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GOALS OF CARE, LIMITATION OF TREATMENT AND RESUSCITATION POLICY- DRAFT 9 (MA)

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Initiator:

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Applies to:

RHH Clinical Staff

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Approved by:

Acting CEO

Authorised by:

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Aim

To ensure the patients who are unlikely to benefit from medical treatment aimed at cure receive care appropriate to their condition, and are not subjected to burdensome or futile treatments (particularly cardiopulmonary resuscitation and MET calls), especially where this is, or may be, contrary to their wishes.

Policy:

1. Medical treatment aimed at either cure or restoration of a patient's condition will be instigated (subject, whenever possible, to consent from the patient or Person Responsible*), in all cases where it is considered appropriate to do so, unless otherwise stated in a 'Goals of Care, Limitation of Treatment & Resuscitation Plan' (GCLT&RP)[1].
2. A GCLT&RP should be made on the dedicated form designed for this purpose (see Appendix Two).
3. A GCLT&RP should be filled out for each patient as part of each admission process.
4. The ultimate responsibility for clinical decision-making and management of patients rests with the medical head of the unit under whom the patient is admitted, following appropriate consultation other staff within their team, and other units or services involved.
5. Decisions regarding limitation of medical treatment are to be accompanied by a clearly defined management plan and regularly reviewed.
6. A decision regarding limitation of medical treatment can be rescinded or changed at any time by the patient or Person Responsible (see below).
7. A GCLT&RP may result in a need to address end of life issues and the timely and appropriate deployment of palliative care.[2]
8. A GCLT&RP **applies to the current admission only.** Where relevant, discussions and decisions about GCLT &RPs can be a useful starting point for Advance Care Planning for future admissions and treatment decisions if the patient is discharged or transferred.

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* There is legal provision for emergency medical treatment to proceed without consent if the patient lacks decision-making capacity, there is no guardian or person responsible immediately available, and delay would be dangerous. See Appendix One for a definition of Person Responsible

1. For all numbered items see Appendix One - Definitions

Standards:

The 'Goals of Care, Limitation of Treatment & Resuscitation Plan' (GCLT&RP) aligns with: EQuIP4 1.1.2; the RHH Strategic Plan 4.1. and 4.2; and Palliative Care Australia Standard 6.

Rationale:

This Policy relates to decisions regarding whether or not to administer medical treatment aimed at cure, remission or restoration of a patient's condition. It recognises that there are limits to the capacity of modern medical treatment to achieve cure, remission or even restoration of a patient's health status and function, and these need to be defined and communicated with clarity and compassion when the need arises. Here are the guiding principles:

- Death is an inevitable consequence of having life. No amount of medical progress can change this fact. Whilst the hospital and its clinical staff recognise a primary duty to try to save and prolong life, this does not mean that we are obliged to treat the dying as if they can be cured.

- If cure, remission or restoration of condition and function are not possible, the hospital has a responsibility to institute palliative care. The best possible pain and symptom relief in the clinical circumstances is both a patient's right and a health carer's duty.
- Appropriately negotiated treatment abatement and administration of symptom relief do not constitute causing death.
- Food and drink are always made available, but medical provision of fluids and nutrition via intravenous lines or enteral feeding tubes is neither mandatory nor indicated during the dying process.
- A person's dying days are of just as much value as their non-dying ones.
- A person has a right to have their beliefs, needs and wishes recognised and respected at all stages of life, including when they are dying. Care should be based on viewing the patient's needs in the context of the whole person rather than a series of (medically defined) parts.
- Care is always focused on the needs and wishes of individual patients. However, due acknowledgement of the patient's key relationships (family and friends) and social context is also important. Few people live in a complete social vacuum and psychological, social, bereavement and other practical support should be offered (where appropriate, and according to resources available) to family, friends and carers.
- Wherever possible, people should have the option of receiving palliative care in the setting that most suits their needs and wishes: home (including nursing home), hospital or specialist hospice/palliative care unit.
- Access to palliative care should be based on patient and family need, rather than solely on prognosis and/or disease type.

The three categories or phases of goals of care: curative, palliative and terminal.

Decision-making is based on determining the **Goal of care** for the patient, whereby the patient's situation is assigned to one of three phases of care according to a realistic assessment of the probable outcomes of medical treatment at this stage of their illness trajectory. The phases are: *curative, palliative and terminal* (Ashby and Stoffell 1991). Patients move from one category to another during their illness trajectory. For some patients cure is never an option, even at presentation, and others only present in the terminal phase. The key question at each ward round is: "what are our goals of care for this patient today?"

Curative Phase ('beating it')

This is the default position for all patients, and all appropriate life-prolonging treatment will be deployed as indicated.

- *Aim:* In the curative phase the goals of care are directed towards cure or prolonged remission.
- *Prognosis:* indefinite, normal life expectancy possible. A key question might be: "is there a reasonable chance of the patient leaving hospital and living a normal life span?" In Aged Care the goals may be 'restorative', ie the question is: "is there a reasonable chance of the patient returning to their previous level of functioning?"
- *Level of adverse effects:* A high level of adverse effects and even a significant chance of treatment-related mortality may be accepted for curative treatment (eg, brain aneurysm surgery, bone marrow transplant). Whilst pain and symptom control should always be addressed, comfort may be secondary consideration if it conflicts with curative treatment.
- *Life-sustaining treatments* all given as needed.
- *Medical provision of hydration and alimentation:* yes.
- *Cardio-pulmonary resuscitation:* yes.

Palliative Phase ('living with disease, anticipating death')

- *Aim:* In the palliative phase the disease is deemed to be incurable and progressive, and the goals of care are modified in favour of comfort, quality of life and dignity. Length of survival is no longer the sole determinant of treatment choice and life-prolongation is advised to be a secondary objective of medical treatment.
- *Prognosis:* Months, but sometimes years (NB if this is the case then 'supportive' care may be a more appropriate term and patients may elect to have curative treatment until the disease, although always incurable, ceases to respond). A key question might be: "would I/we be surprised if this patient died in the next 3-6 months?"
- *Level of adverse effects:* Active treatment of the underlying disease may be undertaken for specific symptoms (e.g. radiotherapy or chemotherapy for palliative endpoint). All treatment-related adverse effects should be proportionate to the goals.
- *Life-sustaining treatments* for other chronic medical conditions are usually continued (e.g.: insulin, anticonvulsants) where cessation would result in premature death unrelated to the main disease that is anticipated to result in death, or where quality of life would be adversely affected. (see Abernethy & Currow).
- *Medical provision of hydration and alimentation:* Given if indicated and desired. (Example: PEG feeding for head and neck cancer patients with obstructed swallowing).
- *Cardio-pulmonary resuscitation (CPR)* is usually not recommended, but this should be discussed with the patient, if competent. If death and dying have already been explicitly discussed with the patient or person responsible, it may be concluded in some situations, that specific discussion of CPR is not warranted.

Terminal Phase ('dying very soon')

- *Aim:* In terminal phase, death is believed to be imminent. Comfort, quality of life and dignity are now the only considerations.
- *Prognosis:* Hours or days. A key question is: "would I/we be surprised if this patient died this week?"
- *Level of adverse effects:* Active treatment of the underlying disease stopped. No treatment-related toxicity is acceptable, this applies to all medical, nursing and allied health interventions.
- *Life-sustaining treatments* for other chronic medical conditions are usually stopped (eg steroids, insulin, anticonvulsants), unless to do so would cause suffering.
- *Medical provision of hydration and alimentation:* Usually ceased and replaced with feeding on request and rigorous mouth care.
- *Cardio-pulmonary resuscitation* is not recommended and a not for resuscitation order is negotiated.
- *Consider:* Implementation of an 'Inpatient end of life Care Pathway'.

Procedure/Process:

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 (see above).

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 GCLT&RP form, at the admitting consultant's discretion. The form should be filled out for all other patients.

STEP TWO. LIMITATION CONSIDERED AND NEGOTIATED

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

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. A GCLT&RP form is to be completed and signed by the senior treating medical practitioner or delegate.
2. The GCLT&RP form is then filed in the current admission medical record, and placed on the Alerts section of the Digital Medical Record.
3. The patient's medical management orders are changed to reflect the Goals of Care and treatment choices that have been agreed.
4. The patient's GP is to be contacted by the treating medical practitioner and advised of the GCLT&RP.
5. All discussion related to the GCLT&RP is to be clearly documented on the form and/or in the patient's progress notes in the medical record.
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.

PALLIATIVE CARE

If the Goals of Care are PALLIATIVE, consult the Palliative Care Guidelines (http://www.dhhs.tas.gov.au/palliative_care/health_professionals/symptom_management_guidelines) and palliative care drug formulary (http://www.dhhs.tas.gov.au/palliative_care/health_professionals/formulary), and consider referral to the RHH Palliative Care Consultative Service, by paging the Clinical Nurse Consultant. A duty medical palliative care consultant is available for advice via the RHH switchboard.

TERMINAL CARE

If the Goals of Care are TERMINAL then an End of Life ('Liverpool') Care Pathway should be initiated and the Terminal Care Clinical Guidelines should be consulted
http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0016/47050/Terminal_Care_Final290909_PCSSubComm.pdf. The pathway is reviewed at three days if death has not occurred.

References:

Limitation of Medical Treatment Policy (2004). Melbourne Health.

RHH 'Not for Cardiopulmonary Resuscitation Policy and Procedure' (COC 27).

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Ellershaw J. Care of the dying: what a difference an LCP makes! Palliative Medicine 2007; 21: 365-368.

Dying with Dignity: Guidelines on the Care and Management of People who are Dying, 1998. DC&HS, Tasmania.

Royal Hobart Hospital Respecting Patient Choices Pilot Project. Final Report, March 2007. Prepared by Jenny Mason-Cox.

Guardianship and Administration Act 1995.

http://www.publicguardian.tas.gov.au/enduring_guardianship, accessed 24/2/08.

http://www.health.gov.au/palliativecare, accessed 24/2/08.

http://www.respectingpatientchoices.org.au/, accessed 24/2/08.

http://www.gpsouth.com.au/downloads/StatementofWishes%20patient%20info.pdf, accessed 24/2/08.

Stakeholders Consulted:

Clinical Ethics Committee

Directors of Nursing, Medical, Surgery, WACS, ICU, DEM.

Audit Tools:

Annual audit of GCLT&RP Form documentation, together with annual audit of GCLT&RP discussions in the patient's Progress Notes in the medical record.

Appendices:

1. Definitions
2. GCLT & RP Order form
3. Advance Care Directive form

Appendix One – Definitions

1. Goals of Care, Limitation of Treatment & Resuscitation Plan' (GCLT&RP). This is a document that forms part of a patient's Royal Hobart Hospital medical record that clearly sets out the goals of care for a patient, and where curative care is no longer assessed as being possible, and consequent limits are being set to the extent of medical treatment for that patient, the reasons for these decisions, and the process of consultation.
2. Palliative Care. The DHHS Palliative Care Service utilises the following definition of palliative care, which is based on the 2002 World Health Organisation definition: *"… an approach that improves quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention of suffering by early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual."*

Other Definitions

Advance Care Planning and Advance Care Directive

Advance care planning is a process of planning for future health and personal care so that a person's values, beliefs and preferences are made known to guide decision-making at a future time when the person cannot make or communicate these decisions themselves. This can either be done by appointing another person to speak for you, or by making written instructions, or both.

The written instruction document is often referred to as an Advance Care Directive (ACD). This can include any aspects of care that the person identifies as important, and in particular, nominate any specific treatments or outcomes that the person wishes to avoid. An ACD for Care at the End of Life has been developed for use in Tasmania (Appendix 3), and people are recommended to fill one out regardless of their present health status. All patients attending the hospital should be offered assistance to complete one. ACDs have common law status in Tasmania, and there is no particular format mandated by law or statute.

Advance Care Planning and Advance Care Directive for a Person lacking Capacity

A common law advance directive in Tasmania, for a person who lacks capacity completed on that person's behalf by a Person Responsible in consultation with the person's treating unit or general practitioner.(Appendix 3)

Advance Directives in other forms.

A statement made in any recognisable format, and in a recognised statutory or non-statutory format from another jurisdiction, may give valuable evidence about a patient's wishes and values. There is an ethical requirement to giving any such document due consideration in the decision-making process.

Enduring Guardian.

A person appointed by law in Tasmania to speak for and make medical decisions for a person who lacks capacity.

To appoint an Enduring Guardian a specific form is required.

An Enduring Guardian can make decisions on a person's behalf only if they are unable to make or communicate decisions themselves. An Enduring Guardian is not authorised to make financial decisions.

An Enduring Guardian must be at least 18 years of age and mentally competent to

make these decisions.

A person may choose to appoint one Enduring Guardian, Joint Enduring Guardians and/or an alternate Enduring Guardian.

The alternate Enduring Guardian will only make decisions on a person's behalf if the primary Enduring Guardian/s is unavailable, or incapable of making decisions.

Two witnesses must sign the Enduring Guardianship form. By law the nominated Enduring Guardian cannot also be a witness to the same Enduring Guardianship form.

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Person Responsible

For patients who lack capacity, a substitute decision-maker known as the Person Responsible will be approached to discuss the GC&RP, according to the hierarchy laid down by Section 4 of the Guardianship and Administration Act. (http://www.guardianship.tas.gov.au/__data/assets/pdf_file/0007/67057/6_Person_Responsible.pdf)

- The person responsible is not necessarily the patient's next of kin. It is a statutory concept defined in the Act. A person responsible makes decisions for children and adults who have a disability and who are incapable of consenting to treatment.
- If the patient is a child, the person responsible is the child's parent or guardian.
- If the patient is an adult, the person responsible in priority order is either:
  - a guardian (including an enduring guardian) who has the power to consent to health care, which includes the power to refuse or withdraw consent to treatment
  - a spouse - including a de-facto spouse
  - an unpaid carer who is now providing domestic services or support to the patient, or who provided these services and support before the patient entered a residential facility
  - a relative or friend who has both a close personal relationship and a personal interest in the patient's welfare.
- It is the responsibility of the medical practitioner recommending treatment to determine whether a person qualifies as the patient's person responsible. If the medical practitioner cannot decide between competing persons, the matter should be referred to the Board.
- There can only be one person responsible for the patient.

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