

# Resuscitation Planning - 7 Step Pathway

## Clinical Directive

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Informal Copy When Printed

# Resuscitation Planning - 7 Step Pathway Clinical Directive

## 1. Policy Statement

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This clinical directive outlines the requirements for SA Health employees to provide a standardised, patient-centred, best practice approach to planning for resuscitation and other care for any adult patient who is likely to be within the last year of their life; and any other patient who may experience acute, rapid, life threatening deterioration requiring resuscitation.

Quality of life and the quality of a death can be improved by health care teams partnering early with a patient, Substitute Decision-Maker (SDM), Person Responsible (PR) or significant others in making and documenting shared decisions about treatment and care at the end of the person's life. Care planning can:

- avoid burdensome, futile, traumatic and/or unwanted treatment and procedures when a person is dying
- provide an opportunity for a patient, and family carers if appropriate, to receive information about treatment options relevant to the patient and their health conditions
- assist or relieve the patient, SDM, their family/friend/carer of difficult life or death decisions during a crisis or emergency
- support a patient to die with respect, dignity and comfort.

Resuscitation planning using the 7 Step Pathway is a standardised process for screening, developing and implementing a clinical care plan based around treatment decisions relating to a patient's resuscitation and care at the end of their life.

The Resuscitation Plan is used to assist clinicians in situations of rapid deterioration to make decisions about care and treatment. It provides a mechanism to respect the person's expressed wishes and preferences, especially if these involve treatment limitations.

The Resuscitation Planning - 7 Step Pathway Clinical Directive applies to resuscitation planning for patients in (or under the direction of) all SA Health hospitals and services including, but not limited to acute and sub-acute facilities, residential care services ambulatory/community settings, and SA Ambulance Service (SAAS).

This clinical directive and the accompanying tools do not apply to children (those under 18 years of age), and should not be interpreted as legal advice.

The Resuscitation Plan - 7 Step Pathway aligns and promotes compliance with:

- [National Safety and Quality Health Service Standards](#)
- [National Consensus Statement: essential elements for safe and quality end-of-life care](#)
- [SA Consent to Medical Assessment or Treatment Where Patient Consent Cannot Be Obtained Policy Directive](#)
- [Consent to Medical Treatment and Health Care Policy Guideline](#)
- [Advance Care Directive Policy Directive](#)
- [SA Advance Care Directive Act 2013](#)
- [SA Consent to Medical Treatment and Palliative Care Act 1995 \(Consent Act\)](#).

## 2. Roles and Responsibility

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### 2.1 Chief Executive, SA Health

The Chief Executive, SA Health is responsible for:

- providing the capability for systems to be established within SA Health to enable the management of clinical care planning, including decisions for resuscitation and other care at the end of life across SA Health in accordance with this Clinical Directive.

### 2.2 Director, Safety and Quality, Department for Health and Wellbeing

The Director Safety and Quality is responsible for:

- establishing, maintaining and periodically reviewing the effectiveness of the Resuscitation Planning - 7 Step Pathway Clinical Directive, toolkit and Resuscitation Plan Forms in supporting best practice;
- monitoring and evaluating the implementation of the Resuscitation Planning - 7 Step Pathway Clinical Directive, including the development of appropriate clinical indicators;
- disseminating learnings from the management of resuscitation planning incidents and issues across SA Health;
- establishing educational tools to support the knowledge and skills of SA Health staff in resuscitation planning.

### 2.3 Chief Executive Officers

Chief Executive Officers of Local Health Networks, State-wide Clinical Support Services and SA Ambulance Service must ensure the health services within their control:

- develop and ensure systems and resources are allocated for the effective implementation of the Resuscitation Planning - 7 Step Pathway Clinical Directive, including governance, monitoring and evaluation;
- ensure that clinicians have access to education and training in the Resuscitation Planning - 7 Step Pathway and associated programs to provide safe and quality care;
- ensure that incidents relating to the development, documentation and enacting of Resuscitation Plans are reported and investigated, and outcomes actioned in accordance with the [SA Health Incident Management and Open Disclosure Policy Directive](#);
- ensure that feedback from consumers is considered and mapped to incidents in order to embed the consumer narrative in incident management processes;
- ensure resources and systems are in place for the provision of safe, high quality care at the end of life
- ensure that services delivered to SA Health patients, and purchased from providers other than SA Health, are in accordance with the Resuscitation Planning 7- Step Pathway Clinical Directive;

### 2.4 Heads of Units and senior managers

Heads of Units and senior managers must:

- provide organisational leadership and governance which supports the effective implementation of the Resuscitation Planning - 7 Step Pathway Clinical Directive;

- ensure implementation of Resuscitation Planning - 7 Step Pathway processes and associated tools and forms are consistent with the Resuscitation Planning - 7 Step Pathway Clinical Directive;
- ensure that Resuscitation Planning - 7 Step Pathway education and training resources enable the implementation and maintenance of high quality care and meet the requirements of the [Resuscitation Planning-7 Step Pathway Education Framework](#);
- ensure that incidents and patient/consumer feedback relating to Resuscitation Planning - 7 Step Pathway are reviewed, and managed to prevent reoccurrence;
- ensure that services cease the practice of using and documenting medical orders such as Not for Resuscitation (NFR), Not for Cardiopulmonary Resuscitation (Not for CPR), and Do Not Resuscitate (DNR).

## **2.5 All medical practitioners and credentialed nurse practitioners working within SA Health**

All medical practitioners and credentialed nurse practitioners (with palliative care, aged care and chronic diseases models of care) must:

- use the standardised screening triggers to assess if a patient may be at end of life and initiate when appropriate, and participate in the screening, assessment using the 7 Step Pathway processes to develop and document a resuscitation plan with patients, their family and carers as applicable;
- review existing resuscitation plans in consultation with patient, their SDM, PR or significant others as part of screening and assessment, and update if required;
- ensure that Resuscitation Planning - 7 Step Pathway processes are patient centered and include the relevant SDM, PR or significant others;
- ensure that Resuscitation Planning - 7 Step Pathway processes are collaborative and that key health care team members are involved in the process;
- ensure that in the event of acute and rapid deterioration that interventions are provided that are guided by the Resuscitation Plan - 7 Step Pathway care plan, and in accordance with legislation, policies, guidelines and the Code of Good Medical Practice (see section 3.8);
- ensure that all education, training and assessment in Resuscitation Planning - 7 Step Pathway is completed to ensure quality and safe clinical practice;
- ensure all incidents relating to resuscitation planning, and providing care in accordance with a resuscitation plan, are reported through the Safety Learning System (SLS) and subject to investigation and quality improvement ([Patient Incident Management and Open Disclosure Policy Directive](#));
- understand that completing and signing the [Resuscitation Alert, Resuscitation Plan - 7 Step Pathway Form](#) (MR RESUS) lies with the patient's responsible medical practitioner and/or credentialed nurse practitioner. The name of the signing medical practitioner or credentialed nurse practitioner must be clearly documented on the Resuscitation Alert, Resuscitation Plan - 7 Step Pathway Form (MR RESUS);
- understand that the task of completing the Resuscitation Alert (MR RESUS) can be delegated to another medical practitioner or credentialed nurse practitioner, however the responsible medical practitioner must ensure that:
  - the delegated practitioner has completed all the Resuscitation Planning - 7 Step Pathway education requirements (as per the [Education and Training Framework for Resuscitation Planning 7 Step Pathway](#)) and is able to comply with relevant legislation and SA Health Policy Directives;
  - the process of delegation is clear and the roles and responsibilities are understood by both the responsible practitioner and the delegated medical practitioner or credentialed nurse practitioner;
  - professional supervision of clinical staff is provided for resuscitation planning, including consultant oversight/advice;

- the task of completing the Resuscitation Alert, Resuscitation Plan - 7 Step Pathway Form (MR RESUS) is not delegated to an intern or other health care professional who is not credentialed to complete the Resuscitation Alert;
- the medical practitioner or credentialed nurse practitioner who have completed and documented the Resuscitation Alert, Resuscitation Plan - 7 Step Pathway Form (MR RESUS) is responsible for communicating the information contained within the form to all members of the patient's treating health care team.

## 2.6 Credentialed specialist palliative care nurses

Specialist palliative care nurses who are credentialed to complete Resuscitation Plan - 7 Step Pathway must ensure that the patient's treating medical practitioner is involved in the Resuscitation Planning - 7 Step Pathway process and must:

- use the standardised screening triggers to assess if a patient may be at end of life and initiate when appropriate, and participate in the screening, assessment using the 7 Step Pathway processes to develop and document a resuscitation plan with patients, their family and carers as applicable;
- review existing resuscitation plans in consultation with patient, their SDM, PR or significant others as part of screening and assessment, and update if required;
- ensure that Resuscitation Planning - 7 Step Pathway processes are patient centered and include the relevant SDM, PR or significant others;
- ensure that Resuscitation Planning - 7 Step Pathway processes are collaborative and that key health care team members are involved in the process;
- ensure that in the event of acute and rapid deterioration provide interventions and care that is guided by the Resuscitation Alert, Resuscitation Plan - 7 Step Pathway Form (MR RESUS), and in accordance with legislation, policies, guidelines;
- ensure that all mandatory education, training and assessment in Resuscitation Planning - 7 Step Pathway is completed to ensure quality and safe clinical practice;
- ensure all incidents and consumer feedback relating to resuscitation planning, and providing care in accordance with a resuscitation plan, are reported through the Safety Learning System (SLS) and subject to investigation and quality improvement ([Patient Incident Management and Open Disclosure Policy Directive](#));
- understand that completing and signing the [Resuscitation Alert, Resuscitation Plan - 7 Step Pathway Form \(MR RESUS\)](#) can occur in conjunction with the patient's responsible medical practitioner and/or credentialed nurse practitioner. The name of the signing medical practitioner or credentialed nurse practitioner must be clearly documented on the Resuscitation Alert Form (MR RESUS);

## 2.7 Nurses, Pharmacists, Paramedics/Ambulance Officers and Allied Health Staff

Nurses, Pharmacists, Paramedics/Ambulance Officers and Allied health staff must:

- be able to use screening to identify patients who may be approaching the end of their life, or at risk of acute deterioration;
- participate in care planning in the event of rapid deterioration, in accordance with this clinical directive;
- ensure appropriate participation and involvement with the implementation or documentation of the Resuscitation Planning - 7 Step Pathway Clinical Directive, including any necessary education and training;
- ensure all incidents and consumer feedback relating to resuscitation planning, and providing care in accordance with a resuscitation plan, are reported through the Safety Learning System.

## 2.8 All SA Health Staff and Staff who provide services on behalf of SA Health

SA Health staff and staff who provide services on behalf of SA Health must:

- adhere to clinical directive rationale and principles and ensure they operate in accordance with associated clinical directive, guidelines, local procedures and legislation; and
- complete the required Resuscitation Planning - 7 Step Pathway education if relevant to their role.

## 3. Policy Requirements

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### 3.1 The 7 Step Pathway for Resuscitation Planning

The 7 Step Pathway is a clear and transparent, step-by-step process to assist clinicians and patients to make decisions about resuscitation and other life-sustaining treatment, and to develop and document a Resuscitation Alert, Resuscitation Plan - 7 Step Pathway Form (MR RESUS) for care in the event of a rapid, acute and life threatening deterioration.

Resuscitation planning, and other end of life decisions, must be integrated into routine risk screening ([triggers, see Tool 2](#)), risk assessment and care planning processes that occur early in an episode of care. These must occur in collaboration with patients, their substitute decision maker (SDM), person responsible (PR) and family/carers consumers, and where practicable, resuscitation planning should be initiated at a time when the patient can engage in shared decision-making. Resuscitation planning, must be aligned with the values, needs and wishes of the individual and their family/carer in regard to their cultural, spiritual and psychosocial needs and the circumstances, environment and place in which they wish to die as far as is practicable and in accordance with best medical care and proper professional standards as per the [Good medical practice: a code of conduct for doctors in Australia](#) and the [Consent to Medical Treatment and Palliative Care Act 1995](#) (see section 3.8).

A standardised [trigger](#) (screening) system must be used to identify a person who may be at or approaching the end-of- life and who may benefit from a Resuscitation Alert, Resuscitation Plan. The five triggers to be used are specified in Diagram 1 below, Step 1.

## Diagram 1 Resuscitation Plan – 7 Step Pathway



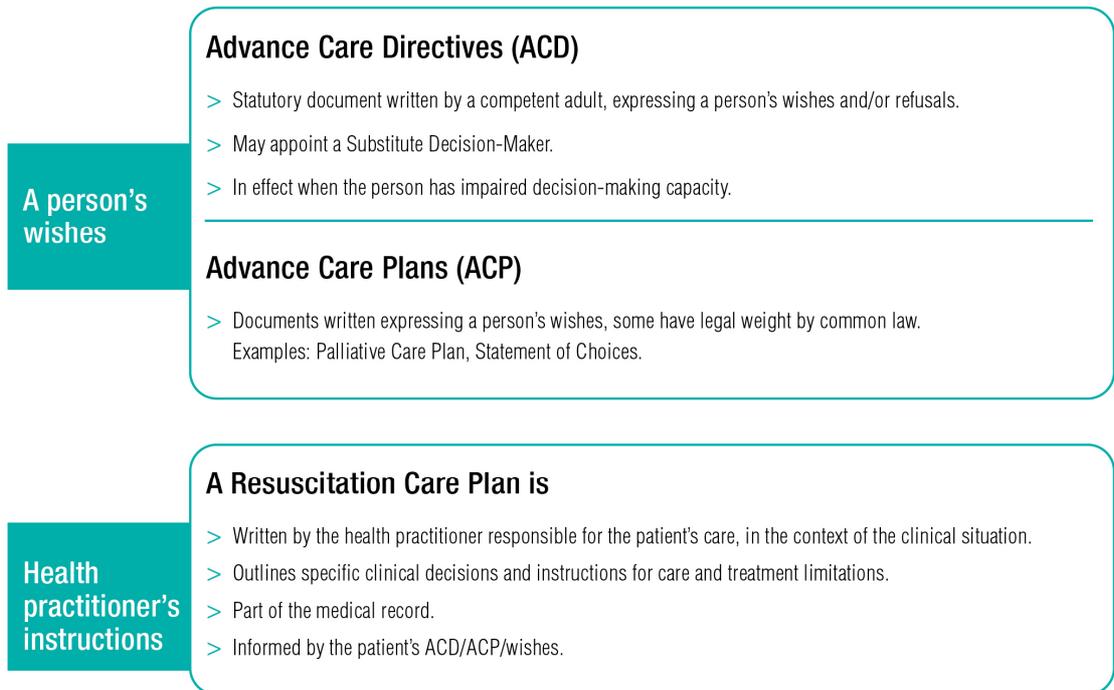
Further information is available: [Resuscitation Planning Toolkit: Tool 2 Recognising when a person is at end-of-life](#) and [Tool 3 Resuscitation Plan-7 Step Pathway – Consultation](#).

### 3.2 The Resuscitation Planning - 7 Step Pathway in relation to Advance Care Directives and Advance Care Plans

The Resuscitation Planning - 7 Step Pathway is the process for the development of the clinical care plan for the patients' wishes for treatment limitations including resuscitation. The care plan "translates" the results or outcomes of the 7 Step process, along with any Advance Care Directive (ACD) or Advance Care Plans (ACP), into a plan that the clinical care team can put into action (see diagram 2).

Patients, their SDMs, PR and family/carers should be made aware of the role of the ACD ACP and Resuscitation Plans.

**Diagram 2**



### 3.3 Extending the Resuscitation Plan (MR-RESUS) beyond the current admission

The responsible medical practitioner and credentialed nurse practitioner can determine the duration of the Resuscitation Alert (MR-RESUS). The plan may be limited to the current admission or remain in place indefinitely until revoked by documenting on the MR-RESUS or Sunrise EMR. The plan may also indicate if the patient does not wish to be transferred to hospital (with care provided in their place of accommodation/residence). Where the plan is:

- valid indefinitely; or
- until revoked; and/or
- indicates that the patient is not for transfer to hospital,

then the discharge plan and the Resuscitation Alert (MR-RESUS) must be:

- appropriate to meet the needs of the patient in the location of their transfer or discharge
- able to be implemented, for example equipment and medications available.

Clinical handover must include the existence and details of the Resuscitation Alert. If the patient is not for any treatment aimed at prolonging life (including CPR), then a plan (or contingency plan) for treatments and/or medications to manage symptoms and maintain their comfort and dignity, must be communicated and documented in the discharge plan.

### 3.4 Resuscitation Plan - 7 Step Pathway documentation requirements

The Resuscitation Alert, Resuscitation Plan - 7 Step Pathway form (MR-RESUS) - is a clinical care plan, not a legislated document, and is therefore legally equivalent to a health practitioner's notes in the patient's medical record. A responsible medical practitioner and credentialed nurse practitioner (whether an SA Health employee or not) – must complete the Resuscitation Alert (MR-RESUS) form correctly, and will comply with the appropriate legal and ethical steps in making decisions about resuscitation and end-of-life care for the patient.

The Resuscitation Alert form (MR RESUS or EMR equivalent\*) is to be used to document resuscitation plans in all SA Health services, excluding those providing care exclusively to persons under the age of 18. It replaces the outdated practice of writing medical orders in patients' medical record such as:

- Not For Resuscitation/NFR
- Not For Cardiopulmonary Resuscitation/Not for CPR
- Do Not Resuscitate/DNR.

\* (Resuscitation Alert, Resuscitation Plan (MR-RESUS) - or electronic (EMR) or other approved SA Health versions).

There are three versions of the form with the same content, each structured for the context of the health care provider/service. The three versions are:

1. [Resuscitation Alert; Resuscitation Planning - 7 Step Pathway \(MR-RESUS\)](#)

This hardcopy form for use within and across SA Health services seeks recognition as a clinical care plan by those outside of SA Health who are accepting responsibility and accountability for a patient being transferred, referred or discharged from an SA Health service.

2. Resuscitation Alert; Resuscitation Plan – Electronic Medical Record (EMR) version

To be used at sites where Sunrise EMR is in use. Can be created and viewed electronically and printed as required to provide to the patient, and for clinical handover upon transfer or discharge.

3. [Resuscitation Alert; Resuscitation Planning - 7 Step Pathway \(MR-RESUS\) Community version](#)

This is for voluntary use in primary care, private, community and residential aged care services. The Community version is available via the [SA Health Website](#) to download or through the [SA Health Distribution Centre](#). The Community version is to be used by general practitioners and aged care nurse practitioners\*.

The use of the completed MR-RESUS, EMR and Community version of the Resuscitation Plan in non-SA Health services is subject to that health service's policies and procedures.

\* Aged care nurse practitioners who have the necessary skills and capability to develop complete Resuscitation Plan in line with their employer's requirements and in conjunction with the patient's general practitioner.

When life prolonging treatments are being withheld, a clear plan with relevant treatment orders, including (where appropriate) medication orders for the patient's symptom control, comfort and dignity must be developed and documented. Where possible this must be done in conjunction with Specialist palliative care services.

Consent is required for medical treatment and must be sought from the patient or their SDM/s or PR, and documented appropriately.

The clinical care plan documented on section 4 on the MR-RESUS form must be completed:

- in consultation with the patient if they have decision-making capacity, or the patient's SDM/s or PR if they do not;
- with consideration of any pre-planning by patients such as an Advance Care Directive or Advance Care Plan; and
- while taking into account the current clinical status, prognosis and wishes of the patient.

The clinical plan documented on a Resuscitation Alert form (MR-RESUS) must be made in line with Part 3, section 17 of the [Consent to Medical Treatment and Palliative Care Act 1995 \(the Consent Act\)](#) and [Good Medical Practice: A Code of Conduct for Doctors in Australia](#)<sup>1</sup>:

'3.12.3 Understand the limits of medicine in prolonging life and recognise when efforts to prolong life may not benefit the patient.

'3.12.4 Understand that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.'

The current and accurately verified Resuscitation Alert (MR-RESUS) must be readily available for clinicians in an emergency situation; regardless of format (e.g. electronic or physical).

Any Electronic Health Records Systems, which have the capability to store electronic records, must ensure the active Resuscitation Alert (MR-RESUS) is available to all clinicians when required.

Physical Health Records must ensure that the active Resuscitation Alert (MR-RESUS) is filed at the front of patient case notes of the physical file and is available to all clinicians when required.

### **3.5 Communication of the Resuscitation Alert**

Health services must have documented processes for communication of critical clinical information, alerts and risks ([NSQHS action 6.8, 6.9](#)). A Resuscitation Alert (MR-RESUS) is critical information that must be communicated to all relevant members of the clinical team in a timely manner and as per all health record alerts must be filed at the front of the paper based health record and in Sunrise EMR is displayed in the header section for patient alerts. It is the responsibility of the clinician completing the Resuscitation Alert (MR-RESUS) (or Sunrise equivalent) to communicate the existence and details of the Resuscitation Alert (MR-RESUS) on admission, at all occasions of handover, documented on section B of the Rapid Detection and Response Observation chart MR-59A (RDR Chart) or Sunrise equivalent (for inpatients) and on patient discharge.

### **3.6 Resuscitation Alert Confirmation**

A process of confirmation of the validity and currency of a resuscitation plan is to occur

- If a patient presents or is admitted to an SA Health service with any version (SA Health (MR-RESUS) or Community version) of the Resuscitation Alert, confirmation of the validity of the Resuscitation Alert (MR-RESUS) must be made by the responsible medical practitioner or credentialed nurse practitioner as soon as practicable after admission and documented on the Resuscitation Confirmation form (MR-Resus A).
- If the plan is no longer valid, it should be revoked and a new Resuscitation Alert (MR-RESUS) completed as required. Documentation and communication of the change to those involved in the patient's care is therefore required; and

- It is recommended that non-SA Health services develop suitable processes for the confirmation of Resuscitation Alert forms for patients who are admitted or transferred to their care with a plan in place.

### 3.7 Surgical and invasive procedures under regional and general anaesthesia

Perioperative procedures must also review documentation of treatment limitations that are already in place, such as a Resuscitation Alert or others documented in an ACD or Advance Care Plan. The medical practitioner responsible for obtaining informed consent (including explaining potential risks) for the procedure must clarify the intent of any instructions documented on a currently valid Resuscitation Alert, ACD or Advance Care Plan with the patient and/or their SDM/PR to ensure that any resuscitation or treatment limitation instructions are fully understood in the context of the surgical/invasive procedure.

The results of conversations with patients and/or their SDM/PR, and the duration of any modifications to the document must be communicated to the perioperative team and other health care professionals involved in the patient's care, and documented in the medical record. Processes for communicating and documenting resuscitation plans for perioperative patients must be in place and evaluated for effectiveness. This should be checked routinely and/or when a change happens to the treatment/care plan.

When caring for a patient when a Resuscitation Alert is in place, the Registered Nurse (RN) is responsible for ensuring the Resuscitation Plan- and Medical Emergency Response (MER) status is documented correctly onto the patient's observation plan (documented on the Adult Rapid Detection and Response (RDR) Observation Chart, MR59A and EMR equivalent).

### 3.8 Legal, ethical and policy considerations

In South Australia, aspects of end-of-life decision-making, including substitute decision-making, are governed by:

- the [Advance Care Directive Act 2013](#);
- the [Consent to Medical Treatment and Palliative Care Act 1995 \(the Consent Act\)](#);
- the [Guardianship and Administration Act 1993](#); and
- common law.

This legal framework supports a patient to participate in end-of-life decisions, including those documented on a Resuscitation Alert, and permits:

- refusal of any or all life-sustaining treatments at the end of life (and at any time) by a person with decision-making capacity;
- refusal of any or all life-sustaining treatments by a SDM or PR for an individual who has lost capacity to make end-of-life decisions;
- an individual to make decisions and give directions in relation to their future health care, including documenting their refusal of life-sustaining treatment (and other medical treatment/health care) at a time of future incapacity in an ACD.

The legal framework does not support:

- health care practitioners being involved in interventions that have as their primary intention the ending of a person's life;
- a SDM or PR refusing:
  - the natural provision of food and water;
  - pain/distress relieving drugs (e.g. palliative care) (Advance Care Directives Act 2013).

Resuscitation plans must consider a patient's wishes and values as expressed in their ACD, as documented in an Advance Care Plan, or by the patient's SDM or PR. [The Advance Care Directives Act 2013](#) supports and directs:

- resolution of disputes around Advance Care Directives;
- decisions made by a doctor to withhold or withdraw life-sustaining measures to give effect to an Advance Care Directive.

A health practitioner can, on conscientious ground, refuse to comply with instructions in an ACD, and in this case, should ensure adequate and proper clinical handover to another treating clinician. This includes good clinical documentation of the discussion and decision made.

Resuscitation plans may provide for the administration of treatments for the relief of pain and distress in the care of a dying patient. Section 17(1) of the [Consent Act 1995](#) provides for a medical practitioner (or a person participating in the medical treatment or care of the patient under the medical practitioner's supervision) to administer medical treatment with the intention of relieving pain or distress:

- with consent of the patient or the patient's representative (SDM or PR); and
- in good faith and without negligence; and
- in accordance with proper professional standards of palliative care even if an incidental effect of the treatment is to hasten the death of the patient. ([Consent Act 1995](#)).

Section 17(2) of the [Consent Act 1995](#) states that a medical practitioner responsible for the medical treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the medical treatment or care of the patient under the medical practitioner's supervision:

- a. is under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state (whether or not the patient or the patient's representative has requested that such measures be used or continued); and
- b. must, if the patient or the patient's representative so directs, withdraw life sustaining measures from the patient. ([Consent Act 1995](#)).

The administration of medical treatment for the relief of pain or distress, or the withdrawal or withholding of life sustaining measures (in accordance with good medical practice and in good faith), does not constitute an intervening cause of death (s17(1) and 17(3) [Consent Act 1995](#)). Section 17 applies irrespective if the patient has an Advance Care Directive or not.

The Code of Conduct for Doctors in Australia (Medical Board of Australia) states that doctors need to understand the limits of medicine and recognise when efforts to prolong life may not benefit the patient. ([Good Medical Practice: a code of conduct for doctors in Australia](#)).

Doctors do not have a duty to try to prolong life at any cost, but they do have a duty to know when not to offer or initiate, and when to cease attempts at, sustaining life. This duty includes ensuring that patients receive appropriate care and relief from distress when they are dying and to focus primarily on the symptom control and maintenance of the patient's comfort and dignity.

Palliative care advice for symptom management is available 24 hours a day, 7 days a week via a dedicated support phone line 1300 673 122. See the SA Health Palliative Care Support Line for Clinicians page for more information.

Care provided must be in accordance with:

- [SA Health Advance Care Directive Policy Directive](#);
- [Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained Policy Directive](#); and
- [Consent for Medical Treatment and Health Care Policy Guideline](#).

#### 4. Implementation and Monitoring

Health services are required to evaluate the safety and effectiveness of the resuscitation planning process outlined in the Resuscitation Planning - 7 Step Pathway Clinical Directive, with appropriate, documented clinical governance structures and processes. Evaluation measures require linkage with regular mortality review processes and data.

The following are examples of measures that could be used to evaluate compliance and effectiveness with the Resuscitation Planning - 7 Step Pathway Clinical Directive.

<b>A health service may require a number of measures to indicate performance in resuscitation planning. Some examples are:</b>		<b>Data source examples</b>
<b>Compliance with a person's resuscitation wishes at EOL</b>	Any incidents where a patient was provided CPR, ICU treatment, admission or life prolonging measures against their expressed wishes (by direct communication with the person, through their Advance Care Directive or their Substitute Decision-Maker or Person Responsible).	SLS - consumer feedback SLS – incident report Relevant documentation from morbidity and mortality meetings and death reviews
<b>Resuscitation planning education</b>	The percentage of clinical staff completing required resuscitation planning education.	Electronic platform for documenting staff training
<b>Consumer feedback</b>	Reports on patient feedback in relation to resuscitation planning and end-of-life care.	SLS – Consumer feedback Consider Patient Reported Experience Measures
<b>Documentation</b>	Periodic audits of the percentage of patients who have a Resuscitation Plan filed as per guideline in the medical record.	Snapshot audit

## 5. National Safety and Quality Health Service Standards

 <a href="#">National Standard 1</a> <a href="#">Clinical Governance</a>	 <a href="#">National Standard 2</a> <a href="#">Partnering with Consumers</a>	 <a href="#">National Standard 3</a> <a href="#">Preventing &amp; Controlling Healthcare-Associated Infection</a>	 <a href="#">National Standard 4</a> <a href="#">Medication Safety</a>	 <a href="#">National Standard 5</a> <a href="#">Comprehensive Care</a>	 <a href="#">National Standard 6</a> <a href="#">Communicating for Safety</a>	 <a href="#">National Standard 7</a> <a href="#">Blood Management</a>	 <a href="#">National Standard 8</a> <a href="#">Recognising &amp; Responding to Acute Deterioration</a>
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## 6. Definitions

**Advance Care Directive:** An Advance Care Directive (ACD) is a legal document written by a competent person 18 years and over. It can record a person's wishes and instructions for future health care decisions, preferred living arrangements and other personal decisions. An ACD can also be used to appoint one or more adults to make these decisions for the person (a Substitute Decision-Maker). An ACD takes effect if a person has impaired decision-making capacity in relation to decision(s). An Enduring Power of Guardianship, Medical Power of Attorney and an Anticipatory Direction completed before 1 July 2014 are considered to be an ACD for the purposes of the *Advance Care Directives Act 2013* until such time that a new Advance Care Directive is given. Advance Care Directives from other jurisdictions are recognised.

**Advance Care Plan:** An Advance Care Plan (ACP) is a general term referring to non-statutory documents which record a patient's wishes regarding future care and medical treatments in the event the patient loses decision-making capacity.

Advance Care Plans include but are not limited to the Palliative Care Plan, the Statement of Choices (Respecting Patient Choices) and forms from aged care facilities (Facility Form) in which a person's end-of-life care preferences are documented.

**Clinical Care Plan:** Clinical Care Plans are written by the clinician responsible for the patient's treatment and care, in the context of the current clinical situation including those expressed on their Advance Care Directive, and/or advance care plan, or by their Substitute Decision-Maker or Person Responsible.

Clinical Care Plans for resuscitation and end-of-life care should contain specific instructions about resuscitation and end-of-life care and set out a practical treatment plan based on the clinical status of the patient and treatment options that are appropriate, available or acceptable. NOTE: The Clinical Care Plan in the Resuscitation Plan-7 Step Pathway is called the RESUSCITATION PLAN.

**Decision-making capacity:** A person may have impaired decision-making capacity temporarily or permanently.

A person has decision-making capacity, in relation to a specific decision, if they can:

1. understand information about the decision (ensuring it is provided in a way the person understands);
2. understand and appreciate the risks and benefits of the choices;
3. remember the information for a short time; and
4. tell someone what the decision is and why they have made the decision.

Also refer to the [Advance Care Directive Policy Directive](#) and the [Advance Care Directive Act 2013](#).

**End of life:** A term used to describe the stage of life where a person is living with, and impaired by, an eventually fatal (or terminal) condition, even if the prognosis is ambiguous or unknown<sup>ii</sup>. It may be the last one to two years of life.

**Health care:** Is used to refer to care, treatment (including medical treatment and life sustaining treatment) and services or procedures to diagnose, maintain or treat a person's physical or mental condition. Health care may be carried out by a range of health care practitioners or may be under the direction or supervision of a medical practitioner.

Health care includes:

- medical treatment
- life-sustaining treatment
- surgery
- mental health treatment
- medications
- dental treatment
- maternity care
- emergency care
- podiatry (foot care)
- physiotherapy
- occupational therapy
- psychological therapy
- palliative care
- alternative therapies such as Chinese medicine

**Health practitioners:** Include registered practitioners<sup>iii</sup> such as medical, nursing and dental practitioners and other registered practitioners who provide health care including Aboriginal and Torres Strait Islander health workers and some allied health staff. It also includes ambulance officers and paramedics.

A person who practices one or more of the following:

- a) a health profession (within the meaning of the *Health Practitioner Regulation National Law (South Australia) 2010*)
- b) any other profession or practice declared by the Advance Care Directives Regulations 2014 and the *Consent Act Regulations 2014* to be included in the ambit of this definition.

**Medical practitioners:** Include registered medical practitioners<sup>iv</sup>.

**Life-sustaining treatment:** Is any medical intervention, technology, procedure or medication that is administered to keep a person alive but not necessarily administered to improve their health. These treatments include mechanical ventilation, artificial hydration and nutrition, dialysis, cardiopulmonary resuscitation and certain medications, including antibiotics at the end-of-life.

**Medical treatment:** Means the provision by a medical practitioner of physical, surgical or psychological therapy to a person (including the provision of such therapy for the purposes of preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life) and includes the prescription or supply of drugs.

**Nurse Practitioner:** Advanced practice nurse endorsed by the Nursing and Midwifery Board of Australia (NMBA) to practise within their scope under the legislatively protected title 'nurse practitioner'.<sup>6</sup>

**Palliative care:** An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention of suffering by early identification and a thorough assessment and treatment of pain and other problems physical, psychological and spiritual<sup>v</sup>.

**Patient:** For the purposes of this document, the term 'patient' describes the person receiving health and/or end-of-life clinical care in a hospital, hospice facility, aged care facility or the home.

**Person Responsible:** Is a person close to the patient who is available and willing to consent to or refuse consent to health care (including medical treatment and life-sustaining measures) when the patient has impaired decision-making capacity. The person can be a family member, close friend or a culturally acceptable person from the same community.

In the absence of an Advance Care Directive (relevant instructions or Substitute Decision-Maker), the Person Responsible is determined in the following order:

1. Guardian with health care decision-making powers (appointed by the South Australian Civil and Administrative Tribunal (SACAT) (formerly the Guardianship Board))  
Prescribed family/carer (adult with a close and continuing relationship)
  - Spouse/domestic partner\*\*
  - Adult related by blood, marriage or by adoption\*\*
  - Aboriginal or Torres Strait Islander kinship/marriage\*\*

And if none of the above then,

2. Adult friend \*\*
3. Adult charged with overseeing ongoing day-to-day care of the patient
4. South Australian Civil and Administrative Tribunal (SACAT), upon application (this is a last resort).

\*\* the person must have a close and continuing relationship with the patient and be available and willing to make the decision.

A Person Responsible must try to make a decision they believe the patient would have made if they were capable of making their own decision, not a decision the Person Responsible thinks is in the patient's best interest.

**Specialist Palliative Care Registered Nurses:** have a specific scope of clinical practice. They have the knowledge and have clinical capability to provide evidence based palliative nursing care to patients who are at the end-of life. They provide nursing care in conjunction with the broader health care team to improve a patient's quality of life across all domains and in a wide range of settings

**Substitute Decision-Maker:** Is an adult one can choose and appoint in an Advance Care Directive to make decisions about their *future* health care, living arrangements and other personal matters when the person giving the Advance Care Directive is unable to make their own decision/s.

An Enduring Guardian and a Medical Agent are considered to be Substitute Decision-Makers for the purposes of the *Advance Care Directives Act 2013*.

## 7. Associated Directives / Guidelines & Resources

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### Relevant legislation

- *Health Practitioner Regulation National Law Act 2010*
- *Consent to Medical Treatment and Palliative Care Act 1995*
- *Consent to Medical Treatment and Palliative Care Regulations 2014*
- *Advance Care Directives Act 2013 (and Regulations)*
- *Guardianship and Administration Act 1993*
- *Health and Community Services Complaints Act 2004*

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- Health Care Act 2008
- Criminal Law Consolidation Act 1935
- Public Sector Act 2009
- Coroners Act 2003
- Mental Health Act 2009
- Transplantation and Anatomy Act 1983

## SA Health related resources

- [Charter of Health and Community Services Rights Policy Directive](#)
- [Code of Ethics for the South Australian Public Sector](#)
- [Your Rights and Responsibilities – A Charter for Consumers](#)
- [Office of the Public Advocate](#)
- [Advance Care Directive fact sheets](#)
- [Advance Care Directive frequently asked questions](#)
- [Supporting a person to make a decision fact sheet](#)
- [Consent to Medical Treatment and Healthcare flow chart - Adults](#)
- [Help Us, Help You – Essential contacts information sheet for consumers](#)

## Other references

- [National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care \(Australian Commission on Safety and Quality in Health Care\)](#)
- [Capacity Toolkit \(NSW Attorney-General\)](#)
- [Conflict resolution in end-of-life settings \(CRELS\) Final CRELS Project working group report \(NSW Health, 2010\)](#)
- [Guidelines for a palliative approach in residential aged care \(NHMRC, 2006\)](#)
- [Good Medical Practice: A Code of Conduct for Doctors in Australia \(2014\)](#)
- [National Safety and Quality Health Service Standards Second Edition](#)
- [Australian Government Department of Health Palliative Care Resources](#)

## 8. Document Ownership & History

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09/02/2021	V2	ED Provider Commissioning and Performance	Reviewed to include provision for Nurse Practitioners and Specialist Palliative Care nurses to complete a Resuscitation Plan - 7 Step Pathway and changed to clinical directive.
14/07/2016	V1		Original version

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- <sup>i</sup> Australian Health Practitioner Regulation Agency - Medical Board of Australia Good Medical Practice: A Code of Conduct for Doctors in Australia (March 2014) [Code of Conduct](http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx)  
<http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx>
- <sup>ii</sup> Palliative Care Australia, Palliative and End-of-life Care – Glossary of Terms. PCA, Canberra
- <sup>iii</sup> *Registered under the Health Practitioner Regulation National Law.*
- <sup>iv</sup> *Registered under the Health Practitioner Regulation National Law (South Australia).*
- <sup>v</sup> World Health Organisation. WHO Definition of Palliative Care (Accessed 19 April 2015, at <http://www.who.int/cancer/palliative/definition/en/>)
- <sup>vi</sup> Australian Nursing and Midwifery Accreditation Council website, <https://www.anmac.org.au/glossary> [Accessed 8 Dec 2020].

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