Residential Goals of Care Guideline

1. Purpose

The WA Country Health Service (WACHS) recognises and fully supports the need for the resident, family, primary carer and / or representative[1]:

- to know and exercise their healthcare rights
- be engaged throughout their care journey
- have access to information about treatment options
- to participate in care planning and treatment decisions
- have access to information about agreed treatment plans.

The purpose of this guideline is to provide WACHS staff with direction for the appropriate implementation of goals of care processes and RC00H.1 Residential Goals of Care (RGoC) form completion in WACHS residential aged care sites.

2. Guideline

2.1 Residential Goals of Care

RGoC conversations help the resident, their family / carers and / or representatives and aged care team to establish the most appropriate, realistic, agreed goals of care that will apply in the event of the resident's deterioration while at the aged care site.

This care planning process facilitates proactive shared discussions and decision-making between clinicians, aged care staff, resident, family / carer, and / or representative, so clear ceilings of care and end of life wishes can be established. This information is recorded on the RGoC form.

RGoC forms are separate but complementary to advance care planning (ACP) and **do not replace** a resident's ACP documents. Refer to Appendix A: WA Advance care planning documentation flowchart and Appendix B: Flowchart for ACP and goals of care in WACHS Aged Care Facilities.

RGoC discussions, like ACP, are voluntary and may be declined by the resident, their family / carers and / or representative. If discussions are declined, this should be documented in the health record.

2.2 Residents for whom initiating RGoC is a priority

All residents of WACHS residential aged care sites should have an opportunity to discuss and document their goals of care and end of life preferences, however, the following people should be prioritised for RGoC discussions:

- residents with an Advance Health Directive (AHD) or other ACP documents
- residents with a completed MR00H.1 Statewide Goals of Patient Care from a recent hospital admission
- residents with advanced, life limiting conditions
- residents who meet clinical indicators for poor or deteriorating health as per the Supportive and Palliative Care Indicators Tool (SPICT™)[2] criteria (Appendix C)

- residents who meet the clinical indicators of one or more life limiting conditions as per the SPICT™ criteria (Appendix C)[2]
- residents with suspected or confirmed COVID-19 illness
- residents who have commenced the process to access voluntary assisted dying (refer to Voluntary Assisted Dying Policy).

If a resident is under a Public Advocate, contact the Office of the Public Advocate prior to commencing a RGoC form.

2.3 Process for initiating RGoC discussion(s)

Staff can initiate a conversation about goals of care with residents and / or their families / carers / representatives at any time during their residency. The RGoC form should be completed as early as practical for newly admitted residents who meet the priority groups in Section 2.2, in particular if clinical deterioration is likely or urgent interventions are planned.

Medical practitioners (MPs), nurse practitioners (NPs), senior nursing and allied health professionals can facilitate goals of care discussion(s) with the appropriate people:

- If the resident has decision-making capacity, they must be included in the discussion. Family members, carers and / or representatives should be included where appropriate and in agreement with the resident.
- If the resident is of Aboriginal and / or Torres Strait Islander decent, consider accessing culturally appropriate Aboriginal health representation during goals of care discussions[3].
- If a resident does not have capacity to determine their goals of care, they can still participate in discussions as appropriate, with support from clinicians and relevant substitute decision-makers. Refer to the Adults with Impaired Decision-Making Capacity Procedure and Appendix D: Hierarchy of Treatment Decision-Makers.

2.4 Interpreters

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

An Aboriginal Language Service (such as Aboriginal Interpreting WA) may be useful where appropriate to the resident's language or communication requirements.

Refer to MP0051/17 Language Services Policy and WA Health System Language Services Policy Guidelines.

Resources also available on the WA Health Language Services webpage.

2.5 RGoC and other ACP documents

Where a resident has ACP document(s), refer to the Advance Health Directive and Enduring Power of Guardianship Procedure to ensure copies of the documents are filed in the correct location in the health record, and a webPAS alert is raised when an AHD is present.

In Section 1 of the RGoC form indicate if the resident has completed ACP documents, review and discuss content of the ACP documents as part of the RGoC conversations. Note the following:

- If there are inconsistencies between a resident's RGoC and any ACP documents, this should be brought to the attention of the resident's MP as soon as practical.
- If an EPG is documented, ensure the EPG is involved in the RGoC discussions.
- If a resident with legal capacity wants to revoke an AHD or EPG, refer to Advance Health Directive and Enduring Power of Guardianship Procedure for guidance.
- Residents with legal capacity should be supported to document AHDs and / or EPGs if they wish to do so.

Refer to Appendix C: Flowchart for ACP and goals of care in WACHS Aged Care Facilities for guidance on ACP and goals of care documents for WACHS aged care sites.

The MR00H.1 Statewide Goals of Patient Care should not be used for residents in aged care settings as it is unlikely to reflect the treatment options available at the site. If the resident has a form from an acute care admission, this can be used to prompt a goals of care discussion and completion of an RGoC form as soon as practical.

2.6 Process for completing the RGoC form

The MP, NP, senior nursing or allied health staff completing the form:

- document the 'person responsible' as defined on the form
- indicate the existence of ACP documents and / or guardianship arrangements in Section 1
- reflect the resident's values and preferences in each part of Section 2
- discuss treatment options, treatment-limiting orders and non-beneficial treatments to enable the resident / person responsible to make an informed goal of care decision (Section 3)
- listen and respond to the resident / family / carer / representative's questions
- accurately record who was present during the discussion(s) and decision-making, including if the resident was able to participate, and if not, the reason (Section 4)
- explain the purpose of the RGoC form (Section 4) and provide an opportunity for the resident or person responsible to sign the form if they wish to
- offer a copy of the completed form to the resident / family
- if the health service has the ability to upload goals of care documents to My Health Record (MHR) on behalf of the person, ask the person if they agree to upload the document to MHR and indicate in the relevant tick box. Instruction to upload the document must come from the person or their authorised or full access MHR nominated representative[4]. If the box is not ticked it will not be uploaded to MHR.
- complete and sign the RGoC form (Section 4).

The form should be filed in the appropriate place in the healthcare record, ideally near or at the bedside to ensure prominent placement and easy access.

RGoC forms should not be completed in an acute care setting prior to discharge back to an aged care site unless the MP has included the resident's primary general practitioner (GP) or NP and site staff in RGoC discussions.

A photocopy of the current RGoC form is to be included in transfer paperwork (MR 184A WACHS Resident Handover form) should the resident be transferred to a hospital or other health care site.

[4] National_Guidelines.pdf (digitalhealth.gov.au)

In the absence of a completed RGoC form, ACP document or other documented evidence by the treating MP / NP in the healthcare record, the default is full resuscitation unless attending MP deems resuscitation measures futile, non-beneficial and / or not in the resident's best interests.

2.7 Validation of RGoC and validity period

The RGoC form is valid once reviewed and signed by the GP, MP or NP involved in the resident's care:

- If the form is not completed by the resident's MP or NP, ensure the form is validated by the resident's MP or NP at the earliest opportunity (Section 4).
- The MP or NP can validate the form for up to 12 months.

2.8 Review and amendment process

The RGoC form should be reviewed every 12 months as a minimum, however, it is likely to require more regular reviews if the resident's goals of care or preferences change:

- The initial review of an RGoC form can be documented in Section 4 of the existing form if the goal of care remains unchanged.
- If there are any changes to the goal of care, a new RGoC form must be completed and previous version revoked.
- If the initial review section is completed and validated again, it can only be for a further 12 months.
- **Forms cannot be amended on the hard copy once validated**.

To revoke an RGoC form, the senior health professional should place a line through the old form, date, sign and print name but leave it in the resident's healthcare record, behind the most current form. Details of the reasons for the change to the RGoC form should be documented in the healthcare record by the senior health professional.

3. Roles and Responsibilities

Medical practitioner

A resident's MP is encouraged to discuss goals of care with the resident and family / carers / representative and complete the RGoC form. If the form has been completed by another member of the aged care team, the resident's MP should review the completed form and if appropriate, validate the RGoC form.

If the resident's preferences or goals of care change, the MP should document a new RGoC form in a timely manner.

Where the goal of care selected is 'Optimal Comfort Treatment', consider pre-emptive care planning and prescribing for clinical deterioration and terminal care.

Members of the multidisciplinary team (MDT)

NPs, senior nursing and allied health staff (including pastoral care staff) can initiate and facilitate goals of care conversations with residents and families, carer and or representative if comfortable to do so and within their scope of practice:

- Staff who wish to participate in RGoC processes, should be supported to complete education and training that will assist them with initiating and facilitating goals of care conversations.
- Aboriginal workforce (including Aboriginal Health Worker, Aboriginal Health Liaison Officer, Aboriginal Liaison Officer, Regional Aboriginal Health Consultant) can support Aboriginal residents and their families, carers and / or representatives in goals of care processes.
- All members of the team can contribute to the RGoC process and provide input into the decisions outlined in the form.
- Senior health professionals can complete sections of the RGoC form prior to validation by the MP or NP.

It is the responsibility of health care professionals and aged care workers to ensure all care and interventions they provide are within their individual scope of practice.

Other aged care workers

Aged care workers who are not registered health professionals but involved in the resident's ongoing care are encouraged to participate in goals of care discussions with residents and their families / carers / representatives with support of health professionals, and within their scope of practice.

Clerical / administration staff

Clerical staff maintaining the resident's health record should ensure the most current RGoC form is filed in the relevant place in the aged care record in accordance with the Residential Aged Care – Order of Forms and Australian Standard AS2828.

Clinical handover

It is the responsibility of staff involved in the clinical handover of a resident's care from one setting to another, to include information on the details of the RGoC in the handover including to transport staff, staff from other WA Health sites and external private organisations where the handover of care is occurring.

It is expected that all healthcare professionals (internal and external) will respect and comply with the agreed RGoC until the document is reviewed and renegotiated with the resident or person responsible at the new care setting / facility.

4. Monitoring and Evaluation

4.1 Monitoring

Monitoring of compliance with this document will be captured annually in residential aged care audit processes.

The regional aged care quality committees will review RGoC use and documentation compliance via regional audit results provided by the WACHS Aged Care Directorate.

Regions may also elect to table regional audit results at the Region's Standard 5: Comprehensive Care Committee or equivalent governance meeting.

4.2 Evaluation

Evaluation of this Guideline is to be carried out by the Aged Care Directorate every 5 years, or more frequently if required. Evaluation data should include any record of consumer complaints or feedback in relation to RGoC processes and documentation, and any clinical incident data.

Clinical incidents related to RGoC are to be reported via the Datix Clinical Incident Management System (Datix CIMS).

Some incidents relating to RGoC in WACHS aged care facilities may also require reporting via the Serious Incident Response Scheme (SIRS) or National Disability Insurance Scheme (NDIS).

5. Compliance

This guideline supports the Residential Aged Care Services Policy which is a mandatory requirement under the under the *Aged Care Act 1997*(Cth).

Guidelines are designed to provide staff with evidence-based recommendations to support appropriate actions in specific settings and circumstances. As such, WACHS guidelines should be followed in the first instance. In the clinical context, where a resident's management should vary from an endorsed WACHS guideline, this variation and the clinical opinion as to reasons for variation must be documented in accordance with the Documentation Clinical Practice Standard.

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

6. 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. Safety and Quality Improvement Guide - Standard 1: Governance for Safety and Quality in Health Service Organisations
2. Supportive & Palliative Care Indicators Tool (SPICT™). Edinburgh Scotland [Internet]. Available from: https://www.spict.org.uk/. [Accessed 25 November 2021]
3. 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]

7. Definitions

Term	Definition
Advance care planning	Advance care planning (ACP) 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
Advance Health Directive	Advance Health Directive (AHD) as defined under the *Guardianship and Administration Act 1990* (WA)
Capacity	In the context of medical treatment, a person has capacity if they can understand the nature, purpose and consequences of the proposed treatment. Capacity must always be assessed in the context of the decision that is to be made. The *Mental Health Act 2014* (WA) (s15) defines a person as having capacity when they: • understand any information or advice about the • decision that is required • understand the matters involved in the decision • understand the effect of the decision • weigh up the above factors for the purpose of • making the treatment decision • communicate the decision in some way.
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)
Enduring Power of Guardianship	Enduring Power of Guardianship (EPG) defined under the *Guardianship and Administration Act 1990* (WA)
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 Care	Goals of Care (includes RGoC, GoPC) is a process which prompts and facilitates proactive shared decision making between the clinicians and person and/or person responsible/family/carer(s) to ensure treatment provided is aligned to the person's preferences, needs, values and wishes. It establishes and documents the agreed goal of care that will apply in the event of the person's clinical deterioration.
Person responsible	Under the *Guardianship and Administration Act 1990*, a person who may legitimately make a treatment decision on behalf of a patient who is unable to make reasonable judgments for him / herself as defined in section 110ZD of the *Guardianship and Administration Act 1990*. Refer to the Hierarchy of Treatment Decision Makers to determine who the 'person responsible' (Appendix D).

Resident	An older person who is residing in a WACHS aged care site, such as a Residential Aged Care Facility or Multi-Purpose Service (MPS) site.
Senior health professional	Registrar, consultant, admitting GP, senior medical officer or district medical officer, senior registered nurse, senior allied health professionals (e.g. social worker).

8. Document Summary

Coverage	WACHS aged care facilities
Audience	All Medical, nursing, allied health and aged care staff providing clinical care to residents of aged care facilities health information and clerical staff
Records Management	• Clinical: Health Record Management Policy • Residential Aged Care Health Record Procedure
Related Legislation	• *Acts Amendment (Consent to Medical Treatment) Act 2008* (WA) • *Guardianship and Administration Act 1990* (WA) • *Voluntary Assisted Dying Act 2019* (WA) • *Mental Health Act 2014* (WA)
Related Mandatory Policies / Frameworks	• MP 0051/17 - Language Services Policy
Related WACHS Policy Documents	• Adults with Impaired Decision Making Capacity Procedure • Advance Health Directive and Enduring Power of Guardianship Procedure • Ethical Decision Making for Clinical or Patient Care Issues Guideline • Residential Aged Care Services Guideline • Residential Aged Care Services Policy • Voluntary Assisted Dying Policy
Other Related Documents	• WACHS Pamphlet for residents – 'Planning ahead in your aged care home' • WACHS Pamphlet for family, friends & carers – 'Planning ahead for medical care' • WACHS Residential Aged Care – Admission to a Residential Facility Flowchart • WA Health System Language Services Policy Guidelines
Related Forms	• MR00H.1 Statewide Goals of Patient Care • MR 184A WACHS Resident Handover • RC00H.1 Residential Goals of Care
Related Training Packages	Nil
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 2376
National Safety and Quality Health Service (NSQHS) Standards	2.06, 6.03, 5.15 & 8.10
Aged Care Quality Standards	Standard 1, Requirement 1 (3) (c) Standard 2, Requirement 2 (3) (b)
National Standards for Mental Health Services	N/A

9. Document Control

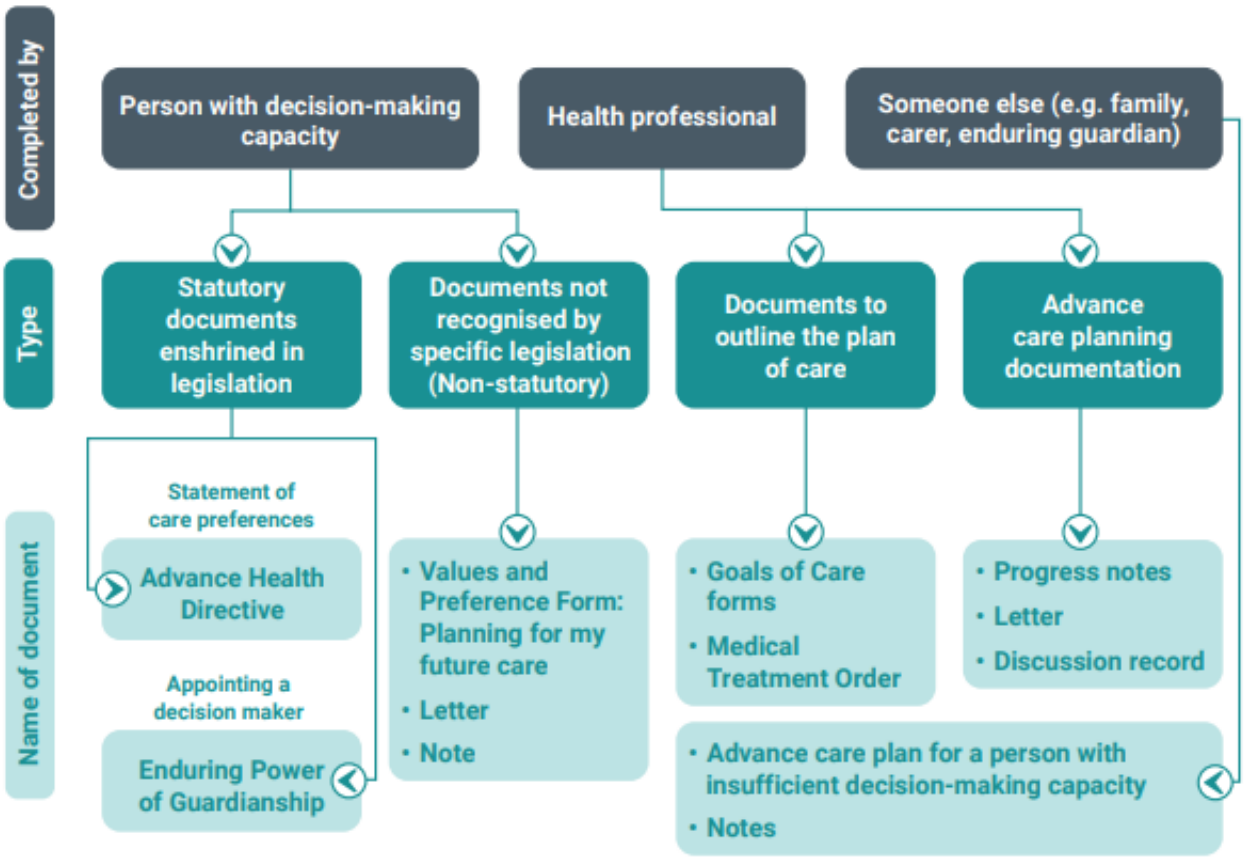
Version	Published date	Current From	Summary of changes
2.00	14 Sept 2023	14 Sept 2023	Updated to align with the revised Residential Goals of Care (RC 00H.1) form

10. Approval

Policy Owner	Chief Operating Officer
Co-approver	Executive Director, Clinical Excellence Executive Director, Nursing and Midwifery Services
Contact	Director, Aged Care
Business Unit	Aged Care
EDRMS #	ED-CO-22-67857

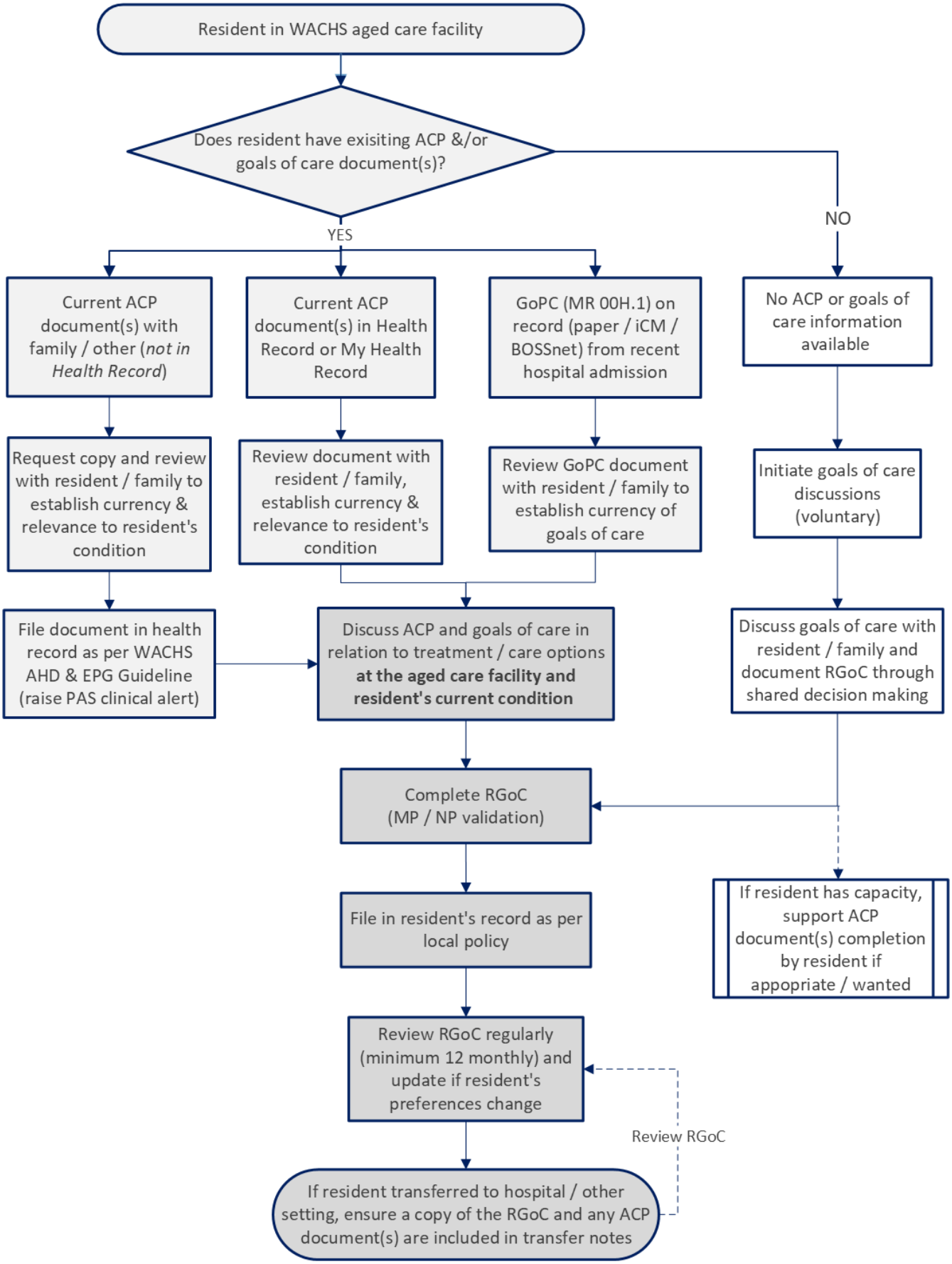
This document can be made available in alternative formats on request.

Appendix A: WA Advance care planning documentation flowchart[5]



[5] Health Professional Guide to Advance Care Planning in Western Australia

Appendix B: Flowchart for ACP and goals of care in WACHS Aged Care Facilities



Appendix C: Supportive and Palliative Care Indicators Tool (SPICT)™

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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

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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.

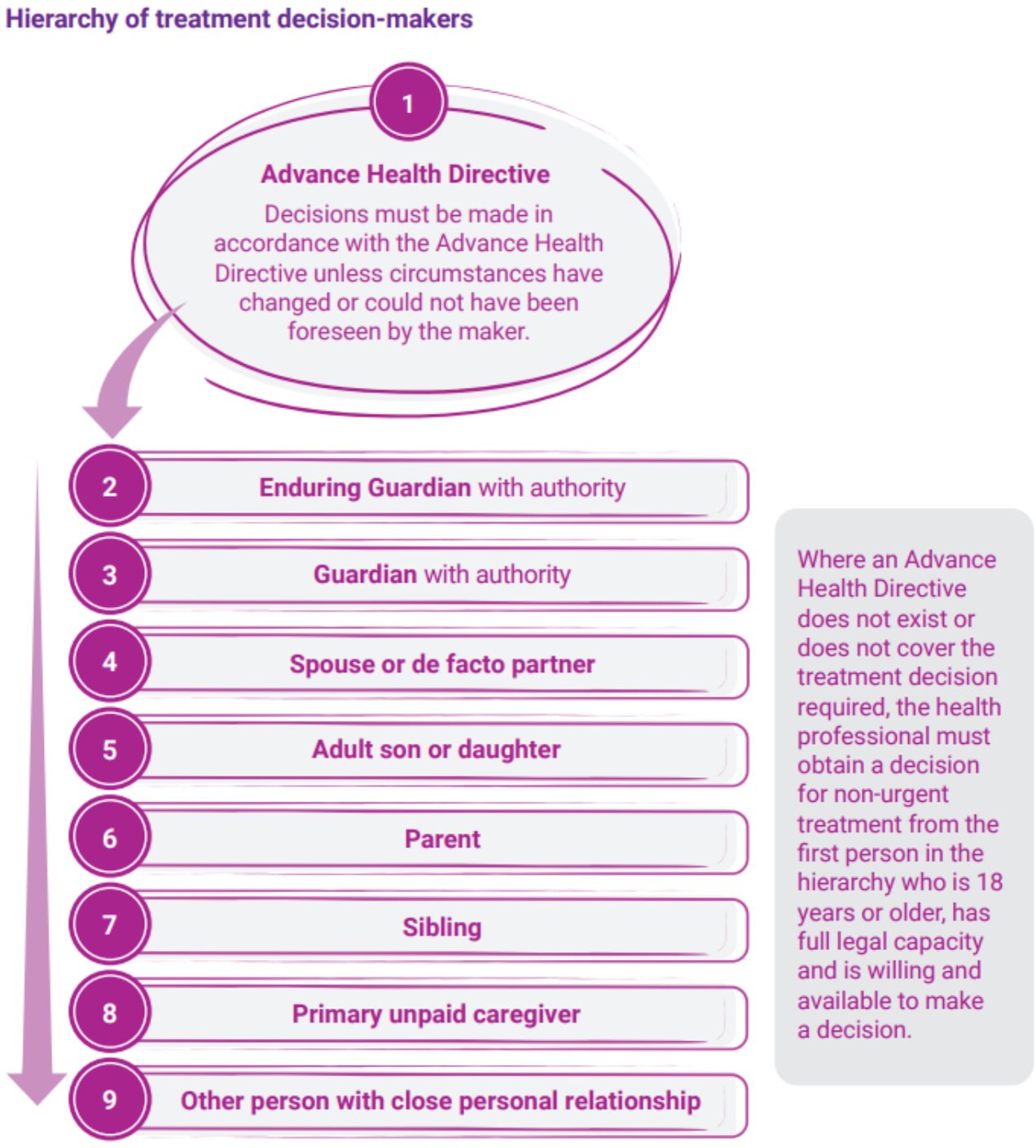
Tips on starting conversations about deteriorating health

- ***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

Appendix D: Hierarchy of treatment decision-makers[6]

The Hierarchy applies in relation to non-urgent treatment decisions when the person cannot make their own decisions at the time. Further information regarding interpreting the hierarchy is provided by the Office of Public Advocate WA, and can be viewed here: Making Treatment Decisions: OPA information (www.wa.gov.au)



[6] A Guide to Making an Advance Health Directive in Western Australia (healthywa.wa.gov.au)