shelter options aging in place vs. transitioning

Document wishes as Health Directives /Living Will

Discuss above with family, SDM(s), Primary Care Team

Goals of Care Discussion

Share Diagnosis and Prognosis

Learn about illness or disease, discuss treatment, risks, benefits and alternative treatment options (including not treating illness); discuss possible complications.

Decide and Create treatment plan(s):

Medical Management Surgical Interventions Nursing Care Plans Rehabilitation Plans Dietary Plans Etc.

Serious Illness Conversation (SIC)

Discuss Patient's understanding of their Illness and share Clinicians understanding and current situation.

Explore key elements: worries, fears, trade-offs, sources of strength, family understanding, sources of support.

Make realistic recommendations based on information patient has shared, patient goals, and what patient hopes for when their health declines

Code status and limits of care

Review Current
Prognosis and change
in status

Discuss Standard of Care/typical approach within context of patient's illness

Discuss realistic options that align with prognosis and GOC.

Enter Code Status on EPIC order set (inpatient) or complete and scan DNR –C Form (outpatient) for patient to take home.