What is the Resuscitation Plan 7 Step Pathway?

The Resuscitation Plan 7 Step Pathway supports safe and high quality resuscitation planning and end-of-life care that is patient centred and, wherever possible, is aligned with the values, needs and wishes of the individual.

The Resuscitation Plan 7 Step Pathway will provide a state-wide best practice process for decision-making and clinical care planning for resuscitation and end-of-life care across SA Health from 1 July 2014.

The Resuscitation Plan 7 Step Pathway is not a legal document but an extension of the medical notes. It can also be used to develop and document end-of-life clinical care plans for patients consistent with the wishes contained in an Advance Care Directive/or expressed by the patient themselves.

What is the Resuscitation Plan 7 Step Pathway?

The Resuscitation Plan 7 Step Pathway provides a step by step process for developing a resuscitation and care plan and for clinical decision-making for patients near the end of their lives.

It describes the process for clinicians to follow to reach sound decisions with their patients about curative treatment through to a palliative approach.

The Resuscitation Plan/Alert form is used to document decisions (and the decision-making process used) about resuscitation and end-of-life clinical treatment and care.

The completion of the Resuscitation Plan/Alert form will reduce the number of inappropriate MER calls for patients.

What does the Resuscitation Plan 7 Step Pathway replace?

The SA Health Resuscitation Plan/Alert form replaces all existing resuscitation forms and the practice of writing informal orders in the patients' case notes such as "Not for Resuscitation/NFR", "Do not Resuscitate/ DNR".

The Resuscitation Plan/Alert form needs to be filed in the Alert section at the front of the patient's medical record.

Why is the Resuscitation Plan 7 Step Pathway needed?

- To avoid inconsistencies in the approach to decision-making for end-of-life care.
- To ensure consistency in documentation of clinical care plans.
- To inform clinicians of the steps that are needed for best practice decision-making and clinical care planning for resuscitation and other end-of-life care.
- To improve communication, consultation and collaboration between health professionals, patients and relatives.
- To ensure patients receive appropriate care, in line with their wishes and refusals of treatment, including those expressed in advance.
- To provide clinicians with information, at the point of care, when it is needed in an emergency.

New Inclusions for Handover:

The existence and details of a Resuscitation Plan/Alert must be communicated at handover.

New Inclusions for Discharge:

On discharge, the duplicate Resuscitation Plan/Alert form is provided to the patient, or the patient's carer in the Resuscitation discharge envelope.

Provide a copy of the Resuscitation Plan/Alert form with the patient's discharge summary to their external health care provider.

Summary of The Resuscitation Plan 7 Step Pathway

- Sets out a process for clinicians making decisions about resuscitation and end-of-life care and for documenting a clinical care plan. This plan is developed and completed by the clinician responsible, describing the patient's treatment and care (including specific resuscitation plans, symptom control and a palliative approach to care) in the context of the current clinical situation.
- Requires the clinician to seek the wishes of the patient, either directly or indirectly through an Advance Care Directive or advance care plan, Substitute Decision-Makers, Person Responsible or relatives. The clinician should communicate and consult with the patient where appropriate (or Substitute Decision-Makers, Person-Responsible and relatives) throughout the decision-making process.
- Does not replace an Advance Care Directive or an advance care plan which set out patient wishes. A patient's instructions written in a valid Advance Care Directive or advance care plan, or given by their Substitute Decision-Makers, Person Responsible or relatives, must be respected if the instructions are relevant to the current situation and were intended by the person to apply to that situation. This includes refusal of medical treatment, such as resuscitation or other life-sustaining measures.
- Encourages consensus between patients, Substitute Decision-Makers, Person Responsible, relatives and clinicians in resuscitation and end-of-life decision-making. However, it also emphasises that, when supported by adequate clinical reasoning, the ultimate responsibility for making decisions about what treatment is to be offered rests with the senior treating clinician.
- Documents decisions about resuscitation and end-of-life care on the standardised clinical care plan form – called the Resuscitation Plan/Alert. Use of this form will provide greater consistency in documenting these plans as well as acting as a checklist for clinicians about the steps that need to be followed in best practice decision-making for resuscitation planning and end-of-life care.

The Resuscitation Plan/Alert replaces existing forms and the current practice of writing informal orders in patients' progress notes such as:

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

For more information

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Email: policy&legislation@health.sa.gov.au
Subject line: What is the Resuscitation Plan 7 Step Pathway?

Government of South Australia
SA Health