Improvement of the process for capturing Resuscitation Status decision and discussion.

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Problem Statement: End of life care is a very sensitive topic. The decisions around the measures that a patient/family wish to have performed during this time are incredibly important and thus capturing the information becomes even more crucial. The former process for capturing this information was disjointed and lacked the detail around those items so personal to the individual. The process included an order for status, a form that would be filled out with basic information about what should/shouldn't be performed and an unstructured note to capture some details about the discussion. **Methods:** Through many design sessions, the team constructed a new process which would allow for any clinician to document the information that the patient/family presents. This information is broken down into three sections. First, Details of the status including broadening the availability of items pertinent to the resuscitation status (dialysis, artificial nutrition and artificial hydration have been added to the options, in addition to fields which allow for the patient/family to specify wishes that might not be part of the standard options). Second, Discussion, replacing the separate note option and driving the user to document not only the details of the discussion, but also the participants in the discussion (which wasn't always captured previously). The addition of a field for MOLST (Massachusetts Orders for Life Sustaining Treatment) allows for the capturing of whether the patient has orders outside of the institution. Third, Removal, as a special section which allows for documentation of status to be removed from the chart (alerts no longer appear) if and when the condition of the patient changes and they no longer want/need the status that was documented. Further improving the process, the indicators for the status are available face up to the end user at the time of entering the patient chart. They are also available on a special patient information page as well as being presented in a structured text document within the patient notes folder. **Results:**This new process has allowed for a more streamlined process for all users to be able to assist in a very sensitive time in the patient care experience.