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

Factsheet for nurses and allied health workers supporting shared goals of care 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, the risk of a resident receiving unwanted or unwarranted treatments if their condition deteriorates, is reduced.

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 discussions 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?

Feedback from consumers has demonstrated that nurses and/or allied health staff have an invaluable part to play in the discussion and shared goals of care decision. This may include preparing and supporting the discussion. Residents, family and whānau may wish to reflect on the discussion and then have further questions. This is also where you may have an important role.

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. Existing advance care plans or advance directives should be used to inform the discussion and give context.

There are three parts to the discussion. All members of the clinical team have a role to play.

1. Prepare

Gather information, including the resident's capacity to have the conversation, privacy needs, their wishes regarding support people they would like to have present and any cultural needs. Nursing and allied health staff have an important role in identifying any needs the resident may have ahead of the discussion. The clinician responsible for making the decision will also need a clear understanding of the future health care needs of the resident. 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 family's, whānau's and EPoA's, as appropriate) current understanding of their condition and what may lie ahead, and 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, including their hopes, worries, what helps in tough times and what they may be willing to go through for more time.

Use the Serious Illness Conversation Guide https://bit.ly/PatientCOVIDSICG, to support these discussions.

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, family and whānau (or EPoA) 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.

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.

New Zealand Government