Implementing the Comprehensive Care Standard

Identifying goals of care

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Disclaimer

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Contents

Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality-assurance mechanism that tests whether relevant systems are in place to ensure expected standards of safety and quality are met.

The second edition of the NSQHS Standards includes the following eight standards:

- Clinical Governance Standard
- Partnering with Consumers Standard
- Preventing and Controlling Healthcare-Associated Infection Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard.

One of these standards, the Comprehensive Care Standard relates to the delivery of comprehensive care for patients within a health service organisation. Safety and quality gaps are frequently reported as failures to provide adequate care for specific conditions, or in specific situations or settings, or to achieve expected outcomes in particular populations.

A focus on patient experience is critical to the delivery of comprehensive care. Developing a shared understanding between clinicians and patients provides a foundation for trust, and a basis for discussion about healthcare options. Understanding a patient's values, and their expectations and aspirations for their health and wellbeing helps to establish their goals of care and contributes to everyone's understanding of the actions to be taken.

Having a clear, shared understanding of goals of care is crucial for all patients regardless of their diagnosis or prognosis, and is particularly important for patients with complex healthcare issues, such as comorbidities or life-limiting illness. Understanding the clinical situation of the patient is essential to the establishment of effective goals of care, and identifying and setting goals of care in collaboration with the patient ensures care is individualised.

The process of identifying goals of care involves a number of stages including goal negotiation, goal setting and evaluation. Goal setting tools have been reported to be useful in tailoring and monitoring treatment, improving team communication and clarifying team roles.[1] There is a range of common principles reflected in goal setting tools which can be used by health service organisations as a framework for goal setting.

This paper

This paper provides practical advice for clinicians and health service organisations about goal setting, based on the common principles found in many goal setting tools. It is part of a series of resources supporting implementation of comprehensive care that are based on six essential elements:

- Element 1: Clinical assessment and diagnosis
- Element 2: Identify goals of care
- Element 3: Risk screening and assessment
- Element 4: Develop a single comprehensive care plan
- Element 5: Deliver comprehensive care
- Element 6: Review and improve comprehensive care delivery.

This paper addresses **Element 2: Identify goals of care**. There are also separate short resources that include tips for patients and consumers and tips for clinicians.

The elements were developed to support practical implementation of the Comprehensive Care Standard and more information about all of the essentials elements is available from: Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care.[2]

This paper has been developed for:

- Clinicians involved in the delivery of care, providers of clinical education and training, research organisations and other health bodies
- Managers and executives responsible for developing, implementing and reviewing processes to support the identification of goals
- Planners, program managers and policymakers responsible for the development of state and territory governments or other strategic programs dealing with the processes associated with providing comprehensive care.

Element 2:
Identify goals of care

Purpose

To develop a shared understanding of:

- The patient's goals for their health care in the short-, medium- and long-term
- The clinical situation, including diagnosis, treatment options and clinical goals
- The patient's values, needs and preferences about their health and care
- The patient's expectations about the care episode and treatment outcomes.

Principles

- Communication about goals is person-centred and tailored to meet health literacy needs of the patient
- Patients, families, carers and other support people as identified by the patient, are involved in discussions about goals
- Clinicians have the skills and capacity to communicate effectively to discuss patient goals and preferences
- A shared understanding of the patient's clinical and personal goals drives comprehensive care planning.

Consumer actions

- Patients engage with clinicians and talk about what they want to achieve and what is important to them
- Families, carers and other support people participate in discussions, including goal setting conversations, when requested by the patient.

Clinician actions

- Clinicians use person-centred approaches to discuss the patient's wishes and expectations
- Clinicians consider the patient's level of health literacy, and tailor communication styles accordingly
- Clinicians identify who the patient wants involved in discussions about goals and planning
- Clinicians use the information about the patient's goals to inform and drive the comprehensive care plan and immediate action that may be needed
- Clinicians document and communicate the outcomes of goal setting discussions.

Organisational actions

- Health service organisations foster a person-centred culture in delivering comprehensive care, including supporting the identification of personal and clinical goals of care
- Health service organisations establish systems and processes that support eliciting and documenting goals of care
- Health service organisations provide access to training and education to support effective communication and a person-centred approach to care.

What are goals of care?

Goals of care describe what a patient wants to achieve during an episode of care, within the context of their clinical situation. Goals of care are the clinical and personal goals for a patient's episode of care that are determined in the context of a shared decision-making process. Identifying goals of care helps to organise and prioritise care activities and contributes to improved satisfaction, quality of life and self-efficacy for patients.[3-5]

The purpose of identifying and agreeing to goals of care is to develop a shared understanding between patients, family, carers, other support people and the clinicians in the multidisciplinary team about the clinical expectations, personal needs and preferences of the patient and the likely steps required to attain the agreed goals.

Goal setting

Identification of goals is variable in clinical practice. The literature on goal setting and goal attainment in health describes various frameworks and models that have been tested in small, specific and largely non-acute populations. This landscape can be confusing; however, the overarching principles are straightforward. Clinicians should, at a minimum, regularly ask patients what is important to them in relation to their health care. This enables a conversation that can inform healthcare planning. For some patients with less complex needs, this approach may be sufficient to gain an understanding of their goals and prompt discussion and shared decision making about care. An example of this approach has been implemented by the Scottish Government and Healthcare Improvement Scotland with their adoption of the 'What matters to you?' campaign to inspire more meaningful conversations between patients and people that provide care.[6] When using the 'What matters to you' approach to establishing goals, consideration should be given as to how this informs actions to include in the comprehensive care plan.

There are more structured approaches to goal setting, each with their own strengths and weaknesses. Popular tools available include: SMART goals; FAST goals; Think Big, Act Small, Move Quick (BSQ); and GROW methodology. However, there is no single gold standard tool that has been agreed for identification of goals in acute care settings. Despite the absence of a gold standard tool, using some kind of goal setting tool, framework or model can provide structure to a goal setting conversation, and serve as a mechanism to build rapport between the patient and clinician.[7]

Examples of goal setting tools

There has been considerable research on goal setting and negotiation, much of which originates in organisational psychology. Some of the tools that have been developed to assist in goal setting are designed specifically for determining the goal (such as SMART), while others span the cycle from goal setting to review (such as the GROW model).

Table 1 outlines tools that could be adapted or have been adapted to suit collaborative goal setting in health care. Where there has been published literature of use in a particular patient cohort or by specific clinical disciplines, it has been noted. Practical examples of how the tools may be used are included below.

Table 1: Summary of goal setting tools

Tool	Time needed to use the tool	Target patient population	Clinician group using the tool	Training required to use the tool
'What matters to you' campaign[6]	5–20 minutes	Not studied	Not studied	Nil
Goal Attainment Scaling (GAS)[8]	30–45 minutes[1]	Mental health Rehabilitation Outpatients[1] Substance abuse treatment Children Older people Brain injury	Occupational therapists	Training required
SMART/ SMARTER	5–20 minutes	Multiple patient populations including patients with diabetes[9, 10] and stroke[11]	Dieticians[9–11] Nurses[9] Occupational therapists[11] Speech therapists[11] Physiotherapists[11]	Minimal
FAST	15–30 minutes	Not studied	Not studied	Minimal
BSQ	5–20 minutes	Not studied	Not studied	Minimal
GROW	60 minutes	Not studied	Nurses	Training required

What matters to you?

The Institute for Healthcare Improvement encourages interactions with patients, families, carers and other support people that promotes a deep understanding of what matters to them. They recommend this as a foundation for developing genuine partnerships and using shared decision making in routine practice.[12]

'What matters to you?' day is a campaign promoted each year in June by the Scottish Government and Healthcare Improvement Scotland. On a specific day, conversations are encouraged to support meaningful listening by clinicians caring for patients, their families, carers and other support people by asking patients what matters to them. More information can be found on the 'What matters to you' website: https://www.whatmatterstoyou.scot/

Questions framed in this way provide an opportunity for patients to disclose their interests, values and preferences, and to promote understanding and empathy. Patients value the quality of interaction with their caregivers, and their perception of this correlates with their overall satisfaction.[13]

Goal Attainment Scaling

Goal Attainment Scaling (GAS) is a well-known tool which is based on the SMART acronym.[14] An example of GAS appears in **Figure 1**. GAS was originally designed for mental health settings and has been adapted for use in other healthcare settings.[15, 16]

Case study using goal attainment scaling

Isabella is a 17 year old female with cystic fibrosis (CF). Although she has had multiple lengthy hospital admissions, Isabella has kept up with her school work and is focused on completing her final high school exams alongside her peer group. Maintaining her education is a long-term goal that Isabella has discussed with her CF nurse specialist, general practitioner (GP) and respiratory physician. They have developed a comprehensive care plan that reflects Isabella's social and clinical goals, which Isabella brings with her when she is admitted to hospital with a chest infection.

Figure 1: Example of goal setting using GAS

Goal attainment scaling template

Name Isabella

Goal To be as well as I can be and to finish my HSC with my class

Timeframe 12 months

Category (select) [ ] Psychological [X] Medical Management [X] Vocational

Outcomes (list)

Most unfavourable outcome	Less than expected outcome	Expected outcome	More than expected outcome	Most favourable outcome
Not complete my HSC with my class and have multiple hospital admissions	ATAR below 70	ATAR of 70	ATAR above 80	ATAR above 85 No more admissions to hospital this year

To achieve goal (list)

Activities needed	Persons involved	Start date	End date
Do school work every day complete assignments from my regular school	Hospital teachers Me Mum My best friend Janine	On admission	Discharge
Get rid of my chest infection	Nurses Physios Doctors Pharmacist	On admission	Before discharge

Goal importance to the patient (select) [ ] Little [ ] Moderate [X] Great

Challenge to the patient in achieving the goal (select) [ ] Little [X] Moderate [ ] Great

SMART and SMARTER goals

A popular goal setting framework for over 20 years has been the SMART theory. The acronym calls for goals to be Specific, Measurable, Achievable, Realistic and Time-bound.[17] More recently SMART goals have become SMARTER with the inclusion of Evaluate and Record. An alternative SMARTER theory (Shared, Monitored, Accessible, Relevant, Transparent, Evolving, Relationship-centred) has been developed which has been used with patients and families in an aphasia rehabilitation setting, providing an easier way to express the collaborative aspects of clinical practice. **Table 2** outlines the goals of SMART and SMARTER.[18]

Table 2: SMART and SMARTER goals

	SMART	SMARTER	SMARTER[18]
S	Specific	Specific	Shared
M	Measurable	Measurable	Monitored
A	Achievable/attainable	Achievable/attainable	Accessible
R	Realistic	Realistic	Relevant
T	Time-bound	Time-bound	Transparent
E	–	Evaluate	Evolving
R	–	Record	Relationship-centred

Case study using SMART and SMARTER

Research suggests that to be successful in achieving goals patients need to feel connected to the goal and want to achieve the end point, and there must be parts of the goal that translate into actions. The following case study illustrates how combining clinical and personal goals can support goal attainment.

Rose is a 75 year old patient admitted to hospital after a stroke. She is now in a rehabilitation phase of her admission. She wishes to be able to return to regularly walking to the local RSL club for social activities with friends. Rose describes the distance as approximately 500 metres away from home and would like to walk there unaided daily. During the assessment Rose is unsteady on her feet and requires assistance from at least one person to mobilise to the bathroom. Rose's prospects for recovery with return to previous function are considered to be limited and it is anticipated that she will require devices to assist with walking.

The following is noted in the comprehensive care plan:

1. Refer to Aged Care Assessment Team
2. Mobilise when able
3. Transfer to rehab bed.

Also noted is Rose's desire to mobilise early. Framing this as a SMART goal could include:

- **Specific**: Rose's goal is being able to walk to the local RSL club unaided.

- **Measurable/monitored**: Measurement of progress towards the goal could focus on vital sign parameters or other symptoms such as fatigue and shortness of breath to determine tolerance and appropriateness in increases to the distance walked.

- **Achievable/attainable/accessible**: Chunking the goal into walking the length of the ward with assistance once a day, building up to being able to walk the length of the ward every two hours during the day without assistance.

- **Realistic**: Starting with a shorter distance and using assistance of a person or device until confidence and strength is increased.

- **Time-bound**: Walking the length of the ward once a day for three days, three times a day for two days, and every two hours within a week.

FAST goals

FAST goals[19] were developed for use in corporate settings as an alternative to SMART goals, but can be adapted easily for use in health care. The four principles that underpin the FAST framework stipulate that goals should be Frequently discussed, Ambitious, Specific and Transparent (FAST). **Table 3** presents these principles along with definitions and a description of potential benefits.

Table 3: FAST goals, definitions and potential benefits

	Principles	Definition	Potential benefits
F	**Frequently discussed**	Goals should be embedded in ongoing discussions to review progress, allocate resources and provide feedback.	• Provides guidance for care • Keeps the focus on what matters to the patient • Links clinical interventions to concrete goals • Allows for regular evaluation of progress.
A	**Ambitious**	Objectives should be difficult, but not impossible, to achieve.	• Boosts performance of individual and team • Encourages innovative ways to achieve goals.
S	**Specific**	Goals are translated into concrete metrics or milestones that clarify how to achieve each goal and measure progress.	• Boosts performance of individual and team • Clarifies what the patient wants to achieve • Helps identify what is and is not working.
T	**Transparent**	Goals and current performance should be documented on the comprehensive care plan and be readily available to all the care team — including the patient and their family, carer and other support people, as identified by the patient.	• Enhances understanding between patient and care team members • Enables support from the team • Identifies activities that are redundant or do not align.

Adapted from Sull and Sull[19]

BSQ

The BSQ (Think Big, Act Small, Move Quick) methodology[20] is based on the research that has found that goal attainment is more likely when goals are specific, ambitious and time-bound.

Thinking Big encourages the person to set an ambitious goal. Acting Small allows the person to chunk down the goal into smaller, achievable goals. Smaller steps in the right direction allow for 'quick wins' which spark motivation and provide the opportunity for re-evaluation and prioritisation of activities to achieve the overarching 'big' goal. Moving Quickly focuses on maintaining momentum and making continual progress. **Table 4** presents an example outlining this the methodology.

Table 4: Example of patient goals set using the BSQ methodology

Think Big	Act Small	Move Quickly
Regain mobility and return to weekly golf within six months of knee replacement surgery	Get out of bed and walk to the toilet	Day of surgery
	Walk around the ward using mobility aid	Week of surgery
	Manage stairs	Before discharge from hospital
	Walk daily with increasing duration if able	Daily, once discharged
	Play nine holes of golf without using the buggy	Within 6 months of surgery

GROW

A number of coaching models can be translated to healthcare settings. These models are often 'solution-focused' rather than 'problem-based'. The GROW model (Goals, Reality, Options, Will or Way forward), is a simple solution-focused coaching framework originally designed to structure mentoring conversations between clinicians.[21] The tool is flexible and when applied in practice, the distinct stages of the conversation may merge. This is to be expected and requires the clinician to check and see that each stage has been covered, revisiting the goals, if necessary. **Table 5** summarises the GROW model and lists actions and sample questions.

Table 5: GROW model

	GROW	IGROW	GROWTH	Actions	Examples of questions
I	–	Issues	–	Ask questions about the patient's situation.	• What's going on? • How are you feeling?
G	Goal setting	Goal setting	Goal setting	Ask questions about the patient's needs, values and preferences. Agree and understand the goals.	• What is important to you? • What are you hoping for? • What do you want to achieve?
R	Reality checking	Reality checking	Reality checking	Explore the facts and feelings around the patient's situation to raise awareness and self-awareness.	• What have you tried? • What do you know about [the situation]? • What did you learn from [the situation]? • What else do you need to know?
O	Options	Options	Options	The clinician can present the treatment options once the patient is aware of the reality of the situation. Offering the patient choices empowers them by giving them control to make decisions over the course of action.	• What has worked well for you before? • How would you make a choice between [the choices]? • How would [the choices] help you achieve [control]?
W	Will / Way forward?	Will / Way forward?	Will / Way forward?	When the choices have been agreed, the clinician and patient can discuss the plan to achieve the goal. Actions and activities are agreed and documented in the comprehensive care plan.	• What will you do about [the choices]? • Who else should be consulted?
T	–	–	Tactics		• How and when will you take action?
H	–	–	Habits		• How will you sustain success?

Tips for identifying goals of care

Regardless of how goals of care are identified, there are some key principles that should be adopted. Clinicians and health service organisations need to be equipped and able to support patients, families and carers to work in partnership to share decisions and identify goals of care. **Table 6** includes a range of tips based on these common principles that health service organisations and clinicians can use when developing systems and processes for identifying goals of care.

Table 6: Tips for identifying goals of care

Tip		Rationale	Example(s)
1	**Ask patients what is important to them and set aside time for the discussion**	Finding out about a person's preferences, values and needs informs healthcare planning and delivery by encouraging meaningful conversations. Setting aside time to discuss treatment options and goals enhances meaning and patient autonomy[22, 23] and promotes a shared understanding of the purpose of care between the multidisciplinary team and the patient, their family, carers and other support people.	A patient identified as nearing the end of life should be asked what is important to them. They should be offered the opportunity to discuss their needs and preferences at a time when there will be minimal interruptions, and in an appropriate place. This is to allow a longer discussion with the patient and their support people about their preferences and options for end-of-life care.
2	**Share decision-making about goals of care**	Using shared decision-making practices[24] enables identification of goals and encourages patients to participate in goal setting processes. The process of sharing decisions during goal setting may decrease anxiety and increase the subjective wellbeing of patients.[14, 22]	The parent of a child with recurrent ear infection should be provided with information about the risks and benefits of prescribing antibiotics, as well as information about other available treatment options, during discussion about the child and parent's preferences and what they hope to achieve through treatment.

Tip		Rationale	Example(s)
3	**Identify multiple goals of care that are positive and achievable yet challenging**	Patients and clinicians usually have multiple goals for an episode of care including short-, medium- and long-term goals. Longer-term goals can be divided into smaller chunks that can be completed daily or several times a day, which supports a feeling of success and moving towards goal attainment. Setting timeframes can help with motivation, and assist with monitoring progress. Not all patient goals are achievable, so clinicians need to be able to discuss what is possible in the current context and assist the patient in formulating goals[22] that are clinically achievable. However, difficult goals can lead to greater achievements[5, 25] so setting goals that are challenging may lead to greater improvement in patient outcomes.	A patient with ruptured anterior cruciate ligament may have a goal of playing football when the season starts in four weeks. While not clinically feasible, the patient and clinician may wish to set a stretch goal around return to training during the current season as well as short-term goals for incremental mobilisation. A long-term goal might be framed as aiming to improve a patient's cardiovascular fitness, rather than as avoiding a future acute stroke. Incremental daily goals for a patient recovering from a sternotomy might be to move from being assisted in care processes such as showering and toileting, to being able to complete these processes independently within 2–3 days.
4	**Clarify roles and responsibilities in achieving goals of care**	The patient, family, carer or other support people, as well as the lead clinician and multidisciplinary team, all have a role to play in identifying and supporting the patient to achieve the goals of care. A multidisciplinary approach increases the range of goals that can potentially be attained. Assigning steps and tasks to members of the multidisciplinary team, the patient, family, carers or other support people make it clear who is responsible for parts of the care plan. The approach also allows for the inclusion of functional, psychosocial and spiritual goals that assist in improving wellbeing.[4]	The lead clinician and a patient may determine that a short-term goal for a patient who has had an acute stroke is to meet nutritional requirements through oral intake without aspirating rather than through a tube. The goal may require support and assistance from a nurse, speech pathologist and dietician. The roles of these team members should be identified in the comprehensive care plan and communicated to relevant clinicians using local processes.
5	**Clearly communicate and document the agreed goals of care**	Goals need to be understood by everyone in the care team. Clear verbal communication and documention of goals of care ensures everyone has the same information and is focused on the same end points.[24, 26] Effective sharing of information between team members reduces the fragmentation of care and can improve quality of care and patient outcomes.[7]	The goals should also be documented in the patient's comprehensive care plan, which could be shared with the patient, family, carers, other support people and the multidisciplinary team. A patient's goals could also be documented on a bedside goals board. The board could be updated as short-term goals are achieved, and new goals are identified and agreed.

Tip		Rationale	Example(s)
6	Track progress and measure achievement against the goals of care	Goals should be tracked and monitored so that progress can be measured and achievements celebrated. Receiving feedback about performance against goals has been shown to help patients cope with emotional distress and goals that are congruent with motivation support improvement in subjective well-being in a rehabilitation setting.[14] Visually displaying incremental progress toward a stated goal may lead to improvements in quality of life and self-efficacy, even in the acute setting.[4]	A patient whose goal is to lose 30 kilograms can visually track quantitative data such as weight loss, time spent exercising and distance mobilised. Monitoring this type of data can provide information about progress and also identify where strategies and interventions may not be resulting in the expected outcome.
7	Recognise that identifying goals of care can be an iterative process	Identifying goals of care, rather than being a unique one-off discussion, is an ongoing process.[7] There may be times during the episode of care when goals may be more relevant or require review.	A patient's goals may be appropriate on admission to hospital or after a major health event, but identified goals of care may need to be reviewed if there is a change in the patient's condition or context. For example, if a patient with pneumonia deteriorates then goals may need to be discussed and renegotiated in light of changed treatment options and expected outcomes.
8	Integrate goals of care into existing systems and processes for care	Ensuring that goals of care are identified, documented and used to form the basis of comprehensive care planning is a person-centred approach to care delivery. Health services should support clinicians to identify goals of care, and deliver person-centred comprehensive care by integrating the identification of goals of care into systems, processes and workforce education.	A health service could integrate identification of goals of care into existing processes such as admission or assessment processes, comprehensive care planning and documentation processes, and multidisciplinary team meeting agendas.

Conclusion

Identifying a person's clinical and personal goals is an important part of delivering meaningful person-centred comprehensive care. A person's goals of care should reflect their personal needs and preferences, and expectations and aspirations for their health and wellbeing, as well as their clinical needs.

Identifying goals of care has been reported to help organise and prioritise care activities and contribute to improved satisfaction, quality of life and self-efficacy for patients.[3-5]

Health service organisations should consider how they support clinicians to identify goals of care, including documenting, communicating and using goals to inform comprehensive care planning and delivery. The approach taken by an organisation may include use of tools, frameworks or models, or adoption of more generalised person-centred communication methods. As a minimum, clinicians should ask patients what is important to them in relation to their health care, and use this information to identify goals of care.

Regardless of the model used, health service organisations and clinicians should consider the following principles when identifying goals of care:

- Ask patients what is important to them and set aside time for the discussion
- Share decision making about goals of care
- Identify multiple goals of care that are positive and achievable, yet challenging
- Clarify roles and responsibilities in achieving goals of care
- Clearly communicate and document agreed goals of care
- Track progress and measure achievement against goals of care
- Recognise that identifying goals of care can be an iterative process
- Integrate goals of care into existing systems and processes for care.

These tips are both pragmatic and person-centred, and will require health service organisations to foster a person-centred culture and provide the appropriate support systems and education for identifying goals of care to promote safe, high-quality care for every patient.

Glossary

carer: a person who provides personal care, support and assistance to another individual who needs it because the individual has a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail and aged.

An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation or caring as part of a training or education program.[27]

clinician: a healthcare provider, trained as a health professional, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.

comprehensive care: health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate.

comprehensive care plan: a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, families, carers and other support people about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will depend on the setting and the service that is being provided, and may be called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.[28]

diagnosis: the identification of a condition, disease, or injury made by evaluating the symptoms and signs presented by a patient.[29]

goal attainment: is the achievement of an agreed goal. Whether or not a patient is able to achieve a particular goal may be affected by the number of goals set, how challenging the goal is, the proximity of anticipated completion and the motivation behind the goal setting.[30]

goal evaluation and measurement: is the assessment and review of the patient's progress towards meeting the agreed goals, with the aim of re-negotiating, modifying or setting new goals, if required.

goal negotiation: is a process of two-way communication and discussion between members of the multidisciplinary team and the patient, their family, carers and other support people to explore the patient's clinical and personal goals in the context of their clinical situation, and to determine meaningful and feasible goals for the episode of care.

goal setting: involves the shared discussion and decision making between the clinician and the patient, their family, carers and other support people about the steps needed to achieve the agreed goal. This can include discussion and decisions about milestones, timeframes and processes for working towards meeting the agreed goals of care, and includes the documentation of the agreed goals into a comprehensive care plan.

goals of care: clinical and personal goals for a patient's episode of care that are determined in the context of a shared decision-making process.

health care: the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.[31]

health literacy: the Commission separates health literacy into two components — individual health literacy and the health literacy environment.

Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action.

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the health system, and it affects the ways in which consumers access, understand, appraise and apply health-related information and services.[32]

health service organisation: a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

long-term goal: may take up to a year or more to attain. Long-term goals are often broadly described or require multiple changes. For example, a patient wants to return to full functioning following a back injury. The patient is required to make a number of lifestyle changes. The clinical team may express the long-term goal of the patient experiencing minimal residual symptoms.

medium-term goal: takes weeks or months, and may also be a stepping stone to achieving a greater, long-term goal. For example, a patient wants to return to full functioning following a back injury. The patient may express medium-term goals like confidence to walk without losing balance or falling, being pain free, or having less sleep disruptions from pain.

multidisciplinary team: a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[33] Multidisciplinary care includes interdisciplinary care. (A 'discipline' is a branch of knowledge within the health system.[34])

patient: a person who is receiving care in a health service organisation.

person-centred care: an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients.[35] Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care.[36] Also known as patient-centred care or consumer-centred care.

policy: a set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

procedure: the set of instructions to make policies and protocols operational, which are specific to an organisation.

process: a series of actions or steps taken to achieve a particular goal.[37]

quality improvement: the combined efforts of the workforce and others — including consumers, patients and their families, researchers, planners and educators — to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[38] Quality improvement activities may be undertaken in sequence, intermittently or on a continuous basis.

responsibility and accountability for care: accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.[39]

risk: the chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood.

risk assessment: assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.[40]

risk management: the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.

screening: a process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.

shared decision making: a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[41]

short-term goal: can be achieved quickly in a limited period of time and frequently leads to the achievement of a long-term goal.[42, 43] Short-term goals may be achieved in the next day or week. For example, a short-term clinical goal may be related to a person mobilising after postoperative bedrest. The patient may express their goal as a desire for independence with personal care.

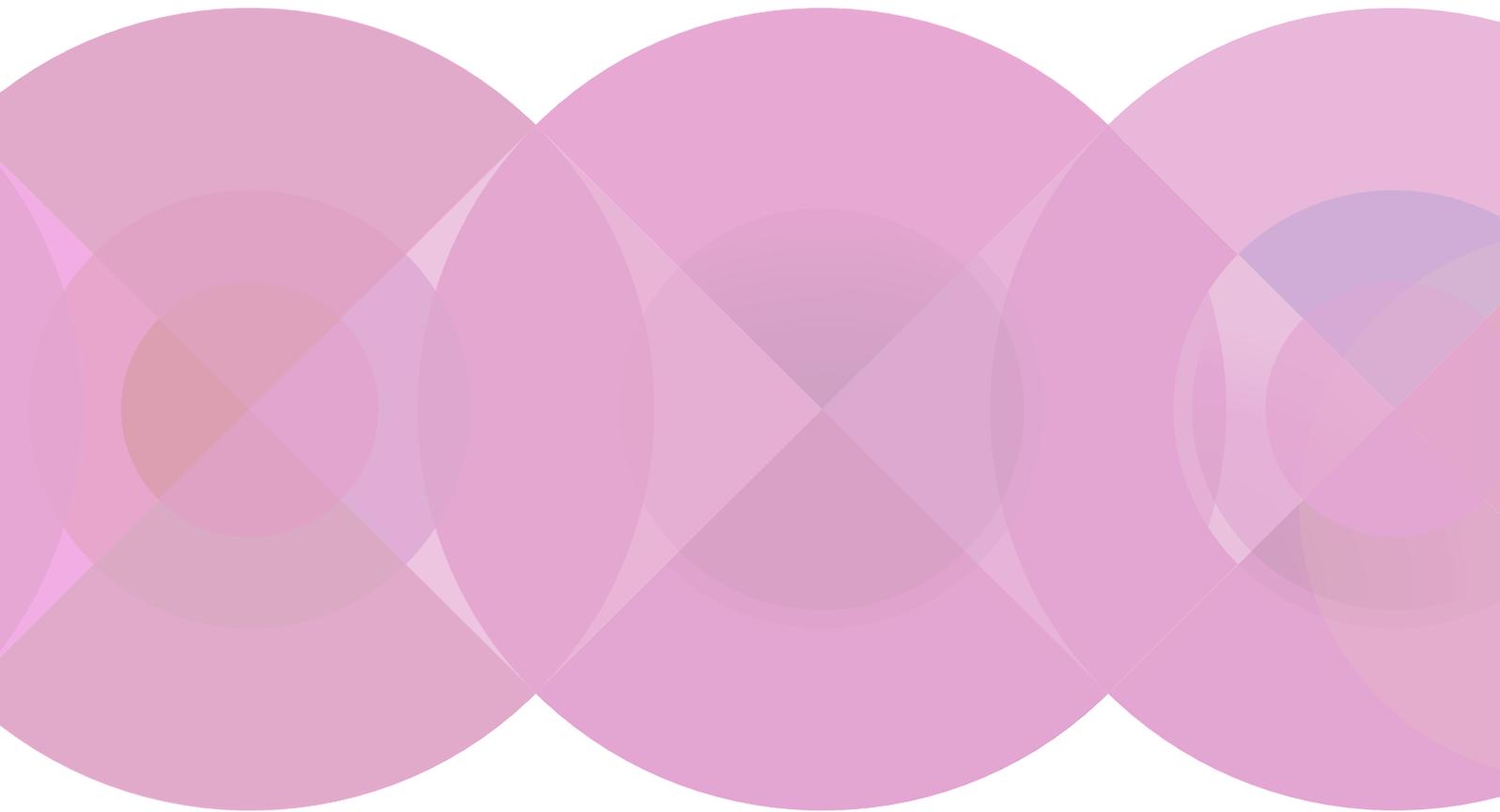**training**: the development of knowledge and skills.

workforce: all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation. *See also* clinician.

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