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| Supporting shared goals of care discussions and decisions for patients with COVID-19  | February 2022 |

**Purpose**

* This factsheet is for health care teams, working with patients in the community assessed as at higher risk of becoming severely unwell after testing positive for COVID-19.
* It explains how to explore patient and whānau values and preferences for care and use what matters most to them to support clinical decision making if they were to become severely unwell after testing positive for COVID-19.
* It describes how to use the [Shared goals of care – COVID-19 in the community](https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-information-health-professionals/covid-19-advice-all-health-professionals#talkingcovid) (“CitC SGoC”) and the [Serious Illness Conversation Guide Aotearoa: Patient with COVID-19 in the community at increased risk of deterioration](https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-information-health-professionals/covid-19-advice-all-health-professionals#talkingcovid) (“CitC Guide”).
* The tools are **not mandatory** for you to use but will be useful to facilitate person- and whānau-centred discussions and decision making.

**Background**

The [COVID-19 Care in the Community Framework](https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-health-professionals/caring-people-covid-19-community) (“The Framework”) provides direction for organisations and providers who are caring for people with COVID-19 in the community. Care should be based on the needs of the person and whānau rather than the needs of the providing organisations.

Older adults, and those living with chronic or life-limiting conditions, are at increased risk of experiencing severe or critical symptoms associated with COVID-19 infection and are more likely to die. They may also experience non-COVID-19-related deterioration in their health status during this period. Advance care planning is critical for this cohort and should form a key part of our health system's COVID-19 response strategy.

Advance care planning is about shared decision-making and delivering care that is person and whānau-centric now and in the future, including at end-of-life. It is not only about death and dying; it is about preparing, the person, their whānau and their healthcare team for what may lie ahead. Advance care planning assists with making decisions in the future, that align with what matters most for that person (their values, concerns, goals and care preferences).

Ideally, these preparatory conversations would happen before people contracted COVID-19. They would take place between the person, their whānau and their medical team.

The CitC SGoC and CitC Guide support COVID-19 specific advance care planning conversations and clinical decision making for patients with COVID-19 who are at higher risk of deterioration. They are the latest additions to a suite of advance care planning resources and are an extension of the resources available on the Health Quality and Safety Commission’s [talkingCOVID website.](https://www.hqsc.govt.nz/our-work/advance-care-planning/talkingcovid/covid-19-and-communicating-with-patients-and-whanau/)

Individuals are being encouraged to think about what matters most if they were to become very sick with COVID-19, what they are worried about, what their priorities are and what gets them through the tough times. Resources for the public available on the Ministry of Health website: [COVID-19 community preparation resource](https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-resources-and-tools/covid-19-being-prepared-what-most-important-you-if-you-become-unwell-covid-19).

**Why shared goals of care are important in the COVID-19 community response**

The process of shared goals of care:

* ensures that what matters most to the patient and whānau informs care planning and delivery.
* is based on Te Tiriti principles to ensure cultural safety (for more about cultural safety, please refer to the [serious illness conversations reference guide for health care professionals](https://www.hqsc.govt.nz/resources/resource-library/serious-illness-conversations-reference-guide-for-health-care-professionals/)).
* provides a framework that is easily accessed, clear and consistent, and based on sound principles, evidence and experience.
* supports you and your colleagues to identify the overall direction of care if the patient was to become more unwell while they have COVID-19 (for example, a restorative, active community care or comfort approach).

When clinical treatment plans are founded on the creation of a shared goal, there is less risk of patients receiving unwanted or unwarranted treatments if their condition worsens.

# What is your role in the shared goal of care process?

Any healthcare professional (doctors, nurses and other healthcare providers) involved in the care of the patient can prepare for, discuss shared goals of care with the patient and their whānau. Often the best person to lead the discussion is a member of the healthcare team who has an existing relationship with the patient and their whānau.

It is important that, as you prepare for the discussion, you clarify with the healthcare team:

* Their understanding of the patient’s current condition and what may lie ahead for them during their COVID-19 illness.
* What future treatments may be offered.

The CitC SGoC form must be checked and signed by a doctor or nurse practitioner.

**How shared goals of care work**

Ideally shared goals of care discussions and planning should be undertaken for all adults assessed as being at a **high risk of deterioration** following a COVID-19 diagnosis. This should happen as early as possible in their COVID-19 illness.

**The shared goals of care process**

**Step 1 - Prepare**

* Gather information, including the patient's capacity, privacy needs, wishes for support people they would like to have present or on the call and any cultural needs.
* Review the patient's information to gain an understanding of their current condition and what may lie ahead for them during their COVID-19 illness.
* Check if they have an advance care plan or advance directive that might be relevant or if they have captured any information on the [COVID-19 community preparation resource](https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-higher-risk-people).
* Identify something that will help you quickly build rapport/whakawhanaungatanga.
* Determine what future treatments may be offered.
* Arrange to talk to the patient and where possible, arrange to have whānau/support people involved.
* *Note: The patient must agree to the discussion going ahead*

**Step 2 – Discuss**

* Build rapport/whakawhanaungatanga with the person – for more information about how to do this, see the [serious illness conversations reference guide for health care professionals](https://www.hqsc.govt.nz/resources/resource-library/serious-illness-conversations-reference-guide-for-health-care-professionals/).
* Acknowledge that this is difficult, but important. If you are not face to face, acknowledge that this is not ideal.
* If you use the CitC Guide,stick to the order of the conversation prompts and, where possible, use the words in the guide (they are evidence-based and tested with those with lived experience) to:
	+ explore the patient’s current understanding of their condition. Explore this with whānau too.
	+ share information with the patient about your understanding of their current condition, and what may lie ahead for them.
	+ explore the patient's values and what is important to them. What matters most to one patient, if they became seriously ill with COVID-19, may be different from what matters most to somebody else.
	+ explore what abilities are so important to them that they can’t imagine living without them and how much they would be willing to go through to try to get better. The responses to these questions will support the clinicians who need to make decisions about care and treatment, to better understand what quality of life is for this patient.
	+ ask about the preferred place of care on deterioration. This gives you an indication of preference. It does not dictate the place of care.
	+ clarify who would they like to be included in decision-making if they are very sick with COVID-19. Check that the named decision-support person/s understand what is most important to the patient.
	+ summarise and check for shared understanding.
	+ recommend a plan including the goal of care for this episode of COVID-19 and close. Explain your recommendation in plain language and then reach a decision with the patient, EPoA, and whānau for the goal of care.

**Step 3 - Document**

* Use the CitC SGoC to capture the keys points of the conversation and the agreed goals of care.
* Document any other relevant advance care planning information.

**Step 4 - Use**

* Share the plan with the patient, and offer them a copy.
* Ensure the documentation is readily available to others.

**Documenting the shared goals of care decision**

This section provides you with guidance about each of the goals of care.

**Goal of care ‘A’ outlines that:**

* the expectation and shared goal is for the patient to recover, and
* full resuscitation, including cardiopulmonary resuscitation (CPR - defined as rescue breaths and chest compressions) and any other appropriate life-sustaining treatments, are recommended and appropriate.

A shared goals of care discussion that results in **goal of care ‘A’** may be straightforward and brief, if the patient and whānau understand the clinical situation, and would like full treatment and escalation to hospital\* if the patient deteriorates.

*\*(escalate to hospital care via local integrated COVID hub)*

**Goal of care ‘B’ outlines that:**

* the expectation and goal are for the patient to recover.
* if the patient were to deteriorate, cardiopulmonary resuscitation (CPR - defined as rescue breaths and chest compressions) should not be attempted as it is unlikely to be successful, is likely to cause more harm than good, or the patient does not want it regardless of the outcome.
* escalation to hospital\* is appropriate if supportive care and treatment cannot be provided in the community.

*\*(escalate to hospital care via local integrated COVID hub)*

**Goal of care ‘C’ outlines that:**

* treatment is primarily aimed at improving quality of life and controlling symptoms in the community.
* in some cases, transfer to acute hospital may be appropriate, particularly if treatments such as auxiliary oxygen and supportive cares are needed and not available in community.
* treatments should be provided after considering whether the benefit of the treatment will enhance wellbeing, and would be easily tolerated by the patient.
* CPR (defined as rescue breaths and chest compressions) should not be attempted.

**Goal of care ‘D’ outlines that:**

* the patient is dying. Coordination and clinical support for palliative care will be escalated via local integrated COVID-19 hub.
* the aim is to alleviate suffering and allow a natural death. Resuscitation including CPR (defined as rescue breaths and chest compressions) should not be attempted.

# If the patient’s condition changes

The shared goals of care decision-making process and documentation does not replace clinical judgement. If the patient’s condition changes or there are any concerns, it is important they are clinically reviewed in line with relevant protocols and clinical judgement. If the shared goals of care change, a new plan needs to be discussed, agreed and documented. The earlier plan must be clearly crossed out or closed if this is recorded electronically

**Most importantly:**

* Keep the patient and their whānau in sharp focus. Be person-centric, not pandemic-focused.
* Follow the CitC Guideif you need support with these discussions.
* Acknowledge how difficult the situation is and how we wish it were different.
* Be honest and kind.
* Continue to include the patient and their whānau as much as possible in all planning and decision-making.
* These are extraordinary times and supporting these conversations can take a toll. Take care of yourself and seek collegial support.