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| Shared goals of care – COVID-19 in the community | February 2022 |

This form documents the shared goals of care discussion for a COVID-19 patient, who is at higher risk of deterioration with COVID-19. This document should inform healthcare treatment decision-making while the patient has COVID-19.

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| **Family Name** |  |
| **Given Name** |  |
| **Gender** |  |
| **Date of Birth** |  |
| **NHI#** |  |

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| **PREPARE** |  |  |  |
| Is the patient competent to make health-related decisions? | Yes | No | Unknown |
| Does the patient have an advance care plan and/or advance directives? | Yes | No | Unknown |
| Does the patient have a legally appointed guardian? | Yes | No | Unknown |
| Does the patient have an Enduring Power of Attorney Personal Care & Welfare (EPA)? | Yes | No | Unknown |
| Full name of EPA or legal guardian | | | |
| Contact details of EPA or legal guardian | | | |
| Full name(s), relationship(s) and role(s) of those present/on the call | | | |
| If discussion was not held with the patient, please record the reason | | | |
| **DISCUSS - use the COVID-19 serious illness conversation guide** | | | |
| What is their understanding of their current condition and what may lie ahead? | | | |
| ***Share your understanding of their current condition and what may lie ahead. Allow silence and respond to emotion*** | | | |
| What is important to them if their health does get worse? | | | |
| What are they most worried about? | | | |
| What helps them through the tough times? | | | |
| What abilities so important, they can’t imagine living without them? | | | |
| What are they willing to go through to try get better? | | | |
| Place of care preference if they deteriorate, e.g. hospital name or address in the community | | | |
| If they are very sick with COVID and decisions need to be made about their care, who would they like to be included?  Name: Contact Number: | | | |
| **CLOSE** | | | |
| Summarise and check for shared understanding. Provide your recommendations. | | | |
| ***Reach a shared decision about the goal of care if they deteriorate. Document the goal of care overleaf.*** | | | |

**Following the discussion, select the agreed goal of care:**

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| 1. A | The goal of care is **restorative (attempt CPR)**.  Treatment aims to restore the health status to best possible.  Transfer to acute hospital if treatment cannot be provided in the community.  Attempt CPR: it is clinically recommended and in accordance with the person's known wishes. |
| Additional comments: |
| 1. B | The goal of care is **restorative**.  Treatment aims to restore the health status to best possible.  Transfer to acute hospital if treatment cannot be provided in the community.  **Do not attempt CPR**: this is likely to cause more harm than benefit or is not wanted by the person. |
| Additional comments: |
| 1. C | The goal of care is active care **in the community**  Treatment aims to slow decline and enhance quality of life.  Do not transfer to acute hospital, unless comfort cannot be maintained, or transfer is advised by doctor/nurse practitioner.  **Do not attempt CPR:** this is likely to cause more harm than benefit. |
| Additional comments including recommended treatments: |
| 1. D | The goal of care is **comfort**.  Treatment aims to optimise comfort rather than attempt to prolong life. When in the last hours or days of life, consider end-of-life guidelines such as Te Ara Whakapiri.  **Do not attempt CPR or transfer to acute hospital.** |
| Additional comments: |

🞐 This plan has been discussed with the person. If not, record reason on page 1.

🞐 A copy has been provided to the patient.

🞐 Usual general practice team informed, if applicable.

🞐 Uploaded to the COVID Clinical Care Module (CCCM).

Name: Date: / /

Role: Signature:

**This plan is not valid unless signed and dated.** Clinically review the person if there are concerns or a change in their condition. Any change to the goal of care requires a new plan and the earlier plan crossed out.

**Ensure a copy of this plan accompanies the patient on any transfer of care.**