Goals of Patient Care (Adults) Guideline

1. Guiding Principles

The Western Australia Country Health Service (WACHS) recognises and fully supports the need for the patient and/or their primary carer to[1]:

- Know and exercise their healthcare rights.
- Be engaged in their healthcare.
- Have access to information about treatment options.
- Participate in treatment decisions.
- Have access to information about agreed treatment plans.

It is the responsibility of each health care provider to ensure all patient care and therapeutic interventions they provide are within their individual scope of practice.

The purpose of this document is to provide clinicians with direction for the appropriate implementation of the Goals of Patient Care (GoPC) process including completion of the GoPC documentation.

This guideline is for adults. Development of a statewide policy and form is being led by Perth Children's Hospital (April 2020). Until this is available, staff are to refer to the WACHS Paediatric / Neonate Not for Cardiopulmonary Resuscitation Policy and use the MR39 WACHS Not for Cardiopulmonary Resuscitation – Paediatric/Neonate available via HealthPoint.

GoPC establishes the most medically appropriate, realistic, agreed goals of patient care that will apply in the event of clinical deterioration, during an episode of care. This clinical care planning process facilitates proactive shared discussion and decision-making between the clinician, patient and family/carer, so clear ceilings of care and end of life wishes can be established.

The state-wide form can be used in other hospital facilities if the patient is transferred during that episode of care. A photocopied GoPC form is to be included in transfer paperwork.

If the patient does not have capacity to determine their goals of care, then refer to the WACHS Adults with Impaired Decision Making Capacity Procedure and Appendix A: Hierarchy of Treatment Decision-Makers.

2. Guideline

Adult patients for whom the GoPC summary form is a priority, are those:

- with an Advance Health Directive (AHD) / Advance Care Plan (ACP) with health-related instructions (refer to the WACHS Advance Health Directive and Enduring Power of Guardianship Guideline)
- with advanced, life limiting conditions
- admitted with suspected or confirmed COVID-19 illness
- that meet clinical indicators (Appendix B) for poor or deteriorating health as per the Supportive and Palliative Care Indicators Tool (SPICT™) criteria
- that meet the clinical indicators of one or more life limiting conditions as per the SPICT™ criteria (Appendix B)

- The GoPC process should be implemented as a matter of priority for the patient groups listed in the box above.
- It is at the discretion of the treating medical practitioner to use this form in other groups of patients.
- For patients with identified AHDs or Enduring Power of Guardianship refer to the WACHS Advance Health Directive and Enduring Power of Guardianship Guideline.
- If the AHD is no longer representing the agreed GoPC during their hospital admission, the AHD can be revoked (refer to the WACHS Advance Health Directive and Enduring Power of Guardianship Guideline). The GoPC form can be completed to reflect the amended treatment plan for the current admission. If the patient is discharged they are encouraged to create a new AHD at their earliest convenience.
- The GoPC should be reviewed / updated at each new admission.

Timeline for GoPC process

- The GoPC form should be completed as early as possible in the patient journey. This includes, where possible, outpatients or pre-assessment clinics. For emergency admissions the organisation-wide goal is to complete the GoPC form within 48 hours of admission for relevant patients. However, if clinical deterioration is likely or urgent interventions are planned then the GoPC form should be completed at the earliest opportunity.
- All senior medical practitioners who have a significant role in any stage of the patient journey should consider completing a GoPC form. In the absence of a completed form the default will be full resuscitation, unless senior medical practitioners have deemed resuscitation measures inappropriate for the patient's best interests.

GoPC validity period

- The GoPC form is valid for the current admission but may be extended for a period of up to 12 months with appropriate consultant endorsement. In many WACHS sites, the consultant role will be fulfilled by the appropriate senior medical practitioner. For subsequent admissions and to avoid unnecessary duplication, the senior medical practitioner will need to view previous GoPC summaries to check if the form is valid for 12months and confirm with the patient/authorised person that the goals of care indicated are still current.

GoPC amendment process

- If the patient's clinical condition and treatment goals change then a new form needs to be completed. In these cases, the senior medical practitioner should place a line through the old form, date, sign and print name but leave it in the patient's medical record, behind the most current form.
- Details of the reasons for the change to the GoPC form should be documented in the medical record by the senior medical practitioner.

3. Definitions

AHD	Advance Health Directive.
Carer	Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged (Carers Australia, 2015)
EPG	Enduring Power of Guardianship.
Goals of Patient Care (GoPC)	A process which prompts and facilitates proactive shared decision making between the clinicians and patients and/or person responsible/family/carer(s) to ensure treatment provided is aligned to the patient's preferences, needs, values and wishes. It establishes and documents the agreed goal of patient care that will apply in the event of the patient's clinical presentation and/or deterioration.
Patient	A person who is receiving care in a health service organisation.
Senior medical practitioner	Registrar, Consultant, admitting General Practitioner (GP), senior medical officer or district medical officer.

4. Roles and Responsibilities

Medical Practitioner

- All Medical Practitioners (MPs) on the treating team (including interns and resident medical officers) are encouraged to complete Section 1 of the GoPC form (Baseline Information).
- A senior MP is responsible for:
    - facilitating the GoPC discussion
    - listening and responding to the patient/family/carer's questions
    - initiating timely discussions around treatment options, treatment-limiting orders and non-beneficial treatments to enable the patient/the person responsible to make an informed GoPC decision
    - accurately reflecting the patient's wishes, values and preferences in the GoPC form
    - timely completion of the GoPC form for relevant patients (Sections 2 and 3, and Section 4, if appropriate/relevant).
    - ensuring the form is signed at the earliest available opportunity.
- Handwritten forms and printed eForms must be filed at the front of the patient's bed file to ensure prominent placement and easy access.*
- If the patient's condition changes, necessitating a new GoPC plan, then a new form is to be completed in a timely manner. **Forms (paper or eForm) cannot be amended on the physical copy**. A new form must be completed, and the new version placed accordingly.
- MPs are responsible for:
    - alerting the nursing or midwifery staff / shift coordinator / nurse or midwife looking after the patient what has been decided (if they were not already involved in the process), and
    - ensuring they are always aware of the patient's treatment preferences as outlined in the GoPC form and complying with them (within the current admission or time period for which the form is valid).

* These tasks may also be undertaken by other members of the MDT/clerical staff.

Members of the multidisciplinary team (MDT)

- Nursing, midwifery and allied health staff and other members of the MDT, although not responsible for completing the GoPC form, are responsible for contributing to the process and providing input into the decisions outlined in the form as necessary.
- MDT members are encouraged to initiate discussion about completing the GoPC process with medical members of the treating team if GoPC has not been considered.
- The MDT may support the medical practitioner with patient and family discussions, provision of information and decision making.

Clerical staff

- Clerical staff maintaining the patient's medical record should ensure the most current GoPC form is filed at the front of the patient's medical record within the Alert divider (if present) and in accordance with Australian Standard AS2828. In the BOSSnet digital environment the GoPC forms are retained within the Summary folder alongside other important alerts.

Clinical handover

- It is the responsibility of all clinical staff involved in the handover of patient care at any stage of the patient's journey to include information on the details of the GoPC in the handover including to transport staff, staff from other WA Health sites and external private organisations where the handover of clinical care is occurring.
- It is expected that all healthcare professionals (internal and external) will respect and comply with the agreed GoPC until the GoPC is reviewed and renegotiated with the patient or person responsible.
- Nursing/midwifery staff will update GoPC instructions in iSoft.
- The wards patient information whiteboard will identify the Goal of Care where treatment responses have been limited e.g. Not For CPR, Not For MET response.
- Medical practitioner to include relevant GoPC discussions in discharge summaries and forward a copy of the GoPC form to the patient's GP.

5. Compliance

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

The GoPC Working Group is responsible for the evaluation of the GoPC program at WACHS and compliance with this policy

6. Records Management

Health Record Management Policy

7. Evaluation

Evaluation, audit and feedback processes are to be in place regionally to monitor compliance.

Clinical incidents related to Goals of Patient Care are to be reported via Datix Clinical Incident Management System (Datix CIMS).

8. Standards

National Safety and Quality Health Service Standards

Comprehensive Care Standard: 5.15

Partnering with Consumers Standard: 2.6

Communicating for Safety Standard: 6.3

Recognising and Responding to Acute Deterioration Standard: 8.10

Australian Standards 2828 - Health Care Records

9. Legislation

Access via: Western Australian Legislation or Commonwealth legislation.

Guardianship and Administration Act 1990
Civil Liability Act 2002
Criminal Code (Compilation Act 1913)
Acts Amendment (Consent to Medical Treatment) Act 2008

10. References

1. Australian Commission on Safety and Quality in Health Care (ACSQH) [Internet] The National Safety and Quality Health Service Standards Safety and Quality Improvement Guide Standard 1 Governance for Safety and Quality in Health Service Organisations. 2nd ed. Sydney, Australia: Australian Commission on Safety and Quality in Health Care; 2017. Available from: https://www.safetyandquality.gov.au/standards/national-safety-and-quality-health-service-nsqhs-standards/assessment-nsqhs-standards [Accessed: 27 March 2020]
2. Government of Western Australia Department of Justice: Office of the Public Advocate [Internet] Making Treatment Decisions. Available from: https://www.publicadvocate.wa.gov.au/M/making_treatment_decisions.aspx?uid=4727-3795-2343-5639 [Accessed: 27 March 2020]
3. Government of Western Australia South Metropolitan Health Service: Rockingham Peel Group. Advance Health Directives and Enduring Power of Guardianship (Acute) Policy and Procedure. Clinical Practice Manual Code AC: 203. Available from: https://healthpoint.hdwa.health.wa.gov.au/policies/_layouts/DocIdRedir.aspx?ID=TS4KSNFPVEZQ-210-18218 [Accessed: 27 March 2020]
4. Supportive & Palliative Care Indicators Tool (SPICT™). Edinburgh Scotland [Internet]. Available from: https://www.spict.org.uk/. [Accessed: 27 March 2020]

11. Related Forms

MR00H.1 State Goals of Patient Care
MR39 WACHS Not for Cardiopulmonary Resuscitation – Paediatric / Neonate

12. Related Policy Documents

WACHS Adults with Impaired Decision Making Capacity Procedure
WACHS Advance Health Directive and Enduring Power of Guardianship Guideline
WACHS Paediatric / Neonate Not for Cardiopulmonary Resuscitation Policy

13. Related WA Health System Policies

OD0657/16 WA Health Consent to Treatment Policy

14. Policy Framework

Clinical Governance, Safety and Quality

15. Acknowledgements

Royal Perth Bentley Group Policy Committee
Rockingham Peel Group
WA Cancer and Palliative Care Network

16. Appendices

Appendix A: Hierarchy of Treatment Decision-Makers
Appendix B: SPICT™ Tool and guidance for use
Appendix C: GoPC Generic Consumer Brochure

This document can be made available in alternative formats on request for a person with a disability

Contact:	WACHS Director of Palliative Care (K. Auret)		
Directorate:	Medical Services	**EDRMS Record #**	ED-CO-20-36030
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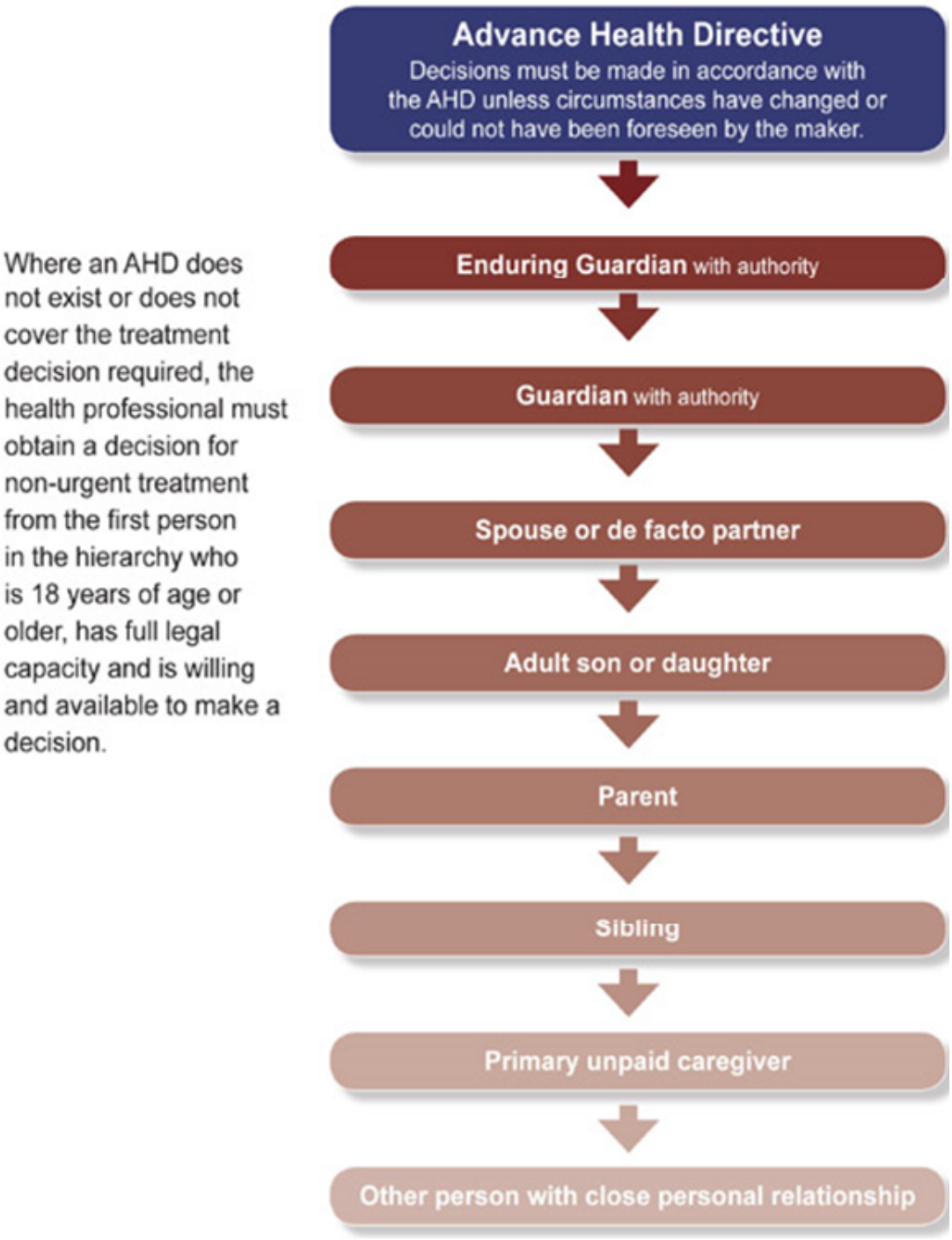
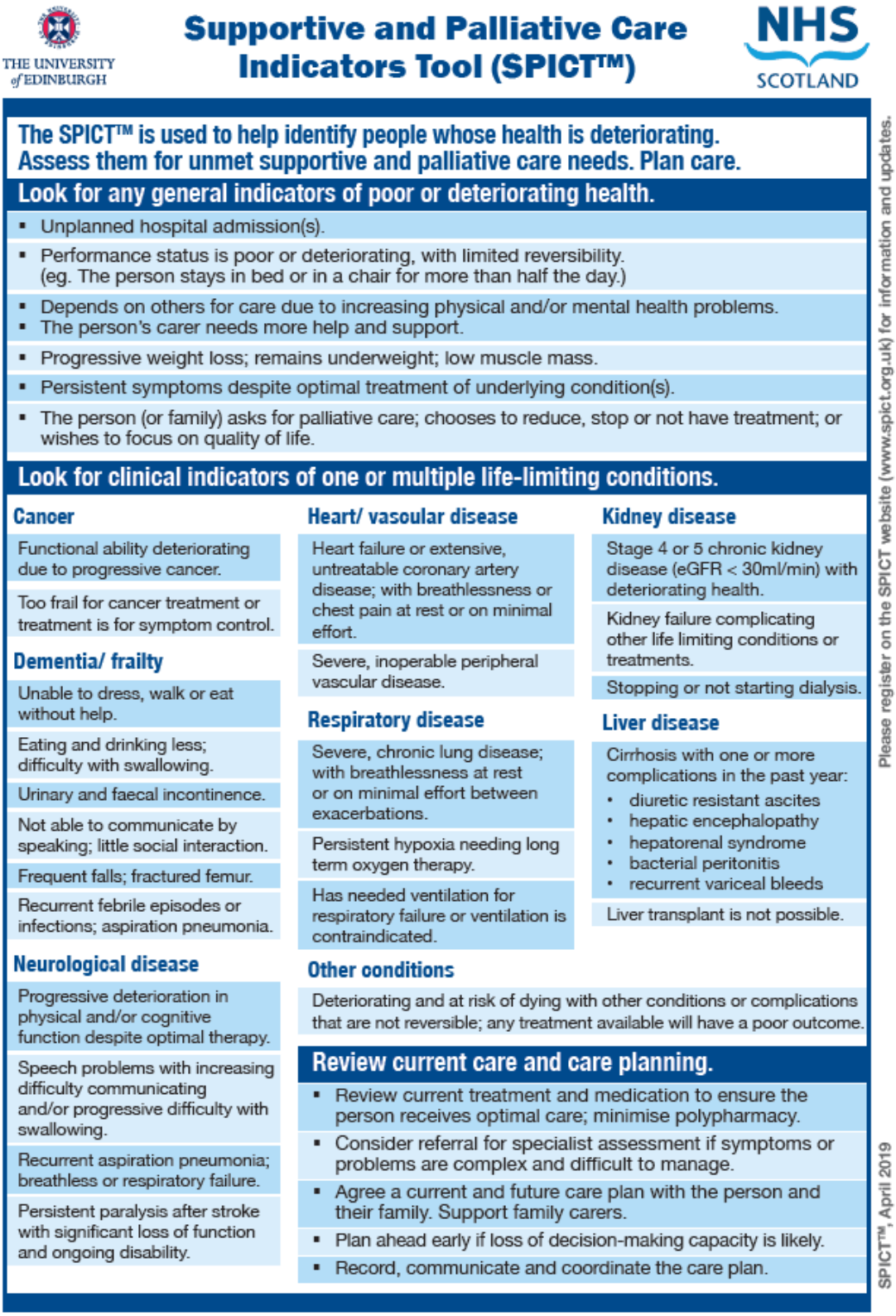
Appendix A: Hierarchy of Treatment Decision-Makers



Source: Government of Western Australia, Office of the Public Advocate 2018

Appendix B: SPICT™ Tool and guidance for use

Source: https://www.spict.org.uk/



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Supportive and Palliative Care Indicators Tool (SPICT™)

NHS SCOTLAND

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vasoular disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

Other conditions

Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2019

SPICT™ THE UNIVERSITY of EDINBURGH

Why use the SPICT™?

The SPICT™ helps professionals identify people with general indicators of poor or deteriorating health and clinical signs of life-limiting conditions for assessment and care planning.

What will happen to each person and when is often uncertain. SPICT™ looks at health status not a prognostic time frame. Identifying people with deteriorating health earlier improves care.

Using SPICT™ to assess people's needs and plan care.

- After an **unplanned hospital admission** or a **decline in health status**: review current care, treatment and medication; discuss future options; plan for managing further deterioration.
- For people with **poorly controlled symptoms**: review and optimise treatment of underlying conditions, stop medicines not of benefit; use effective symptom control measures.
- Identify people who are **increasingly dependent on others** due to deteriorating function, general frailty and/or mental health problems for additional care and support.
- Identify people (and caregivers) with **complex symptoms or other needs**; consider assessment by a specialist palliative care service or another appropriate specialist or service.
- Assess **decision-making capacity**. Record details of close family/ friends and any POA or proxy for decision-making and involve them if the person's capacity is impaired.
- Identify people who need proactive, **coordinated care in the community** from the primary care team and/or other community staff and services.
- Agree, record and share an **Advance/ Anticipatory Care Plan;** include plans for emergency care and treatment if the person's health (or care at home) deteriorates rapidly or unexpectedly.

Talking about future care planning

- Ask:
  - What do you know about your health problems and what might happen in the future?
  - *'What matters'* to you? What are you worried about? What could help with those things?
  - Who should be contacted and how urgently if your health deteriorates?
- Talk about:
  - The outcomes of hospital admission and treatments such as: IV antibiotics; surgery; interventions for stroke, vascular or cardiac disease; tube or IV feeding; ventilation.
  - Treatments that will not work or have a poor outcome for this person. (eg. CPR)
  - POA or proxy for decision-making in case the person loses capacity in the future.
  - Help and support for family/ informal caregivers.

Tips on starting conversations about deteriorating health

- *I wish we had a treatment for…., but could we talk about what we can do if that's not possible?*
- *I am glad you feel better and I hope you will stay well, but I am worried that you could get ill again…*
- *Can we talk about how we might manage with not knowing exactly what will happen and when?*
- *If you were to get less well in the future, what would be important for us to think about?*
- *Some people want to talk about whether to go to hospital or be cared for at home….*

www.spict.org.uk April 2019