

Shared goals of care and resuscitation decisions

Purpose

To support informed decisions about shared goals of care, treatment preferences and resuscitation in the event of cardiac or respiratory arrest or other life-threatening situations.

To promote a consistent approach and clear communication of the plan of care in case of patient deterioration based on what is acceptable to the patient and appropriate to the patient's condition.

To comply with relevant legal, ethical and professional standards.

Application

This policy applies to all patients of Canterbury District Health Board, excluding Child Health.

Definitions

Advance Care Plan: a record describing an individual's preferences for future care based on the individual's values, beliefs, concerns, hopes and goals. Can be viewed in Health Connect South under Shared Care Plans.

Advance Directive: a specific instruction or choice a competent person makes about their future health care. It becomes effective only when a person is not competent to make informed choices about healthcare in the type of situation the directive covers. A written advance directive may be a standalone document or a subsection of an advance care plan.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) means that if a patient has a respiratory or cardiopulmonary arrest, neither basic nor advanced cardiopulmonary resuscitation will be carried out.

Serious Illness Conversation Guide: a set of structured questions drawn from best practices in communication which serves as a framework for clinicians to explore topics that are crucial to gaining a full understanding of what is most important to patients with a serious illness.

Shared goals of care: records conversations between the patient and his or her clinical team and the outcome of a shared decision-making process related to treatment preferences, plans of care and resuscitation.

Resuscitation: encompasses cardiopulmonary resuscitation, ventilator support of different levels, inotropic support and fluid resuscitation.

Principles

Shared Goals of Care

The process involved in deciding on the shared goals of care and treatment preferences encourages patients and clinicians to think about the patient's prognosis and likely response to treatment. It encourages them to determine what treatment options are most important within the context of that person's continuum of care – whether it be restorative or curative, symptom-focused, or care at the end of life. Clinical expectations about treatment benefits, risks and success need to be considered alongside the patient's values, wishes and preferences.

Advance decisions about cardiopulmonary resuscitation in the event of a respiratory or cardiopulmonary arrest can be an important part of care planning. There are two types of DNACPR decisions:

Medically-initiated DNACPR order

A clinician can make a treatment order that cardiopulmonary resuscitation will not be provided in a critical situation because it is not medically indicated.

Patient-initiated DNACPR order

A patient can make an advance directive while competent directing that they do not wish to receive cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. These decisions need to be respected as we would for any competent patient's decision to decline treatment.

Both medically-initiated and patient-initiated DNACPR decisions will be recorded in the patient's clinical record (refer to documentation below).

Policy

Decision-making process

Decisions on shared goals of care, treatment options and resuscitation are a collaboration between the patient, nominated support and their clinical team. The process should begin as soon as practical after admission and includes the following:

Clinical assessment

Clinically assess the patient's prognosis, clinically relevant treatment options and likely response to treatment. This will include an assessment of the extent to which the patient has capacity to make or participate in decisions about their healthcare.

Clinicians must consider whether the patient is likely to survive their present illness, and their overall level of function and life trajectory.

Clinical recommendations need to be governed by what clinically appropriate options are likely to be beneficial. Clinicians are not obliged to provide treatments that are not clinically indicated. Providing clinically contraindicated treatment may breach standards of care.

Discussion with the patient and their whānau

The purpose of these discussions is to establish the patient's knowledge of their illness and prognosis, their values, hopes, fears and wishes. Ideally all discussions should involve the patient and the patient asked who else should be part of the conversation. Other people could include the patient's:

- family/whānau and/or identified significant other
- SMO, General Practitioner, Nurse Practitioner, Delegated Registrar, Senior Registered Nurse
- primary nurse
- support services (Chaplaincy, Social Work, Kaitiaki / Māori Health support).

If the patient lacks capacity, valid advance directives should be followed. For any decision not covered by a valid advance directive, input should be sought from the person who has legal authority to make decisions about the patient's health and wellbeing (e.g. activated EPOA (personal care and welfare) or legal guardian) in line with the CDHB Informed Consent Policy. If no legal representative exists, input should be sought from other suitable persons such as the patient's family/whānau who are interested in the patient's wellbeing and available to advise the clinical team. The purpose of consultation with these other support persons is to find out more about what the patient would likely choose if he or she had capacity.

Use the Serious Illness Conversation Guide to frame and direct the conversation/s, establishing the patient's knowledge of their illness, prognosis, values, hopes, fears and wishes.

Support in complex cases

Whenever the decision is uncertain or unusually complex or difficult, the case should be discussed with others for clinical input (e.g. registrar/nurse practitioner with the responsible SMO or SMO with a senior colleague). A geriatrician or psychiatrist can be asked for a formal second opinion on the decision of the patient's competence if required. The legal team is also available for advice if requested.

Documentation

The [CDHB Shared Goals of Care form](#) Ref: 2406924 (paper or electronic through Cortex) is used to record key points of conversation with the patient about their condition, preferences and goal of care, treatments and resuscitation.

A [DNACPR \(Do Not Attempt Cardiopulmonary Resuscitation\) Order form](#) Ref: 2406846) would normally be completed for any patient who is not for cardiopulmonary resuscitation in the event of a respiratory or cardiopulmonary arrest. In general, the primary source of truth for CPR is the DNACPR Order form, regardless of any documentation about resuscitation on a Shared Goals of Care form. In a rare situation where a DNACPR form is not completed, the reason there is no DNACPR form must be recorded on the Shared Goals of Care form.

Both sides of the DNACPR form must be completed to ensure documentation of the DNACPR order and other appropriate treatments and investigations (page one) and the rationale and discussions for the decision (page two).

Unless there is a valid advance directive or it is clear CPR is not medically indicated (e.g. advanced cancer or dementia), the patient will be for resuscitation if they experience a clinical emergency until the form is filled in. Any alteration in the patient's status is documented on a new DNACPR Order form and details documented in the clinical notes.

Documentation relates to the current inpatient admission and must be legible, signed and dated. Hard copies are filed in the front of the clinical record.

Ensure details of shared goals of care and enduring resuscitation decisions are included in the discharge summary and / or Acute Plan at the time of discharge to ensure visibility.

For any subsequent admission, any previous Shared Goals of Care form or DNACPR Order form should be reviewed with new discussions and new forms completed. Advance Care Plans and advance directives generally continue between admissions but can be updated at any time by a competent patient and will help to inform the shared goals of care and DNACPR processes.

If the patient doesn't have an Advance Care Plan, they should be encouraged to complete one with their general practice team. To help prepare for this information can be given on discharge using HealthInfo.

Review

Documentation about Shared Goals of Care and DNACPR is dynamic and should be reviewed/revisited on a regular basis during the hospital admission to ensure that the decisions are still appropriate for the patient's condition.

A patient's shared goals of care, treatment preferences, and DNACPR status is reviewed:

- if a time limited 'not for CPR 72 hours' has been made on the DNACPR documentation
- if there's a significant change in the patient's condition
- immediately following a transfer of care
- if a competent patient requests review of a decision at any time
- prior to an operative or interventional procedure under sedation or general anaesthetic.

On occasion the patient may need an operative or interventional procedure under sedation or general anaesthetic. The procedure and associated sedation or anaesthetic may result in a reversible complication which is treatable. At the time of consent for the procedure/sedation/anaesthetic, this should be discussed and the goals of treatment for the procedure documented. They may differ from the goals of care because of the reversible nature of the condition and the fact that the procedure/sedation/anaesthetic may be associated with a treatable complication.

If it is determined the patient is in their last days of life, [Te Ara Whakapiri pathway](#) may be started and used to document care.

Communication and transfer of care

Before patient transfer, an electronic handover / discharge summary is completed. As soon as practicable following admission, a senior clinician will review any documented decisions on shared goals of care, treatment options and DNACPR decisions and commence the process if it is necessary. The receiving team will communicate and update information as appropriate to the service/facility (e.g. patient status communication board, FloView, board rounds, handovers).

Roles and Responsibilities

The patient's senior clinician (Senior Medical Officer, General Practitioner, Nurse Practitioner, Delegated Registrar) is responsible for the process to decide upon shared goals of care, treatment preferences and cardiopulmonary resuscitation.

A registered nurse of suitable seniority and experience can put in place a medically-initiated DNACPR order or record a patient-initiated DNACPR order for a patient of a CDHB run Aged Residential Care or Rural Health Service.

It is the joint responsibility of all clinical staff to be aware of the patient's shared goals of care, treatment preferences and DNACPR status.

Education on shared goals of care is professionally and clinically based. Serious illness conversations and advance care planning training is regularly available on request and resources can be found online.

Policy measurement

Service level review may occur as indicated using the following mechanisms: topic specific audit (e.g. DNACPR Order form audit, Quality of Dying audit, as a component of a documentation audit), case review for education purposes or Mortality and Morbidity Meetings, feedback from Patient Experience Survey (via communication and partnership domains), death certificate review feedback.

Incidents and complaints regarding shared goals of care, treatment preferences and resuscitation will be investigated and learnings shared as appropriate.

Associated material

Controlled documents

- [Informed Consent Policy](#) ref: 2400626
- [Shared Goals of Care form](#) ref: 2406924
- [DNACPR \(Do Not Attempt Cardiopulmonary Resuscitation\) Order](#) form (Ref: 2406846)
- Shared goals of care and resuscitation decisions Hospital HealthPathway
- [Making resuscitation decisions – information for doctors](#)
- [Information for Patients, Family/ Whānau – Deciding About Resuscitation](#)

- [Advance Care Planning \(ACP\) Hospital HealthPathway](#)
- Interpreter Services Patient Information
- Electronic Interpreter Booking form

Supporting material

- [Aotearoa serious illness conversation guide](#)
- [Patient COVID-19 Serious Illness Conversation Guide](#)
- [Whānau COVID-19 Serious Illness Conversation Guide](#)
- [Medical Care Guidance \(MCG\)](#)
- [Te Ara Whakapiri – Care in the Last Days of Life pathway](#)

Legislation and standards

- Code of Health and Disability Services Consumers' Rights 1996 (the Code)
- Health and Disability Commissioner Act 1994
- Health and Disability Services Standard NZS 8134:2008: 1.1 (Consumer Rights)
- New Zealand Bill of Rights Act 1990

References

- Options for Treatment and Resuscitation (OtTeR) Nelson Marlborough District Health Board
- Goals of Care Policy, Capital & Coast District Health Board
- Supporting resources, Patient Deterioration Programme and Shared Goals of Care Workstream, Health Quality & Safety Commission

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