POLST
CALIFORNIA

Facilitating Care Conferences & Family Meetings – Cue Card

Family meetings occur in the home, hospital and skilled nursing facility with patients and family members. The following steps help make care conferences and family meetings more meaningful:

- **Prepare for the meeting**:
  - Review the resident's history
    - If you are missing information or the resident/family has questions, write down questions for follow-up with resident's physician.
  - Does the resident have an AHCD?
  - Is he or she decisional? If not, who is the agent/decisionmaker?
  - Have the meeting in a comfortable room, with no distractions.
  - Consider meeting location to enable resident participation (at bedside?)

- **Introductions** – have everyone introduce themselves. Ask family members to state their relationship to the resident. Identify legal or family designated decisionmaker.
  - Build relationship by saying something like "*I know about Mrs. Tu's illness, but tell me something special about her*." (family & staff)

- **Review your plan/goals for meeting**. For example, to discuss goals of care and complete POLST. Ask if the resident or family has other issues they want to discuss during this meeting.
  - May need to identify a time frame and plan a follow-up meeting if needed.

- **Ask what the resident and/or family knows** about the resident's current medical condition? What have the doctors told them? How do they feel things are going? ASK THEM how things have been in the past three to six months – what changes have they noticed in the resident's physical condition and functioning? What do they want to know?

- **Present medical information clearly. Discuss the BIG PICTURE** with current condition. Speak slowly. No medical phrases or terms. Check for understanding. Do not minimize the problem. Well-intentioned efforts to "soften the blow" may lead to vagueness and confusion.
  - Identify current diagnosis and problems
  - What is the medical treatment plan, e.g.
    - resident is at facility for rehabilitation and plan is to go home,
    - versus a long-term resident who has just returned from acute hospitalization for new or worsening serious illness,
    - versus resident who is having on-going declining health or functional status.
    - Is treatment plan in accordance with patient's previously stated wishes/values?
  - Discuss POLST (use POLST Communication Script or Cue Card)

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- With a decisional resident and family members are present – the resident will make his or her own decisions. You can ask the family if they have questions or concerns, but the resident is the decisionmaker (see POLST Conversation Points). Ask, "how can you support your Mom's decision?"
- For the Non-decisional resident – Ask "what do you believe your Mom *(Dad)* would choose if she could speak for herself?" Another way to phrase this question is "if 10 years ago, your Mom knew what her life was like today or what her physical illnesses were today, what would she have wanted?" Although the agent/decisionmaker will make the decisions, you can ask the family members for their thoughts.
  - If the family cannot reach consensus, restate the goal of decision-making, "what would your Mom say to us if she knew her situation and could speak to us?"

- **Reactions & Questions**. Allow silence; give resident and family time to react. Acknowledge and validate reactions before further discussion. Invite questions.
  - If resident or family has questions about the treatment plan, or if they ask questions you cannot answer, it is important to write down these issues and **plan for the primary care doctor to talk with them**.
  - If the resident or family misunderstood something and you are comfortable clarifying the issue, you can respond. If you are uncomfortable or unsure, refer them to the physician.
  - Be prepared to respond to emotions. Have Kleenex available. Remind them their responses are normal.
  - Hope and Truth Telling: talk about how hope means different things as someone moves through the stages of illness. In serious illness or when close to death, hope focuses on short-term or spiritual goals – feeling valued, meaningful relationships, reminiscence, pain and symptom relief. Factors that decrease hope include feeling devalued, abandoned, isolated (instead of "there is nothing that can be done" explain all that we will do to take care of them and manage any pain and symptoms). **We will continue to provide excellent care.**

Conclusion – Review and summarize decisions and issues that need follow-up.

- If POLST is completed, obtain signature of resident or decisionmaker.
- Plan for the next step or next meeting. Reviewing goals of care and POLST are routinely done at quarterly care conferences.
- Follow-up on any identified issues and keep resident and/or family and doctor informed.

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