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| COVID-19: Serious Illness Conversation Guide Aotearoa | February 2022 |

**Patient with COVID-19 in the community at increased risk of deterioration**

**Prepare:** before you see/talk to the patient, make sure you know what treatments are appropriate and available should they deteriorate, as this will frame your conversation.

**Think:** ‘What treatment decisions might we need to make if this person deteriorates?’

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| **Stage** | **Language to use** |
| **Set-up** Introduce yourself and acknowledge  the situation | ‘I am so sorry we are in this situation/you are feeling so unwell.’  ‘We want to make sure you have the best care possible, particularly if your health was to deteriorate. It would be good to talk about what is happening with your health, what might be ahead and what things are most important to you. Is that okay?’  ‘This is an important conversation. Is there anyone else you would like us to include in this conversation [by phone or video call]?’ |
| **Assess** Check patient understanding  Seek permission | ‘To make sure we are on the same page, can you tell me your understanding of what’s happening with your health at the moment?’  ‘That is helpful to know – thank you.’  ‘Is it okay that I share my understanding of where things are at?’ |
| **Share** Provide information about their current condition.  Choose **one** of these prognostic statements based on your assessment of the current situation and the patient’s prognosis  Acknowledge this is difficult news | ‘This is my understanding of where things are at…’  *If recovery is hopeful:* ‘It can be difficult to predict what will happen with your health. I hope that you will continue to do well, but it is possible you could become more unwell quickly. It is important we prepare for that possibility.’  **OR**  *If recovery is uncertain:* ‘It can be difficult to predict what will happen with your health I hope that this is not the case, but I am concerned that you might not recover even if we give you all possible treatment, and you may deteriorate quickly.’  **OR**  *If death is likely imminent:* ‘It can be difficult to predict what will happen with your health. I wish this were not the case, but I’m concerned that time could be as short as a few hours (or days).’  **AND**  ‘I know this is not what you wanted to hear/I am so sorry we are in this situation.’ |
| **Pause** | **Allow silence, respond to emotion with empathy before moving on.** |
| **Explore**  Find out what is most important  for the patient | ‘What is most important to you if your health does get worse (despite everything we are doing)?’  ‘What are you most worried about (when you think about your health changing?)’  ‘What helps you through the tough times?’  ‘What abilities are so important to you, that you can’t imagine living without them?’  ‘If you became very sick while you have COVID, how much would you be willing to go through to try to get better? Would you prefer to be treated in the hospital or where you are living now?’  ‘If you are very sick with COVID and decisions need to be made about your care, who would you like to be included? How much do they know about what is important to you?’ |
| **Close**  Summarise  Recommend the goal of care and medical treatments | ‘I have heard you say […] is really important to you.’  SUGGESTED PLANS aligning with the goals of care on the shared goals of care form:  ‘Keeping that in mind, I suggest that we …’   1. ‘… do everything we can to support you to pull through this infection; if despite our best efforts it becomes clear that you might die, we will do everything we can to keep you comfortable.’   OR   1. ‘… do everything we can to support you to pull through this infection; we wouldn’t attempt to re-start your heart if it stopped; if despite our best efforts it becomes clear you might die, we will do everything we can to keep you comfortable.’   OR   1. ‘… focus on improving your symptoms and your wellbeing; if despite our best efforts it becomes clear you might die, we will do everything we can to keep you comfortable.’   OR   1. ‘… focus on keeping you comfortable and allow a natural death.’   AND  ‘How does this plan seem to you?’  ‘I will do all I can to help you get the best care possible.’  ‘Is there anything you would like to go over again/ask/talk about?’  ‘Is there anyone you would like me to contact to update them about this conversation?’ |

**Conversation flow**

**Prepare *before* seeing the patient:**

* Check which medical interventions are likely to help and are available to this patient if they deteriorate acutely (see local guidelines).
* Check for any pre-existing advance directives and/or advance care plans.
* Consider which prognosis statement you think is most appropriate.

**Set up the conversation**

* Introduce yourself and other members of the care team present.
* Introduce the idea and benefits of having this conversation.
* Ask permission.
* Check whether the person would like anyone else included in the conversation or to be kept up to date – negotiate how you might do that.

**Assess health understanding**

* Ask what the person already knows and seek permission to share your understanding.

**Share prognosis**

* Choose the appropriate prognosis to use, deliver it clearly.
* Allow silence and acknowledge any emotion that arises.

**Explore what matters most to the patient**

* Specifically explore the patient and/or whānau priorities and worries now or if the patient’s health does change.

**Close the conversation**

* Summarise what you have heard, making a recommendation that aligns with a goal of care on the shared goals of care form and agree any additional plans with the patient and their whānau.
* Affirm your commitment to them and check whether there are any other questions or concerns, or if there is someone else they would like you to update about this conversation.

**Document the conversation on the shared goals of care form or local equivalent.**