


# Moving Towards ‘Goals of Care’ Plans for all Hospital Inpatients

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## Dear Editor,

We wish to congratulate the authors on their article, ‘Moving from “Do Not Resuscitate” Orders to Standardized Resuscitation Plans and Shared-Decision Making in Hospital Inpatients’ for highlighting the complexities and advancements of this important topic. We would like to share our recent experiences addressing this in an Irish university teaching hospital (Dignam et al., 2021).

The term ‘Do Not Attempt Cardiopulmonary Resuscitation’ (DNACPR) was chosen in our hospital to highlight that CPR is not always successful and should be attempted judiciously. A DNACPR form was introduced to standardise and improve documentation. As outlined by the authors, a concern is that ‘No CPR’ orders can negatively affect patient care due to misinterpretation (Dignam et al., 2021; O’Brien et al., 2018). Therefore, our form also included a ‘Treatment Escalation Plan’ (TEP) highlighting the appropriate treatment in the event of deterioration.

Poor documentation of resuscitation orders was highlighted by the authors and has been particularly pertinent in the context of COVID-19. Healthcare professionals, the media and patients have become more aware of the importance of discussing goals of care (Coleman et al., 2020). In this context, we designed a new ‘Goals of Care’ (GoC) form for all inpatients to replace the DNACPR form. The form is colour coded, with easy-to-read language. An appropriate goal should be selected, A indicates for CPR, invasive ventilation and ICU if required. B indicates not for CPR, however, for consideration of ventilation, ICU and inotropic support. C indicates not for CPR, however, for best ward level care including non-invasive ventilation. D indicates comfort care or end of life care. The form promotes considered appropriate treatment and moves away from blanket ‘DNACPR’ forms that may put patients at risk of treatment being withheld or delayed. This is similar to ‘Universal Form

of Treatment Options’ which has been shown to significantly reduce the risk of harmful events in patients not for CPR (Fritz et al., 2013).

Our form is consistent with the article’s ‘resuscitation plan’; however, we feel ‘Goals of Care’ may be more palatable to physicians and patients alike. Similar to the authors, we believe that a GoC form promotes a culture of shared decision-making and good communication. It encourages clinicians to consider and discuss appropriate care in a timely fashion. As the article suggests the replacement of ‘do not resuscitate’ with ‘allow natural death’ promotes a move from paternalistic medicalisation to patient-centred care with an acknowledgement that dying is a natural process.

One point to challenge is the language in the conclusion that resuscitation plans are a means of ‘protecting frail, old and dying inpatients from interventions that may be ineffectual, unwanted and distressing.’ Whilst this is true to some extent, the principal aim of these plans is to ensure appropriate care that is patient centred and – *which would be effectual, wanted and ease distress*. This emphasises the move away from paternalistic practice towards medicine in keeping with the patient’s own goals. Overall, this article provided a comprehensive review and aligns with the shift in practice and thinking we are witnessing.

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