**Communication Guide for Goals of Care, advance care planning and DNACPR**

Resource- [www.talkcpr.wales](http://www.talkcpr.wales)

**Goal of Care Discussions**

* Discussions about ceilings of treatment or resuscitation, which constitute advance care planning, are useful during normal times, but even more so during the COVID‐19 outbreak.
* Open, honest discussions regarding ceilings of treatment and overall goals of care are essential
* Such decisions may involve discussion with those close to the patient over the telephone or via internet based communication facilities.
* While this is less than ideal, honest conversations are often what patients and those close to them actually want.

Don’t make things more complicated than they need to be; use a framework such as SPIKES:

o **S**etting / situation

read clinical records, ensure privacy, no interruptions

o **P**erception

what do they know already?; no assumptions

o **I**nvitation

how much do they want to know?

o **K**nowledge

explain the situation; avoid jargon; take it slow

o **E**mpathy

even if busy, show that you care

o **S**ummary / strategy

summarise what you’ve said; explain next steps (putting decision on record, leaving form in the house if required)

Should ceilings of treatment conversations include ethical issues, for example where escalation may or may not be appropriate health professionals should be prepared for anger / upset / questions. These are usually not aimed directly at you, but you may have to absorb these emotions and react professionally, even if they are upsetting / difficult at the time.

Patients or those close to them may request a ‘second opinion’ – this should be facilitated wherever possible

Be honest and clear-

o don’t use jargon; use words patients and those close to them will understand

o sit down; take time; measured pace and tone; use silences to allow people to process information

o avoid using phrases such as “very poorly” on their own – is the patient “sick enough that they may die”? If they are – say it

**Phrasing suggestions**

These are phrases that you might find helpful when discussing advance care planning and DNACPR with patients. Focus on the person you are speaking to- try not to get distracted by other things.

* I know it must be very hard at the moment with all the endless news reports saying don’t worry this only affects the elderly and frail with underlying health issues. I can imagine it makes you feel quite vulnerable.
* Just wanted to let you know we are here and working at the practice and that if you have any concerns or symptoms you can call us.
* We are also aware that a lot of our patients are too worried to bother us in case we are too busy so I just wanted to touch base and make sure you are ok. Is there anything worrying you at the moment or that you would like to ask me?
* It would also be a really good time to make sure we have all your contact and next of kin details up to date – can we check these please?
* What support if any do you have at the moment? Do you have carers coming in, someone to do shopping/get any medications or things you might need during an extended time of staying at home?
* Ceilings of treatment/ DNACPR-

We really are living through an unprecedented time, and we know for some people it makes them start thinking about what they want and what they do not want when it comes to medical treatment. I am sorry to bring this up over the phone like this and if you prefer not to talk about it, that is completely fine. However, if you feel you would like to talk about it, or let me know what those wishes are, so that everyone involved in looking after you knows and is aware what your wishes are, then I would be very happy to discuss that now or another time soon if that is better for you.

If the patient wants further discussion-

* When thinking about the future it can be helpful to think about what you want to do should you become very unwell. If you were sick enough that you might die where would you want to be?
* Do you have any special requests or preferences?
* Is there anything that you would not want to happen?
* Is there anyone you would like to speak on your behalf should you not be well enough to speak for yourself?

**DNACPR**

When explaining CPR make sure that the patient/ their representative knows what you are talking about-

* A physical force/ electric current to restart a heart that has stopped
* Cardiorespiratory arrest is the final stage of dying
* The success rate in frail elderly patients and those with underlying conditions is very low
* DNA CPR does not mean that the patient won’t get good care/ medical treatment

‘When disease has overwhelmed the body, the heart stopping is the last part of that process of being overwhelmed and it is extremely unlikely that we would be able to restart the heart in that condition, unlike when a heart stops for electrical reasons in an otherwise healthy body’

**CMC**

There is a digital system that we have been using across GPs, the ambulance service and the hospitals to share this important information about our patients so we can share information about your medical history and ensure your next of kin details are known by everyone, would you be happy for me to create a record for you on this system, called ‘Coordinate My Care’?

**With thanks** to St George’s Hospital Palliative Care team, Gold Standards framework, RCP- Talking about dying and NHSE/I (London region) End of Life Care Clinical Network.