Goals of Care

By Marnie Shambo RN Nurse Coordinator

What is a Goals of Care discussion

- Meeting with patient and/or family to discuss the patient's health goals.
- Many times, patients have multiple MD/Specialists giving advice on treatments and no one has taken a moment to ask the patient what he/she wants. This is the time that the patient is given the opportunity to express his/her wishes.
- Advanced Directives are discussed if needed. They are given blank POLST forms to be filled out and signed by their MD/NP. Many times when patients are struggling with their advance directive decision, they are encouraged to ask the MD what the "chances" are for surviving CPR/Intubation.
- When the patient has an upcoming appointment with an MD/Specialist, they are given pointers on what questions to ask during their visit.

Who Qualifies for a Goals of Care conversation

Patients with a dx of:

- CHF
- COPD
- End Stage Renal Disease
- ALS
- Metastatic Cancer
- Advanced Dementia/Alzheimer's
- Pancreatic Cancer
- Glioblastoma
- Small Cell Lung Cancer
- Patients who have had multiple hospitalizations
- Patients who have multiple co-morbidities

When should a Goals of Care conversation occur?

- When a patient is not responding to treatment
- When a patient is having multiple ED/Hospitalizations/Urgent MD visits
- When Oasis score indicates patient is likely to not live more than a year
- When a patient has had a decline in functional status and is not responding to rehab therapy
- When a patient has had a decline in appetite with subsequent irreversible weight loss
- When a patient has had multiple infections

Change Talk

When a patient or their representative says:

- “I don’t want to go back into the hospital anymore”
- “I’m tired of all of this”
- “What is the point to all this treatment?”
- “Do I have any other options?”
- “I have a poor quality of life.”

Where do Goals of Care conversations occur?

- Patient's private residence
- Skilled Nursing Facility
- Assisted Living Facility
- Rehabilitation Facility
- Hospital

Who Performs the Goals of Care Conversations

- VNA Nurses
- Hospice Nurses
- LICSW

Outcome

- Patient will remain on VNA with support from York Hospice
- Patient will have more knowledge of Hospice/Care and Comfort and access hospice care as appropriate
- Patient will be more informed of options and able to ask questions to MD's regarding next steps of care
- Patients' goals will be followed
- Avoidable re-Hospitalizations will decrease

Hospice Discussion: Addressing Potential Barriers to Accessing Hospice Care

- When appropriate, Hospice discussion is made during Goals of Care.
- Discuss the Hospice Philosophy, Hospice Team, 24/7 nursing availability, DME coverage, and pharmacy. Medicare coverage.
- Discuss the difference between Homecare and Hospice
- They are made aware that patient's DO NOT need to be a DNR when signing onto Hospice, it is not a contract and they can come off of Hospice at any time.
- They DO NOT have to give up their PCP.
- If appropriate, Hospice House is discussed.
- Biggest goal with this conversation is to lessen the fear of the "H" word.

Hope

- These conversations are not easy. They can sometimes bring up feelings of anger, frustration, sadness, guilt.
- Goals of Care is provided to give "HOPE" to patients and families.
- It is done to provide information on different levels of homecare to help patients/families make informed decisions.
- It is done so that patients/families don't feel alone navigating through their illness.