Appendix

This appendix was part of the submitted manuscript and has been peer reviewed. It is posted as supplied by the authors.

Supplemental Tables and Figures

Supplemental Table 1: Life limiting illness indicators classification and definition

Life limiting illness indicator		
Classification		**Definition**
Organ failure	Heart failure	NYHA stage III/IV or reduced exercise tolerance
	Chronic obstructive pulmonary disease	Disease assessed as severe (eg FEV1 <30% predicted) or log term oxygen therapy / home oxygen or shortness of breath at 100m on level ground
	Renal disease	Stage 5 chronic renal failure or long-term dialysis or nor for dialysis or eGFR less than 15 ml/min
	Neurological disease	Parkinson's disease - assistance with ADL or falls or difficulty swallowing,
		Multiple sclerosis with dysphagia,
		Motor neurone disease with rapid decline or episode of aspiration pneumonia
		Stroke - Minimal conscious state or dense hemiparesis
Frailty/ Functional Decline	Frailty	Clinical frailty score (CFS) 6 to 9
	Dementia	No consistent meaningful conversation or needs assistance with ADL
	RACF	From nursing home or residential aged care facility
Cancer		Metastatic or not amenable to treatment

Supplemental Figure 1: Barwon Health i-validate Goals of Care Form

Barwon Health

RESUSCITATION AND GOALS OF MANAGEMENT

Patient Label Required Here

STEP 1: Assess needs for goals of care discussion

1. Patient/Substitute Decision Maker (SDM) request ☐
2. Existing ACP ☐
3. Clinical indicator ☐ (Gold Standard Framework Clinical Indicators)
4. Functional Indicator ☐ (From nursing home, or >/=2 unexpected admission in previous 6 months)
5. Clinician initiated ☐

If YES to any of above go to STEP 2
If NO to all, ie patient has reversible disease, expected cure and restore function, go to STEP 4

STEP 2: Competence /capacity (weigh up the information?)

Can the patient demonstrate they;

1. Understand information given to them? ☐
2. Retain the information? ☐
3. Understand treatment benefits and burdens ☐
4. Communicate decision? ☐
5. Understands the consequences of the decision made ☐

If **NO** to any, patient is not competent and (SDM) required;

SDM/MEPOA;

Name _____

Relationship to patient _____

Contact phone no. _____

STEP 3: Values, goals, and aims (specific to current admission)

Patient preferences, goals and values:
(What does this person care about? What is important for this person to live well?)

Medical advice provided:

Consensus aims/communication with:

STEP 4: Treatment decisions

☐ **ICU Care**

Full ICU support aimed at cure / restore function
- Ventilation
- Haemofiltration
- Vasoactive agents
- CPR/DCR

Other;
- _____
- _____
- _____

☐ **HDU Care**

Ward-care and limited ICU support;
- NIV
- Vasoactive agents
- CPR /DCR

Other;
- _____
- _____

Not for;
- MV, haemofiltration

☐ **Ward Care**

Treatment and comfort care
- Antibiotics
- Blood transfusion
- O2 therapy
- Nasogastric
- Comfort measures

Other;
- _____
- _____

Not for CPR/DCR/ICU/HDU

☐ **Palliative Care**

Comfort and symptom relief with palliative approach
- Comfort measures
- _____
- _____

Not for CPR/DCR/ICU/ HDU or MET

Consider referral to specialist unit

STEP 5: Clinician completing form

Designation_____**Name**_____**Signature**_____**Date**_____

Supplemental Table 2: Definitions for the purpose of coding

Item	Definition
Value	Something that gives enjoyment to life and/or what is needed to live well
Preference	Defined in terms of treatment or outcome:
Treatment preference	Instructive to guide clinical or care decision
Outcome preference	A goal or indication of end point of treatment or disease
Vegetative state or “Be a vegetable”	Unable to interact cognitively or physically with others
Burden	Requiring care or assistance with activities of daily living equivalent to high level nursing care
Quality of life	Presence of the term in its entirety or a statement linking “quality” with a conception of time (eg years) or “life” or description of living

Supplemental Text 1

Text from the GoC form were analysed using an abductive approach(25) which combines both inductive and deductive approaches for different phases of data analysis. For the purposes of coding, the research group agreed on definitions for the key terms within these statements (Supplement Table 1). Open text from GoC forms were analysed using a four-stage qualitative content analysis process(20). A latent rather than manifest content analysis was used because the text analysed was discussion documented by doctors, rather than actual words of patients (20). Five clinician researchers reviewed 20 forms independently to identify codes (SM, YM, NO, NS, GK). Agreement on codes was not reached so a further 20 forms were analysed and coded, at which time agreement was reached. A coding tool was developed and data sorted using Microsoft Excel (2015). Two researchers (SM, YM) analysed the remaining GOC forms. Text from the GOC forms were divided into meaning units that were condensed and coded.In cases where text did not fit existing codes, consensus was reached amongst the 5 researchers regarding creation of a new code or designation into existing codes. Data saturation was reached when no new codes emerged. Dross content was excluded after another review of the data (20). Codes were interpreted and compared for differences and similarities and sorted into tentative subthemes by three nurse researchers experienced in qualitative analysis (TD, DK, JO) and SM. Through a process of reflection and discussion, the researchers agreed on themes and sub-themes. Discrepancies were resolved through rechecking with 2 clinical researchers (NO, NS).

Meaning units from within each theme/sub-theme were counted and categorised deductively using Charles et al's(26) description of SDM; values, preferences and goals. These were presented in a matrix with theme/sub-themes as rows and values, preferences or goals as columns. The final matrix was sent to all researchers for triangulation by investigators and consensus reached (Supplement Figure 2). Member checking for the final stage of the content analysis was performed by utilising the 'thoughtful practitioner test'(27). This involves experienced clinicians reviewing results to assess if they meet with their experience of the phenomena explored, and is recommended for triangulation to reduce the influence of researcher bias (27). The final matrix was sent to the three experienced end of life and SDM practitioners (TD, CC, PM) to confirm findings were consistent and relevant to their experience.