A Clear Path to Care

Part 4

Resuscitation and End of Life Care Clinical Planning:

The 7 Step Pathway

and the Resuscitation Alert – 7 Step Pathway Form

Government of South Australia

SA Health

This presentation will:

Introduce the 7 Step Pathway:

- a process
- aids the doctor responsible to make decisions about resuscitation and care including end of life
- in line with ethical and legal standards (incl ACD Act)

Introduce the Resuscitation Alert- 7 Step Pathway (the Form):

- allows decisions to be documented
- standardised
- recognised- particularly in emergencies
- not a separate legal document- really only an extension of the case notes
- replaces “NFR” order
- “One form for the patient”: an ACD or ACP, and “one form for the doctor”: the Pathway Resuscitation Alert- 7 Step Pathway

Clarification of Terms

A Person's Wishes

Advance Care Directives (ACDs)

- written by the person
- statutory documents - with specific signing and witnessing requirements expressing a patient's
- wishes, or appointing a substitute, to apply when they have impaired capacity to decide.
- Work within a specific set of laws
- e.g. Advance Care Directive Form (*Advance Care Directives Act 2013*), Anticipatory Direction, Medical Power of Attorney or Enduring Power of Guardianship

Advance Care Plans (ACPs)

- "informal" documents expressing a patient's wishes
- have some legal weight within common law, often about refusals of treatment
- e.g. Good Palliative Care Plan (*Palliative Care Council*), Statement of Choices (*Respecting Patient Choices*), Ulysses Agreements

Clinician's Instructions

Clinical Care Plans

- specific clinical decisions and instructions regarding clinical care
- written by the clinician responsible for the patient's care, in the context of the prevailing clinical situation
- are basically an extension of the clinical notes
- should be informed by patient's ACD/ACP/wishes
- e.g. mental health care plan, nursing care plan, resuscitation plan
- (Resuscitation Alert - 7 Step Pathway)

Why is this important?

- Most Australians die in acute care hospitals – over 70%
- Most Australians want to die at home!
- A major area of disputes, complaints and media attention
- 50% of all health care complaints about end of life care
- And also an area of significant health expenditure
  - 30% of Medicare expenditure in the US is for patients in the last year of life- with up to 40% of this concentrated on patients in the last month of life

Need for improvement

MEDIA RELEASE

Palliative Care Australia
Suite 4, 37 Geils Court, Deakin ACT 2600 | PO Box 24, Deakin West, ACT 2600
t: 02 6232 4433 | f: 02 6232 4434 | w: www.palliativecare.org.au | e: pcainc@palliativecare.org.au

Palliative Care Australia

5 November 2009

Australians dying badly

Have **you** prepared for the end of **your** life? Whether healthy or ill, an individual, a family, a carer, a healthcare practitioner or a health system reform authority, we **all** need to talk about dying – because too many people in Australia **unnecessarily** experience a **bad death.**

Have you asked yourself:

- How would I want to live in the last few months of my life?
- What do I need to arrange to make my wishes happen?
- What decisions should I make now about my health care at the end of my life?

If you haven't prepared, then chances are that when your time comes no-one else will ask for your answers to these questions either! This means that your last months, weeks or days may not go the way that you would wish them to. You could miss out on the right care.

Government of South Australia

SA Health

How do I make a decision?

My job is to save lives isn't it?

What's the legal situation if I don't give treatment? Maybe I'd better keep trying to keep him alive.

What's this bit of paper – an Advance Care Directive? And what's this plan? And who is this person calling themselves a medical power of attorney? Who do I listen to?

What are the clinical parameters that will tell me that this patient is at the end of their life?

What's best for this patient?

His children are saying that we should let him go. But his wife is saying that we must keep him alive. What do I do?

I don't know how to tell them this bad news. I need to give them hope. Maybe I'll give them one more round of treatment…

What is the protocol in this situation? What did the textbook say? What did the consultant do the last time this happened?

What would this patient have wanted if they had been conscious?

My belief is that life is sacrosanct.

Government of South Australia

SA Health

Are Advance Care Directives and Advance Care Plans the only solution?

- often completed a long time before a medical crisis - may not be relevant
- often only vague statements about wishes (e.g. “I do not want to suffer”) - limited use in emergencies
- may be pointless if not converted into clinically useful instructions about resuscitation and care
- 90% of patients presenting don’t have ACDs

So, relying solely upon ACDs and ACPs is common, but fundamentally flawed.

A concern for patients and families

Complaints to Public Advocate and the Health and Community Services Complaints Commissioner from patients and families:

Informal “Not for Cardiopulmonary Resuscitation” and “NFR” orders written in notes and discharge letters without any prior discussion with the patient, family or substitutes.

This led to…

A solution:

ACDs (or ACPs) to tell us the patient's wishes

plus

Clinical/Resuscitation Plans to convert these wishes into usable clinical instructions about resuscitation and end of life care

Make end of life Clinical/Resuscitation Planning:

- not just a form, but a process
- of logical and commonsense steps for doctors to work through

....The 7 Step Pathway

Government of South Australia

SA Health

The SA Health 7 Step Pathway

Trigger

v

Assessment

v

Consultation

v

Develop and Document the Clinical Plan

v

Transparency

v

Implementation

v

Support the Patient and Family

Government of South Australia

SA Health

The Main Improvement

No informal “NFR”, “Not for CPR” or “Not for Cardiopulmonary Resuscitation” orders to be written in the notes

AND

The use of the Resuscitation Alert – 7 Step Pathway for all of these orders

Government of South Australia

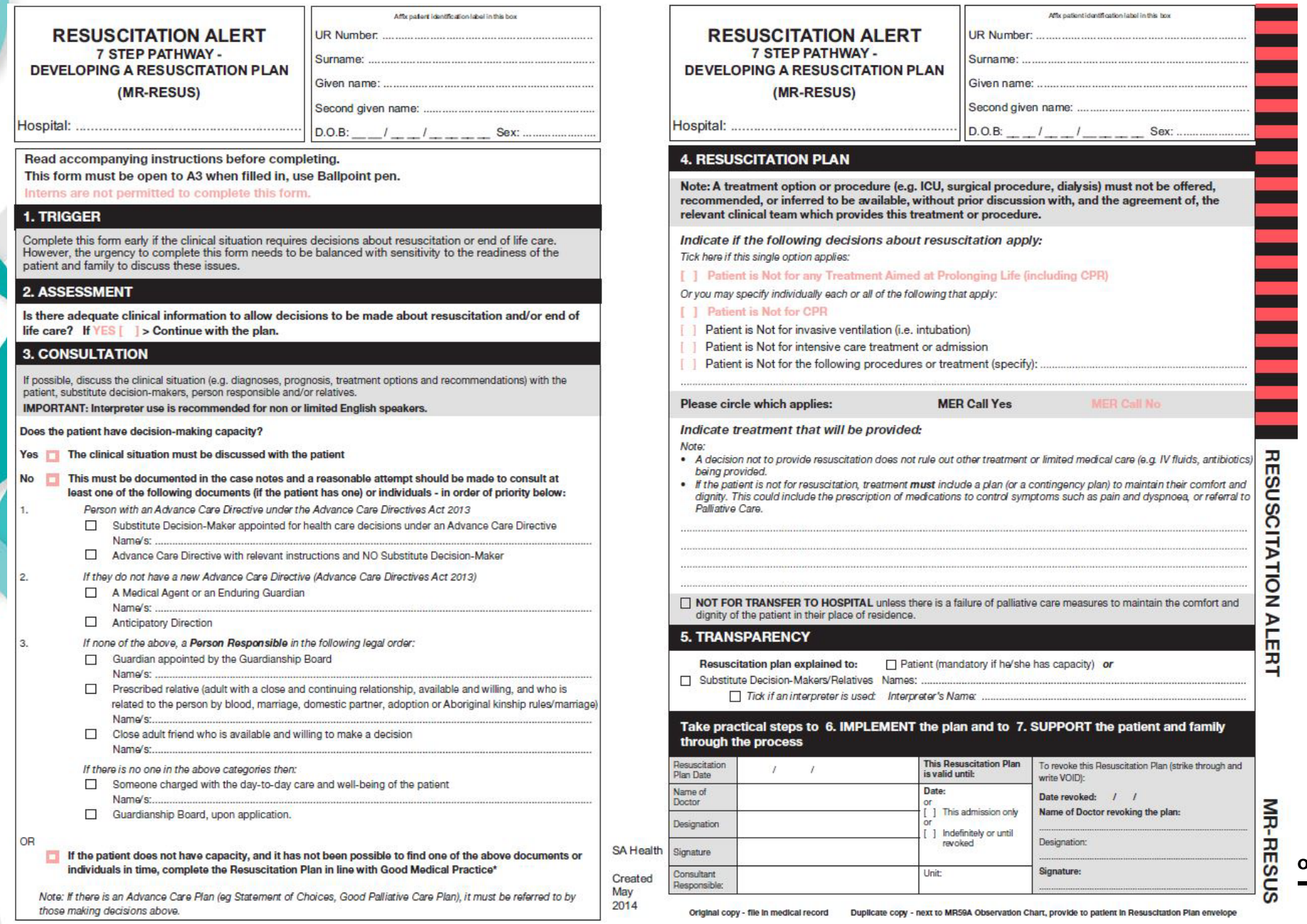
SA Health

The Form

- incorporates the 7 Steps
- encourages the clinician to work through the correct:
  - clinical
  - legal
  - ethical steps in the correct order
- MUST ask:

  “What are you going to do to maintain the patient’s comfort and dignity?”
- instils an intuitive feel, or *“cadence”* to the process

The Resuscitation Alert – 7 Step Pathway



RESUSCITATION ALERT
7 STEP PATHWAY -
DEVELOPING A RESUSCITATION PLAN
(MR-RESUS)

Hospital: .....

Affix patient identification label in this box

UR Number: .....
Surname: .....
Given name: .....
Second given name: .....
D.O.B: __ __ / __ __ / __ __ __ __ Sex: .....

Read accompanying instructions before completing.
This form must be open to A3 when filled in, use Ballpoint pen.
Interns are not permitted to complete this form.

1. TRIGGER

Complete this form early if the clinical situation requires decisions about resuscitation or end of life care. However, the urgency to complete this form needs to be balanced with sensitivity to the readiness of the patient and family to discuss these issues.

2. ASSESSMENT

Is there adequate clinical information to allow decisions to be made about resuscitation and/or end of life care? If YES [ ] > Continue with the plan.

3. CONSULTATION

If possible, discuss the clinical situation (e.g. diagnoses, prognosis, treatment options and recommendations) with the patient, substitute decision-makers, person responsible and/or relatives.
IMPORTANT: Interpreter use is recommended for non or limited English speakers.

Does the patient have decision-making capacity?

Yes ☐ **The clinical situation must be discussed with the patient**

No ☐ **This must be documented in the case notes and a reasonable attempt should be made to consult at least one of the following documents (if the patient has one) or individuals - in order of priority below:**

1. *Person with an Advance Care Directive under the Advance Care Directives Act 2013*
   - ☐ Substitute Decision-Maker appointed for health care decisions under an Advance Care Directive
     Name/s: .....
   - ☐ Advance Care Directive with relevant instructions and NO Substitute Decision-Maker
2. *If they do not have a new Advance Care Directive (Advance Care Directives Act 2013)*
   - ☐ A Medical Agent or an Enduring Guardian
     Name/s: .....
   - ☐ Anticipatory Direction
3. *If none of the above, a **Person Responsible** in the following legal order:*
   - ☐ Guardian appointed by the Guardianship Board
     Name/s: .....
   - ☐ Prescribed relative (adult with a close and continuing relationship, available and willing, and who is related to the person by blood, marriage, domestic partner, adoption or Aboriginal kinship rules/marriage)
     Name/s: .....
   - ☐ Close adult friend who is available and willing to make a decision
     Name/s: .....

   If there is no one in the above categories then:
   - ☐ Someone charged with the day-to-day care and well-being of the patient
     Name/s: .....
   - ☐ Guardianship Board, upon application.

OR

☐ **If the patient does not have capacity, and it has not been possible to find one of the above documents or individuals in time, complete the Resuscitation Plan in line with Good Medical Practice***

Note: If there is an Advance Care Plan (eg Statement of Choices, Good Palliative Care Plan), it must be referred to by those making decisions above.

SA Health
Created May 2014

RESUSCITATION ALERT
7 STEP PATHWAY -
DEVELOPING A RESUSCITATION PLAN
(MR-RESUS)

Hospital: .....

Affix patient identification label in this box

UR Number: .....
Surname: .....
Given name: .....
Second given name: .....
D.O.B: __ __ / __ __ / __ __ __ __ Sex: .....

4. RESUSCITATION PLAN

Note: A treatment option or procedure (e.g. ICU, surgical procedure, dialysis) must not be offered, recommended, or inferred to be available, without prior discussion with, and the agreement of, the relevant clinical team which provides this treatment or procedure.

Indicate if the following decisions about resuscitation apply:

Tick here if this single option applies:

[ ] **Patient is Not for any Treatment Aimed at Prolonging Life (including CPR)**

Or you may specify individually each or all of the following that apply:

[ ] **Patient is Not for CPR**
[ ] Patient is Not for invasive ventilation (i.e. intubation)
[ ] Patient is Not for intensive care treatment or admission
[ ] Patient is Not for the following procedures or treatment (specify): .....
.....

Please circle which applies: **MER Call Yes** **MER Call No**

Indicate treatment that will be provided:

Note:
- *A decision not to provide resuscitation does not rule out other treatment or limited medical care (e.g. IV fluids, antibiotics) being provided.*
- *If the patient is not for resuscitation, treatment **must** include a plan (or a contingency plan) to maintain their comfort and dignity. This could include the prescription of medications to control symptoms such as pain and dyspnoea, or referral to Palliative Care.*

.....
.....
.....
.....

☐ **NOT FOR TRANSFER TO HOSPITAL** unless there is a failure of palliative care measures to maintain the comfort and dignity of the patient in their place of residence.

5. TRANSPARENCY

Resuscitation plan explained to: ☐ Patient (mandatory if he/she has capacity) ***or***
☐ Substitute Decision-Makers/Relatives Names: .....
☐ *Tick if an interpreter is used:* *Interpreter's Name:* .....

Take practical steps to 6. IMPLEMENT the plan and to 7. SUPPORT the patient and family through the process

Resuscitation Plan Date	/ /	**This Resuscitation Plan is valid until:**	To revoke this Resuscitation Plan (strike through and write VOID):
Name of Doctor		**Date:** or [ ] This admission only or [ ] Indefinitely or until revoked	**Date revoked:** / / **Name of Doctor revoking the plan:**
Designation			Designation:
Signature			**Signature:**
Consultant Responsible:		Unit:	

Original copy - file in medical record **Duplicate copy - next to MR59A Observation Chart, provide to patient in Resuscitation Plan envelope**

RESUSCITATION ALERT MR-RESUS

Government of South Australia
SA Health

Why do we need another form?

Actually, we don’t. The heart of this is a process, not a form

- NFR order with process around it
- Helps doctors make the right decision
- Protects both the patient and the doctor
- Standardised document
- So that everyone recognises and respects it- doctors, nurses, ambulance officers, aged care staff

Government of South Australia

SA Health

But, will I have to fill out two forms now?

No!

There is:

- One form for the patient - their ACD (or ACP) - the patient's responsibility, not the doctor's

AND

- One form for the doctors - the Resuscitation Alert - 7 Step Pathway - the doctor's responsibility

Integration of Resuscitation Alert – 7 Step Pathway

With existing systems:

- Medical Record
- EPAS
- Rapid Detection and Response (RDR) Observation Charts

With other health sectors

- **SAAS**
- **GPs**
- **Community Nurses**
- **Aged Care**

Government of South Australia

SA Health

Resuscitation Alert – 7 Step Pathway Form in transfers across health sectors

- From Hospital to Home/RACF

  → Must contact the GP
- From Home/RACF to Hospital

  → Arguments why a completed form can be respected:
  - "Why would you respect the form?" VS "why shouldn't you respect the form?"
  - Another doctor has gone through a process consistent with legal and ethical principles
  - ACD Act is clear: no requirement to provide futile treatment

  → Still use clinical judgement
  - Remember, protection if do provide treatment - via the uncertain/urgent provisions

Government of South Australia

SA Health

Summary of Part 4

Resuscitation Alert – 7 Step Pathway Part 4

The 7 Step Pathway:

- Is a process
- which aids the doctor responsible to make decisions
- in line with ethical and legal standards (incl. ACD Act)

The Resuscitation Alert- 7 Step Pathway (the Form)

- allows decisions to be documented
- standardised
- Recognised - particularly in emergencies
- not a separate legal document - really only an extension of the case notes
- Replaces an “NFR” order

“One form for the patient”: an ACD or ACP, and “one form for the doctor”: the Pathway Resuscitation Alert- 7 Step Pathway