________________ Health Service **Residential Goals of Care – SAMPLE ONLY SEPTEMBER 2023** GP / Doctor: ________________	Surname	UMRN / MRN	
	Given Name	DOB	Gender
	Address		Post Code
		Telephone	

Please complete this form in discussion with the person (resident), person responsible, appointed guardian(s) and / or family / carer(s), and refer to any advance care planning (ACP) documents.

The form helps establish the most appropriate, agreed-upon goal of care that will apply in the event of the person's deterioration, in line with their preferences and priorities of care. The form is complementary to ACP but does not replace Advance Health Directives (AHD) and Enduring Powers of Guardianship (EPG).

Refer to organisation guidelines or instructions for further information about using the form.

SECTION 1: BASELINE INFORMATION Current health, illnesses and / or significant co-morbidities:

List the resident's current health, any illnesses and co-morbidities. Discuss likely complications (e.g. falls, chest infections), disease process / trajectory with resident / family

In the event that the person is unable to speak for themselves, who would they wish to speak for them?

'Person responsible' name: ***This may be a family member, NOK or Appointed Guardian***

Relationship: ***Check - has the resident discussed their preferences with the person?***

Interpreter required: ☐ Yes ☐ No ***For residents with English as a second language or communication difficulties, an interpreter or communication aid should be used***

Does the person have the following document(s)? (*also check My Health Record and local digital records*)

- Advance Health Directive (AHD) ☐ Yes ☐ No If yes, copy in file? ☐ Yes
- Values & Preferences Form / Advance Care Plan ☐ Yes ☐ No If yes, copy in file? ☐ Yes
- Advance care plan for a person with insufficient decision-making capacity ☐ Yes ☐ No If yes, copy in file? ☐ Yes
- Is there an appointed guardian for this person? ☐ Yes ☐ No

  If 'Yes', indicate guardianship type: ☐ EPG ☐ SAT appointed ☐ P

If 'yes', review the content with resident / person responsible.

Appointed guardian name: ***If EPG, check details available on file / record*** Phone:______

SECTION 2: SUMMARY OF DISCUSSION(S), PREFERENCES AND PRIORITIES OF CARE

Complete in discussion with the person / person responsible. Refer to any ACP documents above.

What matters most to the person in relation to:

- Values & wishes, physical, cultural, spiritual & environmental needs? (*include end of life preferences*).

What matters most to the resident? What do they value day to day / what makes them content?
What is personally meaningful to them about their culture / faith / spiritual beliefs?
Are there any religious or cultural practices they want to include in their care?
Are there any particular preferences in relation to customs / ceremonies that must be respected at end of life, death or after-death care?
Who would the resident want present (consider staff, pets). What type of environment is preferred? e.g. scents, music, singing, privacy preferences.

- Medical & life sustaining treatments, transfers & hospitalisations? (*discuss what can be provided at site*)

What are their preferences for being moved to hospital for treatments / care?
How will a transfer to acute care impact the resident?
What can be provided on site and when / why a transfer to hospital is required (post fall, injury).

- Treatments or situations that are undesirable / unwanted? (*include regional / metro hospital preferences*)

What treatments are not acceptable to the person or family?
Discuss benefits and burdens of artificial feeding, breathing, life sustaining medications.
Are there any places the person DOES NOT want to be treated at / transferred to?

Preferred place for end of life care: ***Is there a preference for where they are cared for?***

Location of end of life requests / funeral information (if applicable): ***Is this kept separately? On a different form? Is this kept with a family member?***

SAMPLE

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SECTION 3: GOAL OF CARE (Tick only one and complete Section 4 below to be valid).

Select the most medically appropriate goal of care that aligns with the person's preferences for care (as outlined in Section 2), that will apply in the event of the person's condition deteriorating. **This is subject to clinical judgement at the time of proposed treatment, to ensure the treatment is in the person's best interest.**

☐ **All Life Sustaining Treatment including CPR**

*Transfer to hospital (including metropolitan hospitals) if required treatment cannot be provided in facility.

Ensure residents / family aware this will require hospital transfer. Discuss / consider the resident's likely response to CPR.

☐ **Life Extending Treatment with treatment ceiling**

*Specify maximum level of support that can be provided in facility before transfer to hospital is required:

Not for CPR

Discuss with residents / family that CPR will not be provided by staff should the resident deteriorate, however, the resident / family may agree to have other life extending treatment such as IV antibiotics, IV fluids, non-invasive ventilation. Ensure family / resident are aware that required treatments may require transfer to hospital.

☐ **Optimal Comfort Treatment**

Not for CPR
Not for intubation
Not for ICU
Not for hospital transfer unless measures fail to maintain comfort & dignity at facility

*Active symptom and comfort care including:

Outline the comfort / symptom management available in the facility, and what care may require hospital transfer. Ensure family aware they will still be notified of resident's condition should they deteriorate. Refer to Regional Palliative Care team for assistance with physical / psychosocial support.

** Consider referral to specialist palliative care team / clinici

SECTION 4: DISCUSSION(S) AND REVIEW

Was the person able to participate in the discussion(s)? ☐ Yes ☐ No (*if 'No' reason MUST be in*

If 'No', comment : ***The reason the person was unable to participate MUST be included.***

Name(s) of people involved in discussion(s): ***Include family / carers names and all multidisciplinary and care workers to ensure accurate record of who was involved***

Include cultural representatives in discussions where appropriate (Aboriginal representative).

Optional for person / person responsible to sign below to acknowledge the purpose of the form was e... they are aware they can revisit or revoke the form at any time. A copy can be provided on request.

Goal of care explained to: ☐ Person ☐ Person responsible ☐ Other: ______________________

Name: ____________________ Signature: ____________________________ Date: ___ / ____ / ____

Clinician completing form (name): ______________________________ Designation: __________

Signature: ______________________________________ Date: ____/____/____ Time: ____

Validating Doctor / Nurse Practitioner (name): _______________________ Designation: ____

Signature: ______________________________________ Date: ____/____/____ Time: ____

MHR upload is not available in all facilities / sites.

☐ Valid for up to 12 months OR until: _______ / _____ / _______ (maximum 12 months)

☐ **Yes to MHR upload** (tick if person provided instruction to upload copy of form to their My Health Record)

REVIEW BY DOCTOR / NURSE PRACTITIONER (at 12 months or earlier if indicated)

Review date: ____/____/___ Goal of Care unchanged: ☐ Yes (sign below) ☐ No (complete new form)

Name: ____ Designation: __________

Signature: ______________________________________ Date: ____/____/_____ Time

☐ Valid for a further 12 months OR until: ______ / _____ / ______ (maximum 12 months)

☐ **Yes to MHR upload** (tick if person provided instruction to upload copy of form to their My He

Once validated, extends to transfer between facilities / hospital (provide copy during

You must complete a new form if goal of care changes, or significant new information available

SAMPLE