Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. *Set up the conversation* · Introduce purpose · Prepare for future decisions · Ask permission	"I'd like to talk together about what's happening with your health and **what matters to you** so we can provide you with the care you want." Is that ok with you? Would you like to have anyone join us?
2. *Assess understanding and preferences*	"What's **your understanding** of where things are with your health?" "**How much information** would you like from us?
3. *Share prognosis* · Share prognosis · Frame concerns as a "wish/ hope…but I worry..., and I wonder..." · **Pause. Explore emotional response**: "I can see this is upsetting for you. Can you tell me more about how you're feeling?"	"I want to share with you **my understanding**...." *Uncertain:* "It can be difficult to predict what will happen with your health. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR *Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*." OR *Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. *Explore key topics* · Goals/priorities · Fears and worries · Sources of strength · Daily abilities · Willing to go through · People closest to you	"What are your most important **goals/priorities** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future of your health?" "What daily **abilities** can't you imagine living without?" "How much are you **willing to go through** for the possibility of gaining more time?" "How much do the **people closest to you** know about your priorities and wishes?"
5. *Close the conversation* · Summarize · Make a recommendation · Check in with patient · Express commitment	"**I've heard you say** that ___ is really important to you. Keeping that in mind, and what we know about your health, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. *Document your conversation*	
7. *Communicate with key clinicians*	

Serious Illness Conversation Guide with Substitute Decision Maker (SDM)

*Decide how you will address the resident based on your relationship with the SDM. [name/your - loved one/relative/friend] and consider appropriate pronouns [she/he/they/...].

*Consider who should be involved in this conversation - additional family members, spouse, friends, ...

Conversation Flow	Suggested Language
1. Set up the conversation	"I'd like to talk about what is ahead with [...] health and what is important to [...] so that we can make sure we provide [...] with the care [...] would want — is this okay?"
2. Assess understanding and preferences	"What is your **understanding** now of [...] health?" "What changes have you observed in [...] over the past (3 - 6 months)?"
3. Share prognosis	"I want to share with you my understanding of where things are with [...] health." "[...] is (give examples such as: staying in bed more, not participating in activities, eating less). It can be difficult to predict exactly what will happen and when; but generally, for someone with [...] condition(s), we can expect [describe trajectory] in the near future." "I **hope** [...] will continue to be as well as [...] is /are now for a long time but I'm **worried** that [...] could decline quickly, and I think it is important to prepare for that possibility." OR: "I **wish** we were not in this situation, but I **worry** that [...] may be nearing the end of [...] life in (days/weeks/short months.)" OR: "I **hope** that this is not the case, but I'm **worried** that this may be as strong as [...] will feel, and things are likely to get more difficult."
4. Explore key topics	"Has [...] discussed with you [...] priorities and wishes in regards to [...] health?" "Does [...] have any previous advanced care planning documents?" **"If [...] could express [...] wishes** and make [...] own care decisions, what would [...] say was most important to [...]? (Attempt to understand the values and beliefs of both the client and the SDM) "What might [...] **biggest fears and worries** be? What are your **biggest fears and worries** for [...]?" "If [...] becomes sicker, **how much would [...] be willing to go through** for the possibility of gaining more time?" "Has [...] spent any **time in hospital**? How did [...] seem to feel about being there?" "How much do **other family members** know about [...] priorities and wishes?"
5. Close the conversation	"I've heard you say that ___ is really important to [...] and to you. Keeping that in mind, and what we know about [...] health, I **recommend** that we ___. This will help us make sure that the treatment plan reflects what's important to [...] and to you." "How does this plan seem to you?" "We will do everything we can to help [...] and you through this."
6. Document your conversation	
7. Communicate with key care team members: MRC (most repsonsible clinician), Long Term Care Home, Home Health, ...	

SICG-LTC 2019-06-20. Updated 2023-08-21.