




**PalliativeCare**  
WESTERN AUSTRALIA

# Goals of Patient Care Update

Dr Simon Towler

17 September 2020



After more than 40 years of growing recognition and acceptance, consumer partnerships in health care are now viewed as integral to the development, implementation and evaluation of health policies, programs and services.<sup>39-41</sup> Patient and consumer partnerships are also a pillar of person-centred care – that is, care that focuses on the relationship between a patient and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for the best health outcomes.<sup>42</sup>

## Quality Health Service Standards

Second edition



## GOALS of CARE:

*Clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process*

**National Safety and  
Quality Health Service  
Standards**

Second edition

# National Safety and Quality Health Service Standards

Second edition

*Partnering with Consumers*

*Comprehensive Care*



## Comprehensive Care Standard



**Partnering with Consumers**, which describes the systems and strategies to create a person-centred health system by including patients in shared decision making, to ensure that patients are partners in their own care, and that consumers are involved in the development and design of quality health care.



5

## Care Standard

### Evidence Check

Does comprehensive care lead to improved patient outcomes in acute care settings?

saxinstitute

An Evidence Check rapid review brokered by the Sax Institute for the Australian Commission on Safety and Quality in Health Care. September 2015.

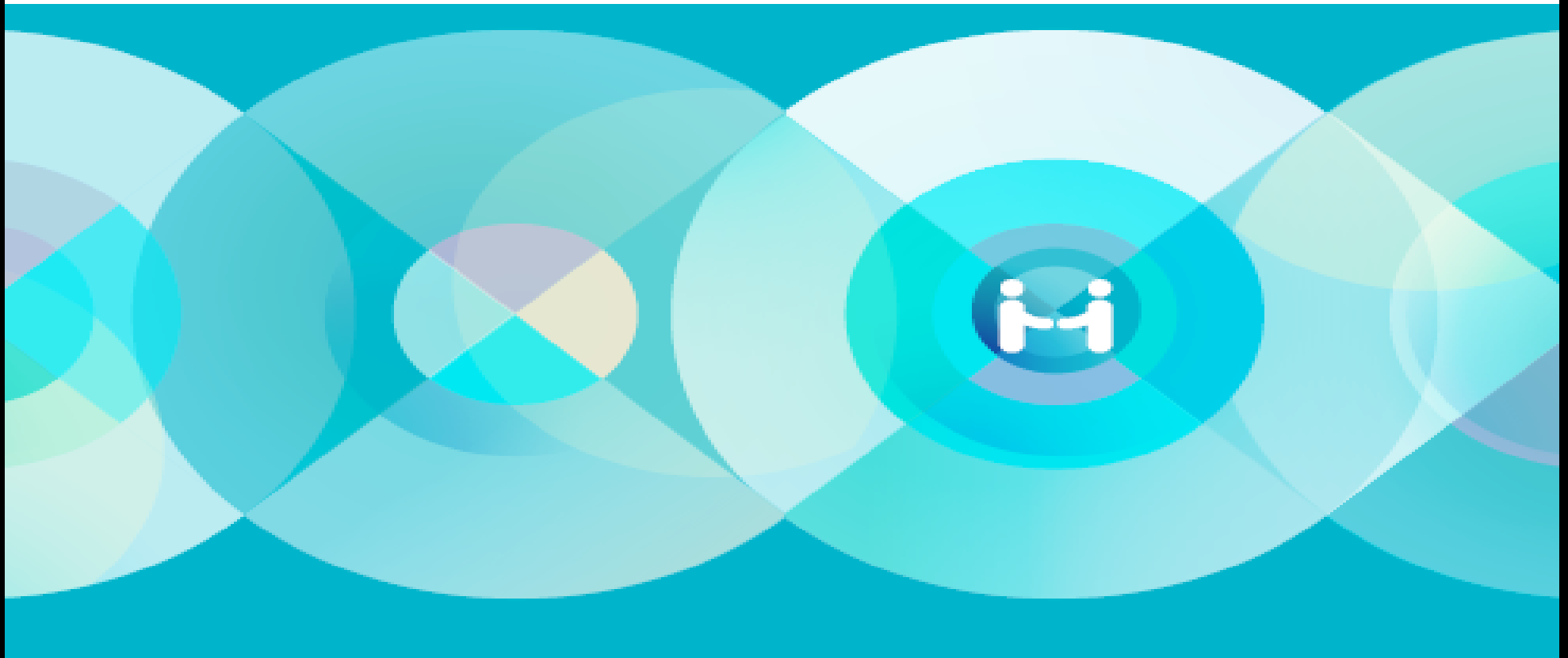


# 5

## Comprehensive Care Standard

Comprehensive care must include at least two of the elements specified above, and involve interventions that include patient-centred care and goal-directed care, where the goals of care have been defined by a shared decision-making process that explicitly includes patient preferences in goal setting and developing a care plan.

## Partnering with Consumers Standard





## Does comprehensive care lead to improved patient outcomes in acute care settings?

### Question 1: Key points and summary

Patient satisfaction, length of stay, costs of care and acute care readmissions were the most frequently measured outcomes in relation to comprehensive care interventions.

Older patients were the most investigated age group in the literature found (12 of the 16 included studies focused on older populations).

Length of stay decreased significantly in 80% of studies measuring this, cost of care decreased significantly in 85.7% of studies, readmission rates decreased significantly in 50% of studies, patient satisfaction increased significantly in 60% of studies, and shared decision making and goals of care increased significantly in 100% of studies investigating these outcomes.

The literature shows that initiating a comprehensive care program can lead to improved health service, patient and clinical outcomes in acute care settings. The evidence is of moderate to high methodological quality (12 high quality (75%), three moderate quality (19%), and one low quality (6%)) and is relevant to the Australian acute care settings and population.

# 5

## Comprehensive Care Standard

Significant increases in the frequency of patient involvement in goals of care discussions and/or shared decision making was found with the application of a comprehensive care intervention by three of the included articles (Lamba 2012, Penticuff 2005, Preen 2005).<sup>3,9,11</sup> Gade<sup>2</sup> found significant increases in communication with health professionals after the intervention.

## Recommendations

Implementation of comprehensive care in an acute care setting, particularly for older adults, can improve patient satisfaction, length of stay, cost of care, readmissions, and shared decision making and goals of care. Implementation of comprehensive care, at an organisational level, should consider aspects of upskilling staff, embedding comprehensive care into ongoing quality improvement initiatives and changes to hospital policies and procedures. At a unit level the goal of comprehensive care needs to be established and appropriate team structures and mode of delivery of comprehensive care established.

### NHMRC grade of recommendation is level B overall

Evidence base	B
Consistency	B
Clinical impact	B
Able to generalise	B
Applicability	A



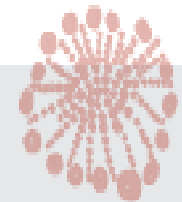
# Comprehensive Care Standard

- New Standard addressing cross-cutting issues that underlie many adverse events
- Focuses on care that is centred on patient goals and well being
- Recognises the importance of teamwork and collaboration
- Introduces important safety and quality requirements for people with mental health and cognitive impairment, or people at the end of life
- Nutrition and hydration – actions are hospital specific
- Incorporates requirements from first edition for falls and pressure injuries

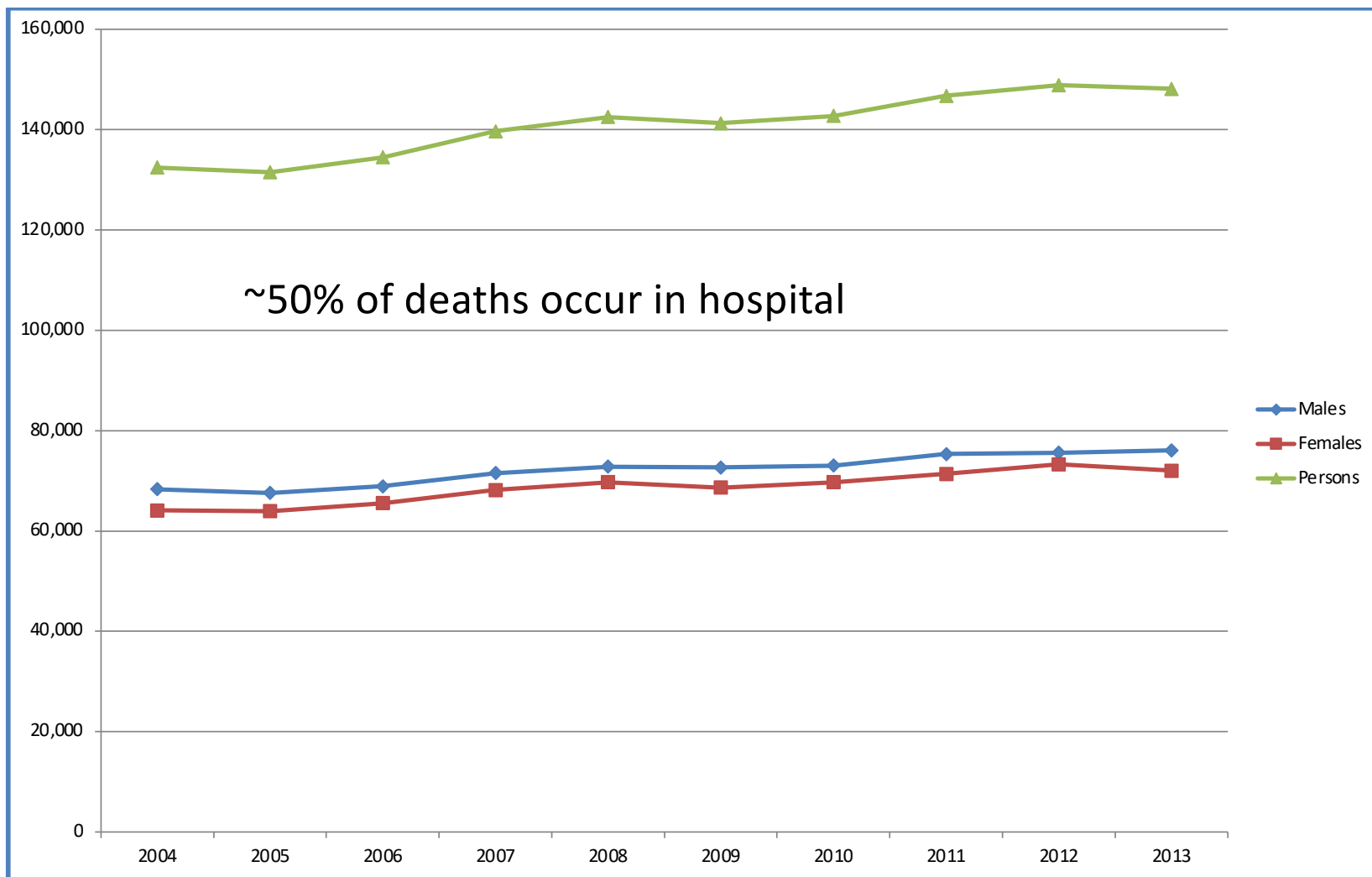
# 5

## Comprehensive Care Standard

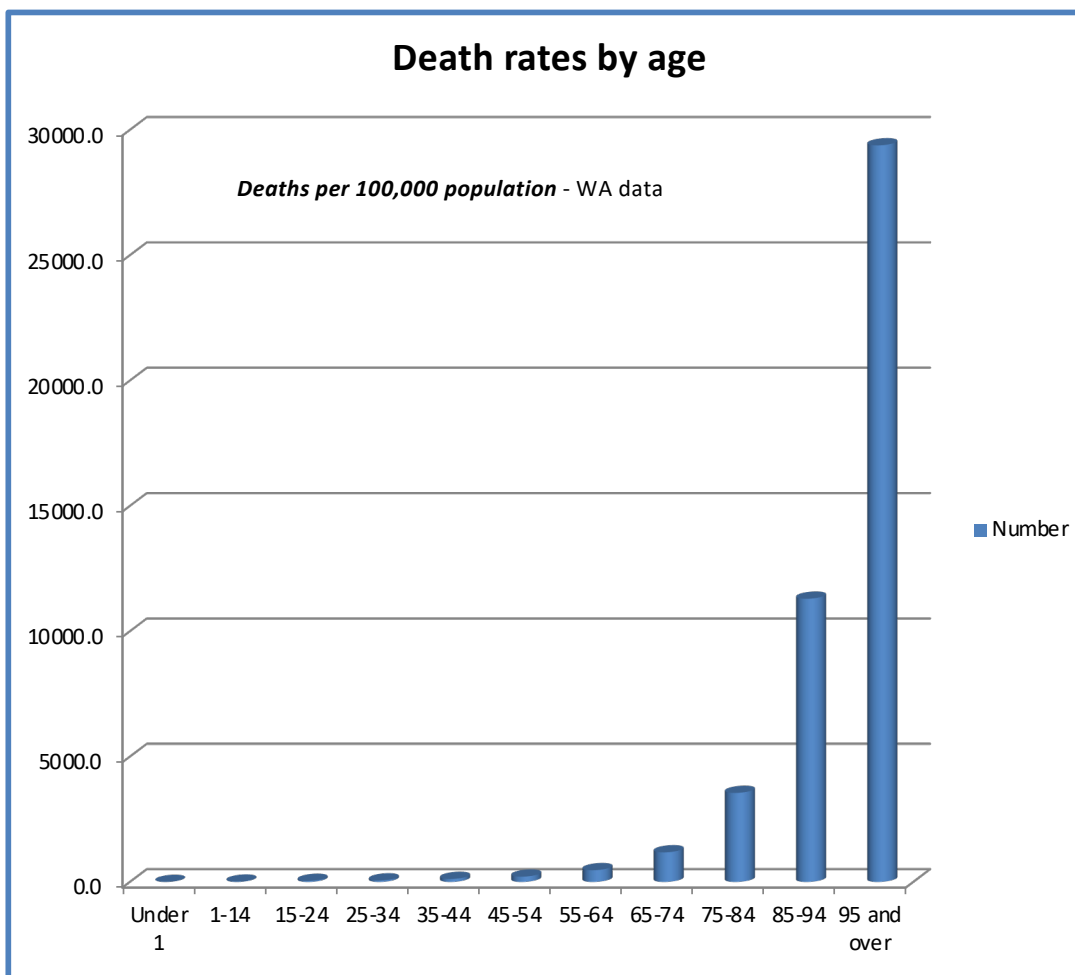
### Action 5.20



Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*<sup>220</sup>



Deaths per year in Australia



Age	Number
<i>Under 1</i>	2.5
<i>1-14</i>	11.8
<i>15-24</i>	42.6
<i>25-34</i>	59.7
<i>35-44</i>	120.0
<i>45-54</i>	211.0
<i>55-64</i>	468.5
<i>65-74</i>	1180.8
<i>75-84</i>	3552.2
<i>85-94</i>	11297.3
<i>95 and over</i>	29382.2
<i>All</i>	535.8

Profile of dying in WA

**HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY**



EMSA #111 B  
(Effective 4/1/2017)

## Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

**A** **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing.*  
*If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check  
One

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

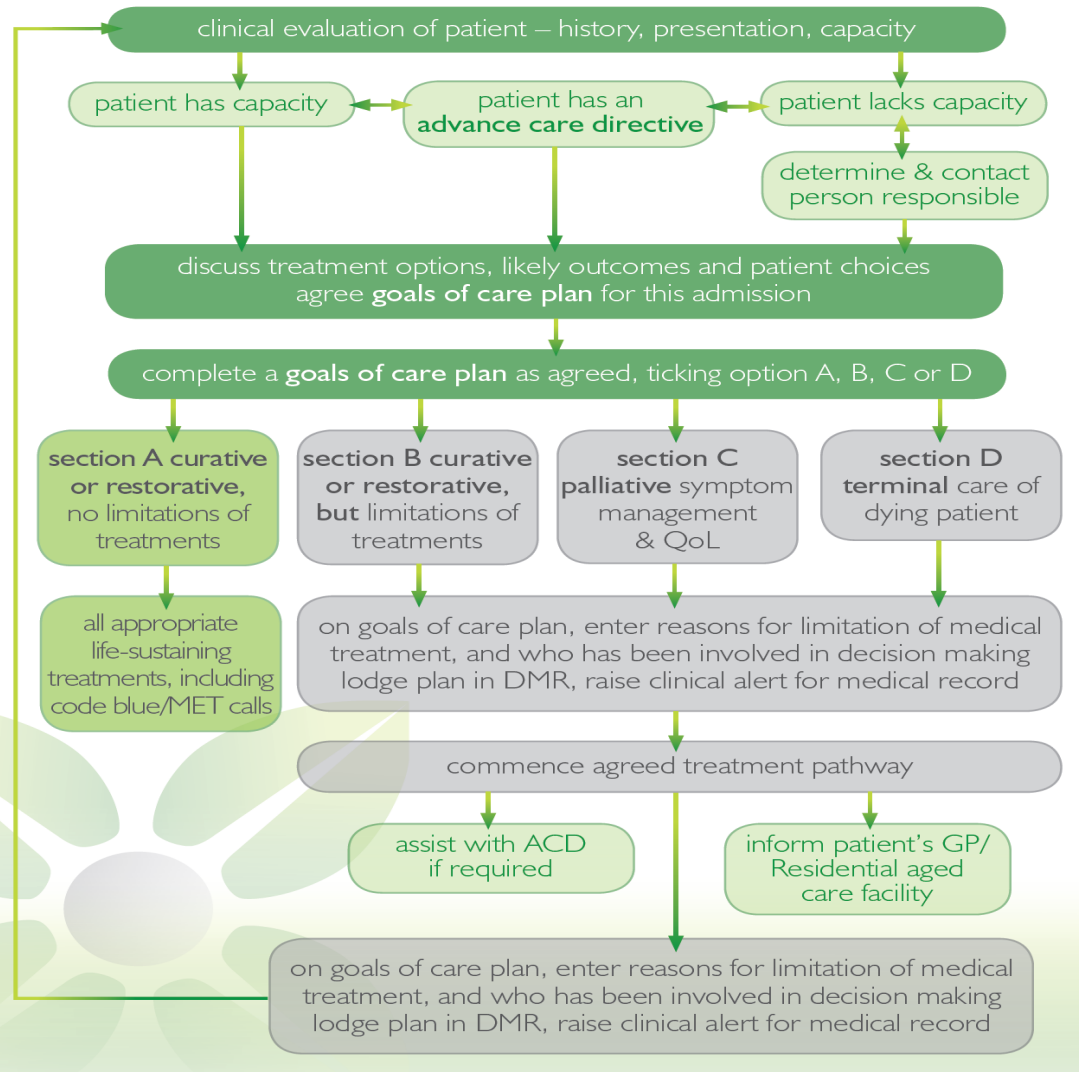
**B** **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

Check  
One

- ☐ **Full Treatment** – primary goal of prolonging life by all medically effective means.  
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.  
☐ *Trial Period of Full Treatment.*
- ☐ **Selective Treatment** – goal of treating medical conditions while avoiding burdensome measures.  
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.  
☐ *Request transfer to hospital only if comfort needs cannot be met in current location.*
- ☐ **Comfort-Focused Treatment** – primary goal of maximizing comfort.  
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

Additional Orders: \_\_\_\_\_





## Goals of Care

Dr Michael ASHBY

DHHS Tasmania



## MEDICAL GOALS OF CARE (GOC) PLAN

TASMANIAN HEALTH ORGANISATION

☐ North ☐ North West ☐ South

PT ID											
FAMILY NAME..... D.O.B.....											
OTHER NAMES.....										SEX	
ADDRESS.....										MARITAL STATUS	
										REL.	

## Goals of Care 2

This form is to communicate the medical decision for appropriate treatment goals of care for this patient. Chose A, B, C or D. If changes are made, this form must be crossed through, marked void and a new form completed.

### DIAGNOSIS:

#### NO LIMITATION OF TREATMENT:

A. The goal of care is **CURATIVE** or **RESTORATIVE**.  
Treatment aim is **PROLONGING LIFE**

☐ For CPR and all appropriate life-sustaining treatments

#### Hospital

CODE BLUE

#### Community

For full resuscitation

#### LIMITATION OF MEDICAL TREATMENT:

☐ Patient has an advanced care directive  
and / or has requested the following treatment limitations:

Please specify:

B. The goal of care is **CURATIVE** or **RESTORATIVE** with limitations:

☐ **NOT FOR CPR** but is for all respiratory support measures

☐ **NOT FOR CPR or INTUBATION** but is for other active management

Specific notes:

For CODE BLUE  
and MET calls

For MET calls  
NOT for CODE  
BLUE

For treatment and  
transfer to hospital

C. The goal of care is **PALLIATIVE**.  
Treatment aim is quality of life

☐ **NOT FOR CPR OR INTUBATION**

Specific notes:

MET call  
☐ YES

MET call  
☐ NO

Contact GP for  
planning

D. The goal of care is  
**COMFORT DURING THE DYING PROCESS**

☐ **NOT FOR CPR or INTUBATION**

For terminal care  
NOT for CODE BLUE  
NOT for MET

Reason for limitation of medical treatment:

☐ medical grounds

☐ patient wishes

Discussed with:

☐ patient

☐ person responsible

PRINT DOCTOR'S NAME:

DESIGNATION:

SIGNATURE:

DATE: DD / MM / YYYY

GP / consultant responsible: PRINT NAME

GP / consultant informed: ☐ YES ☐ NO

This form is endorsed for ambulance transfer, and for the home or care facility.

GOALS OF CARE PLAN

# ADVANCED CARE PLANNING AND MY HEALTH RECORD

---

**Facilitator – Clare Mullen, Health Consumers' Council**



## Goals of care documents in My Health Record

---

- What do you see are the benefits?
- What, if any, questions or concerns do you have?
- What expectations do you have about Goals of Care documents being uploaded to My Health Record?

GoC image



Australian Government

Australian Digital Health Agency

---

# National Goals of Care Collaborative

## Western Australian Department of Health & Australian Digital Health Agency

---

## Agenda item 2.1: WA Implementation Group Consumer Forum outcomes

- Coordinated between Health Consumers' Council WA, Health Support Services, Palliative Care WA and Carers WA.
- 42 attendees
- Over half felt they already had a good knowledge of ACP at beginning of session.
- ACP Information session, followed by My Health Record demonstration.
- Consultation session on ACP, Goals of Care and My Health Record in the afternoon (Facilitated by HCC WA).
- Motivation for attending the session (n=31):

<i>To find out about Advance Care Planning</i>	<i>To find out about My Health Record</i>	<i>To find out about both ACP and My Health Record</i>	<i>To contribute to the consultation process about MHR</i>	<i>Other reasons (Please describe these below)</i>
17	9	16	6	3

## Agenda item 2.1: WA Implementation Group Consumer Forum outcomes

Discussion regarding Goals of Care documents being uploaded to My Health Record?

### Benefits of goals of care in My Health Record

Value in having goals of care discussions in hospital (recognises their wishes for care, supports patient centred care and avoids having repeat conversations about treatments)

Could see value in settings such as community and aged care

Sharing information across multiple providers involved in their care

Relevant for people who did not yet have an ACP document, or did not feel ready to create one.

Some attendees felt they would like to write one themselves or sign it.

### Questions, concerns, expectations

Expectations about how the goals of care discussions would be held in hospital and how the form is completed, for example, who would talk to them about it and how?

There were some concerns about the title of the document (relation to 'clinical deterioration' is not immediately obvious) and how it can be used by health care providers (ensuring shared decision-making with patient / family)

Expectation that there would be some form of notification to the patient if the goals of care was uploaded to their My Health Record. They wanted to be able to remove it or change it if required.

