Person-Centred Decision-Making: Documenting **Goals of Care** Discussions

tGoals of Care (GOC) discussions *occur in the context of a serious illness and there are treatment or care decisions that need to be made. The aim is to align available treatment and care options with the patient's goals and values. If there are no current decisions, please see* ***Advance Care Planning*** *resources on the back of this document.*

1. Reason for the GOC Discussion?	2. Any concerns about patient's ability to participate in the discussion? Yes ☐ No ☐

☐ Treatment or care decisions to make
☐ Admission/Transfer to a new facility
☐ Code status discussion
☐ Follow up from previous GOC discussions
☐ Information sharing
Other _____
	If Yes:
	• Document concerns if patient is mentally incapable to make decision
	  o Engage SDM (patient may still be involved in discussion)
	  o For specific treatments, obtain consent from capable patient or SDM
	  o See below for SDM Hierarchy and resources
	• Address language or communication barriers

3. Document the GOC Discussion

Assess understanding: **Explore and listen** "Tell me in your own words what is happening with your health?" "What is your understanding of where things are with your illness"	Document answers in patient's/SDM's words (e.g. "I know my heart is weak…but I get better each time I come to hospital…"; "I don't know what is wrong…"; "I know I am sick, and I don't know what to expect")
Inform: **Ask permission** "I need to give you some information that is important to the decisions you need to make, is that ok?" "What other information would be helpful to you?"	Document information you provided to patient/SDM (e.g. patient wishes to hear all information. We discussed the benefits and risks of further treatment – he understands that treatment may prolong his life for weeks to months and that the risks are …)
Goals & Values: **What matters to your patient? Ask gently:** "What are you hoping to achieve? "What are your most important goals? "What are your biggest fears and worries about the future? "How much does your family know about your goals and priorities?"	Document answers in patient's/SDM's words (e.g. "I am hoping to get well enough to go home, walk around the house without help"; "I am hoping to get back to work"; "I am hoping to see my cottage one more time"; "I am worried about pain")
Make a Plan: **Based on goals and values** • Recommend treatments based on patient goals (or, explain why goals are not achievable) • Acquire further input from specialists? • Organize further meeting?	Document next steps (e.g. we will arrange a team meeting with all specialists to discuss possible next steps; we will obtain consent to do a trial of antibiotics and reassess in 3 days; "determined no role for dialysis")

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4. Specific Treatment and Care Preferences

Attempts at Resuscitation in the event of cardio-pulmonary arrest:

Many institutions have specific CPR order sets for documentation. Please use those to documents orders. This list is a guide for discussion of preferences and may be used by institutions without specific order sets to create orders.

- ☐ Full Cardiopulmonary Resuscitation (CPR/Intubation/ICU transfer)
- ☐ Modified resucitation for respiratory distress : Intubation and mechanical ventilation only NO CPR
- ☐ Allow natural death

For Long Term Care, Complex Continuing Care or Rehabilitation:
Prefernce for receiving care in current facility or for transfer to acute care

- ☐ Transfer to Acute Care
- ☐ No transfer to Acute Care

**Use this to start a discussion about treatment options available at each facility. Every situation will be different, and a discussion is required before transfer.*

Preferred place of death (if known and appropriate):

Not all options are available in every location (preference is not always possible and decisions may change as illness progresses)

- ☐ Home
- ☐ Hospice / Palliative Care Unit
- ☐ Long Term Care (includes nursing and residential facilities and Complex Continuing Care)
- ☐ Hospital – acute care facility

Discussion occurred with:

- ☐ Patient: _____
- ☐ SDM(s) [specify name(s) & relationship]: _____

_____

- Attach power of attorney document if applicable
- Others present for discussion: _____

_____

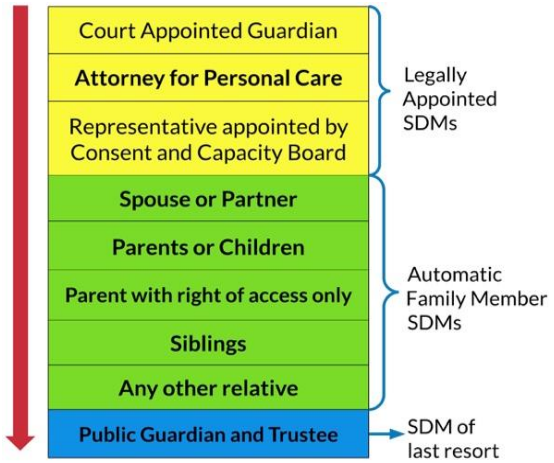
Signed by: (Health Care Provider)

Print Name: _____

Signature: _____

Professional designation: _____

Date: _____



Ontario's Health Care Consent Act, 1996

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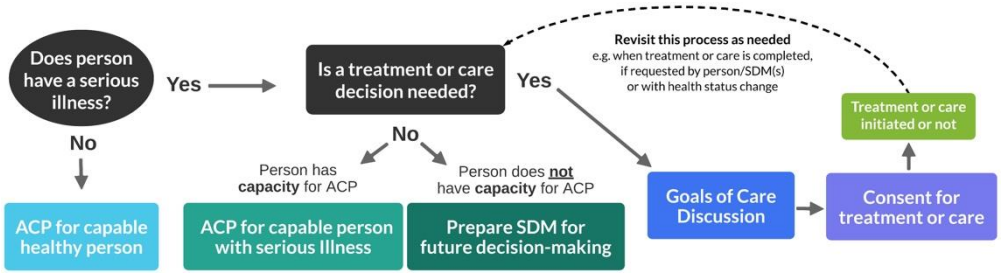
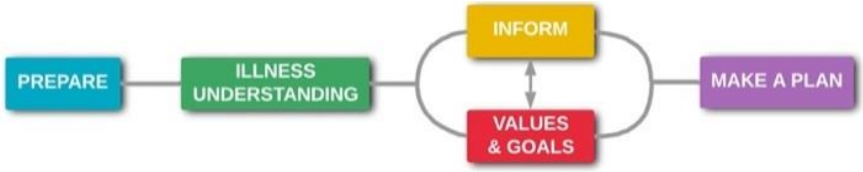
This represents the process an HCP can use to determine which conversation to have.

The skills and the flow of these conversations are all quite similar. The proximity to health care decisions and the need for specific consent are what moves one along the flowchart.



Advance Care Planning (ACP) differs from Goals of Care (GOC) Discussions. The purpose of ACP is to prepare people and their SDMs for future decision-making. ACP is ***not*** consent for future care. (for more information about how to help patients with ACP, see Speak Up Campaign).

Model of a Goals of Care Discussion



PREPARE yourself

- Start by knowing the available treatments, including the burden of the treatment, its risks and likely benefits
- Think about how you are feeling about the conversation and spend a moment to prepare yourself.
- Next, leave your agenda at the door -- you are there to help a patient make decisions -- not convince them of your decision. Once you have understood their needs, understanding, values and goals, you will be in a better position to use your medical expertise to recommend a plan.

Explore your patient's **ILLNESS UNDERSTANDING**

- Explore what your patient knows and thinks about her illness and future. This step requires that you listen closely, ask questions to clarify and explore and use empathic reflections to prompt your patient to continue.
- Some patients will seem to have very little illness understanding initially, but with time and gentle enquiry, you will discover that your patient does in fact know a lot about their illness. Achieving a full illness understanding may take several discussions and may require emotional support.
- The most important thing to do is to listen and refrain from speaking – especially when the patient is thinking.
- Even if time is short (emergency decision to be made), spending a few minutes at this step will often provide information that makes all the next steps easier and quicker.

"I'm worried about your father – he is quite ill, and we may have to make some decisions very soon. But before that, tell me what you know about his cancer…"

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Give INFORMATION if necessary

- Ask for permission to give information
- Give information in short pieces -- one or two sentences at a time and pause frequently to see how the information is being understood and to allow for emotions.
- If possible, provide information that relates to the person's goals
    - How will accepting or refusing the treatment affect what is important to them?

"Does this make sense to you?"

"Is this information new or surprising to you?"

VALUES & GOALS: Ask about goals, values, hopes and fears

- Your work is to help patients uncover their goals. Sometimes, your patient needs your help to express their values, goals and beliefs - through listening, reflecting and clarifying questions.
- Don't worry if the patient's goals are not achievable. It is still their goal and only be knowing it, acknowledging it and discussing it can you help them choose a goal that is within medical reach.

Examples of values and goals

- Attend upcoming family event
- Try a further treatment to reverse underlying illness
- Avoid hospital admission unless for symptom management only
- Get strong enough to walk

Recommend a PLAN that meets those goals

- Recommend a plan based on what you heard about their values and goals.
- This may include proceeding to informed consent for a proposed treatment or the plan may include agreeing to revisit the conversation before moving forward with a treatment plan.
- Note: you are just making just a recommendation. The patient can consider the treatment, reflect on their goals and discuss more fully before making a decision to consent to any treatment or plan.

"Based on what you've told me is important to you, can I suggest a plan going forward?"

Code status and other treatment decisions:

- Even when curative treatments are unavailable, there are many other important treatment decisions that arise in the care of patients. For example, the use of antibiotics, blood transfusions and treatments like chemotherapy/ radiotherapy, dialysis and diuretics can be used for symptom management. The intent of these treatments may also be to delay disease progression.
- Decisions about code status are only one important treatment decision among many.
- GOC discussions may result in a decision to forego attempts at resuscitation, but that is not the sole purpose of a goals of care discussion.

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