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

National Advance Care Planning Week

Key facts

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

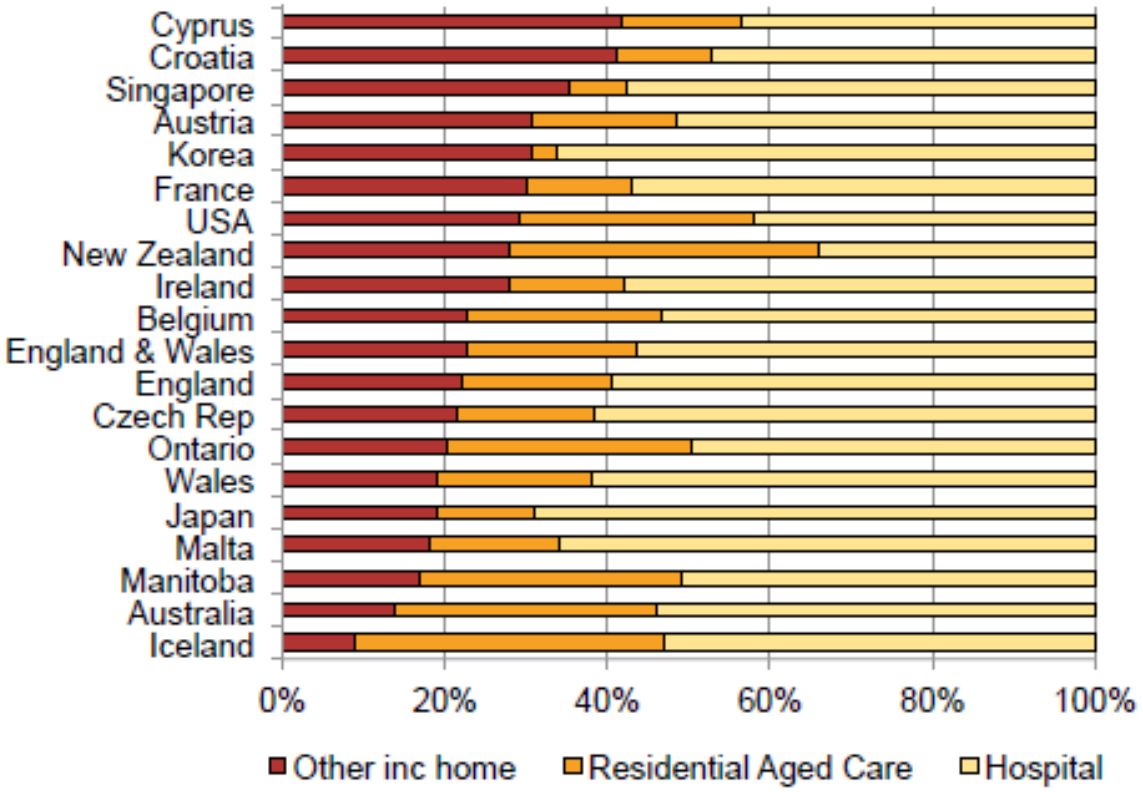
85% of people die after a chronic illness, not a sudden event

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))

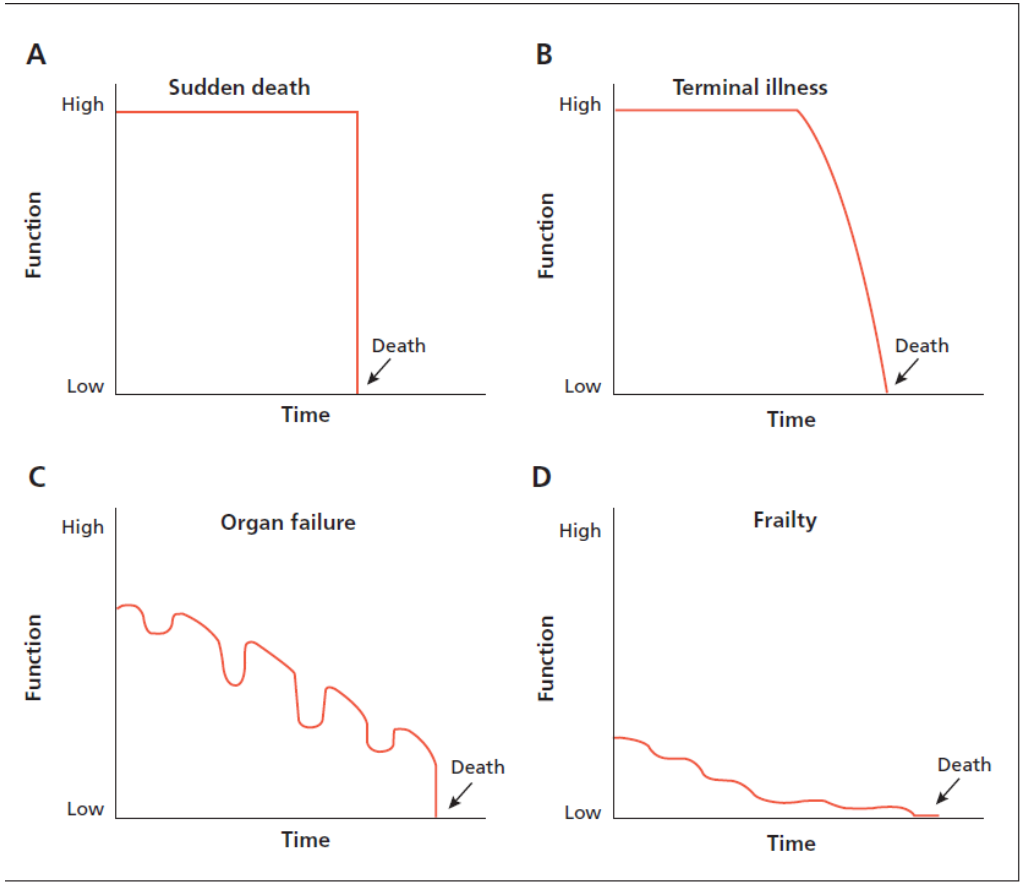
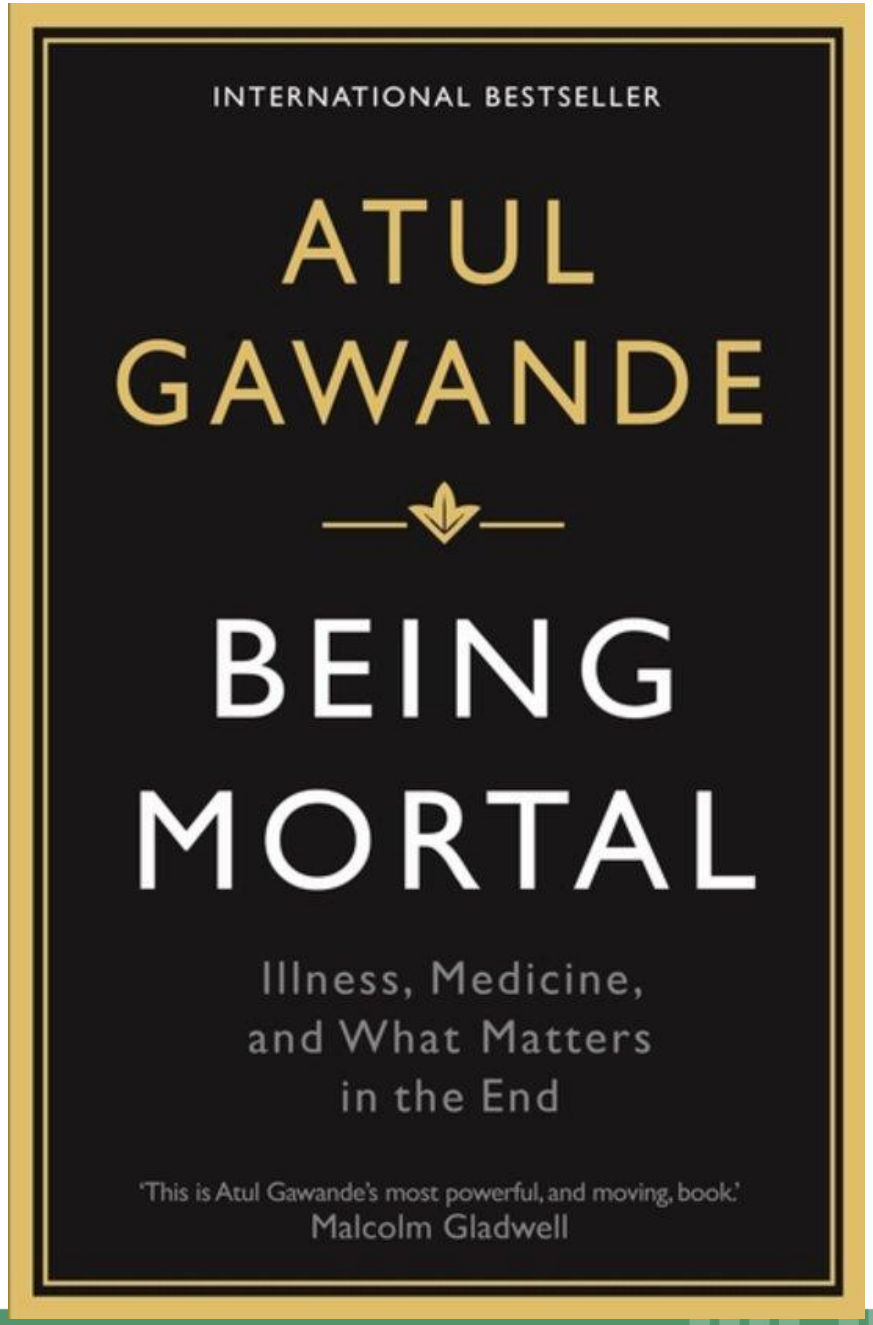


Figure 2: End-of-life trajectories. Reproduced with permission from Lunney JR, Lynn J, Hogan C. Profiles of older medicare decedents. *J Am Geriatr Soc* 2002;50:1108-12.[36]


INTERNATIONAL BESTSELLER
ATUL GAWANDE
BEING MORTAL
Illness, Medicine, and What Matters in the End
'This is Atul Gawande's most powerful, and moving, book.'
Malcolm Gladwell

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

NOT FOR CARDIO-P[illegible] TION

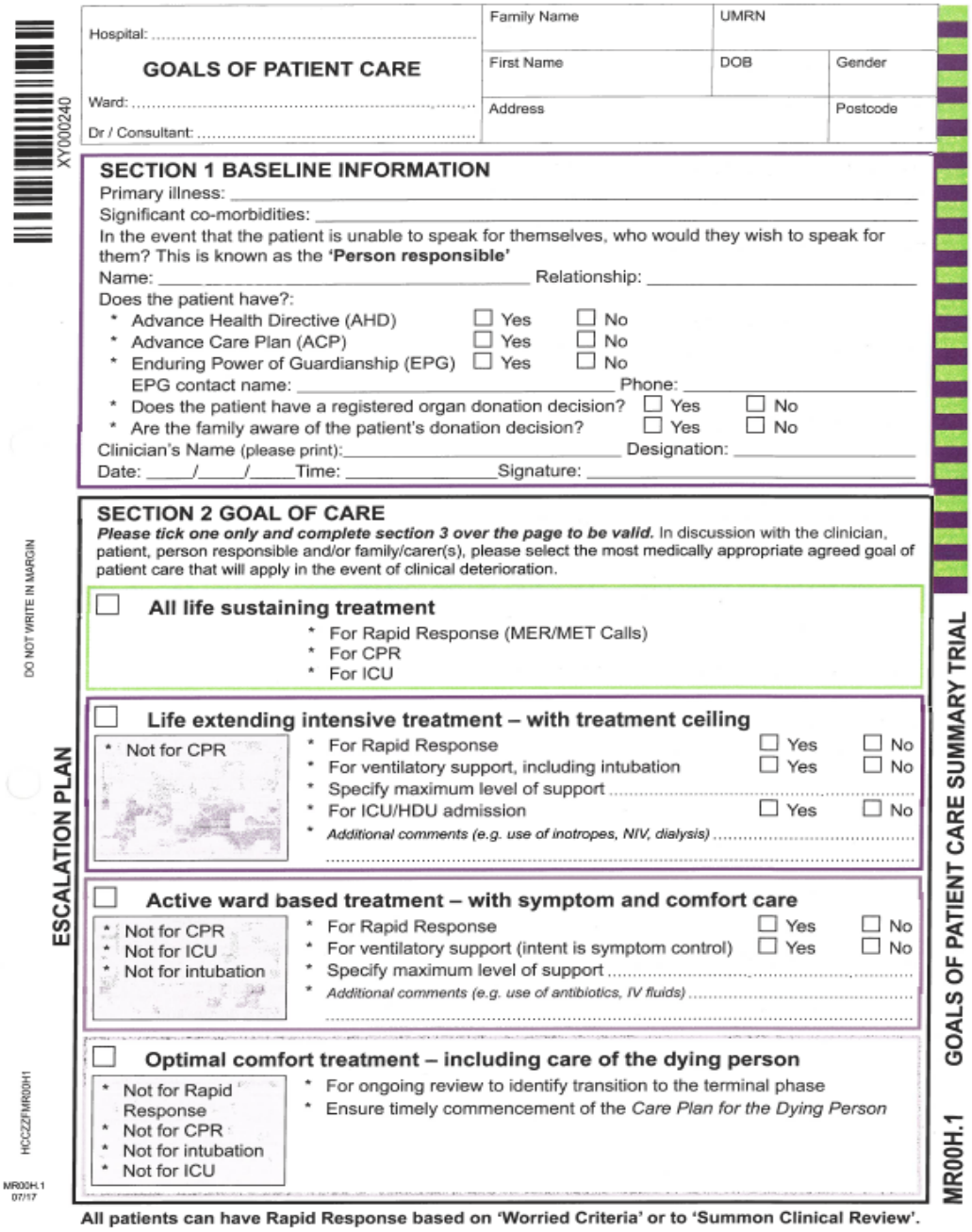
WARD/CLINIC		SEX
CONSULTANT	R.M.O./REG.	DATE

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		
For non invasive ventilation	NO	YES
For endotracheal intubation	NO	YES
For inotropes	NO	YES
For HDA/ICU/CCU	NO	YES
Other (please specify)		

NOT FOR CARDIO-PULM



Hospital: .....

Ward: .....

Dr / Consultant: .....

GOALS OF PATIENT CARE

Family Name	UMRN	
First Name	DOB	Gender
Address		Postcode

XY0000240

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**

* Not for CPR

* For Rapid Response ☐ Yes ☐ No
* For ventilatory support, including intubation ☐ Yes ☐ No
* Specify maximum level of support .....
* For ICU/HDU admission ☐ Yes ☐ No
* *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 ☐ Yes ☐ No
* For ventilatory support (intent is symptom control) ☐ Yes ☐ No
* 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'.

DO NOT WRITE IN MARGIN

ESCALATION PLAN

GOALS OF PATIENT CARE SUMMARY TRIAL

MR00H.1

HCCZZFMR00H1

MR00H.1 07/17

The FORM

Page 1

Hospital:	Family Name	UMRN	
GOALS OF PATIENT CARE	First Name	DOB	Gender
Ward:	Address		Postcode
Dr / Consultant:			

SECTION 3 SUMMARY OF DISCUSSION(S)

Goals of Patient Care has 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: _____

DO NOT WRITE IN MARGIN

ENDORSEMENT BY A CONSULTANT

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: _____

Specialty: _____Date: ____/____/____Time: _____

The FORM

Page 2

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

Functional ability deteriorating due to progressive cancer.

Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Urinary and faecal incontinence.

Not able to communicate by speaking; little social interaction.

Frequent falls; fractured femur.

Recurrent febrile episodes or infections; aspiration pneumonia.

Heart/ vascular disease

Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.

Persistent hypoxia needing long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping or not starting dialysis.

Liver disease

Cirrhosis with one or more complications in the past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is not possible.

THE UNIVERSITY of EDINBURGH

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. (eg. 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