THE IMPORTANCE OF HAVING GOALS-OF-CARE CONVERSATIONS

To the Editor:

Foley's (2019) article "Improving End-of-Life Care for Hospitalized Older Adults: What Can Nurses and Health Care Systems Do?", which was published in the July 2019 issue of the *Journal of Gerontological Nursing,* raises the question of the responsibility of health care systems in preparing nurses to engage in goals-of-care conversations. The article does a great job of addressing the benefits of nurses collecting information on the goals and values of patients and families during treatment and at end-of-life (EOL), as well as the moral distress that can occur with the challenges of this role.

Health care systems use nurses throughout the spectrum of care (e.g., primary, acute, post-acute, palliative, EOL) to support patients and families in meeting their goals. Do health care systems provide the additional education and training needed to support nurses in the role of goals-of-care conversations? Palliative and EOL training may be encouraged or provided, with EOL training available to nursing staff. Nurses having the option of training in either EOL or patient-centered communication while still being expected to engage in goals-of-care conversations can lead to distress.

As a clinician, I see critical care nurses regularly attempt to engage in goals-of-care conversations despite lack of formal training. Hearing the statement, "What are we doing? The patient should be DNR [do not resuscitate]," is not uncommon. Health care systems have a responsibility to provide formal training in patient-centered communication, palliation, and EOL care to assist nurses in patient care. Formal training can help emphasize the purpose of the goals-of-care conversations, which is to ascertain the primary goal of the patient and his/her family to guide treatment. Our role in health care is not to judge the decisions of patients/family, but to make sure our treatment is consistent with their goals. Formal training can assist nurses with their role in these conversations and remove undue distress when values and beliefs differ with that of the patient/family.

In a study by Wittenberg, Ferrell, Goldsmith, Buller, and Neiman (2016), researchers found that nurses' greatest concerns with goals-of-care discussions centered around the function, structure, and process of the care team, and that the preparation to work as a team in goals-of-care discussions was a barrier. Formal training for nurses and care teams can remove this barrier by providing the education and opportunity to formalize the process of these discussions amongst team members. In a study by Patel et al. (2018), findings show that when providers listen to patients and care is provided in line with patient goals, better outcomes are achieved.

Patel et al.'s (2018) study focused on the use of a lay health worker to start conversations and hold them regularly with patients, with conversations followed up by providers. A similar approach can be achieved by using nurses in identifying and establishing patient/family goals, with formal conversations held by the care team afterward. As nurses are a crucial part of the care team, they should be included in these conversations to assist with the support of patients/family as well as to ensure consistency and understanding during goals-of-care conversations. By providing formal education and training for nurses and care teams in goals-of-care discussions, health care systems can design and implement processes that improve patient outcomes at EOL.

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Kimberly Bagley, DNP, AGPCNP-BC, AGACNP-BC, CCRN
Critical Care Nurse Practitioner
Duke Raleigh Hospital
Duke University Health Care System
Raleigh, North Carolina

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Reply:

Thank you for your positive comments regarding my editorial (Foley, 2019) and my stance on the importance of nurses' involvement in goals-of-care conversations. I particularly appreciate your added emphasis on proper training for nurses to have these conversations.

In my experience as a nurse and in discussions with other colleagues, there is a wide variety of comfort levels and desires to have these types of conversations, which can be improved with additional education and training. As you mentioned, there are resources available through the End-of-Life Nursing Education Consortium (ELNEC) as well as other types of formal and informal training to help support nurses in this role. To me, because of the difficult nature of goals-of-care conversations, one key piece to training is to include role-playing where nurses can practice the skills they learn in a safe environment prior to engaging in these conversations with patients and family members. Role-playing can help better prepare nurses to use the communication techniques they learn and decrease the distress of having these conversations that can accompany inadequate preparation.

The articles that you referenced point to the importance of having goals-of-care conversations and the positive impact that this type of communication can have on patient outcomes and satisfaction. This process change can also promote communication within the team and, in turn, benefit patients and families during this critical time. It is also imperative that nurses understand the benefit of providing care that is in line with patients' and families' goals to help decrease the distress that often comes with providing care to critically ill patients. Although I was working as a nurse prior to starting my advanced education, I often felt similar sentiments to what you have heard from other nurses regarding patients being full code when it does not seem "appropriate." During graduate school, I had the opportunity to participate in additional palliative care education, which opened my eyes to the importance of providing care that is in line with patients' values.

I hope that with nurses having more palliative-focused education and taking a more active role in goals-of-care discussions, the moral distress that comes with caring for patients at end of life can be minimized. The positive impact that palliative-focused communication can have on patient outcomes and satisfaction can also promote communication within the team and, in turn, benefit patients and families during this critical time.

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Lindsey M. Foley, DNP, ARNP, ACNPC-AG
Graduate
University of Washington
School of Nursing
Staff Nurse
Swedish Medical Center
Seattle, Washington

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