Nursing: Managing Goals of Care Discussions

Leah Steinberg MD, MA, CFCP
Patricia H. Strachan RN PhD
May 11, 2018
Conflict of Interest

• None for Dr. Steinberg

• None for Dr. Strachan
By the end of today:

• Recognize opportunities to engage in GOC discussions with patients with advanced HF and their families
• Learn an approach to GOC discussions with patients with advanced HF and their families including specific communication strategies and skills to improve these discussions
• Using video material, engage in skill development in GOC discussions

* We will focus on the **process** of GOC discussions
Agenda

• Definitions: what and why

• Challenges

• Learning and practicing model for GOC conversations
What are "Goals of Care?"

• No actual validated practice guidelines or definition

• A conversation to learn and explore your patient’s understanding, belief, hopes and goals for the future

• May or may not lead to treatment decisions

• What do we often think it is?
PERSON-CENTRED DECISION MAKING

A person’s values, wishes, beliefs and goals for their care

- **Advance Care Planning**
  - Only with capable person
- **Goals of Care Discussions**
  - With capable patient or SDM
  - Treatment or care decision is to be made
- **Consent**
- **Treatment or Plan Initiated**
Nurses and GOC Discussions

• GOC discussions are within the nurse’s scope of practice

• GOC discussions include

  • Seeking pt/family values, beliefs, needs, preferences & understandings re: **current illness context** and its implications, including the possibility of death

  • **Ongoing & effective communication, advocacy, and support** to promote autonomy, dignity, patient-centeredness, shared decision-making about care

  • Documenting & communicating with care team

CASN competencies for Palliative and End-of-Life Care: Entry to Practice Competencies and Indicators for Registered Nurses (2014)
CNO Practice Standard: Therapeutic Nurse-Client Relationship, revised 2006. (February 2017)
Why should we have GOC conversations?

- Promote informed patient-centered decision-making that aligns HF Rx with patient/family preferences (ACP)

- Facilitate timely access to necessary and appropriate emotional and physical comfort/care including access to specialist palliative care prn

- Reduce unwanted interventions

- Reduce caregiver stress and suffering; promote coping

- Reduce nurse/health team moral distress
GOC discussions in your practice

What are some examples when goals of care conversation are needed in your practice?

What do you find challenging about having GOC discussions with your HF patients and families?
What makes GOC conversations challenging?

- ‘Uncertain’ prognosis, hx of rescue from ‘brink of death’
- Limited knowledge/understanding re: HF illness, trajectory & meaning of interventions
- Pt capacity; multiple co-morbidities; suboptimal conditions
- “Salvation ethos”: Maintaining hope; More Rx options
- Pt/family challenges in accepting poor prognosis
- Uncertainty about who, how, when, where of GOC conversations; nurse confidence & authority
- Perceptions re time available for conversation
- Nurse knowledge of HF, interventions
- *Support for nurses to have a GOC conversation
GOC Model
Flow of the conversation
Prepare

• Check your own emotions
• Set aside your assumptions and agenda
  • Start with learning about where your patient is or else you will talk at them rather than with them
When can I do this?

When can I have these discussions in my practice?
Opportunities in nursing practice

Formal opportunities
• Family meetings

Informal opportunities
• Embedded in care

Patient cues
• “I don’t know how much longer I can do this.”
• “They want me to go ahead with ……”
• “I’m worried about ....(i.e., my family)…”

HF illness Benchmarks
• ICD battery replacement
• Hospitalization for exacerbation
• Decline when Rx optimized
Flow of the conversation
Explore illness understanding

- Listen closely
- Respond to what you hear, not what you wish you heard
- Encourage your patient to talk
  - They should talk much more than you at this stage
- How do you encourage this?
  - Reflection
  - Silence
  - Open ended questions
- Don’t judge answers
- Be prepared for emotion
Mr. Young

- 45 yr old man with metastatic lung cancer (or heart failure!)
- Spinal cord compression
- Going in to talk to him about palliative care referral
- You know there are no further anti-cancer (or heart failure) treatments
Mr. Young:
Mr. Young’s illness understanding

• What do you think about his illness understanding?
Illness understanding:

What would you say to him now?
Faced with a patient like Mr. Young, many clinicians would give a “correcting response” – information to correct his understanding

• This is a very normal response

What do you think he might do if you do this?

IN the next video, let’s see what the physician did
Illness understanding: Mr Young:
What happened?

- What did physician do?
- What do now think of his illness understanding?
- What is the problem he faces in terms of being able to talk about his cancer?

So what would the equivalent be for heart failure?
Levels of a conversation

• Conversations occur on multiple levels:

  Cognitive
  Emotional
  Social
Theory: So what is the learning here?

- Non-judgmental
- Assume your patient knows
- Unconditional positive regard

- Don’t assume an emotional gap is an information gap
Open ended questions

Examples of open-ended questions to start you off

“Tell me what has happened to you since you started to get weaker?”

“I’m wondering: what does your family know about your illness?”

“Since you’ve known about your illness, is there anything you worry about?”
Reflections

• A statement, not a question
• It encourages your patient to carry on with their thoughts
• It signals that you are listening and checks your understanding
Illness Understanding: Silence

Why is silence important?
What is happening during a silence?
What happens when we interrupt?

Silences are hard for us – not for the patient
Mr Young: Next day
LISTENING PRACTICE

- Dyads
- HF vignette
Inform and Ask
Giving information

• When giving information:
• Speak slowly
• Pause frequently
• Ask for understanding
Think about what you say........

• Use lay terms, avoid HF lingo, aim for common understanding

What does the patient understand when we say...
“*We are going to do a trial of …to see how you respond*”
“*He is failing milrinone/ the inotrope…*”
“*You/he is not a candidate for LVAD, CRT*”
“*There is nothing more we can do…*”
“*Keep her comfortable…. move to comfort care..*”
“*Focus on improving your QoL*”  (Kelemen et al, 2016)
It’s matter of perspective

<table>
<thead>
<tr>
<th>Clinician</th>
<th>Person (patient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>This medication (diuretic) will improve BP control</td>
<td>I have to wake up all night to go to the bathroom or can’t go on car trips because I have to pee too much</td>
</tr>
<tr>
<td>Anti-inflammatory will worsen renal function</td>
<td>Without these pills, I can barely walk and cannot leave the house and see other people</td>
</tr>
<tr>
<td>Another round of chemotherapy may shrink the tumours a bit more</td>
<td>I will be too sick to participate in any family events for the next 6 months</td>
</tr>
</tbody>
</table>
Maintaining hope

• Be present
• Focus on what you will do
• Focus on achieving goal concordant care

• “I wish that I could say…..”
• “I worry that if we don’t have this conversation……”
• “I wonder if it might be helpful to…..”
PRACTICE TRIADS
Asking about values
Asking about values

• What is most important to them?
• What do they hope for?
• What are they worried about?
• What do they need help with?
Recommend a plan
Recommend a plan

Recommend a plan based on patient’s goals and values

• “Based on what you’ve told me, I’d like to suggest a plan going forward…is that okay?”

• May include suggesting a family meeting, discussion with NP, physician &/or health team, getting information or resources to support understanding & decision-making, being present when they speak with family

• Discuss how care can help to meet their goals
Questions
Thank You!

Email:
Leah.Steinberg@sinaihealthsystem.ca
strachan@mcmaster.ca