Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Factsheet for senior clinicians responsible for the shared goals of care decisions

Shared goals of care discussions:

- are facilitated by the appropriate clinician(s)
- should happen close to admission
- include those the patient wishes to have with them
- take place in an environment that maintains patients' privacy and dignity
- are supported by governance systems, organisational culture and resourcing
- have cultural safety as an essential component
- are clearly documented.

Patients, whānau and clinicians are supported before, during and after the discussion.

Basing clinical treatment plans on shared goals of care reduces the risk of a patient receiving unwanted or unwarranted treatments if their condition deteriorates. Effective communication is necessary to elicit patients' values and preferences for care and allow informed choices to be made about complex medical treatment options. Ideally, such conversations occur prior to episodes of acute deterioration so patients, families, whānau and clinicians are able to participate fully in developing shared goals of care without the pressures of an evolving clinical crisis.

Shared goals of care

Principle one states:

> Shared goals of care are when the patient, their family and whānau, and clinicians explore the patient's values along with the care and treatment options available and agree the goal of care for the current admission if the patient deteriorates.

Shared goals of care:

- identify the overall direction for an episode of care (for example, curative, restorative, focused on improving quality of life or comfort whilst dying[1]), outlining which treatments are more likely to cause benefit than harm
- relate to the patient's current admission and what the patient wishes to happen if their condition deteriorates
- focus on providing appropriate care – what we can do – rather than what we won't do.

1 Thomas R, Zubair M, Hayes B, et al. 2014. Goals of care: A clinical framework for limitation of medical treatment. *Medical Journal of Australia* 201: 452–5.

What is my role?

- Understand the principles of shared goals of care.
- Consider all relevant information.
- Facilitate the discussion with the patient and any support people or other team members as appropriate. There are guides and training that can help with these discussions – for example, the Serious Illness Conversation Guide (https://www.hqsc.govt.nz/our-programmes/advance-care-planning/information-for-clinicians/tools/serious-illness-conversations/).
- Come to a shared goals of care decision and document this on the form.
- Understand that patients and whānau may wish to reflect on the discussion and then have further questions. This is where nurses, allied health staff or other members of the team have an important role to support the patient and their whānau.
- Review the shared goals of care throughout the patient journey and commit to updated documentation of any change.

How shared goals of care work

There are three steps in the shared goals of care discussion. All members of the clinical team have a role to play.

1. Prepare

Gather information, including the patient's capacity, privacy needs, wishes for support people they would like to have present, and any cultural needs. Review the patient information to gain an understanding of their potential medical trajectory. Nursing and allied health staff can play a part in this stage of preparing for the discussion. There needs to be agreement from the patient to go ahead with the discussion. Plan having the discussion around who will be involved, including the appropriate environment and space for privacy and to maintain dignity.

2. Discuss

- Explore the patient's (and family and whānau's, as appropriate) current understanding of their condition and what may lie ahead, and find out how much information they would like to know.
- Share with the patient information about the clinical team's understanding of their current condition and what may lie ahead.
- Summarise and check for shared understanding.

3. Recommend and close

Explain your recommendation in plain language, outlining which treatments are more likely to cause benefit than harm. Then reach a decision with the patient and whānau for the goal of care for the admission. This decision and plan should be documented clearly on the patient's shared goals of care form. Any other follow-up actions should also be documented in the clinical record.

How do I clarify and document the decision?

There are four goals of care options to choose from (A&B: curative and restorative, C: quality of life, D: comfort while dying), with room for additional notes as needed. Each case will have factors unique to the individual (see 'Documenting the shared goals of care decision' below).

What do I do if it is not possible to have a discussion?

Document and sign the shared goals of care form for the current admission with the reasons for not having the discussion. Additional documentation may also need to be included in the clinical record.

What do I do if it is not possible to reach a shared decision?

You will need to escalate and discuss the situation with the senior clinician responsible for the care of the patient. If there is disagreement or any concern that agreement can't be reached with the patient, family and whānau, it is important this is clearly documented.

What do I do if the patient's condition changes?

The shared goals of care decision-making process and documentation do not replace clinical judgement. If the patient's condition changes or there are any concerns, it is important they are clinically reviewed in line with district health board (DHB) protocols and clinical judgement. If the shared goals of care change, a new plan needs to be discussed, agreed and documented. The earlier plan must be clearly crossed out.

Documenting the shared goals of care decision

Attempt CPR

A The goal of care is **curative** or **restorative.**

☐ Treatment aims to prolong life.

Attempt CPR: it is clinically recommended and in accordance with the person's known wishes.

Also for referral for ICU level care, RRT calls and all appropriate life sustaining treatments.

Additional comments: _____

_____

Select goal of care 'A' where the expectation and shared goal is for the patient to recover and when full resuscitation and any other appropriate life-sustaining treatments are recommended and appropriate.

A shared goals of care discussion that results in goal of care 'A' being selected may be straightforward and brief if the patient, family and whānau understand the clinical situation and would like full treatment, should the patient deteriorate. This may be able to be discussed on a ward round.

Do not attempt CPR

B The goal of care is **curative** or **restorative.**

☐ Treatment aims to prolong life and enhance its quality.

Do not attempt CPR: this is likely to cause more harm than benefit or is not desired by the person.

Referral for ICU level care is appropriate ☐ Yes ☐ No

RRT calls are appropriate.

Additional comments (e.g. non-invasive ventilation, dialysis): _____

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Select goal of care 'B' where the expectation and goal are for the patient to recover. However, if the patient was to deteriorate, cardiopulmonary resuscitation (CPR) should not be attempted as it is unlikely to be successful, is likely to cause more harm than good, or the patient does not want it regardless of the outcome. Other treatment may be appropriate, such as intensive care unit (ICU) referral, non-invasive ventilation and dialysis.

An example where 'B' may be appropriate would be an older person in reasonable health who had future goals or ambitions for which they were prepared to accept a material burden of treatment to return to their previous level of independence.

Do not attempt CPR

C The goal of care is primarily **improving quality of life.**

☐ Treatment aims to control symptoms, enhance wellbeing and should be easily tolerated.
Do not attempt CPR: this is likely to cause more harm than benefit.
Referral for ICU level care is unlikely to be appropriate.
RRT calls are appropriate ☐ Yes ☐ No

Additional comments (e.g. antibiotics, IV fluids, NG feeding): _____

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You would select goal of care 'C' where treatment is primarily aimed at improving quality of life and controlling symptoms. In this case, ICU referral is unlikely to be appropriate – however, treatments such as antibiotics, intravenous (IV) fluids and nasogastric feeding may be needed. Treatments should be provided after considering whether the benefit of the treatment will enhance wellbeing and would be easily tolerated by the patient. CPR should not be attempted because it would cause more harm than good.

An example where goal of care 'C' may be appropriate would be a frailer, older person who is conscious that they are possibly in the last years of their life and who would nevertheless want treatment that could return them to their previous level of independence. Many people in this situation want whatever time they have to be as good as possible. Management of the ups and downs of chronic health conditions is important, but they might not want more onerous treatments to be considered.

Do not attempt CPR

D The goal of care is **comfort whilst dying.**

☐ Treatment aims to alleviate suffering in the last hours or days of life and allow a natural death.
Consider end of life guidelines such as *Te Ara Whakapiri.*
Do not attempt CPR, refer for ICU level of care or make RRT calls.

Additional comments (e.g. pain management, fluids): _____

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Select goal of care 'D' when the patient is dying. End-of-life guidelines, such as *Te Ara Whakapiri* (https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life) should be considered with the aim of alleviation of suffering and allowing natural death. CPR, referral to ICU or 777 calls should not be attempted.

More information

Go to:
https://www.hqsc.govt.nz/our-programmes/patient-deterioration/workstreams/shared-goals-of-care/
or contact your local DHB's patient deterioration programme lead.