Policy Directive: compliance is mandatory

Resuscitation Planning - 7 Step Pathway

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Summary
Quality of life can be improved by partnering early with a patient, Substitute Decision Maker, Person Responsible or significant others in making and documenting decisions about end-of-life treatment and care.

The Resuscitation Plan-7 Step Pathway Policy is a clear and transparent, step-by-step process to assist clinicians and consumers to make decisions about resuscitation and other life-sustaining treatment, and to develop and document an end-of-life clinical care plan for a patient.

The policy is supported by an extensive toolkit including fact sheets and resources to support in implementation.

Keywords
Resuscitation Planning, 7 Step Pathway, end-of-life care, NFR, palliative, death, policy, directive

Policy history
Is this a new policy? Y
Does this policy amend or update an existing policy? N
Does this policy replace an existing policy? N
If so, which policies?

Applies to All SA Health Portfolio
Staff impacted All Staff, Management, Admin, Students; Volunteers
EPAS compatible Yes
Registered with Divisional Policy Contact Officer Yes
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<th>Director, Safety and Quality, System Performance and Service Delivery</th>
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| Contributors                    | Principal Consultant, Safety and Quality, System Performance and Service Delivery  
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### Document history

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### Approvals

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Resuscitation planning-7 Step Pathway Policy Directive

1. Objective

This policy 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 an adult patient who is at the end-of-life.

Quality of life 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 end-of-life treatment and care. End-of-life care planning can:

- avoid traumatic and/or unwanted treatment and procedures when a person is dying
- assist or relieves 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 the development and implementation of a clinical care plan which documents treatment decisions relating to a patient’s resuscitation and end-of-life care. The Resuscitation Plan- 7 Step Pathway complements and promotes compliance with:

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

2. Scope

All SA Health workers or persons who provide health services on behalf of SA Health must adhere to the standards and principles described in this policy.

The Resuscitation Planning-7 Step Pathway Policy 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 policy directive and the accompanying tools do not:

- apply to children (those under 18 years of age)
- provide legal advice.
3. Principles

3.1 The role of health care is both to maintain and restore the health of individuals and to recognise and care for people when they are dying. Dying is a normal part of life and a human experience, not just a biological or medical event.

3.2 A health care team skilled in recognising when a patient is approaching the end of their life, and knowing about best practice care and symptom control is essential to delivering appropriate, compassionate and timely end-of-life care.

3.3 Safe and high-quality resuscitation planning and end-of-life care requires the availability of appropriately qualified, skilled and experienced interdisciplinary teams that have effective communication, collaboration and teamwork within and between settings and episodes of care.

3.4 Safe and high-quality resuscitation planning and end-of-life care is patient and family/carer centred and, whenever possible, should 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.

3.5 Patients, Substitute Decision-Makers/Person Responsible have the right to refuse some or all medical treatment. Decisions regarding treatment may be made in advance and these remain valid unless stated otherwise by the person.

3.6 Health care systems are designed to support patients, Substitute Decision-Makers/Person Responsible in the preparation and receipt of Advance Care Directives, Advance Care Plans and Resuscitation Plans. Clinicians require timely access to the individual’s Advance Care Directive, Advance Care Plan and/or Resuscitation Plan in their medical record to provide care and treatment in accordance with the person’s expressed wishes.

3.7 It is ethically important not to harm patients approaching the end of life by providing burdensome or futile investigations and/or treatments that can be of no benefit.

3.8 Care of the deceased person, and care for Substitute Decision-Makers, Person Responsible and families/carers, extends to the period after the patient has died.

3.9 Important to maintain good communication with primary care team, as the patient transfers in and out of health care system.

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1Adapted from the National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care (Australian Commission on Safety and Quality in Health Care) 2015
4. Detail

4.1 Standards

SA Health organisations and services will ensure that:

4.1.1 A governance structure and systems are in place, with responsibility and accountability for identifying risk and developing, implementing, evaluating and monitoring improvements in resuscitation planning and end-of-life care systems and processes in accordance with this policy.

4.1.2 The Resuscitation Plan is included in clinical handover and aligns with systems for recognition and response to clinical deterioration as per the SA Health Recognising and Responding to Clinical Deterioration Policy Directive and Guideline.

4.1.3 Administrative, clerical and medical record systems (including electronic) and admission processes collect and record an alert and securely maintain and have readily accessible and visible a patient’s Resuscitation Plan-7 Step Pathway (“How to file hard copy Advance Care Directive, Advance Care Plan and Resuscitation Alert forms in medical records Factsheet”).

4.1.4 Specialist palliative care services can provide advice to SA Health clinical staff 24 hours per day, seven days per week.

4.1.5 Education and training to all health practitioners/workers (who provide care directly or indirectly) and administrative staff who support clinical care processes and documentation of Advance Care Directives, Advance Care Plans and Resuscitation Planning as outlined in the SA Health Resuscitation Planning Education Framework and Advance Care Directives Policy Directive is provided, recorded and evaluated.

4.1.6 Dispute resolution mechanism and resuscitation planning advisory processes and procedures for urgent matters are accessible at all times for disputes about treatment decisions (as per the SA Health Advance Care Directives Policy Directive, Providing Medical Assessment and or Health Care Where Patient Consent Cannot be Obtained Policy Directive and Consent to Medical Treatment and Health Care Policy Guideline).

4.1.7 Access to informal and formal debriefing for both clinical and non-clinical staff involved in resuscitation discussions, limitation of treatment and/or providing end-of-life care is made available.

4.1.8 Collaboration with local residential aged care facilities, general practitioners, community pharmacy, primary health care organisations, private hospitals and community-based service providers occurs to provide continuity and safe, quality, patient centred end-of-life care and resuscitation planning in shared care or transition of care between health care settings and to build capacity and shared expertise.
4.2 The Resuscitation Planning– 7 Step Pathway in relation to Advance Care Directives and Advance Care Plans

4.2.1 The Resuscitation Planning– 7 Step Pathway is the process for the development of the clinical plan of care for a person. The Clinical Care Plan (CCP) “translates” the results or outcomes of the 7 Step process, along with any ACD or ACP, into a plan that clinical care team can put into action, for example describes dosage of the medications to be given.

Diagram 1

4.3 The Resuscitation Planning– 7 Step Pathway

4.3.1 The Resuscitation Plan-7 Step Pathway is a clear and transparent, step-by-step process to assist clinicians and consumers to make decisions about resuscitation and other life-sustaining treatment, and to develop and document an end-of-life Clinical Care Plan (CCP) for a patient.

4.3.2 Where possible, planning should be initiated at a time when the patient can engage in shared decision-making.

4.3.3 Patients, their SDMs, PR and family/carers should be made aware of the role of Advance Care Directives, Advance Care Plans and Resuscitation Plans.

4.3.4 A standardised trigger system is to be used to identify a person who may be at or approaching the end-of-life and who may benefit from a Resuscitation Plan-7
Step Pathway. The five triggers to be used are specified in Diagram 2 below, Step 1.

Diagram 2 Resuscitation Plan-7 Step Pathway

**STEP 1: TRIGGER**

The clinical team caring for the patient should use standardised triggers to assess if a patient may be at end-of-life. If any of the triggers below are met, the clinician responsible for the patient should consider if an end-of-life clinical care plan is needed, the urgency for a plan, and readiness of patient/family to discuss issues.

**Triggers:**

1. The patient, family/carer, Substitute Decision-Maker, Person Responsible or members of the interdisciplinary team express concern or worry that the patient is dying and/or have unmet end-of-life care need.

2. Indicators are met using the Supportive and Palliative Care Indicators Tool (SPICT™), a tool for identifying people at risk of deteriorating and dying (www.spict.org.uk/index.php).

3. The ‘Surprise Question’: the clinician asks him or herself, “Would I be surprised if this patient died in the next 12 months? (and where the response is “No”?”.

4. A patient who has refused life-sustaining treatment in an Advance Care Directive (including in an Enduring Power of Guardianship, Medical Power of Attorney or Anticipatory Direction) or in an Advance Care Plan.

5. Observations triggering or are likely to trigger the activation of a Medical Emergency Response (MER).

**STEP 2: ASSESSMENT**

Obtain adequate clinical information to allow reasonable clinical decisions to be made, and to be the basis for discussions with the patient, Substitute Decision-Maker/Person Responsible. Make an assessment about the capacity of the patient to participate in these discussions.

**STEP 3: CONSULTATION**

When the treating team has reached a clinical decision, sensitively, and clearly explain to the patient, Substitute Decision-Maker/Person Responsible and others as indicated by the patient, the diagnosis, prognosis, treatment options and recommendations; and negotiate clear goals and intent for future treatment. Determine whether the patient has previously refused treatment. If the patient has lost capacity refer to Advance Care Directive/Advance Care Plan.

**STEP 4: DOCUMENT THE CLINICAL CARE PLAN**

Using the Resuscitation Plan form develop and document a realistic and practical clinical plan about resuscitation/life-sustaining measures, or treatment with a palliative approach, informed by the patient’s wishes.

**STEP 5: TRANSPARENCY AND COMMUNICATION**

Explain the plan to the patient, Substitute Decision-Maker/Person Responsible and others as indicated by the patient, in a consistent and compassionate way. Allow time for them to process the information, encourage questions and revisit as necessary to develop a shared understanding. If there is a dispute, then institute dispute resolution process as necessary.

**STEP 6: IMPLEMENTATION**

Take practical steps to implement the plan and revisit as necessary.

**STEP 7: SUPPORT THE PATIENT, SUBSTITUTE DECISION-MAKER/ PERSON RESPONSIBLE AND FAMILY/CARERS**

Throughout the process ensure practical, emotional and spiritual support is offered to the patient, Substitute Decision-Maker/Person Responsible and family/careers including offering support and information after the patient has died.

Further information is available: Resuscitation Planning Toolkit: Tool 1 Recognising when a person is at end-of-life and Tool 2 Resuscitation Plan-7 Step Pathway – Consultation.
4.4 Role of the health care team in resuscitation planning

4.4.1 There is a role for all members of the health care team in:
- recognition of patients whose care may benefit from resuscitation planning and/or advance care planning
- contributing to resuscitation planning, and
- implementation of the resuscitation plan within the scope of their professional practice.

4.4.2 Responsibility for completion of the Resuscitation Plan- 7 Step Pathway Form is with the patient’s responsible medical practitioner. The Resuscitation Plan form must be signed by the registered medical practitioner who is responsible for the coordination of the patient’s medical care. The name of the responsible medical practitioner must be clearly documented and easily accessible by the patient and their family/carer. Health service record keeping systems must be current and accurately maintained.

4.4.3 The task of completing the Resuscitation Plan can be delegated to another medical practitioner, but the responsible medical practitioner must ensure that:
- the medical practitioner to whom the task has been delegated is competent to perform the task and has sufficient skill or experience to provide all necessary and proper information to the patient, SDM/s or PR or family and carers
- the delegated medical practitioner has been trained in the Resuscitation Plan- 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 medical practitioner and the delegated medical practitioner
- the process of delegation is consistent with:
  - the SA Health Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained Policy Directive, and
  - the Consent for Medical Treatment and Health Care Policy Guideline and
  - health service procedures for gaining consent
- professional supervision of clinical staff is accessible for resuscitation planning, including consultant oversight/advice
- the task of completing the Resuscitation Plan-7 Step Pathway is not delegated to an intern or other health care professional, eg nursing staff.

4.5 Extending the Resuscitation Plan - 7 Step pathway beyond the current admission

4.5.1 The responsible medical practitioner can determine the duration of the Resuscitation Plan-7 Step Pathway. The plan may be limited to the current admission or remain in place indefinitely until revoked by documenting on the MR-Resus or EPAS. The plan may also indicate if the patient is not 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 Plan-7 Step Pathway must be appropriate to meet the needs of the patient in the location of their transfer or discharge and must be able to be implemented, for example equipment and medications available.

4.5.2 Clinical handover must include the Resuscitation Plan-7 Step Pathway. If the patient is not for resuscitation measures, then a plan (or contingency plan) for treatments and/or medications to manage symptoms and maintain their comfort and dignity, must be documented in the discharge plan and handed over.

4.6 Resuscitation Plan-7 Step Pathway documentation requirements

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

4.6.2 The Resuscitation Planning-7 Step Pathway form* 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 existing forms relating to resuscitation, and also the practice of writing medical orders in patients’ progress notes of the medical record such as:

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

* (Resuscitation Alert 7 Step Pathway - Developing a Resuscitation Plan (MR-RESUS) - or electronic (EPAS or other approved SA Health versions).

4.6.3 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 7 Step Pathway - Developing a Resuscitation Plan (MR-Resus)
   This carbonless, 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 7 Step Pathway - Developing a Resuscitation Plan – Enterprise Patient Administration System (EPAS) version
   To be used at sites where EPAS 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 7 Step Pathway - Developing a Resuscitation Plan Resuscitation Plan- 7 Step Pathway - Community version
   This is for voluntary use in primary care, private, community and residential aged care services. The Community version is available on application to the Director of Safety and Quality, Department of Health and Ageing. The Community version is to be used by general practitioners in the GP Palliative Share Care Program.
The completed MR-Resus, EPAS and Community version of the Resuscitation Plan– 7 Step Pathway in non-SA Health services is subject to that health service’s policies and procedures.

4.6.4 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 documented.

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

4.6.6 The clinical care plan documented on a Resuscitation Plan -7 Step Pathway 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
- while taking into account the current clinical status, prognosis and wishes of the patient.

4.6.7 When none of the afore-named options are possible, the clinical plan documented on a Resuscitation Plan- 7 Step Pathway form must be made in line with Good Medical Practice: A Code of Conduct for Doctors in Australia:

‘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.’

4.7 Resuscitation Alert Confirmation

A process of confirmation of the validity and currency of a resuscitation plan is to occur in the following situations:

4.7.1 Upon presentation/admission

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 Plan– 7 Step Pathway, confirmation of the validity of the Resuscitation Plan– 7 Step Pathway must be made by the responsible medical practitioner upon 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 Plan–7 Step Pathway completed as required. Documentation and communication of the change to those involved in the patient’s care is therefore required. It is recommended that non-SA Health services develop suitable processes for the confirmation of Resuscitation Plan–7 Step Pathway forms for patients who are admitted or transferred to their care with a plan in place.

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4.7.2 Surgical and invasive procedures under regional and general anaesthesia

4.7.2.1 Perioperative processes must identify patients at end-of-life and bring this to the attention of the medical practitioner responsible for obtaining consent (including explaining potential risks) for the procedure. The medical practitioner is then responsible for formulating a resuscitation plan, in conjunction with the patient and/or their SDM or PR, ensuring that any resuscitation or treatment limitation instructions are fully understood in the context of the surgical/invasive procedure.

4.7.2.2 Perioperative procedures must also review documentation of treatment limitations that are already in place, such as a Resuscitation Alert-7 Step Pathway or others documented in an Advance Care Directive 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 Plan-7 Step Pathway, Advance Care Directive or Advance Care Plan with the patient and/or their Substitute Decision-Maker/Person Responsible to ensure that any resuscitation or treatment limitation instructions are fully understood in the context of the surgical/invasive procedure.

4.7.2.3 The results of conversations with patients and/or their Substitute Decision Maker/Person Responsible, and the duration of any modifications to the documented and 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.

4.7.3 When caring for a patient when a Resuscitation Plan-7 Step Pathway is in place, the Registered Nurse (RN) is responsible for ensuring the Resuscitation Plan-7 Step Pathway resuscitation 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).

4.8 Legal, ethical and policy considerations

4.8.1 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
- common law.

This legal framework supports a patient to participate in end-of-life decisions, including those documented on a Resuscitation Plan-7 Step Pathway, 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 Advance Care Directive or an Advance Care Plan.
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:
  o the natural provision of food and water
  o pain/distress relieving drugs (eg palliative care) (*Advance Care Directives Act 2013*).

4.8.2 Resuscitation plans must consider a patient’s wishes and values as expressed in their Advance Care Directive, 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 Advance Care Directive, and in this case, should ensure adequate and proper clinical handover. This includes good clinical documentation of the discussion and decision made.

4.8.3 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* 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*)

4.8.4 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*)

4.8.5 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) and17(3) *Consent Act*). Section 17 applies irrespective if the patient has an Advance Care Directive or not.

4.8.6 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.

4.8.7 Care provided must be in accordance with:

- the SA Health Advance Care Directive Policy Directive,
- Providing Medical Assessment and/or Treatment Where Patient Consent Cannot be Obtained Policy Directive and
- the Consent for Medical Treatment and Health Care Policy Guideline.
5. Roles and Responsibilities

5.1 Chief Executive, SA Health

5.1.1 Ensure the management of clinical care planning, including decisions for resuscitation and other end-of-life care across SA Health is in accordance with this policy.

5.2 Director, Safety and Quality, System Performance and Service Delivery

5.2.1 Establish, maintain and periodically review the effectiveness of the Resuscitation Planning 7 Step Pathway Policy Directive and toolkit.
5.2.2 Monitor and evaluate the implementation of the Resuscitation Planning 7 Step Pathway Policy Directive, including the development of appropriate clinical indicators.
5.2.3 Disseminate learning from the management of resuscitation planning incidents and issues across SA Health.
5.2.4 Provide advice to health networks in response to specific queries about resuscitation planning and other end-of-life care issues.
5.2.5 Establish educational tools to support the education of SA Health staff in resuscitation planning.
5.2.6 Maintain and evaluate the Resuscitation Plan-7 Step Pathway Forms.

5.3 Local Health Network Chief Executive Officers

5.3.1 Develop and ensure systems and resources are allocated for the effective implementation of the Resuscitation Planning 7 Step Pathway Policy Directive.
5.3.2 Ensure sufficient resources are in place to enable effective implementation, staff education, monitoring, evaluation and governance of the Resuscitation Planning 7 Step Pathway Policy Directive.
5.3.3 Ensure that all SA health services adopt the Resuscitation Plan– 7 Step Pathway process and documentation for all resuscitation planning in patients 18 years and older as per the Policy Directive, including use appropriate forms relating to resuscitation and cessation of the practice of writing medical orders such as Not for Resuscitation (NFR), Not for Cardiopulmonary Resuscitation (Not for CPR), and Do Not Resuscitate (DNR).
5.3.4 Ensure resources and systems are in place for the provision of safe, high-quality end-of-life care (such as private space for the dying person and family/carers, family/carer meetings, equipment and medications).
5.3.5 Clearly articulate organisational and individual accountabilities for the Resuscitation Planning 7 Step Pathway Policy Directive.
5.3.6 Ensure that incidents relating to the Resuscitation Planning 7 Step Pathway Policy Directive are reported and investigated, and outcomes actioned in accordance with the SA Health Incident Management Policy Directive.
5.3.7 Ensure the day-to-day responsibility for establishing and monitoring the implementation of the Resuscitation Planning 7 Step Pathway Policy Directive is delegated to relevant senior managers.
5.3.8 Ensure effective governance structures and processes are in place for the implementation, monitoring and evaluation of resuscitation planning and end-of-life clinical management.
5.3.9 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 Policy Directive.
5.3.10 Generate reports about incidents relating to resuscitation planning and other end-of-life issues conduct trend analysis and develop network- wide
strategies for system improvement, submitting these reports to the Director, Safety and Quality, Systems Performance and Service Delivery.

5.3.11 Receive reports from directors of services about incidents or issues relating to resuscitation planning and end-of-life care.

5.4 **Executive Directors, Directors, General Managers, Heads of Service and other Senior Managers**

5.4.1 Provide organisational governance and leadership in relation to the effective implementation of the Resuscitation Planning 7 Step Pathway Policy Directive.

5.4.2 Develop, implement and monitor local processes that support all clinicians and other health care team members providing services on behalf of SA Health to effectively implement the Resuscitation Planning 7 Step Pathway Policy Directive.

5.4.3 Ensure implementation of the Resuscitation Planning-7 Step Pathway including necessary protocols and processes within the health service.

5.4.4 Ensure that education and training resources are available to enable effective and high quality implementation of the Resuscitation Planning 7 Step Pathway Policy Directive and meet the minimum requirements as defined in the Resuscitation Planning-7 Step Pathway Education Framework.

5.4.5 Ensure that systems are designed, implemented and monitored for their effectiveness in supporting Resuscitation Planning-7 Step Pathway processes.

5.4.6 Establish a collaborative approach with other service providers (local residential aged care facilities, general practitioners, primary health care organisations, private hospitals and community-based service providers) to enable safe, quality discharge planning and clinical handover and support continuity in patient-centred resuscitation planning and end-of-life care between SA Health and other healthcare service providers.

5.4.7 Ensure that any learning gained from reviews of the Resuscitation Planning-7 Step Pathway processes within their area of control is reported to their Local Health Network (LHN) Chief Executive Officer (CEO) and that they are appropriately implemented and monitored.

5.4.8 Ensure that all incidents and patient/consumer feedback are investigated and appropriate action taken in accordance with the Incident Management Policy Directive.

5.5 **Consultants, Visiting Medical Officers, General Practitioners, Registrars, Locum Medical Officers and interns (all medical practitioners) working within SA Health**

5.5.1 Adhere to policy rationale and principles and practice in accordance with associated policy guidelines.

5.5.2 Ensure appropriate participation and involvement with the implementation or documentation of the Resuscitation Planning 7 Step Pathway Policy Directive, including education and training.

5.5.3 Ensure any incidents relating to resuscitation planning and other end-of-life issues are reported through the Safety Learning System.

5.6 **Nurses, Pharmacists, Paramedics/Ambulance Officers, Allied Health Staff**

5.6.1 Participate in the process of recognising patients who may be at end-of-life, participate in resuscitation and end-of-life care planning processes, in accordance with this policy directive.
5.6.2 Ensure appropriate participation and involvement with the implementation or
documentation of the Resuscitation Planning 7 Step Pathway Policy Directive,
including any necessary education and training.

5.6.3 Ensure any incidents relating to resuscitation planning and other end-of-life
issues are reported through the Safety Learning System.

5.6 SA Health employees

5.6.1 Adhere to policy rationale and principles and ensure they operate in
accordance with associated policy, guidelines, local procedures and
legislation.

5.6.2 Complete the required Resuscitation Planning 7 Step Pathway education.

6. Reporting

All SA Health services have a responsibility to ensure an effective clinical governance
structure and systems are in place, with responsibility and accountability for developing,
implementing, evaluating and monitoring risks and improvements in resuscitation planning
and end-of-life care.

Health service management are accountable for establishing a safety culture that
supports reporting of incidents, concerns and complaints related to resuscitation planning
and end-of-life care.

Incidents and complaints related to the safety or quality of resuscitation planning and/or
end-of-life care must be reported on the Safety Learning System (SLS) in the patient
incident module and consumer feedback modules respectively.

(Incident Management Policy Directive)

It is the responsibility of all staff to identify and raise genuine complaints about a
practitioner whose conduct or performance is a risk to patients and/or may meet the
grounds for voluntary or mandatory notification under the Health Practitioner Regulation
National Law. It may also be relevant to report complaints about a health
practitioner/worker related to the legal and professional practice issues of resuscitation
and end-of-life care.

The Resuscitation Planning Reporting Guide provides detail for staff on what should be
reported and the process for reporting incidents, complaints and professional
practice/legal issues related to Resuscitation Planning.

As well as reporting incidents into Safety Learning System (SLS), documentation of all
incidents should occur in the consumer’s medical record (or EPAS) outlining:

- the clinical treatment and management during an incident, for example
  medications given
- the participation of the consumer, family and/or carer in care planning.

7. EPAS

The Resuscitation Plan-7 Step Pathway and Confirmation (EPAS version) is to be used at
health services where EPAS is enabled in accordance with this policy directive.
Processes and structures must be in place for governance of its safe and effective
implementation into clinical practice including ongoing monitoring and evaluation.
8. **Exemption**

Health services that provide care exclusively to persons under the age of 18 are exempt from this policy.

Directors of Safety and Quality/Clinical Governance may request exemption through their Local Health Network or Health Service CEO.

The Department for Health and Ageing, Director, Safety and Quality, System Performance and Service Delivery will assess all the exemption requests and authorise as appropriate.

9. **Associated Policy Directives / Policy Guidelines**

- Advance Care Directives Policy Directive
- Providing Medical Treatment and/or Assessment Where Patient Consent Cannot Be Obtained Policy Directive
- Consent to Medical Treatment and Health Care Policy Guideline
- Recognising and Responding to Clinical Deterioration Policy Directive and Guideline
- Clinical Handover Policy Directive and Guideline
- Incident Management Policy and Guideline
- Open Disclosure Policy Directive
- Consumer Feedback Management Policy and Guideline
- Clinical Handover Policy Directive and Guideline
- Pharmacological Management of Symptoms for Adults in the Last Days of Life Clinical Guideline

10. **References, Resources and Related Documents**

10.1 **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
- 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

10.2 **Relevant SA Health plans**

- Health Service Policy for Older People 2010-2016
- Palliative Care Services Plan 2009-2016
- South Australia’s Health Care Plan 2007-2016
10.3 SA Health related resources

- Charter of Health and Community Services Rights (HCSCC Charter)
- Health Service Framework for Older People 2009-2016
- Code of Ethics for the South Australian Public Sector
- Your Rights and Responsibilities – A Charter for Consumers
- Advance Care Directive fact sheet (PDF 80KB)
- Advance Care Directive frequently asked questions (PDF 96KB)
- Assessing Capacity fact sheet (PDF 87KB)
- How to certify copies of Advance Care Directives fact sheet (PDF 58KB)
- How to file hard copy Advance Care Directive, Advance Care Plan and Resuscitation Alert forms in medical records (PDF 371KB)
- Advance Care Directives and Mental Health Treatment Orders fact sheet (PDF 74KB)
- Supporting a person to make a decision fact sheet (PDF 65KB)
- Consent to Medical Treatment and Healthcare flow chart - Adults (PDF 65KB)
- Help Us, Help You – Essential contacts information sheet for consumers (PDF 115KB)

10.4 Other references

- A National Framework for Advance Care Directives (AHMAC, September 2011)
- National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care (Australian Commission on Safety and Quality in Health Care) 2014
- Capacity Toolkit (NSW Attorney-General)
- Conflict resolution in end-of-life settings (CRELS) Final CRELS Project working group report (NSW Health, 2010)
- Guidelines for end-of-life care and decision-making (NSW Health, 2005)
- 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 Framework for Health Care (ACSQHC, 2011)
- National Safety and Quality Health Service Standards (ACSQHC, 2011)
- Patient/consumer centred care: Improving quality and safety through partnerships with patients and consumers (ACSQHC, 2011)
- Post-coma unresponsiveness (persistent vegetative state): a clinical framework for diagnosis (NHMRC, 2004)
- Supporting Australians to Live Well at the End of Life National Palliative Care Strategy 2010
- The Palliative Approach Toolkit
- Transforming end of life care in acute hospitals: The route to success ‘how to’ guide NHS (UK)
11. Other

11.1 Teamwork, clinical communication and culture

Effective inter-professional teamwork is strongly correlated with the delivery of safe, quality consumer care. Methods of team training, including simulation can improve safety and optimise the contribution from each team member and the consumer. TeamSTEPPS® is an effective, evidenced based tool for improving teamwork, communication and patient safety.

Further information about TeamSTEPPS® is available on the Safety and Quality section of the SA Health website: www.sahealth.sa.gov.au/safetyandquality

Safe care requires that clear, concise, timely communication occurs in a manner that ensures the consumer and those involved in the planning and delivery of care, know the plan and assess the plan for risk. (SA Health Clinical Handover Policy 2010)

11.2 Education and training requirements

11.2.1 Orientation and ongoing training and education programs:
- are provided regularly to the clinical and nonclinical workforce to enable them to have skills and knowledge to support Resuscitation Planning–7 Step Pathway processes and its role in end-of-life care
- consider the individual’s place of work and tailor to individual roles and responsibilities
- are interdisciplinary and include a team approach.

11.2.2 Learning and teaching activities in Resuscitation Planning-7 Step Pathway will include:
- core learning outcomes relevant to the role of the employee as defined in the Tool 3: Resuscitation Planning–7 Step Pathway Education Framework

11.2.3 Delivery and attendance at education programs is supported by allocated time and resources and is reported within organisational structures.

The following eLearning courses for online education are available: Clinical Handover; Communication and Teamwork – TeamSTEPPS® – Why do we have training about teamwork; Communication and Teamwork – TeamSTEPPS® – skills to improve teamwork; Partnering with Consumers.
12. National Safety and Quality Health Service Standards

The Australian Commission on Safety and Quality in Health Care has developed **10 National Safety and Quality Health Service Standards** (the Standards).

The Standards provide a nationally consistent and uniform set of measures of safety and quality for application across a wide variety of health care services. They propose evidence-based improvement strategies to deal with gaps between current and best practice outcomes that affect a large number of patients.

The Resuscitation Planning 7 Step Pathway Policy Directive contributes to the following standards:

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Governance for Safety and Quality in Health Care</td>
<td>Partnering with Consumers</td>
<td>Preventing &amp; Controlling Healthcare associated infections</td>
<td>Medication Safety</td>
<td>Patient Identification &amp; Procedure Matching</td>
<td>Clinical Handover</td>
<td>Blood and Blood Products</td>
<td>Preventing &amp; Managing Pressure Injuries</td>
<td>Recognising &amp; Responding to Clinical Deterioration</td>
<td>Preventing Falls &amp; Harm from Falls</td>
</tr>
</tbody>
</table>

13. Risk Management

Risk associated with the implementation of this policy are to be assessed and mitigated through the review and approval of a Resuscitation Planning–7 Step Pathway Program Implementation Plan by the appropriate governance committee of the health service. The Resuscitation Planning–7 Step Pathway Program Implementation Plan should define actions, accountabilities, and timelines and identify/rate risks and risk mitigation strategies.

14. Monitoring and Evaluation

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

These provide a comprehensive picture of the impact resuscitation planning, and monitoring of the progress with improvement initiatives. The Local Health Network Analytic and Reporting System (LARS) will be used to display this information.

<table>
<thead>
<tr>
<th>A health service may require a number of measures to indicate performance in resuscitation planning. These include:</th>
<th>Data source</th>
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</thead>
<tbody>
<tr>
<td>Timely/Appropriate use of resuscitation</td>
<td>The percentage of deaths reviewed where a Resuscitation Plan-7 Step Pathway was in place, and the person met standard trigger criteria in the</td>
</tr>
<tr>
<td>Planning</td>
<td>current admission and it was appropriate to complete. The percentage of appropriate Resuscitation plans in place in patients who died in hospital.</td>
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<tr>
<td>Effective advance planning and use of MER teams patients at EOL</td>
<td>The number of MER calls where a patient had a Resuscitation Plan in place and ‘No MER’ was indicated on the Resuscitation Plan-7 Step form and/or MR-59A.</td>
</tr>
<tr>
<td>Compliance with a person’s resuscitation wishes at EOL</td>
<td>Any incidents where a patient was provided CPR, ICU treatment, or 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).</td>
</tr>
<tr>
<td>Resuscitation planning education</td>
<td>The percentage of clinical staff completing required resuscitation planning education.</td>
</tr>
<tr>
<td>Consumer documentation of Resuscitation Plan</td>
<td>Periodic audits of the percentage of patients who were provided with a copy of their ‘indefinite or revoked’ Resuscitation Plan completed on that admission when they are discharged/transferred.</td>
</tr>
<tr>
<td>Clinical handover</td>
<td>Periodic audits of the percentage of ‘indefinite or until revoked’ Resuscitation Plans sent to the patient’s general practitioner upon discharge.</td>
</tr>
<tr>
<td>Consumer feedback</td>
<td>Reports on patient feedback in relation to resuscitation planning and end-of-life care.</td>
</tr>
<tr>
<td>Documentation</td>
<td>Periodic audits of the percentage of patients who have a Resuscitation Plan filed as per guideline in the medical record.</td>
</tr>
<tr>
<td>Consumer experience</td>
<td>Patient/carer experience of resuscitation planning and end-of-life care.</td>
</tr>
</tbody>
</table>
15. Attachments

Attachment 1: A guide to using the policy directive and toolkit
Attachment 2: Map of documents and tools for Resuscitation planning
Attachment 3: Recognising a Person at End-of-Life (Triggers)
Attachment 4: Resuscitation Planning–7 Step Pathway- Consultation
Attachment 5: Resuscitation Planning–7 Step Pathway Education and Training Framework
Attachment 6: Evaluation framework for resuscitation planning and end-of-life care
Attachment 7: Resuscitation Alert Confirmation (MR-RESUS-A) Form
Attachment 8: Resuscitation Plan-7 Step Pathway (MR-RESUS) Form
Attachment 9: Resuscitation Plan-7 Step Pathway (Community version) Form

16. 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.

**Competence:** Competence is a legal term used to describe the mental ability required for an adult to complete a legal document. Competence is a requirement for completing a legal document that prescribes future actions and decisions, such as an Advance Care Directive.

An adult is deemed to be either competent or not competent to complete an Advance Care Directive; there are no shades of grey. Competence is assumed unless there is
evidence to suggest otherwise. Having a diagnosis is not always evidence of lack of competence and the below test must be considered.

To be competent and therefore be able to write an Advance Care Directive, a person must be:
- 18 years old or over
- know what an Advance Care Directive is
- know what it will be used for
- and know when it will be used
- it must be the person’s choice to complete
- it is the role of the witness to be satisfied that the person writing an Advance Care Directive is competent (see Advance Care Directive Act 2013 and Regulations).

**Decision-making capacity:** A person’s decision-making capacity relates to their ability to make a particular decision. It is not a global assessment of a person’s ability to manage their own affairs and it is not linked to a diagnosis. Determining whether a person has decision-making capacity is not necessarily a medical assessment. It is based on the person’s ability to think, understand, make a decision and communicate this in some way; it is not dependent on verbal or written communication. A person’s decision-making capacity can fluctuate. 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
4. tell someone what the decision is and why they have made the decision.


**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. It may be the last one to two years of life.

**End stage of an illness:** The final period or phase in the course of a progressive disease leading to a patient’s death, when there is no real prospect of recovery or remission of symptoms.

**Enduring Power of Attorney:** A person appointed under an Enduring Power of Attorney is authorised to make financial and legal decisions. They are not authorised to make health care or medical treatment decisions unless they are also appointed under an Advance Care Directive (including medical Power of Attorney or Enduring Power of Guardianship).

**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
- emergency care
- podiatry (foot care)

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3 Palliative Care Australia, Palliative and End-of-life Care – Glossary of Terms. PCA, Canberra
Health practitioners: Include registered practitioners\(^4\) 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 health profession (within the meaning of the *Health Practitioner Regulation National Law (South Australia) 2010*)
- 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\(^5\) and dental practitioners.

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.

Mediation: When a third party facilitates two or more conflicting people or groups to assist them to reach a mutual agreement or compromise. When resolving disputes under or in relation to an Advance Care Directive, it is the wishes of the person who gave the Advance Care Directive which are of paramount consideration.

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.

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\(^6\).

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

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\(^4\) Registered under the *Health Practitioner Regulation National Law*.

\(^5\) Registered under the *Health Practitioner Regulation National Law (South Australia)*.

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.

** 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.*