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Original Study

Introducing Goals of Patient Care in Residential Aged Care Facilities to Decrease Hospitalization: A Cluster Randomized Controlled Trial

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A B S T R A C T

Objectives: The "Goals of Patient Care" (GOPC) process uses shared decision making to incorporate residents' prior advance care planning (ACP) or preferences into medical treatment orders, guiding health care decisions at a time of clinical deterioration should they be unable to voice their opinions. The objective was to determine whether GOPC medical treatment orders were more effective than ACP alone in preventing emergency department (ED) visits (no hospitalization), ED visits (with hospitalization), and deaths outside the residential aged care facility (RACF).

Design: The study was a prospective cluster randomized controlled trial, with the intervention being the completion of GOPC process by a geriatrician, following a shared decision-making process, incorporating ACP documents or residents' preferences.

Setting and participants: The study took place in 6 RACFs in Northern Metropolitan Melbourne, Australia. Eligible participants included all permanent residents in participating RACFs for whom written informed consent could be obtained.

Measures: The primary outcome was the effect on ED visits and hospitalizations at 6 months. Secondary outcomes included a difference in hospitalization rates at 3 and 12 months, total hospital bed-days, and in-RACF and in-hospital mortality rates.

Results: More than 75% of residents participated, 181 randomized to Intervention and 145 to Control. The intervention did not result in a statistically significant change at 6 months; however, at 12 months, it reached statistical significance with 40% reduction in ED visits and hospitalizations compared with Control, with an incident rate ratio 0.63 [95% confidence interval (CI) 0.41-0.99, $P = .044$]. Mortality rates show increased likelihood of dying in the RACF, with statistical significance at 6 months at a relative risk ratio of 2.19 (95% CI 1.16-4.14, $P = .016$).

Conclusions and implications: In the RACF population, GOPC medical treatment orders were more effective than ACP alone for decreasing hospitalization and likelihood of dying outside the RACF. GOPC should be considered by both RACF staff and health services to decrease hospitalization and in-hospital mortality.

Advance care planning is a process by which people document their preferences and values for health care, planning for a time when they are not able to speak for themselves. The process is centered on resident autonomy and the idea that this autonomy should extend to situations where a person's capacity is impaired.[1] In Australia, although advance care planning has been present to a degree for the past 3 decades, it has become a much greater focus of health care in the last 10 years. Palliative medicine within Australia has championed its development as a result of its association with improved end-of-life care.[2] It is supported by policy, which differs between Australian states but was supported nationally by the National Palliative Care Strategy in 2015, and in Victoria, Australia, where this study took place, the

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Medical Treatment Planning and Decisions Act 2016 gave new legal standing to advance care plans.

Residential aged care facility (RACF) is the term used to refer to permanent nursing care homes providing care to those no longer able to live independently in Australia. They may be publicly owned, privately owned, or owned by not-for-profit organizations. The RACF population are increasingly dependent with multimorbidity, reflected in the high incidence of acute health care utilization.[3] Hospital admission incidence for RACF residents is reported to be up to 3 times that of community dwellers.[4] Research has shown that a large proportion of these hospital transfers are avoidable, up to 48% in studies.[3,5] Strategies to help prevent hospitalization for RACF residents have been studied, and advance care planning is one of the successful interventions targeted at decreasing unnecessary and often unwanted hospital admissions.[6,7] Other successful strategies include providing ambulatory geriatric care,[8] improving palliative care provision,[9–11] and improving treatment of pneumonia within facilities.[12–14] A recent systematic review, however, showed limited high-quality studies examining the effects of advance care planning on residents of RACF.[15]

It is known that the majority of older people welcome the chance to discuss end-of-life care, with most recognizing the risk of leaving it too late.[16] Dementia, estimated to affect more than 50% of RACF residents,[17–19] frequently impairs decision-making capacity, especially at times of acute deterioration, which increases reliance on advance care plans. Standards of advance care plans in RACFs are known to be inconsistent and variable in quality.[20] In RACFs in the United States, medical treatment orders such as the physician orders for limitations of treatment were first introduced to address the shortcomings found with advance care plans, including difficulty with their interpretation[4–8] and their not being in a format of orders that ambulance staff could follow.[9]

Studies in the United States have shown more appropriate treatment choices for residents with the introduction of the physician orders for limitations of treatment and others adapted from it[21] over prior advance care plans. The Goals of Patient Care (GOPC) process was developed to improve health care decisions by documenting resident preferences as medical treatment orders, as has been proven effective with the physician orders for limitations of treatment intervention.[22] Using a goals of care framework is getting increasingly popular in determining health care planning for residents, including life prolongation, restoration of function, or symptom relief.[23] If the study showed decreased hospitalization and increased death within the RACF, which was the preferred choice for the residents, then it would be proven superior to the current advance care planning in place.

Goals of Patient Care

The GOPC form (Appendix 1) is a document used to record medical treatment plans for residents of RACF in the event of clinical deterioration. It considers the current medical condition as well as the residents' preferences and any prior advance care planning. As it is specifically for RACF residents, it identifies whether residents are open to hospital transfer for treatment escalation. The form is completed by a medical physician with the resident or their substitute medical decision maker, or both, following a review process.

There are 6 goal options, as seen in Appendix 1, ranging from goal A, identifying residents for cardiopulmonary resuscitation and all life-sustaining treatments, down to goal D, which identifies residents who are in the terminal stage of illness.

The GOPC is a communique between staff and is completed by a medical physician. It translates advance care planning into clinical language and guides health care professionals in treatment decisions for that resident. It is particularly helpful when a resident is being reviewed by a health care professional who is unfamiliar with that person and his or her values or treatment plans.

Methods

Study Design

The study design was an unblinded prospective cluster randomized controlled trial evaluating the effects of the implementation of the GOPC medical treatment orders for RACF residents. The clusters were defined as the individual RACF, which were then organized into cluster pairs and randomized. Clustering was used to prevent cross-contamination between sites influencing the results. Written informed consent was obtained for RACF participation and to gain access to the local health care services for their prior 12-month acute health care utilization rates in a nonidentifiable format. The RACFs were matched on the key characteristic of hospitalization rates into pairs. The RACF pairs were then randomized to receive either the GOPC intervention or usual care using the add-in random allocation program "ralloc" available in Stata, version 12.1 (StataCorp LP, College Station, TX). Individual recruitment of residents and their substitute decision makers then took place in each participating RACF.

Study Objectives

The primary objective for this study was to show that introduction of the GOPC medical treatment orders would lead to a 40% decrease in emergency department (ED) visits and hospitalizations between the Intervention and Control groups at 6 months postimplementation.

The secondary objectives were that the intervention would result in

- a difference in the rate of ED visits and hospitalizations at 3 and 12 months,
- a difference in total hospital bed-days,
- a difference in in-RACF mortality rate, and
- a difference in in-hospital mortality rate.

Study Participants

Forty-five RACFs in the Northern Metropolitan Melbourne were invited to participate. Of these, 8 initially agreed to participate and had their prior 12-month health care utilization calculated, with 6 (13%) progressing to sign written informed consent. The study commenced in August 2015 with the RACF pair in cluster 1 followed by the RACF pair in clusters 2 and 3, with follow-up for 12 months for each RACF.

All residents for whom individual written informed consent was obtained were eligible to participate and all were included in analysis. In cases of diminished decision-making capacity, consent was obtained from the substitute medical decision maker. Exclusion criteria included residents who were not permanent residents, including residents who were in the RACF for respite care, restorative care, or transition care and thus were not living in the RACF long-term to facilitate follow-up.

Study Intervention

The GOPC process was completed by a geriatrician, the lead investigator in the project, who thoroughly reviewed all residents including RACF notes, completion of baseline characteristics and assessments, review of any prior advance care planning documents they had completed, discussion of current health status with health care staff, and discussion with the resident about his or her health care values and preferences. Where possible, a meeting with all interested parties, including family members, was organized to discuss the GOPC.

Before the meeting, all those involved received a copy of the GOPC document to be completed. The residents' current medical issues and general illness trajectory were discussed at this meeting as well as their health care preferences, including preferred place of death. The GOPC documents were then completed and placed in their RACF notes. The meetings took place in 2015 and 2016, and follow-up was for 1 year from study commencement.

Study Control

Control facilities continued with "usual care," which included the current processes in use within the individual RACF. All residents in these RACF had been invited to complete an advance care plan per the RACF protocols. These advance care plans, when completed, were sometimes completed by the resident and/or their substitute decision maker alone, without input from health care professionals. In other cases, health care professionals, most commonly nurses, were involved in the advance care plan discussion and form completion. In no facilities were medical treatment orders in use.

Investigational Plan

Following written informed consent, residents had their initial review for completion of baseline assessments. In the Intervention Group, the GOPC process was completed as described. The following data were collected at 3, 6, and 12 months for included participants: ED visits, hospitalizations, total hospital bed-days, deaths, and place of death. The facilities recorded this information on a document provided to them by the investigator on a ward level. The investigator reviewed all RACF residents' notes to confirm the validity of these data at 3, 6, and 12 months.

Baseline Characteristics and Assessments

Baseline characteristics and assessments were documented for all participants. A cognitive screen was undertaken using the Mini-Mental State Examination,[24] as well as documentation of whether there was a formal diagnosis of dementia and use of medical treatments for dementia. A functional assessment screen used the Barthel Index.[25] Depression was screened for using the Geriatric Depression Scale.[26] Frailty was assessed with the Clinical Frailty Scale.[27] The presence of a prior instructional advance care plan and/or appointment of a medical enduring power of attorney (MEPOA) was recorded, if copies of these documents were available in the RACF notes.

Statistical Methods

The Statistical Package for the Social Sciences (SPSS), version 23 (IBM Corp, Armonk, NY), was used for data analysis. Descriptive statistics were used to compare baseline characteristics, health care utilization rates, and other secondary outcomes. Multilevel Poisson regression models were established to account for the intraclass correlation within each RACF when assessing the primary outcome of health care utilization rates.

The statistical measurement used for comparison for ED visits and hospitalizations and total hospital bed-days was the incident rate ratio (IRR). The IRR reflects the ratio in the incident rate of these presentations with analysis of days at risk. An IRR of <1 suggests that the intervention has reduced the rate when compared to the Control Group. With regard to the mortality outcomes, the reporting value was the relative risk ratio for comparison of place of death and the odds ratio for overall mortality between the groups. All results were adjusted for the clustering effect.

The full methods have been published earlier.[28] The trial was approved by the Northern Health Human Research Ethics Committee (HREC/15/NH/6), and trial registration took place with the Australia and New Zealand Clinical Trial Registry (trial ID: ACTRN12615000298516) prior to study commencement.

Results

Participants

The residents from the 3 Intervention RACFs were combined for analysis, as were the residents from the 3 Control RACFs. The total potential study population was 445 residents, with 418 fitting inclusion criteria and 326 continuing to randomization. In the 6 RACFs involved, the mean study participation rate was 78%. In total, at study commencement, there were 145 residents in the Control Group and 181 in the Intervention Group.

The CONSORT participant flow diagram indicates the number of residents included in the study and included at each stage of the study (Figure 1).

Baseline Characteristics and Assessments

The complete baseline characteristics and assessment results with the appropriate statistical test comparison and results can be seen in Table 1.

Baseline characteristics

No significant difference was found in the median age for residents in both groups; it was 88 years, $P = .46$. Female gender was comparable in both groups; in the Control Group it was 102 (70%), and in the Intervention Group, 138 (76%), $P = .30$. There was a preponderance of residents with an English-speaking background, 124 (86%) in the Control Group and 139 (77%) in the Intervention Group, which was a significant difference, with $P = .03$. There was no significant difference seen in number of comorbidities or the presence of life-limiting illness between the groups with $P = .68$. The number of residents with a documented diagnosis of dementia was 67 (46%) in the Control Group and 92 (51%) in the Intervention Group, $P = .40$. In regard to medications, there was no significant difference in the number of regular medications that residents were prescribed, with mean values ranging from 9.6 to 9.7, $P = .60$, or the number of residents taking medications for treatment of dementia, with 15 (8%) in the Intervention Group and 10 (7%) in the Control Group, $P = .40$. The number of as-required medications did vary between the 2 groups, with P value $< .001$.

The number of residents with an advance care plan was 88 (61%) in the Control Group and 123 (67%) in the Intervention Group, with no significant difference between them, $P = .17$. However, the number of residents naming a MEPOA on their RACF registration form was 68 (47%) in the Control Group and 115 (63%) in the Intervention Group. There was a significant difference between these 2 groups with $P = .01$. There was no statistical difference in residents with the MEPOA legal document present in their RACF notes. The number of those with legal evidence of said MEPOA in their RACF notes was 32 (22%) in the Control Group and 57 (31%) in the Intervention Group, $P = .10$.

The analysis was controlled for all significantly different variables, namely, English as first language, as-required medications, and those with a named MEPOA.

Baseline assessments

There were no significant differences in the baseline assessment scores between the Intervention and Control groups (Table 1). In terms of cognition, the median Mini-Mental State Examination score was 20/30 in both groups, $P = .82$. This indicates mild dementia overall; however, both groups had a wide interquartile range

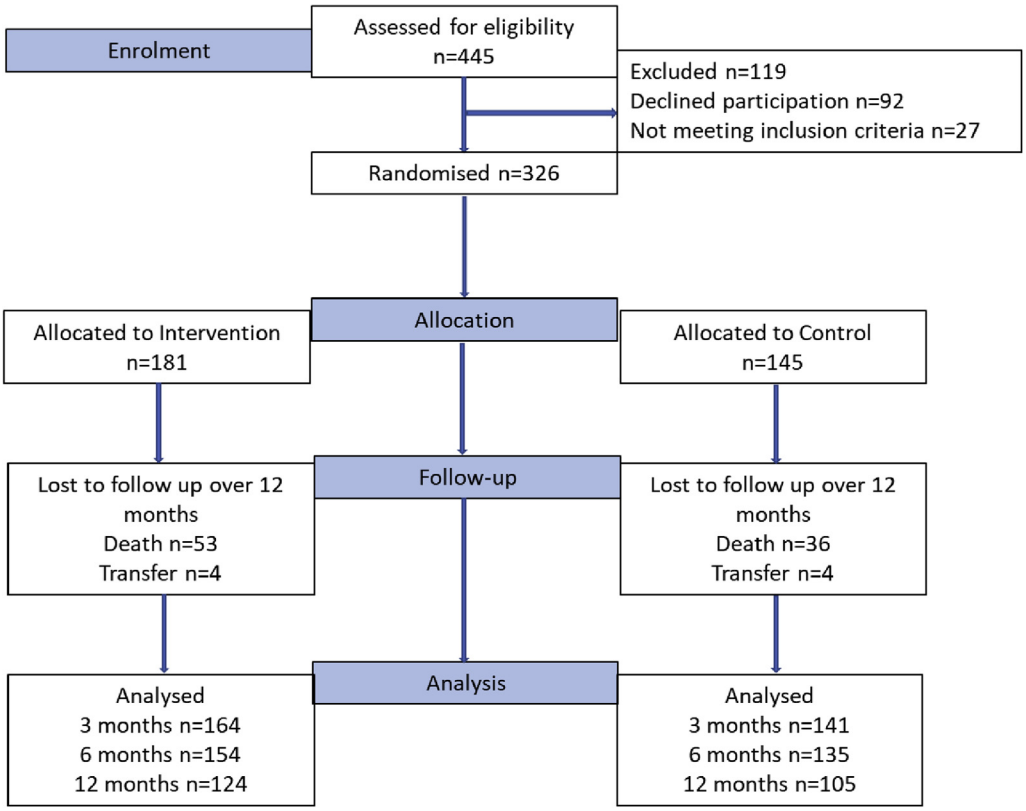

Fig. 1. CONSORT participant flow diagram.

representative of the diverse range of cognitive ability in those present in the RACF. The median Barthel Index was 11/20, $P = .79$, with a considerable range, which was reflective of the range in functional ability but overall showed 2 severely dependent groups. The median Geriatric Depression Scale score was 2/15 in both groups, $P = .28$. A score of 8 or higher indicates possible depression. The median Clinical Frailty Scale was 7/9 in both groups, $P = .09$. Within the scale, a score of 7 indicates severe frailty.

GOPC Choices

The distribution of treatment goals assigned to residents is shown in Table 2. More than 90% of residents were assigned goal C1 or C2, indicating a preference for treatment in their RACF, but although 60% remained open to hospital transfer, for 31% the decision was made not for further hospital transfers even if deteriorating and not responding to treatment.

Table 1
Baseline Characteristics and Assessments of Participating Residents

Baseline Characteristics and Assessments	Intervention (n = 181)	Control (n = 145)	*P* Value
Characteristic			
Age, y, median (IQR)	88 (83-92)	88 (85-91)	.46*
Sex, female, n (%)	138 (76.2)	102 (70.0)	.30†
English first language, n (%)	139 (77)	124 (86)	.03†
Comorbidities, mean ± SD	10.8 ± 3.4	10.9 ± 4.2	.68‡
Life-limiting illness, n (%)	27 (15)	12 (8)	.06†
Dementia diagnosis, n (%)	92 (51)	67 (46)	.40†
Regular medications, mean ± SD	9.6 ± 4.6	9.7 ± 3.8	.60‡
As-required medications, median (IQR)	5 (3-8)	4 (2-5)	<.001*
Dementia treatment medications, n (%)	15 (8)	10 (7)	.68†
Advance care plan, n (%)	123 (67)	88 (61)	.17†
Medical enduring power of attorney (named in RACF notes), n (%)	115 (63)	68 (47)	.01†
Medical enduring power of attorney (legal evidence of appointment in RACF notes), n (%)	57 (31)	32 (22)	.10†
Assessment			
Mini-Mental State Examination score, median (IQR)	20 (10-27)	20 (7.75-26.25)	.82*
Barthel Index, median (IQR)	11 (5-16)	11 (6-15)	.79*
Geriatric Depression Scale score, median (IQR)	2 (0-4)	2 (0.75-5)	.28*
Clinical Frailty Scale score, median (IQR)	7 (7-7)	7 (6-7)	.09*

Total scores in each measure: Mini-Mental State Examination, 30; Barthel Index, 20; Geriatric Depression Scale, 15; Clinical Frailty Scale, 9.
*Mann Whitney *U* test.
†χ^2 test.
‡Independent *t* test.

Table 2
Goals of Patient Care Choices

Goals of Patient Care	Goal Description	n (%)
Goal A	Treat for all reversible illness Limitations: Nil. For CPR and intubation For hospital transfer if required	5 (3)
Goal B	Treat for all reversible illness Limitations: Not for CPR or intubation For hospital transfer if required	7 (4)
Goal C1	Treat reversible illness with only simple nonburdensome treatments Limitations: Not for CPR or intubation Aim to treat at RACF but transfer to hospital if required	110 (60)
Goal C2	Treat reversible illness with only simple nonburdensome treatments. If not improving for symptom management at RACF Limitations: Not for CPR or intubation Not for hospital transfer unless unmanageable symptoms, eg, fracture	56 (31)
Goal C3	For symptom management only Limitations: Not for life-prolonging treatments Not for hospital transfer unless unmanageable symptoms, eg, fracture	3 (2)
Goal D	Treatment for terminal, end-of-life phase. All treatment aimed at symptom management Limitations: Not for life-prolonging treatments Not for hospital transfer unless unmanageable symptoms, eg, fracture	0 (0)

CPR, cardiopulmonary resuscitation.

Outcomes

Primary outcome

The IRR for ED visits and hospitalizations at 6 months was 0.74 [95% confidence interval (CI): 0.48-1.15, $P = .18$]. Thus, the primary outcome showed that although the study did result in a reduced rate of admissions in favor of the Intervention Group with IRR <1, it did not reach statistical significance at 6 months.

Secondary outcomes

ED visits and emergency hospitalizations. The secondary outcomes included the rates of ED visits and emergency hospitalizations at 3 and 12 months. At 3 months, the IRR was 0.76 (95% CI 0.41-1.39, $P = .37$). At 12 months, the IRR was 0.63 (95% CI 0.41-0.99, $P = .044$), indicating a 40% reduction in ED visits and hospitalizations at this time point, as seen in Table 3. At 12 months, the total number of ED visits and emergency hospitalizations in the Intervention Group was 88 (rate 0.77 per resident per time period) vs 118 (rate 1.14) in the Control Group. At both 6 and 12 months, there was a higher number of ED visits, with no hospitalization in the Control Group vs the Intervention Group, but this did not reach statistical significance (Table 3).

Table 3
Effects of GOPC Intervention vs Usual Care in RACF

Outcome Variable	Time Point	IRR, RRR, or OR	95% CI	*P* Value
ED visits and emergency hospitalizations, IRR (95% CI)	3 mo	0.76	0.41-1.39	.37
	6 mo	0.74	0.48-1.15	.18
	12 mo	**0.63**	**0.41-0.99**	**.044**
ED visits without hospitalization	6 mo	0.38	0.08-1.87	.23
	12 mo	0.52	0.16-1.68	.27
Total hospital bed-days	3 mo	0.53	0.09-3.11	.48
	6 mo	0.77	0.32-1.80	.54
	12 mo	0.82	0.43-1.57	.55
In-RACF Mortality, RRR (95% CI)	**6 mo**	**2.19**	**1.16-4.14**	**.016**
	12 mo	1.43	0.81-2.21	.25
In-hospital mortality	6 mo	0.28	0.06-3.97	.50
	12 mo	0.36	0.08-1.60	.18
Overall mortality, OR (95% CI)	6 mo	1.73	0.74-4.04	.21
	12 mo	1.14	0.77-1.67	.51

OR, odds ratio; RRR, relative risk ratio.
Boldface indicates statistical significance ($P < .05$).

Total hospital bed-days. The IRR for hospital bed-days was <1 for all time points, indicating that the intervention had reduced the rate when comparing Intervention to Control Group, but it did not reach statistical significance: 3 months: IRR 0.53, 95% CI 0.09-3.11, $P = .48$; 6 months: IRR 0.77, 95% CI 0.32-1.80, $P = .54$; and 12 months: IRR 0.82, 95% CI 0.43-1.57, $P = .55$ (Table 3).

In-RACF and in-hospital mortality. The hypothesis tested was that the Intervention Group would have a higher likelihood of in-RACF rather than in-hospital mortality, as was the preferred place of death for all residents. At 6 months, there was a greater likelihood of in-RACF mortality in the Intervention Group compared with Control (relative risk ratio, 2.19, 95% CI 1.16-4.14; $P = .02$). Similarly, there was a reduction in the likelihood of a resident death in hospital in the Intervention Group compared to the Control Group. Similar trends were seen at 12 months, although the differences did not hold statistical significance for either in-RACF or in-hospital mortality (Table 3).

Of note, there was no statistical difference in overall mortality between the Intervention and Control groups despite the changes seen in ED visits and hospitalizations. The odds ratio of death in the Intervention vs the Control Group was 1.73 (95% CI 0.74-4.04, $P = .21$) at 6 months and 1.14 (95% CI 0.77-1.67, $P = .51$) at 12 months.

Discussion

The GOPC intervention was found to be superior to advance care planning documents alone in the RACF population with regard to preventing ED visits and emergency admissions 12 months post implementation, aligning with previous studies examining medical treatment orders.[29,30] High hospitalization rates of RACF residents have detrimental effects on residents' quality of life as well as economic consequences for health services, and so interventions to decrease these rates are important for all stakeholders. This 40% decrease in ED visits and emergency hospitalizations between the Intervention and Control Groups was felt to be achieved through clearer documentation of medical treatment goals, with specific discussion and documentation surrounding the issue of hospitalization.

The primary endpoint at 6 months was felt to be too short a time frame to show a statistically significant change. Comparison with a randomized controlled trial evaluating an in-depth advance care planning intervention with education of both hospital and RACF staff and families prior to advance care planning completion showed a similar 40% reduction but at 18 months postintervention.[6] A more recent study involving a Goals of Care video decision-assist tool for residents with dementia and their decision makers included a medical treatment order completion, Medical Orders for Scope of Treatment, as part of their intervention and again found a 50% decrease in hospital transfers over 9 months.[31]

The intervention was performed by the principal investigator—a geriatrician with a specialist interest in future planning—and not the resident's visiting medical physician. At present, this process is not a billable item for visiting medical physicians, and it may affect the time put into the discussion and form completion. However, a recent Goals of Care study used existing RACF strategies, with extra training provided to nursing staff, and found similarly effective outcomes in what is a more sustainable process.[31]

Overall mortality was not significantly affected despite the intervention decreasing hospitalization, as has been seen in prior Goals of

Care and advance care planning studies.[6,31] This study found that following the GOPC process, residents had a higher likelihood of dying in the RACF, which was their preferred place of death, again aligning with prior studies.[7,32–34] It is felt that these outcomes were achieved by discussion of residents' current health status and illness trajectory, which identified 30% of residents who no longer wanted hospital transfers.

In the analysis, there was a decrease in total bed-days in the Intervention vs Control Groups at each time point, but it did not reach statistical significance contrasting prior studies.[6,7,29] The GOPC intervention was targeting hospital transfers rather than length of hospital stay, and it was felt that a more multifaceted approach, as seen in these studies, would be necessary to impact on bed-days.

Strengths and Limitations

Strengths

The study examined the effects of a new medical treatment order form, GOPC, specifically designed for RACF residents.

The study design was a major strength of this study, with the cluster randomized controlled trial giving the best evidence of the impact of the intervention.

This study demonstrated that medical treatment orders can have a significant effect in reducing ED visits and hospitalizations.

Limitations

The sample size was small, including only 6 RACFs. RACF participation rates were low at just 13%. This may have introduced bias in the analysis, with only those with a vested interest in improving their future planning documentation agreeing to participate. A major issue encountered in terms of participation was that decisions about documentation changes were not made at an RACF level but rather at an organizational level in many RACFs. To improve recruitment of RACFs in the future, it would be important to contact an organization rather than the actual RACFs within it.

Within each RACF, there was a high participation rate as the GOPC document was supported by the RACF staff to be completed for every resident, so most were agreeable to its completion and thus to taking part in the study. If the GOPC document is taken up by the RACF as its treatment escalation plan, then participation rates can be expected to be high, but support of the RACF staff is crucial. Participation rates may not be reflected in subsequent studies if RACF staff do not fully support the GOPC implementation.

There was a higher number of named MEPOAs in the Intervention Group, which could reflect a greater involvement in the future planning process for these residents. However, the proportion of residents with the supporting legal documentation in their RACF notes was not statistically different, which could indicate people naming themselves as a MEPOA without ever completing the legal process or supplying supporting legal documents, thus negating this difference.

The study was unblinded and may have led to introduction of bias in outcome measurement and clinician behaviors when engaged in the GOPC discussions.

Conclusions and Implications

In RACFs in Australia, GOPC medical treatment orders had a positive effect on the hospitalization rates and preferred place of death of RACF residents without increasing mortality. The implications of this are that RACF and health services would benefit from GOPC being introduced to improve resident outcomes. In Victoria, new legislation allows only those with decision-making capacity to complete advance care plans, no longer allowing substitute medical decision makers to complete them on their behalf. Given the large percentage of residents with dementia and reduced capacity in RACFs, it will be vital that a provision be made for a form of future planning. The GOPC is a suitable future planning process for these residents and others.

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Residential Aged Care document

GOALS OF PATIENT CARE (MEDICAL)

For completion by Resident's doctor

Facility……..

Address……..……..……..

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____ SEX: _____

Main health problems: _____

Advance Care Directive/Plan available for this resident / patient → ❑ Yes ❑ No ❑ ACP information provided

Name of Medical Enduring Power of Attorney (if appointed) _____

OR

Name of 'Person Responsible' (Legal Substitute decision-maker) _____

♦ Personal & Legal relationship to resident / patient _____

Contact phone numbers Home _____ Mobile _____

Choose ONE option from A, B, C or D --- Add further comments where required

GOAL A: FOR TREATMENT OF ALL REVERSIBLE ILLNESSES

❑ **FOR CPR and appropriate life-sustaining treatments**

➔ **FOR TRANSFER TO HOSPITAL (if required treatment cannot be provided in the facility)**

GOAL B: FOR TREATMENT OF REVERSIBLE ILLNESS WITH FOLLOWING LIMITATIONS

❑ **NOT FOR CPR or INTUBATION**
- but is for other appropriate life-sustaining treatments

➔ **FOR TRANSFER TO HOSPITAL (if required treatment cannot be provided in the facility)**

GOAL C: FOR TREATMENT OF REVERSIBLE ILLNESS ABLE TO BE MANAGED WITH SIMPLE, NON-BURDENSOME TREATMENT. GOOD SYMPTOM MANAGEMENT NOT FOR CPR or INTUBATION

❑ **- is for treatment of illness if this can be done without causing excessive distress. For hospital treatment if required.**

➔ **Aim to provide care in the facility but TRANSFER TO HOSPITAL if necessary**

OR

❑ **- is for trial of treatment at the facility, if this can be done without causing excessive distress. If deteriorates, is for comfort measures only.**

➔ **NOT FOR TRANSFER TO HOSPITAL if condition deteriorates - unless symptoms cannot be managed in facility eg fracture**

OR

❑ **- NOT for life-prolonging treatment of new illness / deterioration. All treatment is aimed at comfort and relieving symptoms.**

➔ **NOT FOR TRANSFER TO HOSPITAL unless symptoms cannot be managed in the facility eg fracture**

GOAL D: COMFORT DURING DYING – TERMINAL CARE (prognosis is assessed to be hours or days)

❑ **All treatment is aimed at relieving symptoms and supporting the resident / patient and their family / important others**

➔ **Commence End-of-life Plan**

➔ **NOT FOR TRANSFER TO HOSPITAL unless symptoms cannot be managed in the facility eg fracture pain**

Northern Health

Last updated Dec 2014

I have discussed above Goals of Care with → ❑ Resident / Patient ❑ Medical EPOA or 'Person Responsible' (named above)

Others involved in discussion _____

Doctor's name (print): _____ Doctor's Designation: _____

Date: _____ Doctor's Signature: _____

CPR = Cardiopulmonary Resuscitation ACP = Advance Care Plan / Directive

RESIDENTIAL AGED CARE --- GOALS OF PATIENT CARE (MEDICAL) - *TRIAL FORM*

Adapted from the Southern Tasmania Goals of Care Plan and Northern Health Goals of Patient Care Summary
Used with permission of Northern Health – not to be modified

SURNAME: _____ GIVEN NAME: _____ D.O.B. _____

COMPLETING AND IMPLEMENTING THE GOALS OF PATIENT CARE SUMMARY

The Goals of Patient Care Summary should be completed by the General Practitioner.

It is important that any Advance Care Planning is translated into Medical Orders using this Goals of Patient Care form, so they can be followed by other clinical staff.

PHYSICIANS TO UPDATE FORM WHEN REVIEWING RESIDENT AT TIMES OF CLINICAL CHANGE

FOR ALL RESIDENTS / PATIENTS: identify and document:

- Appointment of a **Medical Enduring Power of Attorney** and/or other **Advance Care Planning** documents or requests.
- If no **Medical Enduring Power of Attorney** appointed, and the resident / patient has capacity, identify who they would wish to speak on their behalf if they became incapable of participating in medical decisions. The Resident needs to complete a **Medical Enduring Power of Attorney** if that person is not their **'Person Responsible'**.
- If the Resident is unable to nominate a substitute decision-maker, then identify the **'Person Responsible'** (see list below).

GOALS OF CARE ASSESSMENT: Clinical evaluation to determine 'Goals of Care' for this resident / patient:

- **Management of potentially reversible illness (Goal A, B or C)**

  A Treat with no treatment limitation

  B Treat with some treatment limitation including not for CPR and not for intubation and ventilation

  - Limitations of medical treatment should be considered:
    - if the treatment provides no potential benefit to resident / patient
    - if treatment burdens far outweigh potential benefits
    - if resident / patient has refused the treatment; their Medical EPOA has refused the treatment on their behalf; or if their Person Responsible states that the resident / patient would not have wanted that treatment.

  C Treat with simple, non-burdensome treatment. Remember, that what is burdensome for one person may not be burdensome for another person.

  - Some residents and their families will accept / request transfer to hospital if necessary for treatment
  - Some residents and their families will accept treatment at the facility but decline transfer to hospital if the resident is not responding to this.
  - Some residents and their families will choose comfort measures only.
  - Consider if medications need to be prescribed and made available in case of potential symptoms

- **Goal D requires diagnosis and management of dying. All treatment should be aimed at comfort and supportive measures only.** When the resident / patient is clearly dying it is important that the substitute decision-maker / family are aware of this.
  - Prescribe medications that may be needed for symptoms – subcutaneous analgesic, anti-emetic, sedative and others as indicated clinically. Are regular medications required as well as PRN?

ENSURE COPIES OF THE GOALS OF PATIENT CARE SUMMARY AND THE ADVANCE CARE PLAN ACCOMPANY THE RESIDENT IF THEY ARE TRANSFERRED TO HOSPITAL OR ARE ATTENDING A DOCTOR'S APPOINTMENT

PERSON RESPONSIBLE

Reference: http://www.publicadvocate.vic.gov.au/file/Consent_flowchart2011[1].pdf

When a patient is unable to consent to treatment, the practitioner can obtain consent from the Person Responsible in following order:

1. An agent - appointed with enduring power of attorney (medical treatment)
2. A person appointed by VCAT to make decisions about proposed treatment
3. A guardian - appointed by VCAT with health care powers
4. An enduring guardian - appointed with health care powers
5. A person appointed by the patient in writing to make medical & dental treatment decisions including proposed treatment
6. The spouse or domestic partner
7. The primary carer, including Centrelink paid carers but excluding all other paid carers
8. The patient's nearest relative over the age of 18: a. son or daughter, b. father or mother, c. brother or sister, d. grandfather or grandmother, e. grandson or granddaughter, f. uncle or aunt, g. nephew or niece.

(Where two relatives are in the same position, the elder will be the Person Responsible.)