Government of **Western Australia**
Department of **Health**

Residential Goals of Care

Implementation guide for Residential aged care facilities

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Contents

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Version control

Version Number	Reviewers	Date
1.0	WACHS Residential Goals of Care Working Group (WACHS version)	22 November 2022
2.0	WACHS Residential Goals of Care Working Group, Department of Health End of Life Program (current version)	30 November 2023

1. Introduction

This guide aims to support Residential Aged Care Facility (RACF) managers to implement the Residential Goals of Care (RGoC) form at their facility.

In 2022, WA Country Health Service (WACHS) developed a goals of care form for use with older persons living in RACFs in Western Australia (WA). The project was funded by the Department of Health WA End of Life Care Program. The RGoC form was initially rolled out at WACHS aged care facilities from March 2022 to December 2023. In 2023, WACHS and the Department of Health WA End of Life Care Program expanded the use of the form into private regional and metropolitan aged care facilities. This guide encompasses the learnings from the WACHS project and evaluation.

1.1 Goals of care

> Goals of care: clinical and other goals for a person's care that are determined in the context of a shared decision-making process. Goals of care are documented by health care staff.[1]

In WA, most public hospitals have adopted the statewide Goals of Patient Care (GoPC) (MR00H.1) form. The form was designed to document the most medically appropriate, realistic and agreed goal of care that will apply in the event a patient's clinical deterioration while in hospital. The form focusses on acute care episodes and treatments available in hospital settings in the context of end of life.

The Residential Goals of Care (RGoC) form (RC 00H.1) is based on the GoPC but was developed to address the needs of residents of aged care facilities and outline treatment considerations relevant to the setting. WACHS developed supporting guidelines to implement the RGoC form that reflect the following principles:

- Goals of care discussions support shared decision-making between the aged care team, residents and their recognised decision-maker(s) in the context of clinical deterioration and end-of-life care.
- Goals of care discussions are always voluntary.
- Goals of care discussions and documentation are complementary to advance care planning (ACP), and do not replace residents' existing ACP documents.
- Goals of care forms must be reviewed regularly to ensure they reflect the residents' current preferences and priorities for care.
- The residents GP, medical practitioner and / or Nurse Practitioner should be involved in or aware of discussions about goals of care and validate (sign) the form.

1.1.1 Identifying decision-makers

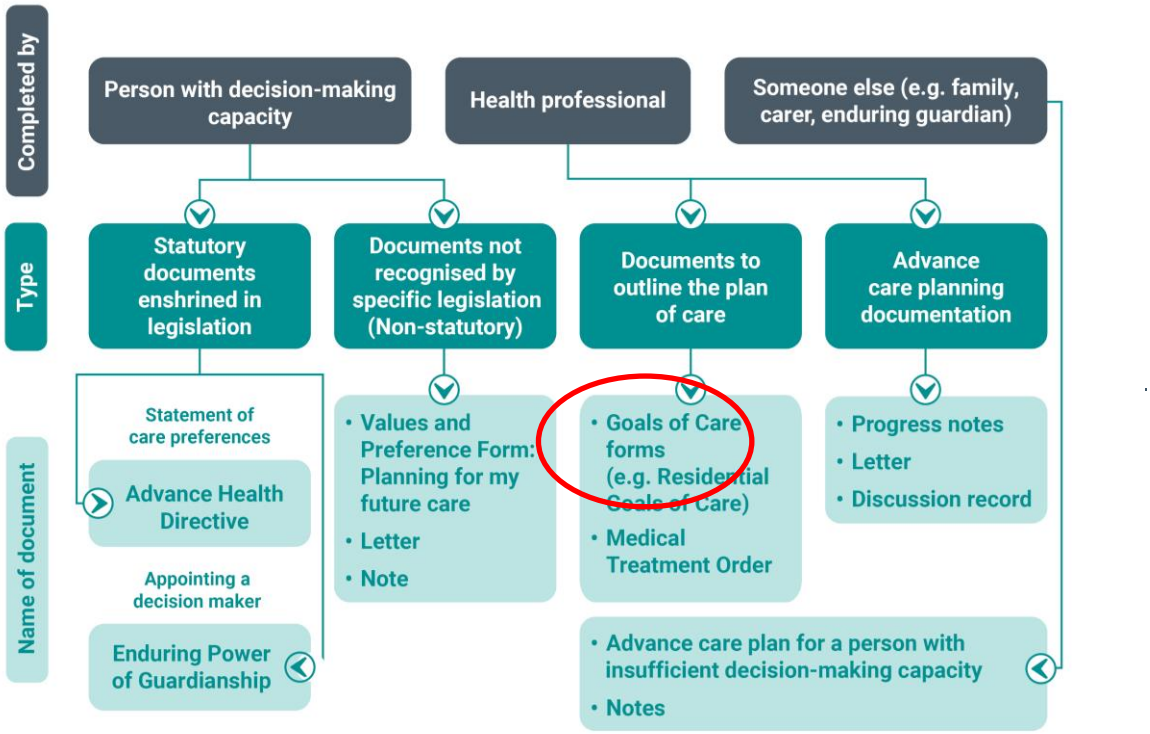
If a resident no longer has capacity to make decisions in relation to goals of care, all discussions regarding their care should involve the appropriate person as per the Hierarchy of treatment decision-makers. For the purpose of this guide, we use the term 'recognised decision-maker(s)' to refer the appropriate person who should be involved in the resident's decision-making. It should be noted that residents without decision-making capacity can participate in the discussions as appropriate. Refer to information about supported decision-making in aged care.

1.2 Advance care planning and goals of care

In Australia, RACFs are encouraged to promote and adopt ACP processes and documentation to support person-centred care. Goals of care are separate but complementary to ACP processes and documents, therefore the RGoC form is not intended to replace ACP in aged care facilities. Refer Figure 1.

It is recommended that RACFs continue to promote the creation and regular review of ACP documents for any residents with decision-making capacity, particularly the statutory documents: Advance Health Directive, Enduring Power of Guardianship. Aged care facilities should document, review, store and access ACP documents for residents in line with their organisation's policies, procedures and guidelines and to support the Aged Care Quality and Safety Commission's Aged Care Quality Standards. Advance Care Planning Australia have specific information and resources for aged care services.

Figure 1. Advance care planning documentation flowchart for WA



Source: Department of Health, WA. Health Professional Guide to Advance Care Planning in WA. Perth: End-of-Life Care Program, Department of Health, WA; 2022.

Advance care planning documents and RGoC forms can complement each other in the following circumstances:

- If a resident has an ACP document(s), the RGoC form is written to align with what is in the ACP document, providing additional or supplementary information relevant to the person's current circumstances in the aged care facility.
    - For example, where the resident would like to be treated if they deteriorate – in the RACF or transferred to a specific hospital, what treatment and care can be provided in the RACF versus what will require transfer to a hospital setting.
- Residents that have an RGoC discussion and form completed can be encouraged to complete an advance care planning document such as an Advance Health Directive

(AHD) and / or Enduring Power of Guardianship (EPG) if they have capacity to make one.

    - For example, a resident has had an RGoC documented and would now like to formally appoint a family member as their Enduring Guardian. A resident may wish to indicate their preferences for participating in medical research through an AHD.

- When a person is admitted to an RACF and no longer has capacity to write an ACP document, an RGoC form can be documented. It does not require the resident to have decision-making capacity, however, they can still participate in the discussions with their recognised decision-maker.
    - For example, a resident with dementia states: "I don't want to go to hospital, I like where I am and I like the staff. Please don't take me to hospital if I am dying". This can be documented on the RGoC form, however, the goal of care selected will depend on clinical judgement of health professionals and agreement with the resident's representative (e.g. guardian or the next person on the Hierarchy of treatment decision-makers).

1.3 Potential benefits of ACP and goals of care in aged care settings

There are multiple benefits to ACP and goals of care processes in aged care settings. Some of the documented benefits are outlined below[1,2,3,4].

- Increased quality of life, quality of care and person and family satisfaction with end-of-life care
- Increase likelihood of death in preferred place
- Can reduce burden of decision-making on family, primary carers and recognised decision-makers at times of crisis, strengthening relationships between the person, their family and health professionals through the process.
- Reduces unnecessary transfers from aged care facilities to acute care, overtreatment and unwanted life-sustaining treatments.
- Respects individual autonomy, residents' values and preferences and sense of control.
- Supports the principles of person-centred care.
- Supports the Aged Care Quality and Safety Commission's Aged Care Quality Standards and the Australian Commission on Safety and Quality in Health Care's National Consensus Statement: Essential elements for safe and high-quality end-of-life care (2023). Refer Table 1.

[1] Scott IA et al. (2022), A whole-of-community program of advance care planning for end-of-life care. Aust Health Review. 46(4), 442–449

[2] Sinclair C et al. (2020). Advance care planning in Australia during the COVID-19outbreak: now more important than ever. Internal Medicine Journal (50) 918-923.

[3] Fleuren, N et al (2020). Underlying goals of advance care planning (ACP): a qualitative analysis of the literature. BMC Palliative Care. 19:27

[4] Sokol-Hessner L et al (2019). White paper: "Conversation Ready": A framework for improving end of life care (Second edition). IHI White Paper.

Table 1. Aged Care Quality Standards and National Consensus Statement elements relevant to ACP and goals of care

Standard and element		Requirements and actions
Aged Care Quality Standards	**1 Consumer dignity and choice**	Requirement (3) (c) Each consumer is supported to exercise choice and independence
	2 Ongoing assessment and planning with consumers	Requirement (3) (b) Assessment and planning identifies and addresses the consumer's current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes
		Requirement (3) (c) Assessment and planning
		Requirement (3) (d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided
		Requirement (3) (e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the need, goals or preferences of the consumer
	3 Personal care and clinical care	Requirement (3) (a) Each consumer gets safe and effective personal care, clinical care, or both personal and clinical care
		Requirement (3) (c) The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved
National Consensus Statement	**2 Person-centred communication and shared decision making**	2.1 Identify opportunities for proactive and pre-emptive advance care planning and end-of-life care discussions with a person, to align care with their values and wishes, and reduce the need for urgent, after-hours discussions in emergency situations.
		2.4 Be respectful, sensitive and responsive to the preferences and needs of the person at the end of their life, including with regard to their identity, culture, religious beliefs, gender, orientation and loved ones (including family of choice).

Standard and element		Requirements and actions
		2.7 Ensure end-of-life conversations are person-centred and tailored to meet the health literacy needs of the person and any other participants – and that they occur regularly.
		2.12 Clearly document the content of discussions and any agreed plan of care in the person's healthcare record and My Health Record if available. Document any unresolved issues along with a plan for follow-up.
		2.13 Communicate the content of the discussion and plan of care, including any limitations of medical treatment and resuscitation plans, to all healthcare workers involved in the person's care and ensure to prioritise the person's wishes.
	4 Comprehensive care	4.1 Discuss goals of care, the comprehensive care plan and any limitations of medical treatment early. Ensure these things are clearly documented in a person's healthcare record by healthcare workers. Ensure documentation is routinely reviewed and updated

2. Implementing RGoC in aged care

This section of the document is designed to guide RACF managers to implement the RGoC form, taking into consideration the holistic needs of the residents, the availability of and access to GPs and specialist palliative care and the skills, existing ACP processes and documentation and confidence of the local aged care staff.

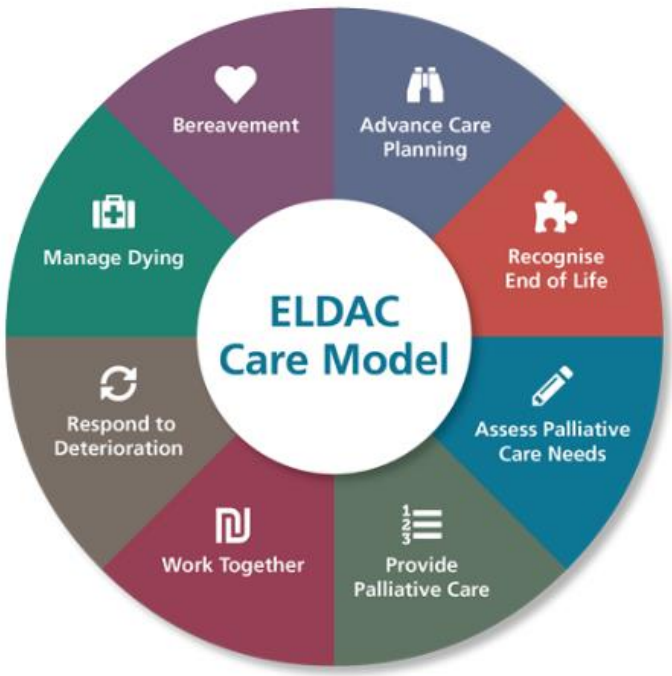
Implementing RGoC at RACFs requires more than just 'completing a document'. It requires agreement about an appropriate model for goals of care discussions that will support shared decision-making and ongoing discussions with all parties involved in care.

2.1 Providing quality palliative and end of life care

Residential aged care facilities should have a suitable framework in place for providing quality palliative and end of life care for residents, for example:

- Identifying and responding to the needs of residents who are deteriorating or approaching end of life.
- Providing palliative and end of life care to residents and ensuring access to GPs who are confident to prescribe appropriate palliative and end of life medications.
- Supporting families, primary carers and recognised decision-makers.
- Upskilling aged care staff in goals of care, palliative care and end of life care (refer to the End-of-Life and Palliative Care Education and Training Framework and the WACHS *RGoC Education and Training Framework* as an example).

Figure 2. End of Life Directions for Aged Care (ELDAC) Care Model



The End of Life Directions for Aged Care (ELDAC) Care Model below, Residential Aged Care: Excellence in Palliative Care Communicate (RACEPC) Communicate and Palliative Care Outcomes Collaboration (PCOC) Aged Care Outcomes program may be suitable and have synergies with RGoC implementation.

Aged care sites can also create a supportive environment for ACP and goals of care discussions by making relevant information accessible to residents, their families, primary carers and recognised decision-makers. Consumer-facing information should be available on site (e.g. pamphlets, posters, admission booklets) and aged care sites can use opportunities such as National Advance Care Planning week and Palliative Care Week to increase awareness of anticipatory care planning and palliative and end of life care.

2.2 Selecting a model for integrating Residential Goals of Care

The following aspects of goals of care processes and documentation should be considered when selecting an appropriate model for implementing RGoC:

- When is the appropriate time and stage to initiate and complete RGoC forms with residents, families, carers and recognised decision-makers?
- Which residents will likely benefit from RGoC discussions and form completion?
- What are the suitable **model(s)** for facilitating RGoC conversations and completing the form?
- How will reviews be completed to ensure ongoing conversations and opportunities to update forms as needed?
- How will you review the quality of goals of care conversations and form completion at your facility and identifying opportunities for improvement?

2.2.1 When to initiate and complete Residential Goals of Care forms

Table 2. Most appropriate time to initiate goals of care discussions with residents, families and recognised decision-makers

During resident admission processes	When staff are completing, reviewing or storing residents' advance care planning documents	During key periods in the resident's life
If the site will initiate RGoC discussions with ALL residents, consider starting this in the admission period: • Ask about and record presence of ACP documents in admission documents. • If the resident has an ACP document, discuss how RGoC may assist in documenting preferences specific to aged care. • If the resident has been admitted from an acute care hospital – is there a GoPC already? Check notes, transfer or discharge checklists. Review the GoPC with the resident, family, carer and recognised decision-maker and update to an RGoC.	Residents may have ACP documents that they bring with them to the aged care site or complete after they are admitted: • Check these are still current and relevant and introduce RGoC as an additional option for recording preference for care in line with these documents. • If a resident is updating or reviewing their ACP documents, use this as an opportunity to discuss or review RGoC. If a resident has capacity and would like to write an AHD and / or EPG provide hard copies and additional information and resources	If there is not an opportunity to introduce RGoC on admission, consider these times to initiate goals of care conversations with residents: • when a resident returns from an acute care admission • if a resident has a new diagnosis, or new illness that may impact their care • if their recognised decision-maker changes • if the resident's care or treatment options change • If the resident or recognised decision-maker asks for palliative care or chooses to

• At the first resident meetings or case conferences, discuss RGoC document and how it may benefit the resident, family. • If a resident, family and recognised decision-maker is not yet willing to discuss goals of care, ensure to identify a time to reintroduce the discussion later (e.g. 6 months review). • Remember - participation is voluntary and unlikely to ever include all residents.	while also introducing RGoC documents. Introduce RGoC for residents that no longer have capacity to complete AHDs, EPGs but would like to have their preferences and wishes documented.	reduce treatments or focus on quality of life. Use family meetings and case conferences as an opportunity to discuss RGoC for current residents.

Goals of care and advance care planning discussions are always **voluntary**. Some residents, families, primary carers and recognised decision-makers will not want to participate, and this must be respected. This can also be documented in the resident's notes for future reference.

If your site is not initiating goals of care discussions for every resident, consider using a prioritisation methodology, similar to below that is based on resident needs:

1. Residents in terminal phase. This is strongly recommended where no other ACP documents exist. Note that the Palliative Aged Care Outcomes Program (PACOP) defines terminal phase as "Death is likely within days - terminal care plan required".
2. Residents that have general indicators of poor or deteriorating health as per the SPICT tool or similar, for example, entering the RACF under the Australian National Aged Care Classification (AN-ACC) funding class 1 (entering the service for the purpose of receiving planned palliative care).
3. Other residents with one or more life-limiting conditions as per the SPICT tool or similar.
4. Residents that you would not be surprised if they died in the next 12 months (unstable).
5. Residents that have had recent hospital admissions (planned or unplanned) or treatments (unstable phase).
6. Any resident where loss of decision-making capacity is likely (unstable) or Guardianship is in place.
7. Any resident or their recognised decision-maker that has requested a discussion or update of ACP or goals of care documents (Stable).
8. Residents that have ACP documents on record that may need review.

It is also worth considering if your facility will complete RGoC forms for respite clients in the RACF, particularly those that are likely to return for multiple respite visits in the future.

Where the Public Advocate is appointed the resident's guardian, contact the Office of the Public Advocate (OPA) for direction in relation to goals of care or end-of-life discussions as the OPA have different processes and forms.

2.2.2 Examples of models for facilitating goals of care conversations and documents

Partnering with palliative care teams or specialist palliative care services

The following model is an example provided from the WACHS Great Southern region. It was implemented by the regional palliative care team in response to delayed referrals to palliative care nurses for residents of local aged care facilities (public and private) and to improve ACP and goals of care documentation for residents of RACFs.

The local palliative care team contacted private RACFs in the region and offered to conduct palliative care reviews of residents, with the support of the local GPs. If accepted, senior aged care staff (nurse and / or allied health) were asked to prioritise residents for review based on a flow chart that included the Surprise Question: *Would you be surprised if the resident died in the next 3-6 months* / *next days or weeks*? If the response was 'no', the team then recommended completion (or review) of ACP documents, RGoC form and a general palliative care review.

- Initial review conducted by the Palliative Care Clinical Nurse, and either an Enrolled Nurse, Registered Nurse or Clinical Nurse at each facility (a staff member who was very familiar with the resident).
- A Palliative Care Consultant participated in reviews and consultations as required (45-60 minutes per resident).
- GPs were contacted to participate in teleconference for case conference or family meeting if required or requested for residents (MBS item applies).
- The team provided a written summary to the aged care team and GP for each resident reviewed.
- A consumer and family leaflet was provided to outline benefits of anticipatory care planning.
- This model was provided within the scope of the WACHS Regional Palliative Care team services.

Although this model was initiated and supported by the local WACHS Regional Palliative Care team, this model could be implemented by RACF staff in partnership with their own Palliative Care link team or specialist palliative care service and / or by implementing Palliative Care Needs Rounds.

Benefits	Challenges
Useful for sites with limited GPs or local medical practitioners to initiate and facilitate discussions	If limited to palliative care team initiation and coordination, RGoC reviews may only occur during scheduled visits.

Benefits	Challenges
Conversations by skilled, confident team or professionals, may also provide opportunity for mentoring	Reliant on workload of regional palliative care team and the ability to replicate model in future for goals of care reviews
Can help identify residents that need further palliative care support (e.g. referrals) and establishes plans for care	Goals of care may appear a palliative care-only initiative (need to include upskilling of aged care staff as part of model)
Build capacity of aged care staff by sharing specialist knowledge and skills about palliative and end of life care	May not suit all GPs who wish to retain goals of care processes and palliative care assessments and plans for care
Provides a model that prioritises residents by need, to assist with staff and workforce limitations	Reliant on aged care staff availability at facility to participate in the reviews
WACHS project team can provide templates, resources to assist with implementation of this model.	

Local resident General Practitioner-led model

This model is based on a current model used in WACHS Great Southern region, where there are several GPs providing services to residents locally. RGoC is generally completed as part of a resident's admission process by the local GP providing care to residents of the aged care facility. It requires GPs to be aware and supportive of goals of care processes, and skilled and confident to hold discussions.

- New residents (and their families, decision-makers) discuss goals of care with GP during the admission process or at a family meeting, when the GP is visiting the facility (face to face).
- Nurse Unit Managers or Clinical Nurse Managers coordinate family meeting or case conferences where appropriate with GP attendance in person or via telephone.
- RGoC form is generally completed by the GP and stored in the aged care record.
- Aged care staff and GP and responsible for initiating reviews as required (although recommended every 6-12 months if stable).
- GP attendance fees as per Medicare Benefits Schedule (MBS)
- Provides an opportunity to expand skills of senior aged care staff in initiating discussions and completing parts of document prior to GP conversation.

Benefits	Challenges
Completion of document by local GP who is familiar with resident, and also responsible for ongoing care of resident	Reviews may only occur every year or less, depending on GP availability and workload
Attendance by GP at case conference or family meeting can attract MBS item payment if all eligibility requirements met	Reliant on GPs workload – noting this increased during COVID-19, and may reduce the number of GPs available to complete the documents
Opportunity to expand the role of senior nursing and allied health staff in goals of care conversations where GP is supportive	Case conferences or family meetings can take time to coordinate (often seek Practice Nurse support to coordinate)

Senior health professional-led model

This model was relatively new to WACHS and supported senior aged care health professionals (for example, Nurse Practitioner, Social Worker, Clinical Nurse Manager) initiating and holding goals of care conversations. The senior health professionals possess or are supported to develop the relevant skills and abilities to initiate and facilitate a goals of care discussion with residents and their recognised decision-makers and complete the RGoC form.

- This can be introduced during the resident's admission period – during an initial family meeting or case conference. Ideally when the primary GP and key family members are present and aware of what is being discussed and plans for documentation.
- Follow up conversations may be completed and documented by the senior aged care health professionals.
- Form validation and sign off is completed by local medical practitioner, GP or Nurse Practitioner during next scheduled visit (this is outlined in the current WACHS RGoC Guidelines).
- Resident GPs and the local RACF management must be supportive of this model of completion for residents prior to implementation.
- Local aged care and acute care staff must be confident in, and supportive of this model when enacting goals of care directions during care at a resident's end of life.
- Prioritisation strategies can be implemented to support this model, for example:
    - commence using this model for reviews only (where the resident already has a goals of care that is being updated, or a GoPC from a recent acute admission)
    - For priority residents as per the SPICT tool when a GP is not readily available.
- Mentoring by senior health professionals, a GP, or palliative care team member should be considered for health professionals commencing this model. This may be possible via a Community of Practice or Telehealth support model.

Benefits	Challenges
Useful for sites with limited access to GPs or local medical practitioners	Requires skilled, confident team and health professionals that are willing to take on the role and any additional training (time commitment)
Provides opportunity to upskill health professionals in goals of care conversations in line with their scope of practice	May be impacted by aged care staff turnover (staff leave after upskilling)
May provide increased focus on palliative and end of life discussions in aged care	
Supports a multidisciplinary approach to care that can optimise the quality of life for the resident and care givers	

2.3 Regular review of RGoC forms

It is vital that RACF staff regularly review completed RGoC forms with residents and their recognised decision-makers to ensure it reflects the resident's current wishes and preferences for care. If the resident rapidly deteriorates, there may be no or limited opportunities to revisit the discussions at the time. Generally, completed RGoC documents for residents that are clinically stable should be reviewed no less than 12 monthly.

More regular reviews are necessary for most residents, and some of the regular review points that should be considered are:

- After an unplanned hospital admission, new diagnosis or illness
- If a resident or their family member expresses change of mind, values or preferences
- When there is a change in the person responsible or substitute decision-maker
- When the resident's treatment options change
- When the resident's general health is poor or deteriorating (Refer to SPICT tools for prompts)
- When the resident, family, primary carers or recognised decision-makers ask for palliative care, choose to reduce treatments or focus on quality of life.

Reasons for an RGoC form review should be documented in the new RGoC form and / or in the progress notes.

2.4 Evaluating the quality of RGoC processes and forms

Goals of care processes and forms align with the requirements of the Aged Care Quality Standards and the National Consensus Statement: Essential elements for safe and high-quality end-of-life care (2023).

It is recommended that RACFs regularly consider:

1. If and how RGoC discussions and documentation are improving resident's experiences and care.
2. If RGoC processes and forms are being implemented as per the organisation's policies, procedures and / or guidelines and supporting quality end of life care.

RACF staff should identify and act on any opportunities for improvement. There are several options for evaluation of current practice, with resources already developed and available:

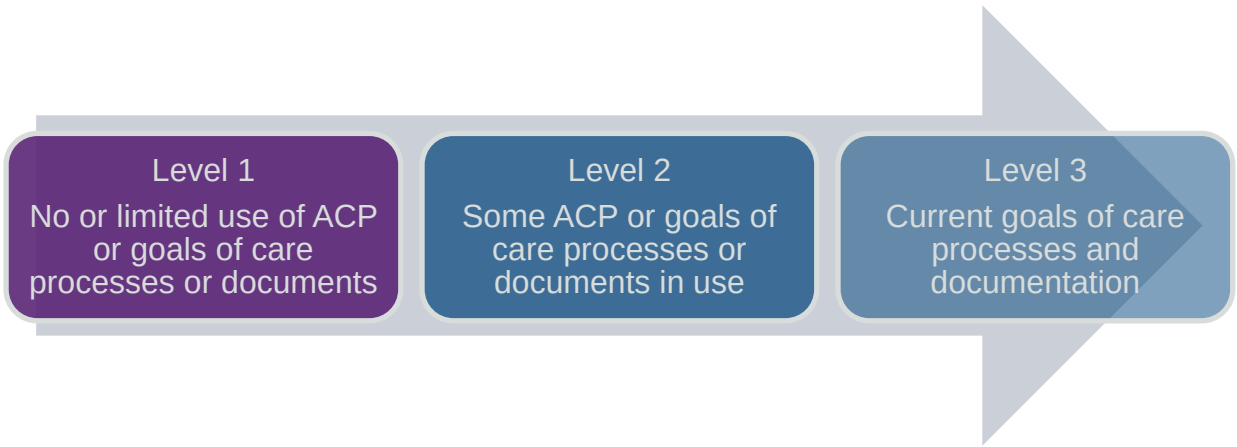
- Audits or audit tool kits of ACP and goals of care (including quality of documented discussions):
  - WACHS-specific RGoC tool available in REDcap (sample available from WACHS team)
  - Advance Care Planning Improvement (ACPI) Toolkit
  - ELDAC - Residential Aged Care toolkits
- Resident and family surveys or feedback
  - Advance Care Planning Improvement (ACPI) Toolkit
- Staff surveys and feedback

- ACSQHC (note focus is on acute care and may need changes for aged care) - End-of-life Care Toolkit: clinician survey questions | Australian Commission on Safety and Quality in Health Care
- Post-death reviews
  - ELDAC - After Death Audit.

3. Implementation approach

The approach outlined below is based on a quality improvement (QI) activity, however, RACFs may prefer to use a general project approach to implementation. It involves the RACF staff identifying the current goals of care readiness of their site and assessing the level of support needed to implement the RGoC appropriately. Sites can categorise themselves as level 1, 2 or 3, depending on current use of ACP documents, goals of care forms and processes.

Figure 3. Categories for current use of ACP documents, goals of care forms and processes



3.1 Categories for goals of care implementation status

Level 1	Level 2	Level 3
RACF sites new to using the RGoC form and requiring a customised implementation plan to help establish suitable processes for holding discussions and documenting them on the RGoC form with or for residents. OR	RACF sites that are new to using the RGoC form but have some experience with goals of care or ACP, and have: • a suitable process in place for holding goals of care discussions and documenting them. • one or more medical staff that are supportive of goals of care process.	RACF sites that are already using a similar goals of care form and have: • suitable processes in place for holding goals of care discussions • one or more medical staff that are clinical champions in goals of care and ACP process • one or more nursing or allied health staff members

Level 1	Level 2	Level 3
RACF sites that already use a goals of care type form but have a large number of residents with specific cultural and language needs that are not being met by existing processes.	• one or more nursing or allied health staff members that are supportive of goals of care process. • Sufficient medical staff to support the documentation of goals of care processes.	that are supportive goals of care process • processes in place to support discussions with residents that have specific cultural and language needs.
Aim: Establish RGoC processes and documentation at site using agreed model, with ongoing monitoring and planned evaluation.	**Aim:** Review current goals of care model, processes and documentation and develop strategies to support the new RGoC form in practice and improve quality of process.	**Aim:** Review and evaluate current use and quality of goals of care model, process and documentation, and complete quality improvement activities to further embed quality RGoC in practice.

3.2 Implementation checklist – Level 1

Site key activities	Examples and recommendations	Support and resources available
PLAN		
Identify a site champion or lead or working group to drive and monitor implementation	Clinical champion(s) can be an aged care worker or health professional with interest and expertise in end of life care and / or advance care planning. A working group should include a chair or lead and relevant staff with interest in improving end of life care and advance care planning.	Contact WACHS / Department of Health staff as needed for accessing resources, linking to other site champions and leads
Determine the appropriate governance locally for the RGoC initiatives for ongoing monitoring and evaluation	If no clear governance exists for RGoC or QI initiatives, consider including in existing governance structures e.g. organisation committee (Clinical Committee) or position already linked to Aged Care Quality Standards 2 and 3. Draft a policy, procedure or guideline to outline governance and RGoC form use.	Refer to WACHS Guideline as an example
Agree to a suitable timeframe to implement the project or QI activity	Develop a project or QI plan with realistic and achievable timeframes (usually 6 months as a minimum to embed change). Seek approvals as per organisation requirements.	Sample QI resources and templates available from WACHS / Department of Health ELDAC Quality Improvement resources
Agree to model(s) to implement goals of care at site, with support from key stakeholders (including GPs and medical practitioners)	Document key decisions and agreed model as part of working group or team meeting. Consider establishing mentoring relationships and arrangements to support staff who will be facilitating goals of care discussions. Identify education and training needs of staff that will be involved in goals of care discussions.	Refer to models in the implementation guide for consideration Liaise with local palliative care specialists (for example MPaCCs, regional palliative care teams) Link with education, training and mentoring programs (e.g PEPA / iPEPA, PaSCE, Residential Care Line)

Site key activities	Examples and recommendations	Support and resources available
		Refer to WACHS RGoC Education and Training Framework (available from WACHS / Department of Health)
Complete a baseline site audit to determine current level of advance care planning and goals of care activities	Audit on ACP and goals of care completion rates, completeness, review dates. Survey and evaluate staff familiarity, understanding and knowledge of ACP and goals of care documents and processes. Review availability and quality of resources for residents, their families, carers.	Sample baseline audit tool in preferred format (paper, electronic) Links to staff, resident, family and carer questions for survey if needed
DO		
Agree to site-specific change management plan and communication plan **Consider how needs of vulnerable groups are captured in process (e.g. Aboriginal; Culturally and Linguistically Diverse; Cognitive impaired; residents and families)**	Develop change management and communication plans to support implementation. Focus on supporting residents and families from vulnerable populations. Consider engaging with local community groups to support ACP and goals of care knowledge and awareness (consider Palliative Care WA workshops). Make use of established communication methods (newsletters, notice boards, meetings) to raise awareness and provide information. Commence regular email communications to key staff for information, status updates, data, education and training resources and opportunities. Plan resident and family communication methods and key messaging.	Examples of change management and communication plans Facilitate links with community groups and local stakeholders if needed

Site key activities	Examples and recommendations	Support and resources available
Commence implementation activities	Staff information and education sessions on completing RGoC form and document compliance. Develop and trial new resources to increase awareness of ACP and goals of care at site with both staff and residents and families. Support staff upskilling and attending external education and training opportunities that focus on ACP and goals of care conversations.	Education and training resources (for example, PEPA / iPEPA, PaSCE, Residential Care Line) RGoC Education and Training Framework
STUDY		
Complete a post-implementation audit	Audit advance care planning and goals of care completion rates, completeness, compliance with review dates. Make comparisons with baseline audit data, highlight improvements, and address ongoing challenges. Survey staff familiarity, understanding and knowledge of ACP and goals of care documents and processes and compare to baseline information – what has changed? Review availability and quality of resources for residents, their families, carers and recognised decision-makers and seek their feedback where possible.	Provide sample baseline audit tool in preferred format (paper, electronic) Provide staff, resident, family and carer questions for survey if required
ACT		
Make recommendations for ongoing improvements and review	Establish regular review periods for residents (six monthly reminder systems, consider coinciding with annual ACP week). Update relevant site-specific documentation (procedures, guidelines) to include ACP and goals of care. Schedule time for any policy, procedure or guideline reviews. Share information with key stakeholders.	

3.3 Implementation checklist – Level 2 & 3

Site key activities	Examples and recommendations	Support and resources available
PLAN		
Identify a site champion, lead or working group to drive and monitor implementation	Clinical champion(s) can be an aged care worker or health professional with interest and expertise in end of life care and advance care planning. A working group should include a chair or lead and relevant staff with interest in improving end of life care and advance care planning.	Contact WACHS / Department of Health staff as needed for accessing resources, linking to other site champions or leads
Determine the appropriate governance locally for the RGoC initiatives for ongoing monitoring and evaluation	If no clear governance exists for RGoC or QI initiatives, consider including in existing governance structures, e.g. organisation committee (Clinical Committee) or position already linked to Aged Care Quality Standards (Standards 2, 3). Draft or update an existing local policy, procedure or guideline to outline governance and RGoC use.	Refer to WACHS Guideline
Agree to a suitable timeframe to implement the project or QI activity	Develop a project plan or enter or register as QI activity as per organisation requirements.	Provide support with example objectives, QI resources and templates ELDAC Quality Improvement resources
Complete a baseline site audit to determine current level of advance care planning and goals of care activities	Audit on ACP and goals of care completion rates, completeness, review dates. Survey and evaluate staff familiarity, understanding and knowledge of ACP and goals of care documents and processes. Review availability and quality of resources for residents, families and carers.	Sample baseline audit tool in preferred format (paper, electronic) Links to staff, resident, family and carer questions for survey if needed

Site key activities	Examples and recommendations	Support and resources available
DO		
Decide on appropriate approach to increasing use and quality of the RGoC based on audit results and general feedback. **Consider how needs of vulnerable groups are captured in process (e.g. Aboriginal; Culturally and Linguistically Diverse; Cognitive impaired; residents and families)**	Review current model for completing RGoC against the information in Part 1 and make changes and improvements where suitable (e.g. priority groups, upskilling allied health professional). Staff information and education sessions on completing form and compliance. Focus on supporting residents, families and carers from vulnerable populations. Trial new and refresh current resources to increase awareness of ACP and goals of care at site with both staff and residents, families and carers. Consider engaging with local community groups to support ACP and goals of care prior to admission.	Provide information on alternate models of completion Access general staff information sessions on RGoC Access generic resources that can be adapted and customised Advice and resources for onsite staff education and training PEPA / iPEPA, PaSCE, Residential Care Line
STUDY		
Monitor ongoing use of the RGoC for the agreed timeframe	Log and record activities within preferred documentation. Create a feedback and lessons learnt log to use throughout the activity.	
Complete a post-implementation audit	Audit on ACP and goals of care completion rates, completeness, compliance with review dates. Survey staff familiarity, understanding and knowledge of ACP and goals of care documents and processes. Compare audit and survey results to baseline audits – what has changed? Review availability and quality of resources for residents, families and carers.	Sample baseline audit tool available (paper, electronic) Sample staff, resident, family and carer questions for survey if required

Site key activities	Examples and recommendations	Support and resources available
	ACT	
Make recommendations for ongoing improvements and review	Establish regular review systems for residents (six monthly reminder systems, consider coinciding with annual ACP week). Update relevant site-specific documentation (procedures, guidelines) to include ACP and goals of care. Set review dates for key documents.	

This document can be made available in alternative formats on request for a person with disability.