Use of a Goals of Care Plan as a Limitation of Medical Treatment Instrument

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Introduction

In March 2011, the Royal Hobart Hospital (RHH) in Tasmania implemented a new limitation of medical treatment instrument, the 'Goals of Care Plan' (GOCP) to facilitate considered and appropriate limitations of treatment for individual patients and establish goals of care for each admission to the RHH.

Patients are assigned to one of four categories: curative with no limitations (A), curative with limitations (B), palliative (C) and terminal (imminently dying) (D).

An audit of compliance with the GOCP prior to inpatient death at the RHH was done two years after introduction of the GOCP.

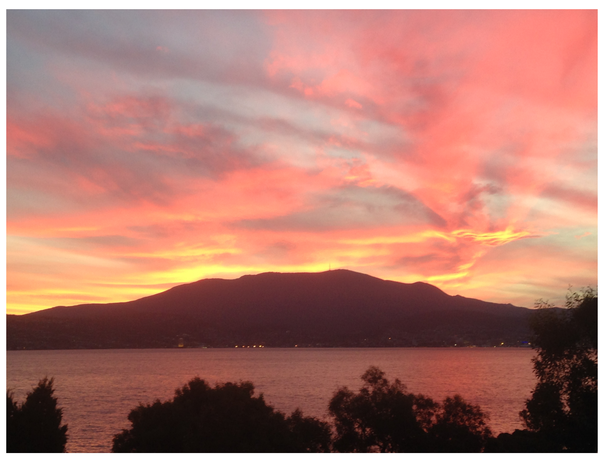
Aim

To audit compliance with and report outcomes following use of a limitation of medical treatment instrument entitled 'Goals of Care Plan' (GOCP) over the course of a final admission. The secondary outcome was to assess its role in the recognition of dying.

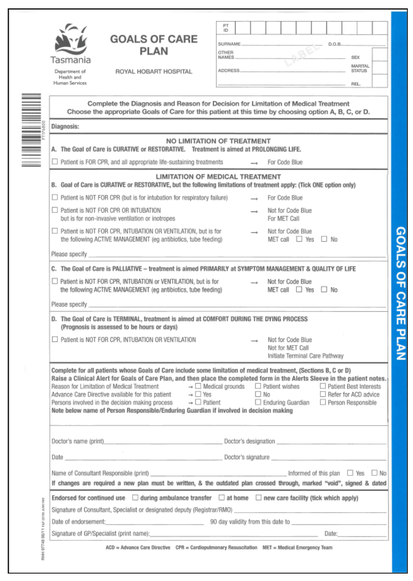
Method

Retrospective analysis of the Digital Medical Record (DMR) of all deceased patients in the Tasmanian Health Service–South (THO-S) over the six-month period 1/1/2013 – 30/6/2013.

The THO-S comprises the RHH as the tertiary referral centre and five Multi-Purpose Centres (MPC's) for Southern Tasmania servicing a population of approximately 250,000.



Sunset over Mount Wellington, April 2015. Photo courtesy of Dr C. Edwards.



GOALS OF CARE PLAN

Tasmania
Department of Health and Human Services

ROYAL HOBART HOSPITAL

Complete the Diagnosis and Reason for Decision for Limitation of Medical Treatment
Choose the appropriate Goals of Care for this patient at this time by choosing option A, B, C, or D.

Diagnosis:

NO LIMITATION OF TREATMENT

A. The Goal of Care is CURATIVE or RESTORATIVE. Treatment is aimed at PROLONGING LIFE.

☐ Patient is FOR CPR, and all appropriate life-sustaining treatments → For Code Blue

LIMITATION OF MEDICAL TREATMENT

B. Goal of Care is CURATIVE or RESTORATIVE, but the following limitations of treatment apply: (Tick ONE option only)

☐ Patient is NOT FOR CPR (but is for intubation for respiratory failure) → For Code Blue

☐ Patient is NOT FOR CPR OR INTUBATION but is for non-invasive ventilation or inotropes → Not for Code Blue For MET Call

☐ Patient is NOT FOR CPR, INTUBATION OR VENTILATION, but is for the following ACTIVE MANAGEMENT (eg antibiotics, tube feeding) → Not for Code Blue MET call ☐ Yes ☐ No

Please specify

C. The Goal of Care is PALLIATIVE – treatment is aimed PRIMARILY at SYMPTOM MANAGEMENT & QUALITY OF LIFE

☐ Patient is NOT FOR CPR, INTUBATION or VENTILATION, but is for the following ACTIVE MANAGEMENT (eg antibiotics, tube feeding) → Not for Code Blue MET call ☐ Yes ☐ No

Please specify

D. The Goal of Care is TERMINAL, treatment is aimed at COMFORT DURING THE DYING PROCESS (Prognosis is assessed to be hours or days)

☐ Patient is NOT FOR CPR, INTUBATION OR VENTILATION → Not for Code Blue Not for MET Call Initiate Terminal Care Pathway

Complete for all patients whose Goals of Care include some limitation of medical treatment, (Sections B, C or D)
Raise a Clinical Alert for Goals of Care Plan, and then place the completed form in the Alerts Sleeve in the patient notes.

Reason for Limitation of Medical Treatment → ☐ Medical grounds ☐ Patient wishes ☐ Patient Best Interests
Advance Care Directive available for this patient → ☐ Yes ☐ No ☐ Refer for ACD advice
Persons involved in the decision making process → ☐ Patient ☐ Enduring Guardian ☐ Person Responsible
Note below name of Person Responsible/Enduring Guardian if involved in decision making

Doctor's name (print) Doctor's designation

Date Doctor's signature

Name of Consultant Responsible (print) Informed of this plan ☐ Yes ☐ No

If changes are required a new plan must be written, & the outdated plan crossed through, marked "void", signed & dated

Endorsed for continued use ☐ during ambulance transfer ☐ at home ☐ new care facility (tick which apply)

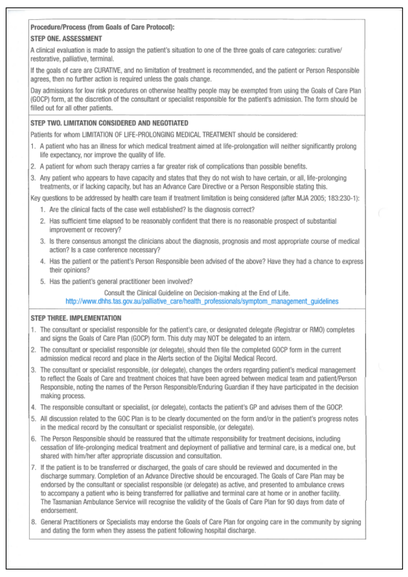
Signature of Consultant, Specialist or designated deputy (Registrar/RMO)

Date of endorsement 90 day validity from this date to

Signature of GP/Specialist (print name) Date:

ACD = Advance Care Directive CPR = Cardiopulmonary Resuscitation MET = Medical Emergency Team

Royal Hobart Hospital Goals of Care Plan (Front page).



Procedure/Process (from Goals of Care Protocol):

STEP ONE. ASSESSMENT

A clinical evaluation is made to assign the patient's situation to one of the three goals of care categories: curative/restorative, palliative, terminal.

If the goals of care are CURATIVE, and no limitation of treatment is recommended, and the patient or Person Responsible agrees, then no further action is required unless the goals change.

Day admissions for low risk procedures on otherwise healthy people may be exempted from using the Goals of Care Plan (GOCP) form, at the discretion of the consultant or specialist responsible for the patient's admission. The form should be filled out for all other patients.

STEP TWO. LIMITATION CONSIDERED AND NEGOTIATED

Patients for whom LIMITATION OF LIFE-PROLONGING MEDICAL TREATMENT should be considered:

1. A patient who has an illness for which medical treatment aimed at life-prolongation will neither significantly prolong life expectancy, nor improve the quality of life.
2. A patient for whom such therapy carries a far greater risk of complications than possible benefits.
3. Any patient who appears to have capacity and states that they do not wish to have certain, or all, life-prolonging treatments, or if lacking capacity, but has an Advance Care Directive or a Person Responsible stating this.

Key questions to be addressed by health care team if treatment limitation is being considered (after MJA 2005; 183:230-1):

1. Are the clinical facts of the case well established? Is the diagnosis correct?
2. Has sufficient time elapsed to be reasonably confident that there is no reasonable prospect of substantial improvement or recovery?
3. Is there consensus amongst the clinicians about the diagnosis, prognosis and most appropriate course of medical action? Is a case conference necessary?
4. Has the patient or the patient's Person Responsible been advised of the above? Have they had a chance to express their opinions?
5. Has the patient's general practitioner been involved?

Consult the Clinical Guideline on Decision-making at the End of Life.
http://www.dhhs.tas.gov.au/palliative_care/health_professionals/symptom_management_guidelines

STEP THREE. IMPLEMENTATION

1. The consultant or specialist responsible for the patient's care, or designated delegate (Registrar or RMO) completes and signs the Goals of Care Plan (GOCP) form. This duty may NOT be delegated to an intern.
2. The consultant or specialist responsible (or delegate), should then file the completed GOCP form in the current admission medical record and place in the Alerts section of the Digital Medical Record.
3. The consultant or specialist responsible, (or delegate), changes the orders regarding patient's medical management to reflect the Goals of Care and treatment choices that have been agreed between medical team and patient/Person Responsible, noting the names of the Person Responsible/Enduring Guardian if they have participated in the decision making process.
4. The responsible consultant or specialist, (or delegate), contacts the patient's GP and advises them of the GOCP.
5. All discussion related to the GOC Plan is to be clearly documented on the form and/or in the patient's progress notes in the medical record by the consultant or specialist responsible, (or delegate).
6. The Person Responsible should be reassured that the ultimate responsibility for treatment decisions, including cessation of life-prolonging medical treatment and deployment of palliative and terminal care, is a medical one, but shared with him/her after appropriate discussion and consultation.
7. If the patient is to be transferred or discharged, the goals of care should be reviewed and documented in the discharge summary. Completion of an Advance Directive should be encouraged. The Goals of Care Plan may be endorsed by the consultant or specialist responsible (or delegate) as active, and presented to ambulance crews to accompany a patient who is being transferred for palliative and terminal care at home or in another facility. The Tasmanian Ambulance Service will recognise the validity of the Goals of Care Plan for 90 days from date of endorsement.
8. General Practitioners or Specialists may endorse the Goals of Care Plan for ongoing care in the community by signing and dating the form when they assess the patient following hospital discharge.

Royal Hobart Hospital Goals of Care Plan (Back page).

Results

There were 352 deaths over the six months, 328 at the RHH and 24 at the five MPC's.

Table 1. Age and Gender of Deceased Patients 1/1/2013 – 30/6/2013

Age Range	Deceased Males	Deceased Females	TOTAL
0yrs	4	4	8
1-10yrs	1	0	1
11-20yrs	2	1	3
21-30yrs	4	0	4
31-40yrs	4	2	6
41-50yrs	10	3	13
51-60yrs	29	14	43
61-70yrs	43	27	70
71-80yrs	54	35	89
81-90yrs	46	35	81
91-100yrs	14	20	34
Totals	211	141	352

290 (82.4%) patients had a completed GOCP and 62 (17.6%) did not.

After exclusion of sudden unexpected deaths and the rural MPC deaths, the compliance rate for GOCP completion was 94.5%.

74% of forms were completed on the day of admission and 83.5% within 48 hours.

Final GOCP category was either C or D for 86% of the deceased patients studied.

78% of patients assigned to category D died within 72 hours reflecting expectation of dying within hours to days.

Of the 62 patients without a GOCP, 45(73%) died within 72 hours of admission. Many were sudden, unexpected deaths with 27 (44%) dying within 24 hours of admission. 12 patients died in the rural MPC's where the GOCP was not formally in use.

Table 2. No GOCP Group (62 patients = 17.6%)

Comments On No GOCP deaths	No of patients
Post arrest via ambulance or arrested in DEM/ICU	15
Intracranial Haemorrhage/SAH/massive stroke	9
Transfers to RHH from intrastate	7
Very premature babies (<25 weeks)	6
MPC's where GOCP not formally in use	12
Coroner's cases	8

Discussion

The 'Healthy Dying' initiative at the RHH incorporates the GOCP at the time of admission. Treating doctors assess and discuss treatment options with the aim of allowing thoughtful consideration about the appropriateness of providing potentially futile life-sustaining treatments (such as CPR, intubation, ventilation, inotropic support and parenteral feeding), particularly in the frail aged and those with advanced disease.

In those patients with GOC A or B on admission, it was interesting to note that 72 hours appeared to be a consistent timeframe to reassess progress and note signs of deterioration. Having some limitations to treatment appropriately negotiated within the B group may provide both the patient and their families with a 'warning shot' that their situation is fragile. The hope is for a good response to return home and to also acknowledge that deterioration is possible.

Conclusion

Compliance with completion of the GOCP at the RHH two years after its introduction was very high at 94.5% adjusted and done in a timely manner (83.5% within 48 hours).

There was timely recognition of the imminently dying patient, and the GOCP framework prompted appropriate limitations to medical treatment escalation, and deployment of necessary and appropriate palliative and terminal care. Skilled communication is critical whilst discussing goals of care and can be taught.

Acknowledgements

Dr Robyn Thomas, Staff Specialist Palliative Medicine, RHH

References:

Smith CB, O'Neill LB. Do Not Resuscitate does not mean Do Not Treat: How palliative care and other modalities can help facilitate communication about goals of care in advanced illness. Mount Sinai J Med 2008; 75: 460-465. ***Clayton JM, Hancock KM, Butow PN***, Tattersall MNH, Currow DC. Clinical Practice Guidelines for communicating prognosis and end-of-life issues with adults in the advanced stages of a life-limiting illness, and their caregivers. MJA 2007; 186(12): S77-S108. ***White J, Fromme EK***. "In the beginning…" – Tools for talking about resuscitation and goals of care early in the admission. Am J Hosp Palliat Care 2013; 30:676-682 ***Smith RL, Hayashi VN, Lee YI et al***. The Medical Emergency Team Call: A Sentinel Event that triggers Goals of Care Discussion. Critical Care Medicine Journal 2014; 42(2): 322-327***ANZSPM*** Position Statement 2014 on Quality End-of-Life Care – Part 1