



THE GOAL SETTING CONFERENCE



BEFORE THE MEETING

- Review chart-know all medical issues: history, prognosis, treatment options
- Coordinate medical opinions among consultant physicians
- Decide what tests/treatments are medically appropriate (i.e., likely to benefit the patient)
- Review Advance Care Planning documents
- Review/obtain family psychosocial information
- Decide who you want to be present from the medical team
- Clarify your goals for the meeting-what decisions are you hoping to achieve?

10 STEP GUIDE

HELPFUL LANGUAGE

1. ESTABLISH PROPER SETTING

Private, comfortable; Everyone seated, Turn off/forward pager

2. INTRODUCTIONS

- Allow everyone to state name and relationship to patient
- Build relationship: ask non-medical question about patient

“Can you tell me something about your father? What kind of person is he?”

3. ASSESS PATIENT/FAMILY UNDERSTANDING

- Encourage all present to respond
- Ask for a description of changes in function over course of illness/hospitalization

“What have the doctors told you about your wife’s condition at this point?”

“What is your assessment of the current medical situation?”

4. MEDICAL REVIEW/SUMMARY

- Summarize “big picture” in few sentences- use “dying” if appropriate; avoid organ-by-organ medical review
- Avoid jargon
- Answer questions

“I’m afraid I have some bad news. I wish things were different. Based on what you have told me, and what I see, I believe your mother is dying”

5. SILENCE/REACTIONS

- Respond to emotional reactions (have tissues available)
- Prepare for common reactions: acceptance, conflict/denial, grief/despair; respond empathically

“This must be very hard”

“I can only imagine how scary/difficult/overwhelming this must be”

“You appear angry, can you tell me what is upsetting you?”

6. DISCUSS PROGNOSIS

- Assess how much patient and family want to know
- Provide prognostic data using a range
- Respond to emotion

“Some people like to know every detail about their illness, others prefer a more general outline. What kind of person are you?”

“Although I can’t give you an exact time, given your illness and condition, I believe you have (hours to days) (weeks to months).

This is an average, some live longer and some live shorter”



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<p>7. ASSESS PATIENT/FAMILY GOALS</p> <p><u>Possible goals:</u></p> <ul style="list-style-type: none"> • prolong life • improve function • return home • see a family milestone • relief of suffering • staying in control 	<p><i>“What do you wish to accomplish?”</i></p> <p><i>“Are there any important goals or tasks left undone?”</i></p> <p><i>“What is most important to you at this time?”</i></p> <p><i>“Knowing that time is short, what goals do you have?”</i></p> <p><i>“How do you picture your death?”</i></p> <p><i>“Where do you want to be when you die?”</i></p>
<p>8. PRESENT BROAD CARE OPTIONS</p> <ul style="list-style-type: none"> • Stress priority of comfort, no matter the goal • Make a recommendation based on knowledge/experience 	<p><i>“Given what you have told me, about your mother and her goals, I would recommend . . .”</i></p> <p><i>“These decisions are very hard; if (patients name) were sitting with us today, what do you think he/she would say?”</i></p> <p><i>“How will the decision affect you and other family members?”</i></p>
<p>9. TRANSLATE GOALS INTO CARE PLAN</p> <ul style="list-style-type: none"> • Review current and planned interventions-make recommendations to continue or stop based on goals • Discuss DNR, Hospice/Home Care, Artificial Nutrition/Hydration, future hospitalizations • Summarize all decisions made <p style="text-align: center;">CONFIRM YOUR CONTINUED AVAILABILITY REGARDLESS OF DECISIONS</p>	<p><i>“You have told me your goals are ____ With this in mind, I do not recommend the use of artificial or heroic means to prolong your dying process. If you agree with this, I will write an order in the chart that when you die, no attempt to resuscitate you will be made, is this acceptable (ok)?”</i></p> <p><i>“All dying patients lose their interest in eating in the days to weeks leading up to death; this is the body’s signal that death is coming.”</i></p> <p><i>“I am recommending that the (tube feedings, IVF) be discontinued (or not started) as these will not improve her living and may only prolong her dying.”</i></p>
<p>10. DOCUMENT AND DISCUSS</p> <ul style="list-style-type: none"> • Write a note: who was present, what decisions were made, follow-up plan • Discuss with team members (consultants, nurse, etc.) • Check your emotions 	<p>Team debriefing = Opportunity for Teaching and Reflection</p> <p>Ask team members:</p> <p><i>“How do you think the meeting went?” “What went well?” What could have gone more smoothly? “What will you do differently in the future?”</i></p>
<p><u>MANAGING CONFLICT</u></p> <ul style="list-style-type: none"> ➤ Listen and make empathic statements ➤ Determine source of conflict: guilt, grief, culture, family, dysfunction, trust in med team, etc. ➤ Clarify misconceptions ➤ Explore values behind decisions ➤ Set time-limited goals with specific benchmarks (e.g. improved cognition, oxygenation, mobility) <p><i>WHEN YOU NEED ADDITIONAL ASSISTANCE OR SUPPORT CONSIDER A PALLIATIVE CARE CONSULT</i></p> <p>Palliative Care Service consult pager: (917) 632-6906 or 9399</p>	