Advance Care Planning and POST Decision Tree

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

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.

No ↓

Is there a legally authorized representative?
- Health care power of attorney
- Health care representative
- Court appointed guardian

Yes →

No ↓

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

Yes →

No ↓

Is there someone available to serve as a representative?

Yes →

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.

No →

Notify facility social worker; consider pursuing guardianship.

OPTIMISTIC
TRANSFORMING CARE