

POLICY APPLIES TO:

All Mercy Hospital Nursing/Allied Health Staff

Compliance by Credentialed Specialists will be facilitated by Mercy staff

RELATED STANDARDS:

EQulP Standard 1.1 Consumers / patients are provided with high quality care throughout the care delivery process.

Criterion 1.1.7 Systems exist to ensure that care of the dying is managed with dignity and comfort (refer to the 'Death of a patient' policy).

The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996

RIGHT 7; Right to Make an Informed Choice and Give Informed Consent

Every consumer has the right to refuse services and to withdraw consent to services.

RATIONALE:

Shared goals of care are when the patient, their whānau, and clinicians explore the patient's values along with the care and treatment options available and agree the goal of care for the current admission.

This decision describes what will be offered if the patient deteriorates.

This is a move away from the binary decision-making of 'for/not for resuscitation'.

CULTURAL CONSIDERATIONS:

See within document.

DEFINITIONS:

Advance Directive

This is defined in the Code of Health and Disability Services Consumer's Rights as *'a written or oral directive – (a) by which a consumer makes a choice about a possible future health care procedure; and (b) that is intended to be effective only when he or she is not competent.*

Right 7 (5) of the Code states that: *'Every consumer may use an advance directive in accordance with the common law.'* (refer Consent Policy)

Advanced Care plan

A document that includes what is meaningful to a person, such as people and pets, their values and the ways they would like those caring for them to look after their spiritual and emotional needs. It also tells their loved ones and medical staff about the treatment and care they want if they are no longer able to communicate.

Competent

A person is competent when there are reasonable grounds for believing that the patient has the capacity to understand the information, appreciate the situation and manipulate the information.

“The doctor should consider whether at the time the patient had a capacity which was commensurate with the gravity of the decision which the patient purported to make. The more serious the decision, the greater the capacity required.” Lord Donaldson, M.R., cited pgs 174 and 175, “Medical Law in New Zealand”, Skegg Paterson Ed, 2006, Thomson Brookers. (Refer to Mercy Hospital Consent policy).

Enduring Power of Attorney (EPA) for personal care and welfare.

A legal document that a person uses to authorise someone else (called an ‘attorney’) to make decisions on their behalf about personal care and welfare if they become mentally incapable. The attorney is often a whānau member or trusted friend. The EPA starts once the person has been declared mentally incapable. A relevant health practitioner or Family Court must decide that the person is not capable of making a decision about their care or welfare.

SHARED GOALS OF CARE PRINCIPLES (SGOC)

1. when the patient, their whānau / family , and clinicians explore the patient’s values along with the care and treatment options available and agree the goal of care for the current admission if the patient deteriorates.
2. governance systems and organisational culture and structures encourage shared goals of care discussions through resourcing and by supporting patients, whānau and clinicians to have these discussions.
3. Cultural safety is an essential component of shared goals of care discussions.

Consider;

- The effect of your own culture, history & attitudes
- Ongoing development of your own cultural awareness and understanding of how your sociocultural influences inform biases that impact your interactions with patients, whanau & colleagues
- Consciously not imposing your cultural values & practices
- Recognising power imbalances

Aligning with the articles of the Tiriti o Waitangi is the use of the Te Whare Tapa Whā framework (developed by Sir Mason Durie) which provides a useful link with Shared goals of care discussions.

Te Whare Tapa Whā describes a holistic approach to wellbeing using four cornerstones of health: taha tinana (physical health),

taha wairua (spiritual health), taha whānau (family health) and taha hinengaro (mental health). All four cornerstones are important. A person (or collective) may become ‘unbalanced’ if one of these cornerstones is missing or damaged.

Te taha tinana: <i>Physical health</i>	Te taha hinengaro: <i>Mental health</i>
1.1 Recognition the person is dying or is approaching the last days of life	1.5 Assessment of the person's preferences for care
1.2 Identification of the lead health practitioner	Te taha whānau: <i>Extended family health</i>
1.3 Assessment of physical needs	1.6 Identification of communication barriers
1.4 Review of current management and initiation of prescribing of anticipatory medication	1.8 The family/whānau's awareness of the person's changing condition
1.7 The person's awareness of their changing condition	1.9 Discussion of cultural needs
1.11 Provision of food and fluids	1.15 Provision of information to the family/whānau about support and facilities
1.12 Availability of equipment to support the person's care needs	Te taha wairua: <i>Spiritual health</i>
1.13 Consideration of cardiac devices	1.10 Provision of opportunity for the person and family/whānau to discuss what is important to them
1.14 Advice to relevant agencies of the person's deterioration	

4. Patients, whānau and clinicians are supported before, during and after shared goals of care discussions.
5. Patients have those they want to have with them, including those who have decision-making responsibilities.
6. Shared goals of care discussions take place in appropriate environments to maintain patients' privacy and dignity.
7. Shared goals of care discussions are facilitated by the appropriate clinician(s) and may include other members of multi-disciplinary teams involved in patients' care.
8. Shared goals of care discussions happen where possible, prior to admission and with the agreement of the patient. The patient, whānau or clinician can begin the discussion.
9. Shared goals of care discussions result in a shared understanding through engaging with patients and whānau, sharing clinicians' understanding and exploring patients' values and what is important to them.
10. Shared goals of care discussions and decisions are documented in a clearly identifiable and accessible clinical form, with information available to all clinicians caring for

As Mercy Hospital is an elective surgical hospital the likelihood of a unexpected deterioration is slightly less likely than that of an acute admitting hospital.

Table 1: Shared goals of care options and interventions

	Treatment aims to	Cardiopulmonary resuscitation	Rapid response calls	Referral for ICU-level care	Other options
A: Curative and restorative	Prolong life	Attempt as this is clinically recommended and in line with the person's known wishes	Appropriate	Appropriate	All appropriate life-sustaining treatments
B: Curative and restorative	Prolong life and enhance its quality	Do not attempt as this is likely to cause more harm than benefit or is not desired by the person	Appropriate	Decide if appropriate	Appropriate treatments
C: Improving quality of life	Control symptoms, enhance wellbeing, and should be easily tolerated	Do not attempt as this is likely to cause more harm than benefit	Decide if appropriate	Unlikely to be appropriate	Appropriate treatments
D: Comfort whilst dying	Alleviate suffering in the last hours or days of life and allow a natural death	Do not attempt as this is likely to cause more harm than benefit	Not appropriate	Not appropriate	End-of-life guidelines like <u>Te Ara Whakapiri</u> and other appropriate treatments

The care options and interventions are outlined above and form the basis of the Shared goals of Care conversations

There are guides and training that can help with these discussions, for example, the Serious Illness Conversation Guide.

IMPLEMENTATION:

For Credentialed Specialists;

- Policy available on the website
- At credentialing interview
- At time of re-credentialing

Staff education on Shared Goals of Care.

EVALUATION:

- Where appropriate SGOC conversations occur and are documented prior to admission.
- Shared Goals of Care pack sent out to all credentialed specialists.
- Shared Goals of Care are documented on the SGOC care plan
- SGOC are re-documented on each admission
- Patient/family feedback on SGOC process is sought

ASSOCIATED DOCUMENTS

External

(This is not exclusive)

- Crimes Act 1961
- Code of Health and Disability Service Consumers' Rights 1996-update
- Human Rights Act 1993
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- New Zealand Bill of Rights 1990
- Protection of Personal and Property Rights Act 1988
- "Medical Law in New Zealand", Skegg Paterson Ed, 2006, Thomson Brookers.
- HQSC Resources:
 - ✓ [Shared goals of care page](#)
 - ✓ [Guide to preparing and implementing your shared goals of care approach](#) (April 2021)
 - ✓ [Shared goals of care principals for health service providers](#) (April 2021)
 - ✓ [Shared goals of care frequently asked questions](#) (May 2021)
 - ✓ [Serious Illness Conversation Guide Aotearoa](#)
 - ✓ [Factsheet for nurses and allied health workers supporting shared goals of care decisions](#) (March 2020)
 - ✓ [Factsheet for senior clinicians responsible for shared goals of care decisions](#) (March 2020)
 - ✓ [Factsheet for patients and whanau when having a shared goals of care discussion](#) (June 2020)

Internal

- Cultural Policy
- Consent Policy
- Death of a Patient Policy
- Mercy Hospital Ethics Directives
- CPR Policy

Policy Process

New Zealand law:

Clearly requires that a patient be resuscitated where the procedure would be beneficial to them;

Places a legal duty on Health Professionals to provide the necessities of life to patients (Section 151 of the Crimes Act 1961);

States that necessary/reasonable treatment that is readily available may not be withheld or withdrawn from a competent patient against their will;

‘NOT FOR RESUSCITATION’ orders are not clearly defined in any one statute or case law within New Zealand however resuscitation does come under the Health & Disability (1993) and Health & Disability Commissioner- Code of Health & Disability Services Consumer Rights (1996) in NZ.

The New Zealand Bill of Rights Act 1990, Section 11 states: *Everyone has the right to refuse any medical treatment.*

When an individual patient’s clinical condition is such that active resuscitation will only defer their imminent death, the Health Professional is not under a duty to avert that death at all costs. In such circumstances, there must be a lawful reason for omitting to carry out resuscitation.

Such a lawful reason must comply with accepted clinical standards and good clinical practice.

Introduction

Shared goals of care discussions take place before episodes of acute deterioration so everyone can engage fully without the pressures of an evolving clinical crisis.

Prior to any conversation, where appropriate, you can give the patient and their whānau a copy of the *Factsheet for patients and whānau when having a shared goals of care conversation*

The aim is to have these discussions documented for all adult patients, ideally within 24 hours of admission, or prior to admission by appropriately trained staff. (See *Shared Goals of Care plan appendix 1*)

These are then reviewed and documented if there are changes in the patient’s condition. If patients have advance care plans and/or advance directives, these need to support the discussion.

Shared goals of care:

- identify the overall direction for an episode of care (for example, curative, restorative, focused on improving quality of life or comfort whilst dying) outlining which treatments are more likely to cause benefit than harm
- relate to the patient's current admission and what the patient wishes to happen if their condition deteriorates
- focus on providing appropriate care – what we can do – rather than what we won't do.

What is the credentialed specialist role?

- Understand the principles of shared goals of care.
- Consider all relevant information.
- Facilitate the discussion with the patient and any support people or other team members as appropriate. There are guides and training that can help with these discussions – for example, the Serious Illness Conversation Guide (<https://www.hqsc.govt.nz/our-programmes/advance-care-planning/information-for-clinicians/tools/seriousillness-conversations/>).
- Come to a shared goals of care decision and document this on the form. (See *Shared Goals of Care plan appendix 1*)
- Understand that patients and whānau may wish to reflect on the discussion and then have further questions. This is where nurses, allied health staff or other members of the team have an important role to support the patient and their whānau.
- Review the shared goals of care throughout the patient journey and commit to updated documentation of any change. How shared goals of care work

There are three steps in the shared goals of care discussion. All members of the clinical team have a role to play.

In terms of content of the discussion see;

Factsheet for senior clinicians responsible for the shared goals of care decisions HQSC

Factsheet Having a Shared Goals of Care discussion

Serious Illness Conversation Guide Aotearoa HQSC

1. **Prepare Gather information**, including the patient's capacity, privacy needs, wishes for support people they would like to have present, and any cultural needs. Review the patient information to gain an understanding of their potential medical trajectory. Nursing and allied health staff can play a part in this stage of preparing for the discussion. There needs to be agreement from the patient to go ahead with the discussion. Plan having the discussion around who will be involved, including the appropriate environment and space for privacy and to maintain dignity.

2. Discuss

- Explore the patient's (and whānau / family's, as appropriate) current understanding of their condition and what may lie ahead, and find out how much information they would like to know.
- Share with the patient information about the clinical team's understanding of their current condition and what may lie ahead.
- Summarise and check for shared understanding.

3. Recommend and close

Explain your recommendation in plain language, outlining which treatments are more likely to cause benefit than harm. Then reach a decision with the patient and whānau for the goal of care for the admission. This decision and plan should be documented clearly on the patient's shared goals of care form. Any other follow-up actions should also be documented in the clinical record

How do I clarify and document the decision?

There are four goals of care options to choose from (A&B: curative and restorative, C: quality of life, D: comfort while dying), with room for additional notes as needed. Each case will have factors unique to the individual (See Table 1 above for treatment response).

Curative & Restorative with all appropriate life sustaining treatments

Select goal of care A where the expectation and shared goal is for the patient to recover and when full resuscitation and any other appropriate life sustaining treatments are recommended & appropriate.

Curative & restorative

Select goal of care B where the expectation and goal is for the patient to recover. However, if the patient was to deteriorate, CPR should not be attempted as it is unlikely to be successful, is likely to cause more harm than good, or the patient does not want it regardless of outcome.

Quality of life

Select goal of care C where treatment is primarily aimed at improving quality of life and controlling symptoms. In this case ICU referral is unlikely to be appropriate, however treatments such as antibiotics, IV fluids and NG feeding may be necessary. CPR should not be attempted as it would cause more harm than good. Treatments should be provided after considering whether the

benefit will enhance wellbeing and would be easily tolerated by the patient.

Comfort while dying

Select goal of care D when the patient is dying. CRR, referral to an ICU should not be attempted.

The patient's SGOC status may only be documented by a Credentialed Specialist.

- In all inpatient cases the SGOC options and interventions must be fully documented in the patient's SGOC care plan (appendix 1)

This ensures clarity of

communication with other members of the clinical team, and also records information provided to key persons.

This is necessary to make sure all staff are clear what options and interventions have been chosen.

SGOC documentation must be reviewed at every admission as to ongoing appropriateness.

What do I do if it is not possible to have a discussion?

Document and sign the shared goals of care form for the current admission with the reasons for not having the discussion. Additional documentation may also need to be included in the clinical record

What do I do if it is not possible to reach a shared decision?

You will need to escalate and perhaps discuss the situation with a senior colleague. If there is disagreement or any concern that agreement can't be reached with the patient, and whānau/family, it is important this is clearly documented.

The Credentialed Specialist may access legal advice if needed from a legal advisor

What do I do if the patient's condition changes?

The shared goals of care decision-making process and documentation do not replace clinical judgement. If the patient's condition changes or there are any concerns, it is important they are clinically reviewed.

If the shared goals of care change, a new plan needs to be discussed, agreed and documented. The earlier plan must be clearly crossed out.