A Clear Path to Care

Part 5
The Resuscitation Alert – 7 Step Pathway
Using the Form
This presentation will:

• Provide detail on how to complete the Resuscitation Alert - 7 Step Pathway Form
• Discuss triggers and provide examples of trigger tools for initiating a Resuscitation/end of life plan
• Discusses the necessary inter-disciplinary team consultation that may be required in planning options for resuscitation/end of life planning
• Discusses consultation and consent with the patient, SDM/person responsible, family in resuscitation/end of life planning
• Describe the considerations, communication and documentation requirements in developing the clinical plan including medication and treatment orders for palliation
• Provides overview of on-going nature of the process to meet needs of the patient and the family
The 7 Step Pathway

The 7 Step Pathway:
• is a process
• which aids the doctor responsible to make decisions
• in line with ethical and legal standards (incl ACD Act)

The Resuscitation Alert- 7 Step Pathway (the Form)
• allows decisions to be documented
• standardised process
• recognised- particularly in emergencies
• should not be thought of as a separate legal document- it’s really only an extension of the case notes
Resuscitation Alert – 7 Step Pathway

**1. TRIGGER**

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

**2. ASSESSMENT**

Is there adequate clinical information to allow decisions to be made about resuscitation and/or end of life care? **YES** / **NO**

**3. CONSULTATION**

Discuss the clinical situation (e.g., diagnoses, prognosis, treatment options and recommendations) with the patient, substitute decision-maker, person responsible and/or relatives.

**IMPORTANT:** Interpreter use is recommended for non- or limited English speakers.

Does the patient have decision-making capacity? **YES** / **NO**

**NOTE:** This must be documented in the case notes and a reasonable attempt should be made to consult at least one of the following documents if the patient has or individuals in the order of priority below:

1. Person with an Advance Care Directive under the Advance Care Directives Act 2012
   - Substituted Decison Maker appointed for health care decisions under an Advance Care Directive

   - Advance Directive with relevant instructions and NO Substituted Decision Maker

2. A Medical Act or an Enduring Guardian

   - Anticipatory Directive

   - If none of the above, a Person Responsible in the following legal order:

     - Guardian appointed by the Guardianship Board

     - Prescribed relative (adult with a close and continuing relationship, available and willing, and who is related to the person by blood, marriage, domestic partner, adoption or Aboriginal kinship ties/marriage)

     - Close adult/child who is available and willing to make a decision

   - If there is no one in the above categories then:

     - Someone charged with the day-to-day care and well-being of the patient

     - Guardianship Board, upon application.

**5. TRANSPARENCY**

Resuscitation plan explains and the patient's wishes considered:

- Patient (mandatory: if patient has capacity) or

  - Substitute Doctor/Medi-Role Name

  - Title of interpreter used: Interpreter's Name

**Take practical steps to implement the plan and support the patient and family through the process**

- For each step, provide specific details and instructions for implementation.

**SA Health**

Created May 2014
1. TRIGGER

Complete this form early if the clinical situation requires decisions about resuscitation or end of life care. However, the urgency to complete this form needs to be balanced with sensitivity to the readiness of the patient and family to discuss these issues.
7 Step Pathway: Step 1

What things should “trigger” the use of this form?

Which patients should we be completing this Resuscitation Plan for?

How can we be consistent in identifying appropriate patients?
Potential triggers:

- a patient with a serious illness or a condition with a poor prognosis
- a patient who has refused life-sustaining treatment in their ACD/ACP
- a significantly aged patient particularly if they suffer from poor general health
- a patient with a severe and chronic progressive disorder
- a patient who is deteriorating and is being repeatedly admitted to hospital
- a patient who is admitted to a high care residential care facility
- a patient who expresses a readiness to die
- a patient, their substitute decision-makers or relatives enquiring about palliative care
Success Rates of CPR for hospital inpatients:

- Despite numerous advances made in the delivery of medical care, on average, only 17% of all adult arrest patients who have CPR survive to hospital discharge.*
- With huge variance according to patient selection:
  - 100% (survival) if arrest during coronary angiography
  - 70% for VF in CCU after myocardial infarct
  - 15-20% for a general hospital patient
  - < 5% for those with advanced illness – cancer, dementia etc.
- Often with significant morbidity in survivors – 30-50% in the last 2 groups

*Peberdy et al. 2003; Gwinnutt et al. 2000; Thorns & Ellingworth 1991; Smith et al. 2007
7 Step Pathway: Step 1
Clinical Tools
Barbara Hayes

Would the patient survive CPR?

- NO
  - Dying patient
    - Discuss good dying
  - Medically unwell - not imminently dying
    - Discuss why CPR not being offered

- Possibly YES
  - Very poor outcome likely from CPR
    - Discuss why CPR may be inappropriate but accept opposite view
  - Uncertain outcome from CPR
    - Discuss to obtain informed decision
7 Step Pathway: Step 1
Clinical Tools
Amber Care Bundle

### Stage 1: Identification

- **Is the patient suitable for the AMBER care bundle?**
  1. Is the patient deteriorating, clinically unstable, and with limited reversibility? and
  2. Is the patient at risk of dying within the next 1-2 months?

### Stage 2: AMBER care bundle day one interventions

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Action</th>
<th>Comments</th>
<th>Name</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical plan documented in patient record including:</td>
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<tr>
<td>• current key issues</td>
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<tr>
<td>• anticipated outcomes</td>
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<tr>
<td>• resuscitation status</td>
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<tr>
<td>Escalation decision documented including:</td>
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<td>Yes</td>
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<tr>
<td>• For Clinical Review Calls</td>
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<td>No</td>
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<tr>
<td>• For Rapid Response Calls</td>
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<tr>
<td>Medical plan discussed and agreed with multidisciplinary team</td>
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<td>Yes</td>
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<td>No</td>
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<tr>
<td>Patient and carer discussions or meeting held and clearly documented</td>
<td></td>
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<td>Yes</td>
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<tr>
<td>Which may include:</td>
<td></td>
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<td>No</td>
<td></td>
</tr>
<tr>
<td>• uncertain recovery and treatment options</td>
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<tr>
<td>• preferred place of care</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>• any concerns or wishes</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• who was present</td>
<td></td>
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</tbody>
</table>

**Record details in the patient’s record**

### Stage 3: ACT daily monitoring and review

- **Remember to ACT daily:**
  - Assess patient capacity to be involved for each decision
  - A. Is your patient still AMBER?
  - B. Are there any medical changes?
  - C. Have you touched base with the patient carer?
  - D. Has patient’s preferred place of care changed?

### Stage 4: AMBER care bundle cessation

- The AMBER care bundle stops if:
  - Patient recovers
  - ‘Last days of life’ plan is commenced
  - Patient dies
  - Patient is discharged or transferred to a clinical area not familiar with its use
7 Step Pathway: Step 1
Clinical Tools
SPICT
7 Step Pathway: Step 1
Clinical Tools as Triggers

1) The Surprise Question: *Would you be surprised if this patient died within the next 12 months?*

2) Supportive and Palliative Care Indicators Tool: *SPICT*

Using them together captures almost everyone.
2. ASSESSMENT

Is there adequate clinical information to allow decisions to be made about resuscitation and/or end of life care? If YES [ ] > Continue with the plan.
How do you decide on how far to investigate?

The clinician is not compelled to order investigations that are inappropriate:
- if investigations would be considered invasive or distressing,
- if they would not change future decisions about care.
- ask: “what is the ultimate goal?” and “will a given investigation make any difference to management?”

Consider the decision-making capacity of the patient to participate in these discussions.
### 3. CONSULTATION

If possible, discuss the clinical situation (e.g. diagnosis, prognosis, treatment options and recommendations) with the patient, substitute decision-makers, person responsible and/or relatives.

**IMPORTANT:** Interpreter use is recommended for non or limited English speakers.

Does the patient have decision-making capacity?

<table>
<thead>
<tr>
<th>Yes</th>
<th>The clinical situation must be discussed with the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>This must be documented in the case notes and a reasonable attempt should be made to consult at least one of the following documents (if the patient has one) or individuals - In order of priority below:</td>
</tr>
<tr>
<td></td>
<td>1. Person with an Advance Care Directive under the Advance Care Directives Act 2013</td>
</tr>
<tr>
<td></td>
<td>- Substitute Decision-Maker appointed for health care decisions under an Advance Care Directive</td>
</tr>
<tr>
<td></td>
<td>- Name(s): ..................................................</td>
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<tr>
<td></td>
<td>- Advance Care Directive with relevant instructions and NO Substitute Decision-Maker</td>
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<td></td>
<td>2. If they do not have a new Advance Care Directive (Advance Care Directives Act 2013)</td>
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<td></td>
<td>- A Medical Agent or an Enduring Guardian</td>
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<td>- Name(s): ..................................................</td>
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<td></td>
<td>- Anticipatory Direction</td>
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<td></td>
<td>3. If none of the above, a Person Responsible in the following legal order:</td>
</tr>
<tr>
<td></td>
<td>- Guardian appointed by the Guardianship Board</td>
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<td></td>
<td>- Name(s): ..................................................</td>
</tr>
<tr>
<td></td>
<td>- Prescribed relative (adult with a close and continuing relationship, available and willing, and who is related to the person by blood, marriage, domestic partner, adoption or Aboriginal kinship rules/marriage)</td>
</tr>
<tr>
<td></td>
<td>- Name(s): ..................................................</td>
</tr>
<tr>
<td></td>
<td>- Close adult friend who is available and willing to make a decision</td>
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<td></td>
<td>- Name(s): ..................................................</td>
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<tr>
<td></td>
<td>- If there is no one in the above categories then:</td>
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<td></td>
<td>- Someone charged with the day-to-day care and well-being of the patient</td>
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<td></td>
<td>- Guardianship Board, upon application.</td>
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</tbody>
</table>

**OR**

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

*Note: If there is an Advance Care Plan (e.g. Statement of Choices, Good Palliative Care Plan), it must be referred to by those making decisions above.*
A Doctor’s Professional Standards:
AHPRA Medical Board of Australia
Good Medical Practice: A Code of Conduct for Doctors in Australia (March 2014)

3.12.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient

3.12.4 Understanding 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.
7 Step Pathway: Step 3

Good communication with the patient, SDMs and family is critical.
## 7 Step Pathway:
### Step 4

### 4. RESUSCITATION PLAN

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

**Indicate if the following decisions about resuscitation apply:**

Tick here if this single option applies:

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

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

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

---

**Indicate treatment that will be provided:**

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

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- [ ] NOT FOR TRANSFER TO HOSPITAL unless there is a failure of palliative care measures to maintain the comfort and dignity of the patient in their place of residence.
There are basically 3 steps:
1) Determine treatment that will not be provided
2) Decide on treatment that will be provided
3) If the patient is not for resuscitation, or if resuscitation is likely to fail, ensure that there is a plan to maintain the comfort and dignity of the patient

Then comes the question: to MER or Not to MER?:
If a patient is not for resuscitation, and a thoughtful contingency plan is implemented, is MER really required?

Question of future transfer of the patient to hospital:
If the patient is not for hospital transfer, the GP must be contacted directly

7 Step Pathway: Step 4

4. RESUSCITATION PLAN

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

Indicate if the following decisions about resuscitation apply:
- [ ] Patient is not for any treatment aimed at prolonging life (including CPR)
- [ ] Patient is not for CPR
- [ ] Patient is for resuscitation
- [ ] Patient is for invasive ventilation (i.e. intubation)
- [ ] Patient is not for intensive care treatment or admission
- [ ] Patient is not for the following procedures or treatments (specify):

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

Indicate treatment that will be provided:
- [ ] NOT FOR TRANSFER TO HOSPITAL unless there is a failure of palliative care measures to maintain the comfort and dignity of the patient in their place of residence.
Plan should be consistent with the expressed wishes of the patient
Disputes may arise when:
- Requests are made that are not consistent with good medical care
- Disagreement with the recommendations of the clinician
The clinician should:
- Understand that they have ultimate responsibility for decisions
- Consider options:
  - Decision support strategies, second medical opinions, counsel from mentors, or advice from risk managers
  - Strategies to resolve disagreements
Refusals of treatment (expressed directly, or by SDM, documented on ACD, or by Persons Responsible) must be respected if relevant even if the clinician disagrees.
What treatment or referral options are there to prevent the patient suffering pain and distress?
How can you answer the question: “if the patient is not for resuscitation, what are you going to do next?”

Options to ensure the comfort and dignity of the patient:
1) Writing up medications
2) Implementation of a local palliative care protocol
3) Or referral to a specialist palliative care service.

If the patient is not for resuscitation, you must pick one of these options.
Dyspnoea

Moderate to Severe Pain

Anxiety associated with Dyspnoea

Nausea

Noisy Breathing

Agitation associated with Delirium

Delirium

- Morphine Inj
- Morphine Oral Mix
- Oxycodone Inj
- Oxycodone Oral Mix
- Hydromorphone Inj
- Hydromorphone Oral Mix
- Fentanyl Inj
- Oxycodone Inj
- Oxycodone Oral Mix
- Hydromorphone Inj
- Hydromorphone Oral Mix
- Fentanyl Inj
- Clonazepam Inj
- Clonazepam Oral Drops
- Midazolam Inj
- Haloperidol Inj
- Dexamethasone Inj
- Metoclopramide Inj
- Promethazine Inj
- Atropine Inj
- Hyoscine Butylbromide Inj
- Hyoscine Hydrobromide Inj

- Anxiety
- associated
- with
- Dyspnoea

- Agitation
- associated
- with
- Delirium

- Nausea

- Noisy
- Breathing
7 Step Pathway: Step 5

5. TRANSPARENCY

Resuscitation plan explained to:

- Patient (mandatory if he/she has capacity) or
- Substitute Decision-Makers/Relatives
- Tick if an interpreter is used

Names: ...................................................................................................................

Interpreter’s Name: ..........................................................................................
7 Step Pathway: Step 5

- Documentation of who the plan was discussed with should occur in the Medical Record
- If resuscitation or life-sustaining treatments are not to be initiated and symptomatic or palliative care is to begin – do not describe as "giving up" or "doing nothing", explain the plan as active care to maintain comfort and dignity. Emphasise the care of the patient
- If disagreement – local dispute resolution processes should be considered early
- If unresolved – escalate to the Public Advocate
  - 24/7 dispute resolution service (adults and children)
Take practical steps to 6. IMPLEMENT the plan and to 7. SUPPORT the patient and family through the process.
7 Step Pathway: Step 6 and Step 7

- What things do you do to support a dying patient and their family?
- What resources do you use?

- Ensure that all members of the care team know the plan
- Take practical steps to implement the clinical plan (facilitate return to home/RACF if this is the patient’s wish)
- Practical, emotional and spiritual support
- Spiritual and psychosocial care
- Provide information material, counselling support, psychological care or psychiatric care if appropriate.
7 Step Pathway: Step 6 and Step 7

- Most importantly, continue to communicate and support the patient and relatives:
  - regularly update them about progress
  - be alert to misunderstandings
  - if the patient is approaching death, often helpful to sensitively inform relatives of the possible distressing appearance of the patient in the final phase of dying
    - cyanosis
    - the irregular breathing pattern (Cheyne-Stokes)
    - “gurgling” and “rattling” sounds (mucous secretions).
  → Reassure them that this does not reflect patient distress as long as adequate palliative measures are provided.
7 Step Pathway: Step 6 and Step 7

• Provide information, care and support to the relatives after the patient dies including:
  • allowing family to spend time with the patient
  • offer emotional support
  • offer referral to bereavement services if appropriate (or available)
  • follow-up after a family leaves could include:
    • a condolence card from staff
    • a discussion or phone call
Finalising the Form

<table>
<thead>
<tr>
<th>Resuscitation Plan Date</th>
<th>/ /</th>
<th>This Resuscitation Plan is valid until:</th>
<th>To revoke this Resuscitation Plan (strike through and write VOID):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Doctor</td>
<td>Date: or [ ] This admission only or [ ] Indefinitely or until revoked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designation</td>
<td>Date revoked: / /</td>
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<td></td>
</tr>
<tr>
<td>Signature</td>
<td>Name of Doctor revoking the plan:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Responsible:</td>
<td>Designation:</td>
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</tr>
<tr>
<td></td>
<td>Signature:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Top copy - file in medical record  Back copy - provide to patient in Resuscitation Plan envelope
Instructions

Use Ballpoint pen to complete this form.

1. Please note Interns are not permitted to complete this form.
2. Only clinicians/medical officers above the level of Intern should complete the 7 Step Pathway Resuscitation Plan. Include your designation e.g. Consultant, Registrar, Resident or GP.
3. Please begin from 1. TRIGGER moving through to 7. SUPPORT.
4. Document with whom Consultation has occurred and whether this patient has an Advance Care Directive, substitute decision maker, or advance care plan. If others are present at the time, record this in the case notes.
5. Turn to 4. RESUSCITATION - clearly document the patient’s Resuscitation Plan by using a Tick to indicate which decisions about resuscitation apply, and Circle which option applies - MRR Call Yes or No
6. Indicate what treatment is to be provided, including a plan for maintaining comfort and dignity if the patient is not for resuscitation.
7. If relevant, please consider whether and under what circumstances at a future time the patient might or might not be transferred to hospital. If “Not for Transfer to Hospital” is ticked, the patient’s GP MUST be contacted and notified of this decision before the patient is discharged. If the patient is to be transferred to another health facility, the medical officer who will be responsible for the patient’s care should be notified.
8. Document who you discussed the end-of-life Resuscitation Plan with in the Transparency section. Record what was discussed in the patient’s case notes.
9. The clinician/medical officer completing the 7 Step Pathway Resuscitation Plan form must include the date the Resuscitation Plan is completed, their name, designation and signature and also the name of the Consultant responsible for the patient’s treatment and care as is indicated on the front page.
10. The Resuscitation Plan must be communicated at handover and discharge summary, and the resuscitation status transcribed on the RDR chart (MR51A).
11. Document when and if this Resuscitation Plan is revoked or if it is ongoing.
12. Remember to take all practical steps to implement the plan and to support the patient and family through the process.
13. Provide patient and/or family with a copy on discharge, if appropriate in Resuscitation Plan envelope.

* Medical Board of Australia. Good Medical Practice: Code of Conduct for Doctors in Australia (2014). This includes points 1, 2, 3, 5, 7. Doctors should understand the limits of medicine by prolonging life and recognize when efforts to prolong life may not benefit the patient, since, 2, 5, 7. Doctors do not have a duty to prolong life at all cost. However, they do have a duty to know when to institute and when to causally attempts at prolonging life, while ensuring that the patient receives appropriate relief from distress.
Standardised processes for triggering the initiation of a resuscitation plan/end of life care plan can improve opportunities for provision of appropriate care and enabling a patient centred approach to end of life care.

Inter-disciplinary team consultation may be required to ensure the appropriate type of treatments are provided.

Consultation and consent with the patient, SDM/person responsible, family in resuscitation/end of life planning is critical.

Good end of life care requires planning and orders/referrals and interventions to alleviate end of life/dying patient symptoms and assist the patient and family/carers.

Resuscitation plans need to be effectively communicated with the care team and family and in documentation.

When uncertain, ask for assistance and when disputes cannot be resolved, follow your local procedure.