**Goals of Care Conversations Talking Map**

**For Renal Teams**

**Introduce the Conversation**

*“You’ve been through a lot with your health problems, and we want to be sure we always provide the care that matches your preferences. It helps to understand what you want to achieve through your health care, and what you want to avoid. Is this a good time to talk about this?”*

**Reassess Understanding of Health:**  **Reframe** if Necessary, **Expect Emotion** and Respond

*“What do you understand about your [medical condition]?”*

*“What changes have you noticed over the past [X] months?”*

*“What have you been told you might expect in the future?”*

**ENSURE ADEQUATE UNDERSTANDING OF MEDICAL CONDITION BEFORE MOVING ON.**

**IF NECESSARY, ALLOW TIME TO ADJUST TO SERIOUS NEWS.** *RESPOND TO EMOTION WITH EMPATHY.*

**Map the Future:** Elicit Patient’s Values and Goals of Care

*RESPOND TO EMOTION WITH EMPATHY.*

*”What matters most to you as you think about the future?”*

 *“What else?”*

*“Given this situation with your health, what’s most important to you?”*

*“What do you hope for with your medical care?”*

*“What concerns or worries do you have as you think about your health and the future?”*

*“Is there anything you would want to avoid?”*

*“Is there anything that would be helpful for me to know about your religious or spiritual beliefs?”*

**Align:** Repeat what you heard and check to be sure it is correct

**Plan:** Support Patient’s Goals

**Topics – address within your scope of practice:**

* **Dialysis**
* **Supportive services** (e.g., home health services, palliative care, hospice, long-term care, respite)
* **Other treatments, including life-sustaining treatment** (e.g., CPR, ventilator, feeding tubes)

**A. If the patient’s goals point to a clear plan, ask permission and make a recommendation:**

 *“Would it be ok if I make a recommendation, or would you like to tell me your thoughts first?”*

 *“Based on your goals of …., I would recommend…”*

**B. If the patient’s goals don’t point to a clear plan, or the patient wants more information, or treatment preferences don’t appear to match goals, EXPLORE:**

 *“Tell me what you know about .”*

*“Would it be ok if I shared some information about ?”*

*“Tell me what you’re hoping for with [treatment/service] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?”*

*“I worry that [treatment/service] won’t help you reach your goals.”*

**C. If not in your scope of practice to make shared decision about life-sustaining treatment, provide basic information and help patient write down questions for their provider.**

**D. Summarize the plan and ask if it seems right**

**Identify or Confirm Patient’s Authorized Surrogate**

*“Have you thought about who you’d want to communicate your health care decisions for you if you were ever too sick to speak for yourself?”*

Has the patient completed an advance directive to name that person as their health care agent?

**ASK SURROGATE:** *“Do you think you’d have any trouble carrying out [the patient’s] wishes?”*

**Summarize and Establish Next Steps**:

**Summarize what has been discussed and check for accuracy.**

**Discuss a plan for follow-up:**

⭘Continue conversation in a follow-up visit. Topics to cover:

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⭘ Help with new advance directive.

⭘ Help with new portable orders for life-sustaining treatment.

⭘ Make referral(s):

⭘ Follow-up with other team member(s):

⭘ Additional information on medical condition, prognosis

⭘ Additional discussion about treatment options

⭘Specific questions to address: