Information for Residential Aged Care

It is important to understand that an Advance Care Planning document completed by a Resident for themselves is the best information. If a Resident is admitted with a Victorian Advance Care Directive, do not ask them to transfer the information to a facility Advance Care Planning form unless they want to update their Advance Care Planning document.

Similarly, do not ask a family to transfer the information from an Advance Care Directive, completed by a person with capacity, onto a facility form if the Resident has now lost capacity. This is exactly why the Advance Care Directive was completed, and it is now time to use it.

The RACF Goals of Care form can be a way to bring together the Advance Care Planning with the information that is now available about the Resident's health condition.

The RACF Goals of Care form is a summary of their medical treatment plan. It describes the treatment that the Resident or their MTDM consents to within the limits of what might be possible. It is clear information that can be accessed quickly in a crisis and acted upon. Think of the RACF Goals of Care as a 'now care plan'. It is based on the current illness context. If that illness context changes, the Goals of Care will need to be updated. Similarly, if a Resident with capacity to change their mind about the treatment they would consent to, their Goals of Care will also need updating.

In Victoria, there is a range of support available depending on your location:

- Your local Residential InReach service
- Victorian Virtual Emergency Department based at Northern Health
  Home – Victorian Virtual Emergency Department (vved.org.au)
- Palliative Care Advice Service
  Phone: 1800 360 000 (7 am-10 pm every day)
- Community Palliative Care Services

If you have questions about interpreting Advance Care Planning documents, it may be helpful to speak to the Office of the Public Advocate Victoria if you don't have someone to seek advice from.

Aged Care Facility Goals of Care Form

FNH010212

NORTHERN HEALTH

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 ☐ 3 points of ID checked

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: ____/____/____ Time: ________

☐ 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

RESIDENTIAL AGED CARE – GOALS OF CARE – MEDICAL TREATMENT ORDERS

010212