* Decide how you will refer to the patient or resident based on your relationship with the Substitute Decision Maker (SDM). Will you refer to them by their [name or as 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

<table>
<thead>
<tr>
<th>Conversation Flow</th>
<th>Suggested Language</th>
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</thead>
<tbody>
<tr>
<td>1 Set up the conversation</td>
<td>“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?”</td>
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<tr>
<td>2 Assess understanding</td>
<td>“What is your understanding now of [...] health?”&lt;br&gt;“What changes have you observed in [...] over the past (3 - 6 months)?”</td>
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<td>3 Share prognosis</td>
<td>“I want to share with you my understanding of where things are with [...] health.”&lt;br&gt;“ [...] 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.”&lt;br&gt;<strong>Select one – most appropriate sentiment.</strong>&lt;br&gt;<strong>Uncertain</strong> “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.”&lt;br&gt;<strong>Time</strong> “I wish we were not in this situation, but I worry that [...] may be nearing the end of [...] life in (days/weeks/short months).”&lt;br&gt;<strong>Functional</strong> “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.”</td>
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<td>4 Explore key topics</td>
<td>“Has [...] discussed with you [...] priorities and wishes in regards to [...] health?”&lt;br&gt;“Does [...] have any previous advanced care planning documents?”&lt;br&gt;<strong>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)</strong>&lt;br&gt;“What might [...] biggest fears and worries be? What are your biggest fears and worries for [...]?”&lt;br&gt;“If [...] becomes sicker, how much would [...] be willing to go through for the possibility of gaining more time?”&lt;br&gt;“Has [...] spent any time in hospital? How did [...] seem to feel about being there?”&lt;br&gt;“How much do other family members know about [...] priorities and wishes?”</td>
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<td>5 Close the conversation</td>
<td>“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.”&lt;br&gt;“How does this plan seem to you?”&lt;br&gt;“We will do everything we can to help [...] and you through this.”</td>
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<tr>
<td>6 Document your conversation</td>
<td></td>
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<tr>
<td>7 Communicate with key care team members: MRC (Most Repsonsible Clinician), Long Term Care Home, Home Health, ...</td>
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</tbody>
</table>
## Conversation Flow

### 1. Set up the conversation
- Introduce purpose
- Prepare for future decisions
- Ask permission

### 2. Assess understanding

### 3. Share prognosis
- Explain changes and illness trajectory
- Frame as a “wish...worry,” “hope...worry” statement
- Allow silence, explore emotion

### 4. Explore key topics
- Goals and critical abilities
- Fears and worries
- Tradeoffs
- Past care
- Family

### 5. Close the conversation
- Summarize
- Make a recommendation
- Check in with patient
- Affirm commitment

### 6. Document your conversation

### 7. Communicate with key care team members