Residential Goals of Care

Please discuss these points with the Person, Person Responsible and / or Family / Carer(s).

- The form is designed to support and facilitate ongoing Advance Care Planning (ACP) discussions.
- It is supplementary to an Advanced Health Directive (AHD) and will support Enduring Power of Guardianship (EPG), Next of Kin (NOK) and Family throughout ACP discussions.
- The most appropriate, agreed-upon clinical decision will be made with the intent to honour individuals wishes as outlined in this form.

SECTION 1: BASELINE INFORMATION  Primary illness and significant co-morbidities:

<table>
<thead>
<tr>
<th>Primary illness and significant co-morbidities:</th>
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In the event that the person is unable to speak for themselves, who would they wish to speak for them?

This is known as the ‘Person Responsible’

Name: ___________________________  Relationship & Contact: ____________________________

Does the person have:

- Advanced Health Directive (AHD)  
  - Yes  
  - No
- Advance Care Plan  
  - Yes  
  - No
- Is there an appointed Guardian for this person?  
  - Yes  
  - No
- If Yes, indicate Guardianship type:  
  - EPG  
  - SAT Guardian  
  - Public Advocate

EPG Contact Name: ___________________________  EPG Contact: ________________________________

SECTION 2: SUMMARY OF DISCUSSION(S), PREFERENCES AND PRIORITIES OF CARE

The discussions and decisions are informed by any advance care planning documents ticked in Section 1.

Things to consider: (Person’s Needs, Values, Wishes)

- What is important to the person re hospitalisation and / or life sustaining treatments?

- What are the person’s cultural, spiritual and environmental needs? (Consider end of life preferences).

- What treatments or situations are undesirable to the person.?

Preferred Place of End of Life: ______________________________________________________

Funeral Preference Discussed:  
  - Yes  
  - No

Interpreter Required:  
  - Yes  
  - No  Languages: ________________________________________
SECTION 3: GOAL OF CARE (Tick only one and complete Section 4 below to be valid).
In discussion with the clinician, person / family / legal representative / person responsible, please agree the most medically appropriate goal of care that will apply in the event of the person’s condition deteriorating. This is subject to clinical judgement at the time of proposed treatment, to ensure the treatment is in the person’s best interest.

- **All Life Sustaining Treatment including CPR**
  *Transfer to hospital if required treatment cannot be provided in the facility (including transfer to metropolitan hospitals if required).

- **Life Extending Treatment with treatment ceiling**
  *Specify maximum level of support including transfer to hospital if required treatment cannot be provided in the facility. (Consider referral to palliative care).

- **Optimal Comfort Treatment**
  *Active symptom and comfort care including (Consider referral to palliative care):

  - Not for CPR
  - Not for intubation
  - Not for ICU
  - Not for hospital transfer unless for symptom management

SECTION 4
Name(s) of those involved in discussion(s): ____________________________________________

Was the person able to take part in the discussion:  
☐ Yes  ☐ No

If No, Comment: ________________________________________________________________

Is there a shared agreement about this Goals of Care decision?  
☐ Yes  ☐ No

Name (Person or Responsible Person): ________________________________________________

Signature: ___________________________ Date: ____/____/____ Time: __________

Clinician completing the form:
Name: ___________________________ Designation: (DR / RN / EN / SW) _________

Signature: ___________________________ Date: ____/____/____ Time: __________

Medical Officer validating form:
Name: ___________________________ Designation: (DR / MO) __________________

Signature: ___________________________ Date: ____/____/____ Time: __________

This form is valid until: ____/____/____ (Maximum one year or if change in health status)

Person / Responsible Person consent to share form:  ☐ RACF  ☐ GP  ☐ Other: ____________________