**The Advocate Nurse**
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# Communication Strategies for Goals of Care Discussions: "What's in your Tool Box?"

*Jean M. Mau DNP, MSN, ACNS-BC, CHFN* *
*Diane Boyle APN, ACHPN* **

* Advocate Lutheran General Hospital, Park Ridge, Illinois ** Rainbow Hospice and Palliative Care, Chicago, Illinois

Rainbow Hospice and Palliative Care

## Background

Conversations about one's wishes and goals for health care increase the likelihood that care will be consistent with the individual's preferences. Advanced Practice Nurses (APN's) are in a position to influence these conversations, especially with the geriatric population. By providing tools and strategies to support optimal communication skills, the APN can assist patients and families in exploring their hopes and goals for their health care future.

## Literature Review

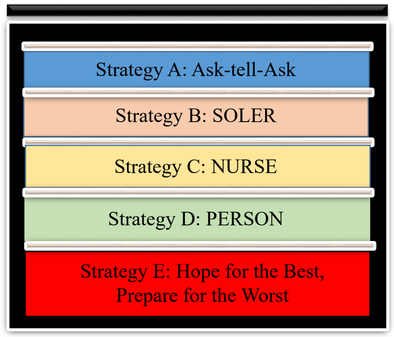
The American Nurses Association and the American Association of Colleges of Nursing mandate that nurses have a responsibility to educate the patients and families about End-of-Life (EOL) issues including life preferences, communication of relevant information and established competencies for end-of-life care.

The National Consensus Project developed Clinical Practice Guidelines for Quality Palliative Care, which state that effective communication skills are essential to EOL discussions.

Several barriers with facilitating goals of care discussions exist including: lack of training, fear of saying the wrong thing, fear of emotions, personal discomfort and a desire to maintain hope of patients and family members (Peereboom, Coyle 2012).

## Opportunity

Currently, there is no consensus approach on how to have these conversations (Edmonds, 2014). As a result, a "Tool Box of Strategies" was developed to provide APNs with structure on how to have goals of care conversations with complex older adults. (Peereboom, Coyle 2012, and Edmonds, 2014).




## Tool Box Strategy A: Ask-tell-Ask

Ensures that the interaction remains a conversation, providing appropriate information for the patient.

**APN:** How are things going Mr. K?

**Mr. K.:** Not so good. I don't think I am ever going home.

**APN:** You sound discouraged today. Has something happened?

**Mr. K.:** My provider gave me some bad news today…I have heart failure!

**APN:** Share with me what you heard and understand from this news.

Retrieved from: http://ish-tmc.org/conversations-on-end-of-life-conversations/

## Tool Box Strategy B: SOLER

Utilizes nonverbal expressions of empathy during discussions focused on goals of care.

**S:** Face the patient squarely *(demonstrates interest in their story)*

**O:** Open body posture *(communicates openness to the patient)*

**L:** Lean toward the patient *(shows flexibility and interest)*

**E:** Eye contact *(in Western cultures demonstrates APN is paying attention and focused on patient)*

**R:** Relaxed posture *(helps to decrease patient's anxiety)*

## Tool Box Strategy C: NURSE

Focuses on using expressions of empathy.

**N:** Naming the emotion *(you seem really upset)*

**U:** Understanding *(non-judgmental response, understands they are having a difficult time)*

**R:** Respect *(recognizing the challenges she faces)*

**S:** Support *(assuring patient of non-abandonment, communicate your presence)*

**E:** Explore *(demonstrate interest in their "story" "tell me more")*

## Tool Box Strategy D: PERSON

Encourages us to know the person before making important medical decision.

**P:** Perception *(What have the doctors told you?)*

**E:** Explore *(What was your life like before you got sick?)*

**R:** Relate *(connect medical reality to patient's story)*

**S:** Sources of Worry *(explore patient's fears/hope/worry)*

**O:** Outline Plan *(Outline plan going forward)*

**N:** Notify *(Notify others who need to know)*

## Tool Box Strategy E: Hope for the Best, Prepare for the Worst (Peereboom, Coyle 2012, and Edmonds, 2014).

Opens discussion for possible alternative outcomes for practical planning without taking away hope.

**Example:**
While we are all hoping for the best, we should also prepare for the worst. Have you and your wife ever talked about what you would want if your heart failure worsened?

## Additional thoughts for consideration:

This toolkit incorporates several different approaches the APN can integrate into their current practice.

- Active listening demonstrates respect for patient and family values, preferences, goals of care and shared decision making.
- Reframing provides focus on finding the patient's inner wisdom (Back, 2014). "We are in a different place now, here is what we can do."
- Clarification of goals of care differs from plan of care discussions: it's not just about code status.

## Conclusion

Using the available resources will not only optimize health related outcomes, but also enhance the quality of care for older adults.

## References

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## Contact Information

Jean.mau@advocatehealth.com
DBoyle@rainbowhospice.org

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