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

Factsheet for clinicians* responsible for the shared goals of care decisions in aged residential care

Shared goals of care principles:

- proactively align the resident, family, whānau and clinician goals
- may be one-off or ongoing/updated
- are undertaken with all residents
- are led by the appropriate clinician (and includes others)
- should happen early, once becoming a resident
- should take place in an appropriate environment
- must be clearly documented
- need to be underpinned by Te Tiriti o Waitangi.

When shared goals provide the basis for clinical treatment plans, there is less risk of a person receiving unwanted or unwarranted treatments if their condition deteriorates.

Effective communication is necessary to draw out the resident's 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 residents, families, whānau and clinicians can participate fully in developing shared goals of care without the pressures of an evolving clinical crisis. This also assists the care facility in preparing for the provision of care and the appropriate supports if the resident is to remain in the facility.

Shared goals of care:

- are the outcome of a decision-making process between the resident, family, whānau and the clinical team(s)
- identify the overall direction for an episode of care (for example, restorative, on-site active care, comfort) and any limitations on medical treatment
- focus on providing appropriate care – what we can do – rather than what we won't do.

What is my role?

- Consider all relevant information.
- Lead the discussion with the resident, or if they are not competent, with the enacted Enduring Power of Attorney (EPoA) (see 'How shared goals of care work' below); include any support people or other team members as appropriate. Use the Serious Illness Conversation Guide https://bit.ly/PatientCOVIDSICG to support these discussions.
- Come to a shared goals of care decision and document this on the form.
- Understand that residents, family 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 resident and their whānau.

*refers to a registered health professional

How shared goals of care work

Shared goals of care should be completed on admission, at the six-monthly multidiscipline review or when there is any change in the resident's health condition.

There are three steps in the shared goals of care discussion.

1. Prepare

Gather information, including the resident's capacity, privacy needs, wishes for support people they would like to have present and any cultural needs. Review the resident's information to gain an understanding of their future health care needs. Nursing and allied health staff and care assistants can play a part in this stage of preparing for the discussion. There needs to be agreement from the resident to go ahead with the discussion.

Please note, if the resident is not competent, it is recommended that you follow the advice in the *Frailty care guides* about capacity assessment and EPoA www.hqsc.govt.nz/our-programmes/aged-residential-care/projects/frailty-care-guides.

2. Discuss

- Explore the resident's (and EPoA's 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 resident information about the primary health team's understanding of their current condition and what may lie ahead.
- Summarise and check for shared understanding.

Note, it is important to explore the resident's values and what is important to them, including their priorities, hopes, worries, what helps in tough times and what they would be willing to go through for more time.

When documenting the people present for the discussion, include the resident even if they have limited capacity. Also note if they have limited capacity in the reason section for not holding the discussion with the resident.

3. Recommend and close

Explain your recommendation in plain language and then reach a decision with the resident, EPoA, family and whānau for the goal of care. This decision and plan should be documented clearly on the 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: restorative, C: on-site active care, D: comfort), 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). The outcome of the discussion should be documented on the shared goals of care in aged residential care form. The aged residential care form is closely aligned with the hospital shared goals of care form and should be shared if any transfer of care setting occurs.

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

Document and sign the shared goals of care form with the reasons for not having the discussion. It is expected that alternative ways of having the discussion are explored, eg, telephone, telehealth, etc. Additional documentation may need to be included in the clinical record.

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

Try to discuss the situation with your primary care colleagues, with the care facility senior staff, or it may be appropriate to discuss with a specialist geriatrician for further advice. The resident may also have a hospital team they are under for other conditions who could be helpful in the decision-making. If there is disagreement or any concerns that agreement can't be reached with the resident, EPoA, family and whānau, it is important this is clearly documented.

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

The shared goals of care decision-making process and documentation does not replace clinical judgement. If the resident's condition changes or there are any concerns, it is important they are clinically reviewed in line with facility 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 or closed if this is recorded electronically.

How do shared goals of care link with advance care plans and/or advance directives?

Advance care plans and/or advance directives should be used to inform the shared goals of care discussion and to give context to the resident's wishes. It is important to be familiar with existing advance care plans and/or advance directives prior to the shared goals of care discussion and decision.

Documenting the shared goals of care decision

Attempt CPR

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

☐ Treatment aims to restore the health status to best possible.
Transfer to acute hospital if treatment cannot be provided on site.
Attempt CPR: it is clinically recommended and in accordance with the resident's known wishes.

Additional comments: _____

_____

Select goal of care 'A' where the expectation and shared goal is for the resident to recover, and when cardiopulmonary resuscitation (CPR) 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 resident, EPoA, family and whānau are aware of the clinical situation and desire full treatment should deterioration occur.

Do not attempt CPR

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

☐ Treatment aims to restore the health status to best possible.
Transfer to acute hospital if treatment cannot be provided on site.
Do not attempt CPR: this is likely to cause more harm than benefit or is not desired by the resident.

Additional comments (e.g. specific treatments to do): _____

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_____

Select goal of care 'B' where the expectation and goal are for the resident to recover. However, if the resident was to deteriorate, CPR should not be attempted as it is unlikely to be successful, is likely to cause more harm than good, or the resident does not want it regardless of the outcome. Other treatment may be appropriate such as discussion with specialist geriatrician or transfer to acute hospital.

An example where goal 'B' may be appropriate would be an older person in reasonable health, who had future goals or ambitions. For these ambitions they are prepared to accept treatment that may be difficult to tolerate in order to return to their previous level of independence.

Do not attempt CPR

C The goal of care is **on site active care.**

☐ Treatment aims to slow decline and enhance quality of life.

Do not transfer to acute hospital, unless comfort cannot be maintained or transfer is advised by GP/NP.

Do not attempt CPR: this is likely to cause more harm than benefit.

Additional comments (e.g. antibiotics, sub-cutaneous fluids): _____

_____

_____

You would select goal of care 'C' where treatment is primarily aimed at slowing decline and enhancing quality of life. In this case transfer to acute hospital is unlikely to be appropriate, however treatments such as antibiotics or subcutaneous fluids 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 resident. CPR should not be attempted as it would cause more harm than good.

An example where 'C' may be appropriate would be a frailer resident who would 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.**

☐ Treatment aims to optimise comfort rather than attempt to prolong life. When in the last hours or days of life, consider end of life guidelines such as *Te Ara Whakapiri.*

Do not attempt CPR or transfer to acute hospital.

Additional comments (e.g. any treatments to be/not be provided): _____

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_____

Select goal of care 'D' when the resident requires comfort care. When in the last hours or days of life, end-of-life guidelines, such as *Te Ara Whakapiri* (www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life) should be considered with the aim of alleviating suffering and allowing natural death. CPR should not be attempted and referral to acute hospital is unlikely to be appropriate.

More information

Go to:

www.hqsc.govt.nz/our-programmes/patient-deterioration/workstreams/shared-goals-of-care/

or contact your DHB's patient deterioration programme lead.