

**SERIOUS ILLNESS CONVERSATION GUIDE
NOVEMBER 2022**

PRINTED copies may not be the most recent version.
The **OFFICIAL** version is available on the InsideNet.

1.0 STANDARD PROCESS

This standardized process supports the clinician workflow for Serious Illness Conversation (SIC).

The Serious Illness Conversation Guide (SICG) is a patient-tested evidence-based practice approach, which supports clinicians having conversations with individuals who are living with advancing life-limiting illness.

Clinicians are strongly encouraged to complete the 3-hour SICG workshop before using the SICG in practice. ILearn (# 2301) lists available workshops, to increase competence and confidence in having SIC.

Additional tools are available to support clinicians, individuals and families with SIC.

2.0 DEFINITIONS AND ABBREVIATIONS

Individual/Person	Patient/Resident/Client
SDM	Substitute Decision Maker
Serious Illness	A condition that: carries a high risk of death over the course of a year; has a strong negative impact on quality of life and functioning in life roles; is highly burdensome to a person and his/her/their family (Kelley, 2014). This may be a malignant or a non-malignant condition.
SIC	Serious Illness Conversation
SICG	Serious Illness Conversation Guide
SICG workshop	A 3-hour continuing medical education accredited clinician workshop designed to support the interdisciplinary use of the Serious Illness Conversation Guide in practice. The tools are designed to help individuals prepare for the conversation; help clinicians guide the conversation; and then help the individuals talk to their families about their goals and values regarding their future care.
SIRA	Serious Illness Recommendation Aid

3.0 DOCUMENTATION CONSIDERATIONS

[#826571](#) Serious Illness Conversation Documentation

4.0 PROCEDURE**4.1 IDENTIFY**

Clinicians **identify** who would benefit from having a Serious Illness Conversation (SIC). Useful screening tools that can be used include:

- Surprise Question: A clinician reflects on the question:

“Would I be surprised if this person died in the next 1 to 2 years?”

If the answer is **No** (I would **not** be surprised if this person died in the next 1 to 2 years), the person may benefit from having a Serious Illness Conversation.

- Clinical/Diagnostic Triggers including:
 - [SPICT](#)
 - [iPall](#)
 - [Clinical Frailty Scale](#) (refer to page 2, Clinical Frailty Scale 4-9)

Clinicians **identify** who will be having the conversation with the individual, and arrange a time and place to have the conversation. Clinicians who have completed the SICG workshop are better equipped to have serious illness conversations. Clinicians engage individuals in serious illness conversations early in the person's illness trajectory, where possible. "*Early, more, better*" SIC are recommended, and an integral component of a Palliative Approach to Care.

Electronic Medical Record (EMR) functionality may support the identification of individuals who would benefit from a SIC, i.e. clinically extremely vulnerable (CEV).

4.2 PREPARE

Where possible, **Prepare** the person/SDM to engage in a serious illness conversation by having a preparatory conversation to plan for a SIC on another day in the near future.

Resources are available to provide to individuals in preparation for the planned SIC:

- What Matters to Me workbook (available at <https://theconversationproject.org/new-workbook-what-matters-to-me/>)
- Serious Illness Conversation Pre-Visit Letter (a resource provided to participants attending SICG workshops)

4.3 ENGAGE

Engage in a SIC with the person/SDM using the SICG framework. The standard guide that is evidence based, person informed and helps elicit the individual's wishes, values and preferences.

4.3.1 Serious Illness Conversation Guide Conversation Flow

- Set up the Conversation
- Assess Understanding and Preferences
- Share Prognosis
- Explore Key Topics
- Close the Conversation – refer to the Serious Illness Recommendation Aid (SIRA) (a resource provided to participants attending SICG workshops)

4.3.2 Serious Illness Recommendation Aid (SIRA)

- Wellbeing
- Illness
- Support System
- Help

4.3.3 Serious Illness Conversation Family Communication Aid: *Talking about your illness with loved ones and caregivers* is a booklet to support individuals talk with loved ones about their illness and future. This resource is available to participants who attend a SICG workshop.

An inter-professional team approach can be used for SIC, by multiple clinicians over a series of interactions. E.g. physician sets the stage, discusses understanding and share prognosis

4.4 DOCUMENT

Document the conversation using the SICG documentation tool in the permanent health record.

Standardized Process and Procedure

This ensures the individuals' wishes, values and preferences are honoured; and supports clear communication across the system of care.

- [Serious Illness Conversation Guide Documentation \(#826571\)](#)
- Documentation storage for inter-professional availability and accessibility
 - Document in Meditech
 - Profile Library
 - Paper chart – complete fillable form #826571, print and file in the Green Sleeve

4.5 COMMUNICATE

Obtain permission from the person with whom the SIC occurred to share information with other members of the health care team. Refer to the 'Caring for your Information' brochure (#807248).

Communicate to the inter-professional team members involved in the person's care that the serious illness conversation has occurred. Consider how this information can be shared:

- Interdisciplinary team meetings i.e. huddles, status assessment exchange, whole community palliative rounds.
- Updates sent to the primary care provider or most responsible provider
- Other local tools for communication i.e. Kardex, Care Plan

Ensure the individual's care plan reflects the result of the conversation, striving for goal-concordant care.

ADDITIONAL RESOURCES

Advance Care Planning page in Clinical Care Resources on the InsideNet
<http://insidenet.interiorhealth.ca/Clinical/General/Pages/ACP.aspx>

Palliative Care page in Clinical Care Resources on the InsideNet
<http://insidenet.interiorhealth.ca/Clinical/PalliativeEOL/Pages/default.aspx>

Scripts for Confident Conversations: Integrating MAiD into Palliative and End of Life Care Conversations, can be found in the Education: Staff section of the Palliative Care page in Clinical Care Resources

<http://insidenet.interiorhealth.ca/Clinical/General/Documents/MAiD%20Script%20Scenarios.pdf>

5.0 REFERENCES

Baxter, R., Fromme, E., & Sandgren, A., (2022). *Patient identification for serious illness conversations: A scoping review*. The International Journal of Environmental Research and Public Health. 19, 4162.
<https://doi.org/10.3390/ijerph19074162>

Bernacki, R.E. & Block, S.D. (2014). *Communication about serious illness care goals: A review and synthesis of best practice*. JAMA Internal Med. 174(12):1994-2003.
<https://doi:10.1001/jamainternmed.2014.5271>.

Kelley, A.S., (2014). *Defining serious illness*. Journal of Palliative Medicine. 17(9): 985. <https://doi:10.1089/jpm.2014.0164>

Lakin, J.R. et al. (2019) *Prioritizing primary care patients for a communication intervention using the "surprise question": a prospective cohort study*. J Gen Intern Med. 34(8), 1467-74.
<https://doi.org/10.1007/s11606-019-05094-4>

Palliative Care
Standardized Process and Procedure

Temel, J. et al. (2010). *Early palliative care for patients with metastatic non-small-cell lung cancer*. N Engl J Med. 363(8), 733-42.

Temel, J. et al. (2017). *Effects of early integrated palliative care in patients with lung and GI cancer: a randomized clinical trial*. J Clin Oncol. 30(8), 834-841.

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9.0 VERSION HISTORY

DMS ID	Key Changes	Revised By	Effective Date
931	New		11/14/2022