# GOALS OF CARE CONVERSATION

- *Suggested dialogue below, but you're the best judge of how to talk with your patient!*
- *See supporting documents for more ideas.*

**OPENING/CONTEXT**

- Today, I'm hoping to discuss 'Goals of care' or 'Advance directives' - basically, your wishes for treatment and care if you were very ill.
- We're being encouraged to do this with all of our patients over 70 who have any health issues. Its' just good proactive care - especially in this time of Covid-19!
- If you wish, we can also send a summary to LGH, to go into your hospital chart. That way, it's there if you did end up in hospital. It's extremely helpful for your care - to have a record saying that we talked, and what your wishes were today.
- But they would still look at the actual situation, and discuss with you and your family what to do.
- Does all this make sense? Would it be ok to talk about it?

**EXPLORE**

- So taking a hypothetical situation: if you became so ill you couldn't speak for yourself, who would you want as your **Substitute Decision Maker**?
- How aggressive should the treatments be? We call this the "**Level of Intervention'**. Here are some examples:
  - Just keep me comfortable! [Most M1]
  - Try hard but I don't want to go on machines to keep me alive especially if there's no hope of reasonable recovery. [MOST M3]
  - Do your utmost! No holding back! [MOST C2]
  - It depends on the details, I can't give you a simple answer.
  - I need to go away and think about this! [Fill in the box on the right that says 'Specific comments on….']
- What **about CPR?** If the end came, should we allow natural death, or try to restart the heart?
  - Attempt CPR [Checkbox in category B: 'Attempt Cardiopulmonary Resuscitation']
  - No CPR [Checkbox in Category B: 'Do Not Attempt Cardiopulmonary Resuscitation'

**PLAN** (Close, Summarize)

- To review the main points: If you were seriously ill:
  - Your **Substitute Decision Maker** would be…
  - Your preferred **'Level of Intervention'** would be…
  - Regarding **CPR**: If the end came you're saying you [want/don't want] CPR.
- I'd like to give you a copy of this form. We can review it from time to time, and change it if your situation or your wishes change.
- I'd also like to send a copy to LGH if you agree. And as I mentioned before - your wishes would be discussed again if you did end up in hospital!

**DOCUMENT the conversation**

- Record the encounter in the EMR, in the usual way
- MOST form
  - Sign and date (near the bottom – 'This MOST Order first documented' ]
  - Add the MOST form to the patient's EMR record.
  - Provide a copy to the patient if possible.
  - Fax to 604.984.5718 if patient agrees.