EMR300070

Hospital: .....

GOALS OF PATIENT CARE

Ward: .....

Dr / Consultant: .....

Family Name	UMRN	
First Name	DOB	Gender
Address		Postcode

SECTION 1 BASELINE INFORMATION

Primary illness: _____

Significant co-morbidities: _____

In the event that the patient is unable to speak for themselves, who would they wish to speak for them? This is known as the **'Person responsible'**

Name: _____ Relationship: _____

Does the patient have?:

* Advance Health Directive (AHD) ☐ Yes ☐ No
* Advance Care Plan (ACP) ☐ Yes ☐ No
* Enduring Power of Guardianship (EPG) ☐ Yes ☐ No

EPG contact name: _____ Phone: _____

* Does the patient have a registered organ donation decision? ☐ Yes ☐ No
* Are the family aware of the patient's donation decision? ☐ Yes ☐ No

Clinician's Name (please print):_____ Designation: _____

Date: _____/_____/_____Time: _____Signature: _____

SECTION 2 GOAL OF CARE

Please tick one only and complete section 3 over the page to be valid. In discussion with the clinician, patient, person responsible and/or family/carer(s), please select the most medically appropriate agreed goal of patient care that will apply in the event of clinical deterioration.

☐ **All life sustaining treatment**

* For Rapid Response (MER/MET Calls)
* For CPR
* For ICU

☐ **Life extending intensive treatment – with treatment ceiling**

* Not for CPR

* For Rapid Response ☐ Yes ☐ No
* For ventilatory support, including intubation ☐ Yes ☐ No
* Specify maximum level of support .....
* For ICU/HDU admission ☐ Yes ☐ No
* *Additional comments (e.g. use of inotropes, NIV, dialysis)* .....
  .....

☐ **Active ward based treatment – with symptom and comfort care**

* Not for CPR
* Not for ICU
* Not for intubation

* For Rapid Response ☐ Yes ☐ No
* For ventilatory support (intent is symptom control) ☐ Yes ☐ No
* Specify maximum level of support .....
* *Additional comments (e.g. use of antibiotics, IV fluids)* .....
  .....

☐ **Optimal comfort treatment – including care of the dying person**

* Not for Rapid Response
* Not for CPR
* Not for intubation
* Not for ICU

* For ongoing review to identify transition to the terminal phase
* Ensure timely commencement of the *Care Plan for the Dying Person*

All patients can have Rapid Response based on 'Worried Criteria' or to 'Summon Clinical Review'.

DO NOT WRITE IN MARGIN

ESCALATION PLAN

GOALS OF PATIENT CARE SUMMARY

MR00H.1

HCCZZFMR00H1

MR00H.1
10/19

Hospital:	Family Name	UMRN	
GOALS OF PATIENT CARE	First Name	DOB	Gender
Ward:	Address		Postcode
Dr / Consultant:			

SECTION 3 SUMMARY OF DISCUSSION(S)

Goals of Patient Care has been discussed with: Date: ____/____/____Time: _____

Patient: ☐ Yes ☐ No Person Responsible: ☐ Yes ☐ No Family/carer(s): ☐ Yes ☐ No

Name(s) of those present at this discussion: _____

_____

_____

Is the patient able to fully participate in this discussion? ☐ Yes ☐ No

Comments: _____

_____

_____

What is the patient's likely response to CPR and critical intervention? _____

_____

_____

_____

Patient preferences (needs, values and wishes): _____

_____

_____

_____

_____

_____

Decision rationale for agreed **Goals of Patient Care** (please tick one only):

☐ Medically-driven decision ☐ Patient wishes ☐ Shared decision-making

Other information:

_____

_____

_____

_____

Doctor's name (please print): _____Designation: _____

Signature: _____Date: ____/____/____Time: _____

Consultant review completed: Name (please print): _____

Signature: _____Date: ____/____/____Time: _____

SECTION 4 EXTENDED USE

ENDORSEMENT BY A CONSULTANT

Consultant endorsement for extended use beyond this admission for 12 months or until ___ /___ /____

This includes patient transportation to another facility or home following the current admission.

Consultant's comments: _____

_____

_____

_____

_____

Consultant's name (please print): _____Signature: _____

Specialty: _____Date: ____/____/____Time: _____

DO NOT WRITE IN MARGIN