What are “Goals of Patient Care”?

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Goals of Patient Care (GOPC) 2014-2019 RPH

- Pre-emptive Clinical care pathway
- Life limiting co-morbidities
- Hospital based
- State-wide
- GOPC: now part of every day language at RPH
- Areas for improvement: Many!
  - Communication with primary care
Key facts

Around half of Australians will not be able to make their own end-of-life medical decisions.

85% of people die after a chronic illness, not a sudden event.

Typically Australians think about life and death as black and white, yet in reality there’s an extended ‘grey’ period, with more of us living with ongoing health issues.

In fact 85% of people die after a chronic illness, not a sudden event. We want to empower people to understand that they have a choice about their end-of-life care and the steps they can take today to ensure their preferences are known and respected.”
60-70% of Australians want to die at home

Figure 1: Few Australians aged over 65 die at home
Location of deaths in selected OECD countries; per cent of deaths

Source: (Broad et al., 2013 (2013))
Spending one’s final days in an ICU because of terminal illness is for most people a kind of failure. You lie attached to a ventilator, your every organ shutting down, your mind teetering on delirium and permanently beyond realising that you will never leave this borrowed, fluorescent place.
Treated cardiac arrest survival

~100% with coronary angiography (elective)
~60% for VF in CCU after myocardial infarct

~18% for general hospital patients*
< 5% for advanced illness - cancer, dementia etc*

*~30-50% of these survivors will have further impairment
ROYAL PERTH HOSPITAL

Ward/CLINIC

CONSULTANT R.M.O./REG.

RATIONALE FOR NOT ATTEMPTING CPR

FOR CPR

IS PATIENT FOR MEDICAL EMERGENCY TEAM CALLS? NO

YES

PATIENT FOR MET CALLS – PLEASE DOCUMENT LIMITS OF THERAPY

<table>
<thead>
<tr>
<th>Therapy</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>For non-invasive ventilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For endotracheal intubation</td>
<td></td>
<td></td>
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<tr>
<td>For inotropes</td>
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<td></td>
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<tr>
<td>For HDA/ICU/CCU</td>
<td></td>
<td></td>
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<tr>
<td>Other (please specify)</td>
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GOALS OF PATIENT CARE

SECTION 1 BASELINE INFORMATION
Primary illness:
Significant co-morbidities:
In the event that the patient is unable to speak for themselves, who would they wish to speak for them? This is known as the 'Person responsible'
Name: ___________________________ Relationship: ___________________________
Does the patient have?
- Advance Health Directive (AHD) □ Yes □ No
- Advance Care Plan (ACP) □ Yes □ No
- Enduring Power of Guardianship (EPG) □ Yes □ No

EPG contact name: ___________________________ Phone: ___________________________
Does the patient have a registered organ donation decision? □ Yes □ No
Are the family aware of the patient’s donation decision? □ Yes □ No
Clinician’s Name (please print): ___________________________ Designation: ___________________________
Date: ___________________________ Time: ___________________________ Signature: ___________________________

SECTION 2 GOAL OF CARE

Please tick one only and complete section 3 over the page to be valid. In discussion with the clinician, patient, person responsible and/or family/carer(s), please select the most medically appropriate agreed goal of patient care that will apply in the event of clinical deterioration.

☐ All life sustaining treatment
  * For Rapid Response (MER/MET Calls)
  * For CPR
  * For ICU

☐ Life extending intensive treatment – with treatment ceiling
  * For Rapid Response
  * For ventilatory support, including intubation
  * Specify maximum level of support
  * For ICU/HDU admission
  * Additional comments (e.g. use of inotropes, NIV, dialysis)

☐ Active ward based treatment – with symptom and comfort care
  * Not for CPR
  * Not for ICU
  * Not for intubation
  * For Rapid Response
  * For ventilatory support (intent is symptom control)
  * Specify maximum level of support
  * Additional comments (e.g. use of antibiotics, IV fluids)

☐ Optimal comfort treatment – including care of the dying person
  * Not for Rapid Response
  * Not for CPR
  * Not for intubation
  * Not for ICU
  * For ongoing review to identify transition to the terminal phase
  * Ensure timely commencement of the Care Plan for the Dying Person

All patients can have Rapid Response based on ‘Worried Criteria’ or to ‘Summon Clinical Review’.
SECTION 3 SUMMARY OF DISCUSSION(S)

Goals of Patient Care have been discussed with:

Date: / / Time:

Patient: ☐ Yes ☐ No  Person Responsible: ☐ Yes ☐ No  Family/carer(s): ☐ Yes ☐ No

Name(s) of those present at this discussion: ____________________________

Is the patient able to fully participate in this discussion?  ☐ Yes ☐ No

Comments: ____________________________

What is the patient’s likely response to CPR and critical intervention? ____________________________

Patient preferences (needs, values and wishes):

________________________________________________________

________________________________________________________

________________________________________________________

Decision rationale for agreed Goals of Patient Care (please tick one only):

☐ Medically-driven decision  ☐ Patient wishes  ☐ Shared decision-making

Other information: ____________________________

Doctor’s name (please print): ____________________________  Designation: ____________________________

Signature: ____________________________  Date: / / Time: ____________________________

Consultant review completed: Name (please print): ____________________________

Signature: ____________________________  Date: / / Time: ____________________________

SECTION 4 EXTENDED USE

Consultant endorsement for extended use beyond this admission for 12 months or until / / This includes patient transportation to another facility or home following the current admission.

Consultant’s comments: ____________________________

________________________________________________________

________________________________________________________

Consultant’s name (please print): ____________________________  Signature: ____________________________

S描: ____________________________  Date: / / Time: ____________________________
### Look for clinical indicators of one or multiple life-limiting conditions.

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Heart/ Vascular Disease</th>
<th>Kidney Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional ability deteriorating due to progressive cancer.</td>
<td>Heart failure or extensive, untreated coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.</td>
<td>Stage 4 or 5 chronic kidney disease (eGFR &lt; 30ml/min) with deteriorating health.</td>
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<tr>
<td>Too frail for cancer treatment or treatment is for symptom control.</td>
<td>Severe, inoperable peripheral vascular disease.</td>
<td>Kidney failure complicating other life limiting conditions or treatments.</td>
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<tr>
<td>Dementia/ Frailty</td>
<td>Respiratory Disease</td>
<td>Stopping or not starting dialysis.</td>
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<tr>
<td>Unable to dress, walk or eat without help.</td>
<td>Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.</td>
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<tr>
<td>Eating and drinking less; difficulty with swallowing.</td>
<td>Persistent hypoxia needing long term oxygen therapy.</td>
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<tr>
<td>Urinary and faecal incontinence.</td>
<td>Has needed ventilation for respiratory failure or ventilation is contraindicated.</td>
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</tr>
<tr>
<td>Not able to communicate by speaking; little social interaction.</td>
<td>Liver Disease</td>
<td>Liver transplant is not possible.</td>
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<tr>
<td>Frequent falls; fractured femur.</td>
<td>Cirrhosis with one or more complications in the past year:</td>
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<tr>
<td>Recurrent febrile episodes or infections; aspiration pneumonia.</td>
<td>• diuretic resistant ascites</td>
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<tr>
<td></td>
<td>• hepatic encephalopathy</td>
<td></td>
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<tr>
<td></td>
<td>• hepatorenal syndrome</td>
<td></td>
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<tr>
<td></td>
<td>• bacterial peritonitis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• recurrent variceal bleeds</td>
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</tbody>
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Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (e.g. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person’s carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.
Work in progress

- Join the dots!
  - My Health Record
  - National/state wide databases
  - GP Liaison