

# Communication: the way forward

PCA Conference Workshop 2015

Dr Julia Wootton

Mrs Anne Ogden

Dr Elisa Agostinelli

# Discussing and planning goals at the end of life

Dr Julia Wootton Palliative Medicine Specialist St  
Vincent's Brisbane and President of Palliative  
Care Queensland

Mrs Anne Ogden Counsellor Patient and Family  
Support Team St Vincent's Brisbane

# The iconic Story Bridge over the Brisbane River



# Aim

To improve participants confidence in facilitating discussions about goal setting

# Objectives

- Consider the concept of patient readiness when discussing end of life goals
- Explore topics to be considered when approaching goal setting in end of life care
- Explore strategies and techniques for starting a conversation about end of life goals
- Consider issues that can affect the desired outcomes when talking about end of life goals with patients and families

# What is the difference between goal setting and ADHD's

- Discussion

# Why is it important to get the communication right?

- Discussion
- Example

# Role play 1

- Anne is a 65 year old lady with metastatic breast cancer diagnosed 12 years ago. She is a widow and has 2 children one of whom lives locally and one in the USA. She was referred to your service 3 months ago and you feel that she has deteriorated over this time. You have visited her 3 times and feel that the time has come to explore where she is at and how she sees the future. Does she have thoughts about her goals of care?



# Role play 2

- Same patient

# Principles of goal setting

- Goal setting is voluntary – no pressure
- Patient centered dialogue over a period of time, it is not a single conversation
- Content is determined by the client and should reflect their personal autonomy
- Staff need to be aware of own limitations
- Discussions should focus on the client
- Staff require knowledge of what is possible
- Planning ahead to avoid undesired care
- Responds to changing scenarios ...
- Continuous .

# What do we mean by goals?

- Individuals concerns
- Important values or personal goals for care
- Preferences for care
- Statement of wishes and preferences for the future
- Getting to know .. 'what's the most important thing' at each step in the process
- Being honest about what's realistic

# Timing and context

- Any time – from the start, not necessarily during disease progression or just towards the end
- Often at life changing event, significant shift in treatment focus, obvious deterioration
- Multiple problems, repetitive admissions
- Respond to cues
- Planting the seed ... *may be not a conversation for today .. but next time ..*
- Always asking how are going emotionally

# What impacts on goal setting?

- Client readiness
- Cultural background
- Understanding & acceptance of prognosis
- Unskilled professionals
- Family dynamics
- Unrealistic goals
- Starting too late
- Poor communication & documentation of client goals

# Knowing when to hold off from goal setting

- When it's not natural, avoid going there routinely as part of the assessment
- Respond to cues which indicate the client is not ready
- When the goal setting is initiated by outside pressure (family, organisation)
- When you don't know the client, their condition, treatment options & 'the person'
- When the time and setting is not appropriate for a private discussion

Thank you: any questions?

