

# Advance Care Planning and POST Decision Tree

Does the resident have decisional capacity to talk about the decisions on the POST form?

No



Is there a legally authorized representative?

- Health care power of attorney
- Health care representative
- Court appointed guardian

No



Does the resident have the ability to identify a Health Care Representative?

No



Is there someone available to serve as a representative?

No



Notify facility social worker; consider pursuing guardianship.

Yes →

Yes →

Yes

Yes

## Engage in ACP, discuss POST, and document:

- 1) Confirm resident is appropriate for POST
- 2) Gather appropriate individuals for advance care planning discussion using Respecting Choices Last Steps model.
- 3) Appoint health care representative if needed.
- 4) Discuss goals of care and treatment preferences.
- 5) Prepare a POST form and obtain signature of resident or legally authorized representative.
- 6) Document ACP conversation in medical record using template.
- 7) Obtain physician, advance practice nurse, or physician assistant signature on POST form and place in record.
- 8) Provide copy of POST form to family if appropriate.

## Engage in ACP and document:

- 1) Gather appropriate individuals for advance care planning discussion using Respecting Choices Last Steps model.
- 2) Discuss goals of care and treatment preferences.
- 3) If appropriate, prepare an Indiana Out of Hospital DNR order form and obtain signature of resident/family member and witnesses.
- 4) Document ACP conversation in medical record using template.
- 5) Obtain physician signature on "Out of Hospital DNR" and place in record. Propose DNH or No Feeding Tube order if indicated.