**Appendix**

Our primary variable of interest was any documentation in the hospital medical record of a discussion that occurred during hospitalization between physicians and the patient, family, or SDM regarding GOC. A GOC discussion was considered to have taken place if, in the hospital medical record (e.g. physician orders, consultation notes, interdisciplinary clinical notes) there was documentation of at least one of the following: (1) understanding/expectation of treatment options; (2) patient’s preferences for life-sustaining measures. Examples illustrating each criterion are provided.

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| **Understanding/expectation of treatment options** |
| Mrs. S is not for CPR or defibrillation in the event of a cardiac arrest. She is not for NIV or intubation. In the event that 48 hours of ward-based therapy does not improve her physiological state then focus of therapy should be palliative care. Discussed with Mr. S (Thomas) |
| Discussion with son re use of intubation and other invasive procedures if required. He will confer and discuss with team later. |
| Discussed with Mr. B. Deteriorating over last few years in nursing home (since husband died of CVA 3 years ago). Functional state poor. Doesn’t feel heroic measures are appropriated. If no improvement despite current therapy, focus should change → palliative following. |
| 1. DNR, see orders
2. Continue with current treatment. NB if no improvement in physiological state then focus of therapy → palliative focus
 |
| Called son, continuedresuscitation until son arrived and then decision was made to pursue palliative and comfort measures. |
| **Patient’s preferences for life-sustaining measures** |
| Discussion with family, patient has had recent wishes to be DNR, include no invasive procedures such as endoscopy |
| Patient’s family expressed wishes for limits on care – blood, general medical care. DNR, no endoscopy / invasive procedures. If treatment painful, futile then palliation is xxx. |
| Family clear do not want aggressive measures / investigation but trial medical therapy |
| Patient seen and examined. Daughter () at bedside.Discussions with daughter last night took place and per their wishes patient is now palliative and for comfort care only. Daughter updated. She is agreeable with plan. |
| As per son, patient palliative. No further blood work. For palliation.No labs. No Abx as per son. Plan to return to nursing home for palliation. |