FNH010212

Northern Health

RESIDENTIAL AGED CARE
GOALS OF CARE
MEDICAL TREATMENT ORDERS

AFFIX PATIENT IDENTIFICATION LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____ SEX: _____

Facility: _____ **Address:** _____

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:_____ Contact 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

❑ 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

❑ 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*

OR

❑ 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)

❑ 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 ❑ MTDM (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 themselves

HEALTH

NORTHERN

RESIDENTIAL AGED CARE – GOALS OF CARE – MEDICAL TREATMENT ORDERS

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GOALS OF CARE
MEDICAL TREATMENT ORDERS

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U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____ SEX: _____

(For completion by Doctors only)

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.

Record of discussion about treatment goals and limits to treatment escalation

Date / Time	Details of who was part of the discussion & the content of discussion
	(date & sign entries; update as needed)

WRITE ADDITIONAL 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'

Ensure a copy of Goals of Care and copies of any Advance Care Planning documents are sent with the Resident if transferring to hospital.