Grampians Region Palliative Care Consortium
Patient journey chart

STATE	Reasonably well	Unwell	More unwell	Dying	Dead
Condition	Healthy; or may have chronic illness	Acutely ill	Progressive disease	Rapidly deteriorating	
Events		Life-threatening illness/injury	Relapse/failure of treatment	Dying	Death
Outlook	Years	Years	Months – Years	Days	
Treatment type	Preventive	Curative/restorative	Palliative	Terminal care	Bereavement care
Goals of care	Maintain reasonable health	Return to reasonable health and independence	Management of symptoms including pain	A comfortable death	Care of family and friends through grieving process
Clinician planning	Preventive health care plan; and/or disease specific care plan	Disease specific care plan	Palliative care plan	Terminal care plan	
Living arrangements	Home and independent; engaged with community	Home, hospital or aged care facility; engaged with health system		Home, hospice, palliative care ward, aged care facility or hospital	
ACD	Knows about; may complete; may retain a form in case	May lead to appointment of Substitute Decision Maker and/or discussion with family and health care providers			
ACD records	SDM and sometimes values and life goals	May add values, life goals and circumstances to avoid	May add specific directions for SDM, and preferred outcomes	May add specific interventions refused	
Completes	Independently or with legal advice	Independently, with legal advice or within an advance care planning program			

Patient journey chart

Adapted from Lynn J, Adamson DM. *Living well at the end of life; adapting health care to serious chronic illness in old age*. Arlington, VA, Rand Health, 2003 in *A National Framework for Advance Care Directives*, Australian Health Ministers' Advisory Council, September 2011 at http://www.ahmac.gov.au/cms_documents/AdvanceCareDirectives2011.pdf accessed April 2013