



## **Procedure/Process (from Goals of Care, Limitation of Treatment and Resuscitation Policy):**

### **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 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 MEDICAL TREATMENT 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](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.