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| **Residential Aged Care Facility**  **GOALS OF CARE**  **Medical Treatment Orders**  Facility …………………………………………………..  Address ………………………………………………… | | AFFIX IDENTIFICATION LABEL HERE  U.R. NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GIVEN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DATE OF BIRTH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_\_\_\_\_\_ | | | | **RACF - GOALS OF CARE** |
| **TO BE COMPLETED BY DOCTORS ONLY**  **Main health problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Advance Care Directive / Advance Care Planning document for this Resident? ❑ No ❑ Yes *(ensure copy in Resident’s file)*  Medical Treatment Decision Maker (MTDM) if patient lacks capacity to make medical decisions  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Resident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Has the MTDM been appointed by the Resident? ❑ No ❑ Yes *(ensure copy of document in Resident’s file)*  Identify the appointment: ❑ MTDM ❑ MEPOA ❑ Enduring Guardian ❑ EPOA Personal ❑ VCAT Guardian | | | | | |
| **Choose ONE option from A, B, C or D --- Add further comments when required.**  **If UNSURE about goals, or treatment decisions, contact the GP or Residential In-Reach for advice.** | | | | | |
|  | | | | | |
| **GOAL A: FOR TREATMENT OF ALL REVERSIBLE ILLNESS** | | | | | |
| ❑ | **FOR CPR and appropriate life-sustaining treatments** | | 🡺 ***FOR TRANSFER TO HOSPITAL IF*** *required treatment cannot be provided in the facility* | | |
|  |  | |  |  |  |  |  |
| **GOAL B: FOR TREATMENT OF REVERSIBLE ILLNESS WITH FOLLOWING LIMITATIONS** | | | | | | **MEDICAL TREATMENT ORDERS** |
| ❑ | NOT FOR CPR or INTUBATION - but is for other appropriate life-sustaining treatments | | 🡺 ***FOR TRANSFER TO HOSPITAL IF*** *required treatment cannot be provided in the facility* | | |
|  | | | | | |
| **GOAL C: FOR TREATMENT OF REVERSIBLE ILLNESS WITH SIMPLE, NON-BURDENSOME**  **TREATMENT. FOR GOOD SYMPTOM MANAGEMENT. NOT FOR CPR or INTUBATION** | | | | | |
| ❑  *OR* | **FOR TRIAL OF TREATMENT AT THE FACILITY, if this can be done without causing excessive distress. If deteriorates despite this, for comfort measures only.** | | 🡺 ***NOT FOR TRANSFER TO HOSPITAL UNLESS symptoms cannot be managed in the facility. eg fracture*** | | |
| ❑ | **NOT FOR LIFE-PROLONGING TREATMENT of new illness / deterioration. All treatment is aimed at comfort and relieving symptoms.** | | 🡺 ***NOT FOR TRANSFER TO HOSPITAL UNLESS symptoms cannot be managed in the facility. eg fracture***  *🡺* ***Commence Palliative Care Plan*** | | |
|  |  | |  |  |  |  |  |
| **GOAL D: COMFORT DURING DYING – TERMINAL CARE (prognosis assessed as hours / days)** | | | | | | GOPC Version Sept 2017 |
| ❑ | **All treatment is aimed at relieving symptoms and supporting the Resident and their family / important others.** | | 🡺 ***NOT FOR TRANSFER TO HOSPITAL UNLESS symptoms cannot be managed in the facility. eg fracture***  *🡺* ***Commence Palliative Care Plan*** | | |
| **I have discussed above Goals of Care with**  ❑ Resident ❑ Medical Treatment Decision Maker *(named above)*  Others involved in discussion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Doctor’s name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Designation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Doctor’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ❑ **Review in** \_\_\_\_\_\_\_\_\_ **months**  *OR* ❑ **Review as needed** | | | | | |
| CPR = Cardiopulmonary Resuscitation  MEPOA = Medical Enduring Power of Attorney EPOA Personal = Enduring Power of Attorney for Personal Matters  MTDM = the person who is the legal medical treatment decision-maker for the Resident who lacks capacity to do this for themself | | | | | |

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| **Residential Aged Care Facility**  **GOALS OF CARE**  **Medical Treatment Orders**  (For completion by Doctors only) | AFFIX IDENTIFICATION LABEL HERE  U.R. NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GIVEN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DATE OF BIRTH: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ SEX: \_\_\_\_\_\_\_\_\_\_\_ |

**RECORD OF DISCUSSION ABOUT TREATMENT GOALS AND LIMITS TO TREATMENT ESCALATION**

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*(date & sign entries; update as needed)*

**Ensure a copy of Goals of Care and copies of any Advance Care Planning documents**

**are sent with the Resident if transferring to hospital.**

**WRITE COMMENTS ON GOAL CATEGORY, IF NEEDED FOR CLARIFICATION OR TO RECORD VARIATIONS**

**eg. Goal of care is non-burdensome treatment but to receive CPR – tick Box C and write clearly ‘FOR CPR’**

***RACF GOALS OF CARE*** *is a medical treatment order. It describes a medical treatment plan that takes account of:*

*(i) the Resident’s medical illness, illness trajectory and the limits to what is medically feasible; and*

*(ii) the Resident’s preferences and values related to medical treatment, within the limits of what is medically feasible.*

*Date / time Include details of content of discussion and who was involved*