**Goals of Care Conversations with High Risk Patients:**

**Staff Roles and Responsibilities**

|  |  |
| --- | --- |
| **Preparing for Goals of Care Conversations**  | **Notes** |
| Identify high-risk Veterans |  |
| If decision-making capacity is in question, perform or obtain assessment | MD, APRN, PA, PhD only |
| If patient lacks decision-making capacity, identify authorized surrogate per policy/law |  |
| Inform the Veteran (or surrogate) about diagnosis/prognosis, provide time for questions, ensure understanding | MD, APRN, PA only |
| Initiate invitation, provide information about the purpose of a goals of care conversation, encourage participation of Veteran’s trusted support system |  |
| Schedule the goals of care conversation |  |
| **Conducting Goals of Care Conversations** |  |
| **If the conversation takes place with the Veteran (and ideally, their support system)…** | **If the conversation takes place with the surrogate…** |  |
| Explain role of the surrogate, and inform Veteran who would be authorized to serve as surrogate per law/policy | Explain the surrogate’s role in decision making |  |
| If the Veteran chooses a different surrogate, assist in completing a VA and/or state-authorized Durable Power of Attorney for Health Care | Review documents reflecting the Veteran’s wishes  |  |
| Elicit understanding of health condition | Elicit understanding of health condition |  |
| If needed, deliver news about diagnosis/prognosis | If needed, deliver news about diagnosis/prognosis | MD, APRN, PA only |
| Elicit Veteran’s values and goals of care | Elicit Veteran’s values and goals of care |  |
| Provide basic information about services, treatments | Provide basic information about services, treatments |  |
| Provide patient-specific information about life-sustaining treatment outcomes | Provide patient-specific information about life-sustaining treatment outcomes | MD, APRN, PA only |
| Make shared decisions with Veteran regarding life-sustaining treatment | Make shared decisions with surrogate regarding life-sustaining treatment | MD, APRN, PA only |
| **Follow-up** |
| Make referrals, follow-up appointments |  |
| Assist Veteran in completing advance directive |  |
| Complete Life-Sustaining Treatment progress note and orders | MD, APRN, PA only |
| Fill out state-authorized portable order (e.g., POLST) | State-specific rules |
| Sign state-authorized portable orders (e.g., POLST) | State-specific rules |



**Goals of Care Conversations & Documentation:**

**Tracking Record**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **HIGH RISK PATIENT NAME** | **LAST 4** | **Goals of Care Conversation****(GoCC)** | **G&P Note\*** | **LST Note** | **LST Orders** | **Advance Directive** | **State-Authorized Portable Orders****(SAPO)** | **Consistent?** | **Follow Up** |
| (e.g. complete LST Plan, complete SAPO, rescind duplicate AD, referral) |
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\*Goals & Preferences to Inform Life-Sustaining Treatment Plan progress note is an optional note title; this heading should be adjusted based on how your facility documents GoCCs completed by nurses, social workers, psychologists, and chaplains.



**Use this form to take notes while observing another clinician during a Goals of Care Conversation. Provide notes to the clinician, if desired.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Subject** | **Complete** | **N/A** | **Comments:** |
| **Introduces Conversation**(Step 1) |  |  |  |
| **Discusses Surrogate** (Step 2) |  |  |  |
| **Discusses Understanding of Health**(Step 3) |  |  |  |
| **Explores Values and Goals of Care**(Step 4) |  |  |  |
| **Discusses Services**(Step 5) |  |  |  |
| **Discusses Life-Sustaining Treatment(s)**(Step 5) |  |  |  |
| **Develops Follow-up Plan** (Step 6) |  |  |  |

**Debrief the conversation as follows, with self-reflections first and observer feedback second:**

One thing that went well that I/you should continue doing in the future is …

One thing that I/you may want to do differently in the future is …

