Caressant Care Nursing and Retirement Homes Limited

| PROCEDURE NO. | PROCEDURE TITLE:<br>Goals of Care Form |
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# Goals of Care

It is important that we understand your personal health needs and goals to align care that is respectful of your desired outcomes.

Goals of care conversations provide a framework for us to work together when discussing treatment decisions and informed consent. These conversations can help prepare you for decisions you have to make, or prepare your SDM(s) for decision-making at a time when you are mentally incapable to provide informed consent. You are no longer mentally capable to make an informed decision if a medical professional has assessed that you (the resident) are not able to understand the information and appreciate the consequences of the decision required. If a determination has been made that you are not mentally capable to provide informed consent for a treatment decision, this will be documented in your health record and your SDM(s) will be required to make the health or personal care decision on your behalf.

**Elements of a person-centered goals of care (GoC) discussion should include:**

- Asking permission to engage in a GoC conversation (staff to provide information of what GoC is and purpose of engaging in the conversation)
- Assessment of the Resident's/SDM(s) understanding of their illness/conditions (diagnosis) and prognosis
- With the permission of the patient, providing information about the trajectory and prognosis for this illness/condition, and what to expect in the future.
- Understanding the Resident's values, beliefs, and personal and clinical goals.
- Discussions and information sharing around the available treatment options; and which of them would meet the care goals identified by the Resident
- Recognition and respect that the articulation of goals may take some time and thought to consider and finalize.
- An understanding that goals can be revisited at any time and especially with a change in health status and may require input from other team members or specialists

## Documentation of Goals of Care Discussion*

| **Ask Permission**: | **Document Answers in Resident's/SDM's Words:** |
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| "e.g. Would it be Okay with you if we talked about what is important to you now and how that might make a difference in how we look after you?" | |

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| **Assess Understanding**:<br><br>"e.g. Can you tell me in your own words what is happening with your health? What is your understanding of why you are now coming to our home for care?" | **Document Answers in Residents/SDMs own Words:**<br>"e.g. I don't know what is wrong, I just know that I can't look after myself anymore." |
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| **Inform**:<br><br>Permission may be necessary again – "e.g. Can I tell you from what we have seen what usually happens to people who have this?"<br>What other information would be helpful to you?" | **Document Information you Provided to Resident/SDM:**<br>"e.g. SDM wishes to hear all information. We discussed the prognosis of memory loss and the likely future complications. |
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| **Goals & Values**:<br><br>Ask about what matters to your resident – "e.g. What is important to you now and what are your most important goals? What are your biggest fears and worries about the future? Does your family know about your goals and priorities?" | **Document Answers in Residents/SDMs Words**:<br>"e.g. I don't want to be a burden to my family; I still want to spend time with my children and grandchildren; I don't want to be pain; I am worried about falling." |
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| **Make a Plan:**<br><br>Based on goals and values (or, explain why some goals are not achievable) "e.g. Perhaps if we reduced some of your medication you might be less likely to fall; we could ask our physiotherapist to see you." | **Document Next Steps** (e.g. we will ask the doctor to review your medication list with you) |

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| **Time to Think**:<br>Explain that the articulation of goals may take some time, discussion, and thought to consider and finalize. Consider the need for a further meeting. | |

☐ I agree that my goals and my decisions about treatment could be documented in my health record and shared with my care providers.

☐ If my condition changes my plan of care will be reviewed and a new plan of treatment will be developed with consent from myself or my SDM(s), based on my condition at the time.

**Resident Name: _____**

**Signed: _____**

**Date: _____**

**Caressant Care Health Care Professional/Staff who discussed and documented the Goals of Care:**

**Print Name: _____**

**See Also:**

Other Tools listed here

| **APPROVED:** | **REVISED/REVIEWED:**<br>February 2020 | **AUTHORIZED BY:**<br>Caressant Care Operations Team |
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*Adapted from: **Person-Centred Decision-Making:** Documenting **Goals of Care** Discussions,