Goals of Patient Care Guideline

1. Guiding Principles

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

- Know and exercise their healthcare rights
- Be engaged throughout their healthcare journey
- Have access to information about treatment options
- Participate in treatment decisions and care planning
- 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 for both adult and paediatric patients.

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 discussions and decision-making between the clinician, patient and family/carer, so clear ceilings of care and end of life wishes can be established. For Residential Aged Care facilities refer to the WACHS Residential Goals of Care Guideline.

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

2.1 Paediatrics

- The Child and Adolescent Health Service (CAHS) Paediatric Goals of Care Policy should be read and used in conjunction with this WAHCS guideline – additional WACHS specific information to the CAHS policy
- A collaborative approach is needed for complex paediatric patients. The primary team is a valuable resource and collaboration with Perth Children's Hospital Palliative Care Team is essential to assist with the process. The PCH Palliative Care Team are aware of the GoPC Paediatric Champions within the WACHS regions
- Inclusive of the potential triggers for commencing a Paediatric Goals of Care discussion outlined in the CAHS policy – priority includes paediatrics admitted with suspected or confirmed COVID-19 illness
- The WA Paediatric Strategy for End-of-Life and Palliative Care 2021-2028 includes neonates in the definition of a child and supports the use of the Paediatric Goals of Care discussion and completion of the WACHS MR00H.1P.

Additional WACHS specific information to the CAHS Policy:

2.1.1 Paediatric Goals of Patient Care (GoPC) form

- Where CAHS refer to their form, WACHS staff use the MR00H.1P WACHS Paediatric Goals of Patient Care
- Where a child is transferred into WACHS from another Health Service with a Paediatric Goals of Patient Care form this is reviewed for currency with the child and primary decision maker and transferred to the WACHS MR00H.1P form

2.1.2 Record keeping

- When a paediatric GoPC form is completed, the form is scanned and sent to the PCH Standard 5 End of Life Care email address (on the form) for auditing and monitoring purposes by PCH. Emailing of the form must be done from within the WA Health System in order to comply with MP 0067/17 Information Security Policy
- During an inpatient episode of care, the form is kept in the front of the patient's working folder at the bedside to ensure prominent placement and easy access

2.1.3 Decision making and consent to medical treatment

- Where there is conflict among clinicians or there is difficulty determining what is in the child's best interest, refer to the WACHS Ethical Decision Making for Clinical or Patient Care Issues Guideline of the Escalation Flow Chart (Appendix B)

2.1.4 Roles and responsibilities

- Where Senior Medical Officer is referred to, the WACHS context includes Registrar, Consultant, admitting General Practitioner (GP), senior medical officer or district medical officer

2.1.5 Community based providers (general and mental health) –

- Mental Health services – A copy of the document must be filed in the child's medical record and the physical medical condition and risks must be put as an alert under Medical category on PSOLIS
- Community Health (WACHS Child Health Nurses / School Nurses / Child Development Services - clinic or home setting) staff provided with a copy of the form, must scan and upload the copy to the Community Health Information System (CHIS)
- Aboriginal Medical Service or Aboriginal Community Controlled Health Services staff must provide a copy of the form to community based providers if they are to be involved with the child.

2.2 Adults

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
- who meet clinical indicators (Appendix B) for poor or deteriorating health as per the Supportive and Palliative Care Indicators Tool (SPICT™) criteria
- who meet the clinical indicators of one or more life limiting conditions as per the SPICT™ criteria (Appendix B)
- who have commenced the process to access voluntary assisted dying.

- 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 Advance Health Directives (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 with medical support
- The GoPC should be reviewed and updated at each new admission.

2.3 Timeline for the process

- The GoPC forms 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 (refer to the WACHS Recognising and Responding to Acute Deterioration Policy).

2.4 Use of interpreters

If English is not the person's first language or they have communication difficulties, an interpreter or communication aid can be used.

Provision of an Aboriginal Liaison Officer or accessing an Aboriginal Language Service may be useful where appropriate to the patient's language or communication requirements.

Refer to MP0051/17 WA Health System Language Services Policy and Guidelines. Resources also available on the WA Health Language Services webpage.

2.5 Validity period

- The GoPC forms are 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
- The state-wide forms 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.

2.6 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.

2.7 Consumer information

A WACHS Goals of Patient Care Consumer Brochure is available for consumers. his brochure is editable to enable regional contextualisation. To be saved regionally in the records management system and then printed onsite.

3. Definitions

AHD	Advance Health Directive.
ACP	Advance Care Plan – care planning is a process of discussions between families and health care providers about references of care, treatments and goals in the context of the patient's current and anticipated future health. The objective is to determine the overall goal of medical care, and the interventions that should and should not be provided. This will guide current treatment, as well as future treatment in the event of deterioration in the person's condition. It also helps families to prepare for the future, consider priorities and plan where they would hope to be (home, hospital or hospice) when their family member reaches the end of their life[5]
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
Family	The term 'family' includes people identified by the person as family and may include people who are biologically related such as siblings and grandparents, foster parents, people who joined the family through marriage or other relationships, as well as the family of choice and friends (including pets)
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 working file (bedside) 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 (including pastoral care staff) have a central and supportive role in facilitating advance care planning conversations with patients and families as they are often a trusted source of healthcare information, know the people involved well and may have opportunities to talk about quality of life, goals and preferences during routine care
- Aboriginal workforce (including Aboriginal Health Worker or Aboriginal Health Liaison Officer or Regional Aboriginal Health Consultant) are to be included/ engaged as part of the MDT to support Aboriginal patients
- All members of the MDT 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 healthcare 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/MER 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.

6. Records Management

Health Record Management Policy

7. Evaluation

The WACHS End of Life Subcommittee (*in development – to sit under the WACHS Comprehensive Care Committee*) will be responsible for the evaluation of the GoPC program at WACHS and compliance with this policy.

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

8. Standards

National Safety and Quality Health Service Standards: 2.6, 5.13, 5.14, 5.17, 5.20, 6.3, 8.10

Australian Standards 2828 - Health Care Records

9. Legislation

Acts Amendment (Consent to Medical Treatment) Act 2008 (WA)
Civil Liability Act 2002 (WA)
Criminal Code (Compilation Act 1913 (WA)
Guardianship and Administration Act 1990 (WA)
Voluntary Assisted Dying Act 2019 (WA)

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/our-work/clinical-governance/clinical-governance-standard [Accessed 25 November 2021]
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 25 November 2021]
3. Government of Western Australia South Metropolitan Health Service: Rockingham Peel Group [Intranet]. 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 25 November 2021]
4. Supportive & Palliative Care Indicators Tool (SPICT™). Edinburgh Scotland [Internet]. Available from: https://www.spict.org.uk/. [Accessed 25 November 2021]
5. Government of Western Australia Child and Adolescent Health Service [Intranet]

Paediatric Goals of Care Policy (2021 January) Available from: https://healthpoint.hdwa.health.wa.gov.au/policies/_layouts/DocIdRedir.aspx?ID=TS4KSNFPVEZQ-210-20427 [Accessed 25 November 2021]
6. Department of Health, Western Australia. Western Australian Paediatric Strategy for End-of-Life and Palliative Care 2021-2028. Perth: End-of-Life Care Program, Health Networks, Western Australian Department of Health; 2021. Available from: https://ww2.health.wa.gov.au/~/media/Corp/Documents/Health-for/End-of-Life/Paediatric-Strategy-for-EoLPC.pdf [Accessed 08 February 2022]
7. Government of Western Australia, Department of Health [Intranet] WA End-of-Life Palliative Care Strategy 2018-2028 Perth, Western Australia; 2018. Available from: https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Health%20Networks/Palliative%20care/WA%20End-of-life%20and%20Palliative%20Care%20Strategy%202018-2028.pdf [Accessed 17 January 2022]
8. Government of Western Australia, Department of Health [Intranet] Aboriginal End-of-Life and Palliative Care Framework 2018-2028 Perth, Western Australia; 2021. Available from: https://ww2.health.wa.gov.au/~/media/Corp/Documents/Health-for/End-of-Life/Aboriginal-EoLPC-Framework.pdf [Accessed 17 January 2022]

11. Related Forms

MR00H.1 State Goals of Patient Care
MR00H.1P WACHS Paediatric Goals of Patient Care
RCOOH.1 Residential Goals of Care

12. Related Policy Documents

CAHS Paediatric Goals of Care Policy
WACHS Adults with Impaired Decision Making Capacity Procedure
WACHS Advance Health Directive and Enduring Power of Guardianship Guideline
WACHS Recognising and Responding to Acute Deterioration (RRAD) Policy
WACHS Residential Goals of Care Guideline
WACHS Ethical Decision Making for Clinical or Patient Care Issues Guideline
WACHS Use of Advance Care Planning, Advance Health Directives and Goals of Patient Care in Residential Facilities Flowchart
WACHS Voluntary Assisted Dying Policy

13. Related WA Health System Policies

MP 0067/17 Information Security Policy
WA Health Consent to Treatment Policy
MP0051/17 WA Health System Language Services Policy
WA Health System Language Services Policy Guidelines

14. Policy Framework

Clinical Governance, Safety and Quality

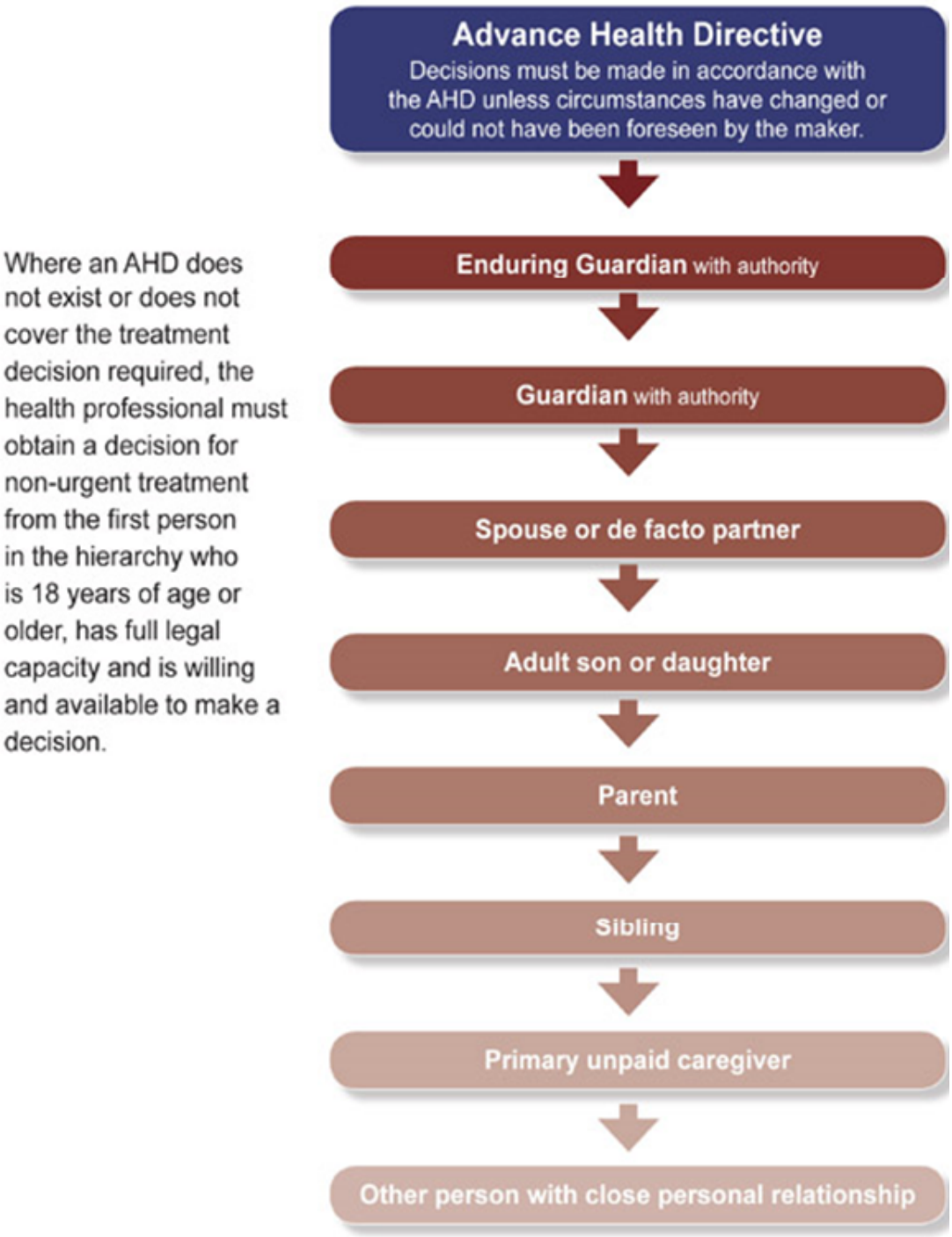
15. Appendices

Appendix A: Hierarchy of Treatment Decision-Makers
Appendix B: SPICTTM Tool and guidance for use

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

Contact:	WACHS Director of Palliative Care		
Directorate:	Medical Services	**EDRMS Record #**	ED-CO-20-36030
Version:	2.00	**Date Published:**	9 March 2022

Appendix A: Hierarchy of Treatment Decision-Makers



Note: Consideration should be given to Aboriginal family structures and kinship systems as this may be required, within the context of the hierarchy of treatment decision-makers.

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

Appendix B: SPICT™ Tool and guidance for use

THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT™)

Government of Western Australia
WA Country Health Service

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

THE UNIVERSITY of EDINBURGH

SPICT
SUPPORTIVE AND PALLIATIVE CARE INDICATORS TOOL

Government of Western Australia
WA Country Health Service

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