

GOALS OF CARE PLAN

ROYAL HOBART HOSPITAL

PT ID									
SURNAME					D.O.B.....				
OTHER NAMES					SEX				
ADDRESS					MARITAL STATUS				
					REL.				



Complete the Diagnosis and Reason for Decision for Limitation of Medical Treatment
Choose the appropriate Goals of Care for this patient at this time by choosing option A, B, C, or D.

Diagnosis:

NO LIMITATION OF TREATMENT

A. The Goal of Care is CURATIVE or RESTORATIVE. Treatment is aimed at PROLONGING LIFE.

Patient is FOR CPR, and all appropriate life-sustaining treatments → For Code Blue

LIMITATION OF MEDICAL TREATMENT

B. Goal of Care is CURATIVE or RESTORATIVE, but the following limitations of treatment apply: (Tick ONE option only)

Patient is NOT FOR CPR (but is for intubation for respiratory failure) → For Code Blue

Patient is NOT FOR CPR OR INTUBATION but is for non-invasive ventilation or inotropes → Not for Code Blue
For MET Call

Patient is NOT FOR CPR, INTUBATION OR VENTILATION, but is for the following ACTIVE MANAGEMENT (eg antibiotics, tube feeding) → Not for Code Blue
MET call Yes No

Please specify _____

C. The Goal of Care is PALLIATIVE – treatment is aimed PRIMARILY at SYMPTOM MANAGEMENT & QUALITY OF LIFE

Patient is NOT FOR CPR, INTUBATION or VENTILATION, but is for the following ACTIVE MANAGEMENT (eg antibiotics, tube feeding) → Not for Code Blue
MET call Yes No

Please specify _____

D. The Goal of Care is TERMINAL, treatment is aimed at COMFORT DURING THE DYING PROCESS (Prognosis is assessed to be hours or days)

Patient is NOT FOR CPR, INTUBATION OR VENTILATION → Not for Code Blue
Not for MET Call
Initiate Terminal Care Pathway

Complete for all patients whose Goals of Care include some limitation of medical treatment, (Sections B, C or D)
Raise a Clinical Alert for Goals of Care Plan, and then place the completed form in the Alerts Sleeve in the patient notes.

Reason for Limitation of Medical Treatment → Medical grounds Patient wishes Patient Best Interests
Advance Care Directive available for this patient → Yes No Refer for ACD advice
Persons involved in the decision making process → Patient Enduring Guardian Person Responsible

Note below name of Person Responsible/Enduring Guardian if involved in decision making

Doctor's name (print) _____ Doctor's designation _____

Date _____ Doctor's signature _____

Name of Consultant Responsible (print) _____ Informed of this plan Yes No

If changes are required a new plan must be written, & the outdated plan crossed through, marked "void", signed & dated

Endorsed for continued use during ambulance transfer at home new care facility (tick which apply)

Signature of Consultant, Specialist or designated deputy (Registrar/RMO) _____

Date of endorsement: _____ 90 day validity from this date to _____

Signature of GP/Specialist (print name): _____ Date: _____

Procedure/Process (from Goals of Care Protocol):

STEP ONE. ASSESSMENT

A clinical evaluation is made to assign the patient's situation to one of the three goals of care categories: curative/restorative, palliative, terminal.

If the goals of care are CURATIVE, and no limitation of treatment is recommended, and the patient or Person Responsible agrees, then no further action is required unless the goals change.

Day admissions for low risk procedures on otherwise healthy people may be exempted from using the Goals of Care Plan (GOCP) form, at the discretion of the consultant or specialist responsible for the patient's admission. The form should be filled out for all other patients.

STEP TWO. LIMITATION CONSIDERED AND NEGOTIATED

Patients for whom LIMITATION OF LIFE-PROLONGING MEDICAL TREATMENT should be considered:

1. A patient who has an illness for which medical treatment aimed at life-prolongation will neither significantly prolong life expectancy, nor improve the quality of life.
2. A patient for whom such therapy carries a far greater risk of complications than possible benefits.
3. Any patient who appears to have capacity and states that they do not wish to have certain, or all, life-prolonging treatments, or if lacking capacity, but has an Advance Care Directive or a Person Responsible stating this.

Key questions to be addressed by health care team if treatment limitation is being considered (after MJA 2005; 183:230-1):

1. Are the clinical facts of the case well established? Is the diagnosis correct?
2. Has sufficient time elapsed to be reasonably confident that there is no reasonable prospect of substantial improvement or recovery?
3. Is there consensus amongst the clinicians about the diagnosis, prognosis and most appropriate course of medical action? Is a case conference necessary?
4. Has the patient or the patient's Person Responsible been advised of the above? Have they had a chance to express their opinions?
5. Has the patient's general practitioner been involved?

Consult the Clinical Guideline on Decision-making at the End of Life.

http://www.dhhs.tas.gov.au/palliative_care/health_professionals/symptom_management_guidelines

STEP THREE. IMPLEMENTATION

1. The consultant or specialist responsible for the patient's care, or designated delegate (Registrar or RMO) completes and signs the Goals of Care Plan (GOCP) form. This duty may NOT be delegated to an intern.
2. The consultant or specialist responsible (or delegate), should then file the completed GOCP form in the current admission medical record and place in the Alerts section of the Digital Medical Record.
3. The consultant or specialist responsible, (or delegate), changes the orders regarding patient's medical management to reflect the Goals of Care and treatment choices that have been agreed between medical team and patient/Person Responsible, noting the names of the Person Responsible/Enduring Guardian if they have participated in the decision making process.
4. The responsible consultant or specialist, (or delegate), contacts the patient's GP and advises them of the GOCP.
5. All discussion related to the GOC Plan is to be clearly documented on the form and/or in the patient's progress notes in the medical record by the consultant or specialist responsible, (or delegate).
6. The Person Responsible should be reassured that the ultimate responsibility for treatment decisions, including cessation of life-prolonging medical treatment and deployment of palliative and terminal care, is a medical one, but shared with him/her after appropriate discussion and consultation.
7. If the patient is to be transferred or discharged, the goals of care should be reviewed and documented in the discharge summary. Completion of an Advance Directive should be encouraged. The Goals of Care Plan may be endorsed by the consultant or specialist responsible (or delegate) as active, and presented to ambulance crews to accompany a patient who is being transferred for palliative and terminal care at home or in another facility. The Tasmanian Ambulance Service will recognise the validity of the Goals of Care Plan for 90 days from date of endorsement.
8. General Practitioners or Specialists may endorse the Goals of Care Plan for ongoing care in the community by signing and dating the form when they assess the patient following hospital discharge.