Shared goals of care and resuscitation decisions

Contents

Purpose

To support informed decisions about Shared Goals of Care (SGoC), 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.

Scope and applicability

This policy is followed by all staff providing patient care in Te Whatu Ora Waitaha Canterbury facilities. A Shared Goals of Care plan is available for all adult inpatients, excluding Child Health, Maternity and Specialist Mental Health Services.

Roles and Responsibilities

The Shared Goals of Care process supports a team approach. All clinical staff can engage and document Shared Goals of Care Plan conversations. The patient's senior clinician (Senior Medical Officer, Senior Dental Officer, General Practitioner, Nurse Practitioner, Delegated Registrar) is responsible for the final endorsement of the Shared Goals of Care Plan decision regarding treatment preferences and cardiopulmonary resuscitation.

A registered nurse of suitable seniority, training and experience can put in place a Shared Goals of Care Plan for a patient at a Te Whatu Ora Waitaha Canterbury run Aged Residential Care or Rural Health Service facility. For certainty, a nurse of suitable seniority, training and experience can put in place a Shared Goals of Care Plan which includes a clinically indicated or patient initiated DNACPR order for a patient at a Te Whatu Ora Waitaha Canterbury run Aged Residential Care or Rural Health Service facility.

It is the joint responsibility of all clinical staff to be aware of the patient's Shared Goals of Care Plan, treatment preferences and DNACPR status.

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

Definitions

Shared Goals of Care (SGoC) / ngā whāinga tauwhiro (sustainable goals): a shared conversation between the patient, nominated support persons and the clinical team regarding the person's understanding of their illness, likely prognosis, values and wishes for their future health and clinically appropriate treatments that align with the identified goals.

Shared Goals of Care (SGoC) Plan: 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 for that episode of care.

Cardiopulmonary Resuscitation (CPR): chest compressions and rescue breaths.

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.

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

Episode of Care: in the context of Shared Goals of Care, the term 'episode' relates to the patient's condition for which they are currently being cared for / treated and can work across Te Whatu Ora Waitaha facilities. An episode is usually an inpatient admission and can include some outpatient treatments that require frequent hospital visits (e.g. bone marrow transplant, chemotherapy, dialysis). If a patient's condition changes during the 'episode of care', the shared goals of care plan should be reviewed to ensure decisions made are still appropriate.

Advance Care Plan: a description of an individual's preferences for future care based on the individual's values, beliefs, concerns, hopes and goals. If published, the plan can be viewed in Health Connect South under Care Plans.

Advance Directive: a specific instruction or choice a competent person makes, which could include consent or refusal for a specific treatment or event, 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.

N.B. 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 Plan.

Enduring Power of Attorney (EPA): The Protection of Personal and Property Rights Act 1988 allows people aged 18 or over to plan ahead and prepare for future possibilities by formally appointing people to act on their behalf (the Donor). The person who acts on the Donor's behalf is known as their "Attorney". The document used to appoint the Attorney is known as the "Power of Attorney" or EPA. There are two types of EPA: Personal Care and Welfare, and Property.

Activated Enduring Power of Attorney (EPA): An EPA can be active or inactive. An EPA for Personal Care and Welfare is not active at the time it is set up and can only be activated when the person is deemed to lack capacity. This is a formal process usually performed by a specified person or a medical treatment provider acting within an appropriate scope. It is important medico-legally to obtain a copy of an active EPA before assuming it exists. Refer to Hospital HealthPathways Mental Capacity: Future Planning / 2. Activating an EPA.

Serious Illness Conversation Guide (SICG): a set of structured questions drawn from best practices in communication which serves as a framework for clinicians to explore what is most important to patients with a serious illness.

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. Treatment options need to be considered and align with the patient's values and wishes. Any recommendations for treatment need to be clinically appropriate and support the goal of care identified.

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:

Clinically indicated DNACPR order

A clinician can make a treatment order that cardiopulmonary resuscitation will not be provided in a critical situation because it is not clinically 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. A valid advance directive is binding on health professionals and should be followed unless there are reasonable grounds for believing it is not valid.

An advance directive is valid when the person:

- Was competent at the time they made the advance directive.
- Anticipated and intended his or her decision to apply to the prevailing circumstances.
- Had been sufficiently informed to make the decision and
- Reached their decision without undue influence or coercion.

Both clinically indicated and patient initiated DNACPR decisions will be recorded in the patient's clinical record and Shared Goals of Care Plan (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 persons and their clinical team. The process should begin as soon as practical after admission (and preferably completed within 24 hours) or diagnosis (as an outpatient) and includes the following:

Clinical assessment

- Review the patient's clinical records (including Health Connect South, Cortex and HealthOne) for previously completed Shared Goals of Care Plans, advance care plans and advance directives to inform and support Shared Goals of Care conversations with patients.
- 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.

Conversation with the patient and their whānau

Conversations around goals of care should start as soon as possible at times this will occur in the Emergency Department or acute admitting area. If the Shared Goals of Care conversation is not able to occur in ED or acute admitting area, the process is completed on the ward within 24 hours of admission.

The purpose of these conversations is to establish the patient's knowledge of their illness and prognosis, their values, hopes, fears and wishes. Any clinician can have the conversation and include the patient as much as is practical. The patient should always be offered the opportunity to have their support people present. These people may 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).

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.

If the patient lacks capacity, any valid advance directives need to be followed (located in the Legal section of the HCS document tree or within a published ACP located in the windowlet). If the Advance Directive is not valid for the decision, then informed choice should be sought by any person who has legal authority to do so e.g. activated EPA (Personal Care and Welfare) or legal guardian (see also Te Whatu Ora Waitaha Informed Consent Policy Ref: 2400626).

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 with the responsible SMO or SMO/Nurse Practitioner 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. Hauora Māori Health will also be able to provide cultural support and guidance. The legal team is also available for advice if requested.

Documentation

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

Documentation relates to the current inpatient admission and must be legible, signed and dated.

All sections (electronic) / both sides (paper) of the Shared Goals of Care Plan must be completed to ensure documentation of the patient's treatment aim, any limitations, other appropriate treatments, investigations, the rationale and conversation for the decision. Hard copies are filed with page two uppermost.

Depending on the clinical record format in use, refer to the following for details:

- Cortex workflow
- Cortex completion rules
- HCS workflow
- Paper workflow

Unless there is a valid advance directive, or it is clear CPR is not clinically indicated (e.g. advanced cancer), the patient will be for resuscitation if they experience a clinical emergency until the form is filled in.

Any alteration in the patient's resuscitation status is documented on a new Shared Goals of Care Plan. If hard copy, the previous Shared Goals of Care Plan is crossed through, dated, time stamped, signed and filed. If Cortex, the plan is amended and snapshotted.

Ensure details of shared goals of care and resuscitation decisions are included in the eHandover / Discharge Summary (Transfer of Care) and / or Acute Plan at the time of discharge to ensure visibility. Ensure Cortex Shared Goals of Care Plans are ended and printed if transferring to another facility. If the resuscitation decision is an ongoing decision, this will be noted against the resuscitation decision with the reason why it is ongoing and how long for.

If the patient doesn't have an Advance Care Plan, they should be encouraged to complete one with their general practice team. Add this as a note in the Discharge Summary / Transfer of Care information for the General Practice Team to continue the conversation. To help them prepare for this, information can be given on discharge using HealthInfo or pamphlets which can be ordered from ACP | Community & Public Health (cph.co.nz)

Review

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

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

- if there's a significant change in the patient's condition
- as soon as practicable following a transfer of care if clinical advice indicates the goal of care is likely to change (refer to Communication and transfer of care below)
- 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. Note: signalling that CPR (chest compressions and rescue breaths) is not clinically appropriate does not exclude other forms of resuscitation such as defibrillation for monitored arrhythmia, ventilation or intensive care.

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. If there is no advance directive available a Shared Goals of Care Plan should be completed.

Communication and transfer of care

Before patient transfer, an electronic handover / discharge summary (Transfer of Care) is completed.

If a patient's care is transferred from one Te Whatu Ora facility to another Te Whatu Ora facility, the goal of care continues for the period of transport, as the goal of care is unlikely to materially change between discharge from one destination and arrival at another.

On arrival at a new facility the Shared Goals of Care Plan is reviewed as soon as possible following admission or if there is a change in the patient's clinical condition, whichever comes first. A senior clinician will review any documented decisions on shared goals of care, treatment options and DNACPR decisions and commence a Shared Goals of Care Plan conversation if it is necessary.

Note: there is a low threshold for revisiting the goal. A new Shared Goals of Care Plan must be started if there is clinical indication the goal of care is likely to change (e.g. a patient recovering from stroke is transferred to another facility for rehabilitation). The receiving team must communicate and update information as appropriate to their service/facility (including documenting in the clinical notes, patient status communication board, FloView, board rounds, handovers).

Policy measurement

Service level review may occur as indicated using the following mechanisms: HQSC Shared Goals of Care audit markers (and training attendance), topic specific audit (e.g. Quality of Dying audit, as a component of a documentation audit), case review for education purposes or Mortality and Morbidity Meetings, 'after action review' style debriefings, feedback from Patient Experience Survey (via communication and partnership domains), death certificate review feedback.

Incidents and complaints regarding Shared Goals of Care Plans, treatment preferences and resuscitation will be investigated, and learnings shared as appropriate.

Te Tiriti o Waitangi

Three Ministry of Health's Te Tiriti o Waitangi goals must be considered with Shared Goals of Care:

- **Mana motuhake:** Enabling the right for Māori to be Māori (Māori self-determination); to exercise their authority over their lives, and to live on Māori terms and according to Māori philosophies, values and practices including tikanga Māori.
- **Mana tangata:** Achieving equity in health and disability outcomes for Māori across the life course and contributing to Māori wellness.
- **Mana Māori:** Enabling Ritenga Māori (Māori customary rituals) which are framed by te ao Māori (the Māori world), enacted through tikanga Māori (Māori philosophy & customary practices) and encapsulated within mātauranga Māori (Māori knowledge).

In practice, this means during Shared Goals of Care Plans kōrero with Māori, we must take into account te ao Māori and tikanga. It also means we are alert to inequities in outcomes and work to address them between Māori and non-Māori with shared goal of care. The Hauora Māori Team may be able to assist with this.

Associated material

Controlled documents

- Informed Consent Policy *Ref: 2400626*
- Shared Goals of Care Plan form *Ref: 2406924*
- Shared Goals of Care Plan form - ARC/Rural Health Service Facility *Ref: 2410475*
- Deciding About Resuscitation Information for Patients, Family/Whānau *Ref: 2401641*
- Interpreter Services Patient Information *Ref : 2400445*
- Shared Goals of Care Patient Information, Te Tāhū Hauora HQSC *Ref: 2410485*

Supporting material

- Shared goals of care and resuscitation decisions Hospital HealthPathway
- Electronic Interpreter Booking form
- Making resuscitation decisions – information for doctors
- Advance Care Planning (ACP) Hospital HealthPathway
- PRISM Shared Goals of Care
- 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
- Electronic Handover (eHandover) procedure

Legislation and standards

- Te Tiriti o Waitangi – Treaty of Waitangi
- Code of Health and Disability Services Consumers' Rights 1996 (the Code)
- Health and Disability Commissioner Act 1994
- Health and Disability Services Standard NZS 8134:2021: 1.1 (Consumer Rights)
- New Zealand Bill of Rights Act 1990
- Consumer Code of Expectations 2022
- Pae Ora (Healthy Futures) Act 2022
- Plain Language Act 2022

References

- Options for Treatment and Resuscitation (OtTeR) Te Whatu Ora Nelson Marlborough
- Goals of Care Policy, Te Whatu Ora Capital, Coast and Hutt Valley
- Shared Goals of Care Policy, Southern District Health Board
- Te Tāhū Hauora Health Quality & Safety Commission