19. The dying person should not be allowed to make decisions about his/her physical care.

20. Families should maintain as normal an environment as possible for their dying member.

21. It is beneficial for the dying person to verbalize his/her feelings.

22. Nursing care should extend to the family of the dying person.

23. Nurses should permit dying persons to have flexible visiting schedules.

24. The dying person and his/her family should be the in-charge decision-makers.

25. Addiction to pain relieving medication should not be a nursing concern when dealing with a dying person.

26. I would be uncomfortable if I entered the room of a terminally ill person and found him/her crying.

27. Dying persons should be given honest answers about their condition.

28. Educating families about death and dying is not a nursing responsibility.

29. Family members who stay close to a dying person often interfere with the professionals job with the patient.

30. It is possible for nurses to help patients prepare for death.

---

**Appendix H: Tips for Conducting a Family Conference**

**After the Pre-conference, proceeds either to 2 or 3.**

1. **Pre-conference:**
   a. Clarify conference goals and roles with the health-care team.
   b. Identify participants (health-care team, individual and family).
   c. Organize date, time and location (private space when available).

2. **Conference with individual capable to make decisions and family if desired:**
   a. Introduce self and others.
   b. Review meeting goals; clarify if specific decisions need to be made.
   c. Determine urgency of decision-making.
   - Establish ground rules: Each person will have an opportunity to ask questions and express views without interruption; a legal decision-maker will be identified; and the importance of supportive decision-making will be described.
   d. Review health status:
      i. Determine what the patient and their family already know: “Tell us what you understand about your current situation.”
      ii. Review current health status.
iii. Ask individual and family members if they have any questions about the current situation.

e. Clarify expectations

f. Clarify beliefs and values to determine what goals are most important to avoid or achieve.

g. Discuss practical implications of preferences and expectations (i.e. are goals realistic and achievable?).

h. Allow time for private discussion.

i. Review and/or set goals of care.

3. Conference with substitute decision-maker(s) and others as identified:

a. Introduce self and others.

b. Clarify role of substitute decision-maker(s) and confirm willingness to participate in decision-making.

c. Review meeting goals; clarify if specific decisions need to be made.

d. Determine the urgency of decision-making.

e. Establish ground rules: Each person will have an opportunity to ask questions and express views without interruption; a legal decision-maker will be identified; and the importance of supportive decision-making will be described.

f. Review health status.

   i. Determine what the substitute decision-maker(s)/family already know: “Tell us what you understand about the individual’s current situation.”

   ii. Review current health status.

   iii. Ask the substitute decision-maker(s) and family members if they have any questions about the current situation.

g. Clarify expectations:

   i. Ask substitute decision-maker(s): “What do you believe the individual would choose if he/she could speak for him or herself?”

   ii. Based on what the substitute decision-maker(s) understand about what the individual would have wanted, ask he/she: “What do you think should be done?”

h. Clarify beliefs and values to determine what goals are most important to avoid or achieve.

i. Discuss practical implications of preferences and expectations (i.e. are goals realistic and achievable?).

j. Allow time for private discussion.

k. Review and/or set goals of care.

4. Wrap-up:

a. Summarize consensus, disagreements, decisions and goals of care.

b. Caution against unexpected outcomes.

c. Identify family spokesperson for ongoing communication.

d. Document in the health care record: who was present, goals of care, what decisions were made, follow-up plan.

e. Maintain contact with individual, substitute decision-maker(s), family and health-care team.

f. Schedule follow-up meetings as needed.

N.B. When there is no consensus:

• Determine unmet needs for information and support.

• Assist the individual/substitute decision-maker(s) to access resources to address unmet needs.

• Reinforce role of substitute decision-maker if applicable.

• Schedule a follow-up conference.