Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Factsheet for response teams supporting shared goals of care decisions

(Rapid response and medical emergency teams, hospital coordinators and other responders)

Shared goals of care discussions:

- are facilitated by the appropriate clinician(s)
- should happen close to admission
- include those the patient wishes to have with them
- take place in an environment that maintains patients' privacy and dignity
- are supported by governance systems, organisational culture and resourcing
- have cultural safety as an essential component
- are clearly documented.

Patients, whānau and clinicians are supported before, during and after the discussion.

Basing clinical treatment plans on shared goals of care reduces the risk of a patient receiving unwanted or unwarranted treatments if their condition deteriorates. Effective communication is necessary to draw out patients' values and preferences for care and allow informed choices to be made about complex medical treatment options. Ideally, such discussions occur prior to episodes of acute deterioration so patients, families, whānau and clinicians can participate fully in developing shared goals of care without the pressures of an evolving clinical crisis.

Shared goals of care

Shared goals of care are when the patient, their family and 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 if the patient deteriorates.

At a minimum, shared goals of care should identify the overall direction for an episode (for example, curative, restorative, improving quality of life or comfort whilst dying[1]), outlining which treatments are more likely to cause benefit than harm.

Shared goals of care focus on providing appropriate care – what we can do – rather than what we won't do.

1 Thomas R, Zubair M, Hayes B, et al. 2014. Goals of care: A clinical framework for limitation of medical treatment. *Medical Journal of Australia* 201: 452–5.

What is my role?

- Locate and familiarise yourself with the shared goals of care form and decision that has been reached.
- Initiate or continue appropriate treatment, including but not limited to cardiopulmonary resuscitation and/or intensive care unit referral, in line with the agreed shared goals of care.
- Ensure family, whānau, enduring power of attorney, legally appointed guardians or others identified on the shared goals of care form, and next of kin or point-of-contact have been notified of the change in the patient's condition.
- Consider the overall goals agreed with the patient, family and whānau and begin planning for any escalation of care that may occur, such as processes for consulting with or transfer to an intensive care unit. This may include movement of other patients.
- Any change to the shared goals of care requires a new discussion, as detailed further on in this factsheet.
- Be aware that all members of the clinical team may require reflection/debrief following a critical event. Consider the wider team, such as the role of the telephonists. Access your district health board (DHB) process for debrief.

How shared goals of care work

There are three parts to the discussion. All members of the clinical team have a role to play.

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 family and whānau'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.

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

The goal of care for the current admission and the reasons for not having the discussion should be documented and signed on the shared goals of care form. Additional documentation may also be present in the clinical record.

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

You will need to escalate and discuss the situation with the senior clinician responsible for the care of the patient. If there is disagreement or any concern that agreement can't be reached with the patient, family and whānau, it is important that this is clearly documented.

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

The shared goals of care decision-making and documentation do not replace clinical judgement. If the patient's condition changes or there are any concerns, it is important that they are clinically reviewed in line with DHB protocols and clinical judgement. If the shared goals of care change, a new plan needs to be discussed, agreed and documented, and the earlier plan must be clearly crossed out.

More information

Go to:
https://www.hqsc.govt.nz/our-programmes/patient-deterioration/workstreams/shared-goals-of-care/
or contact your local DHB's patient deterioration programme lead.