A Clear Path to Care

Part 5

The Resuscitation Alert – 7 Step Pathway

Using the Form

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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

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

Hospital: .....

Affix patient identification label in this box

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

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

1. TRIGGER

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

2. ASSESSMENT

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

3. CONSULTATION

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

Does the patient have decision-making capacity?

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

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

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

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

OR

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

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

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

Hospital: .....

Affix patient identification label in this box

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

4. RESUSCITATION PLAN

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

Indicate if the following decisions about resuscitation apply:

Tick here if this single option applies:

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

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

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

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

Indicate treatment that will be provided:

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

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

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

5. TRANSPARENCY

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

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

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

RESUSCITATION ALERT MR-RESUS

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Created May 2014

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

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7 Step Pathway: Step 1

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?

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7 Step Pathway: Step 1

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

7 Step Pathway: Step 1

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**

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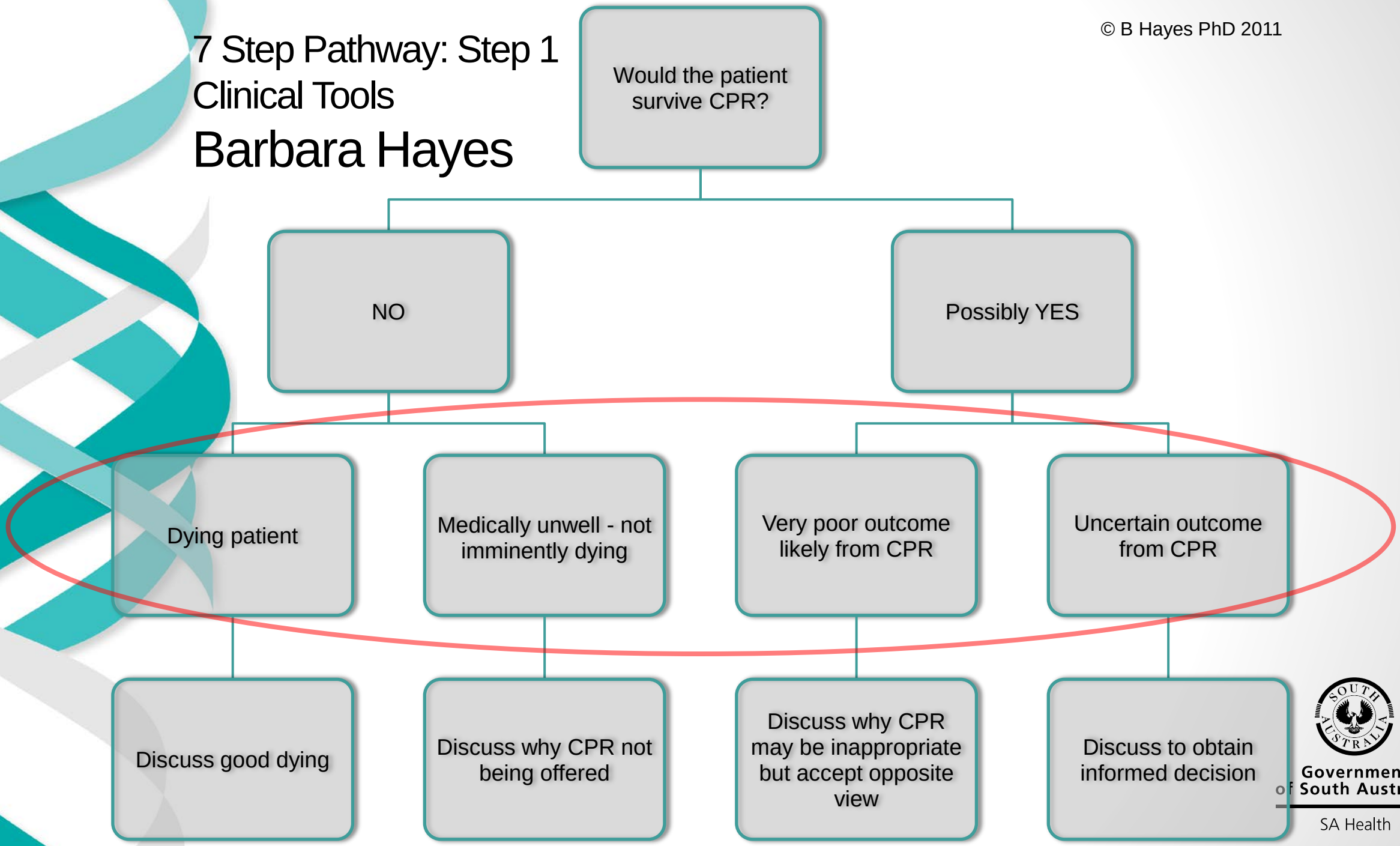
*Peberdy et al. 2003; Gwinnutt et al. 2000; Thorns & Ellingworth 1991; Smith et al. 2007

7 Step Pathway: Step 1 Clinical Tools

Barbara Hayes



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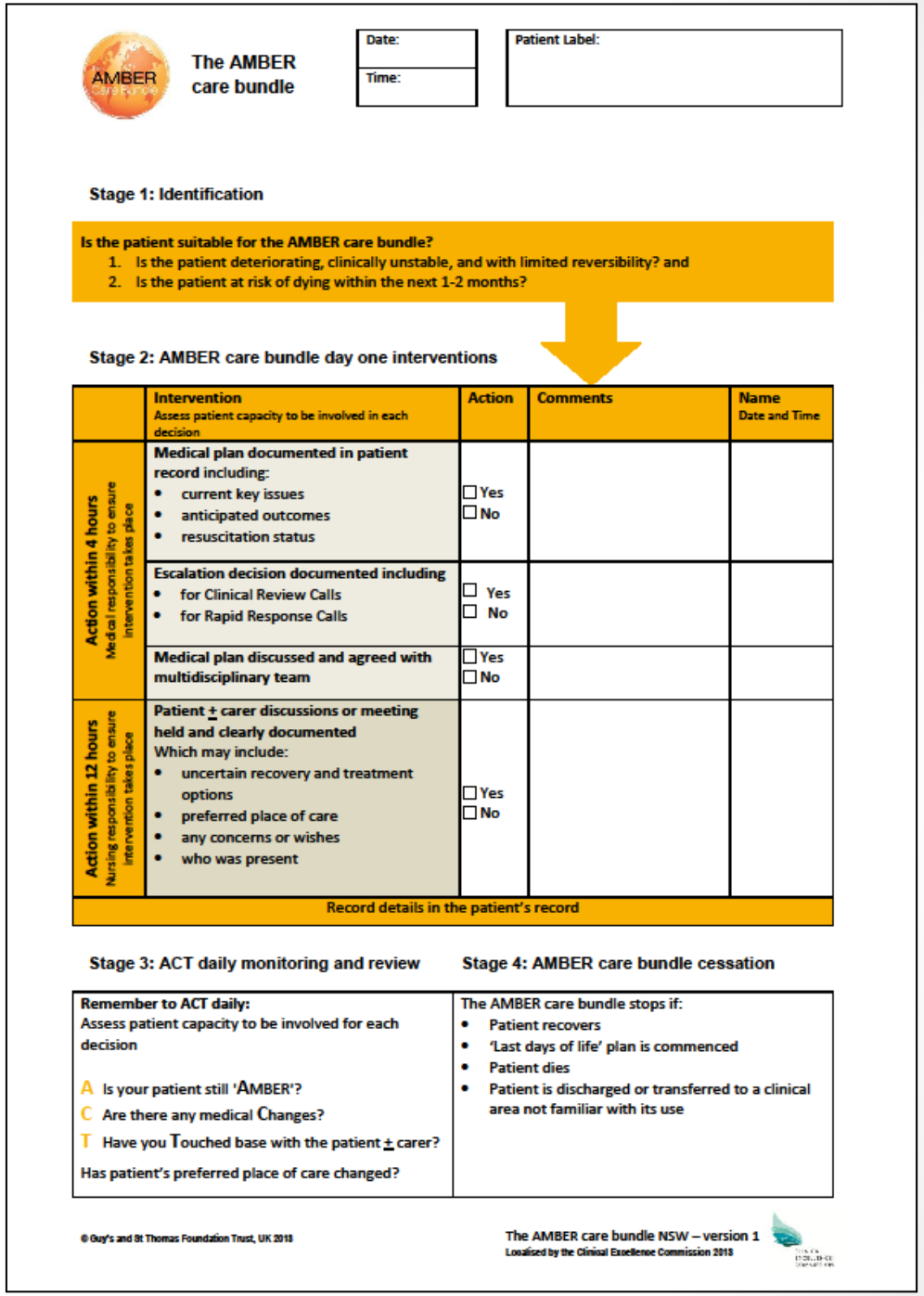
7 Step Pathway: Step 1 Clinical Tools

Amber Care Bundle



The AMBER care bundle

Date:
Time:

Patient Label:

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

	Intervention Assess patient capacity to be involved in each decision	Action	Comments	Name Date and Time
Action within 4 hours Medical responsibility to ensure intervention takes place	**Medical plan documented in patient record including:** • current key issues • anticipated outcomes • resuscitation status	☐ Yes ☐ No		
	Escalation decision documented including • for Clinical Review Calls • for Rapid Response Calls	☐ Yes ☐ No		
	Medical plan discussed and agreed with multidisciplinary team	☐ Yes ☐ No		
Action within 12 hours Nursing responsibility to ensure intervention takes place	**Patient ± carer discussions or meeting held and clearly documented** Which may include: • uncertain recovery and treatment options • preferred place of care • any concerns or wishes • who was present	☐ Yes ☐ No		
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'?
C Are there any medical Changes?
T Have you Touched base with the patient ± carer?

Has patient's preferred place of care changed?

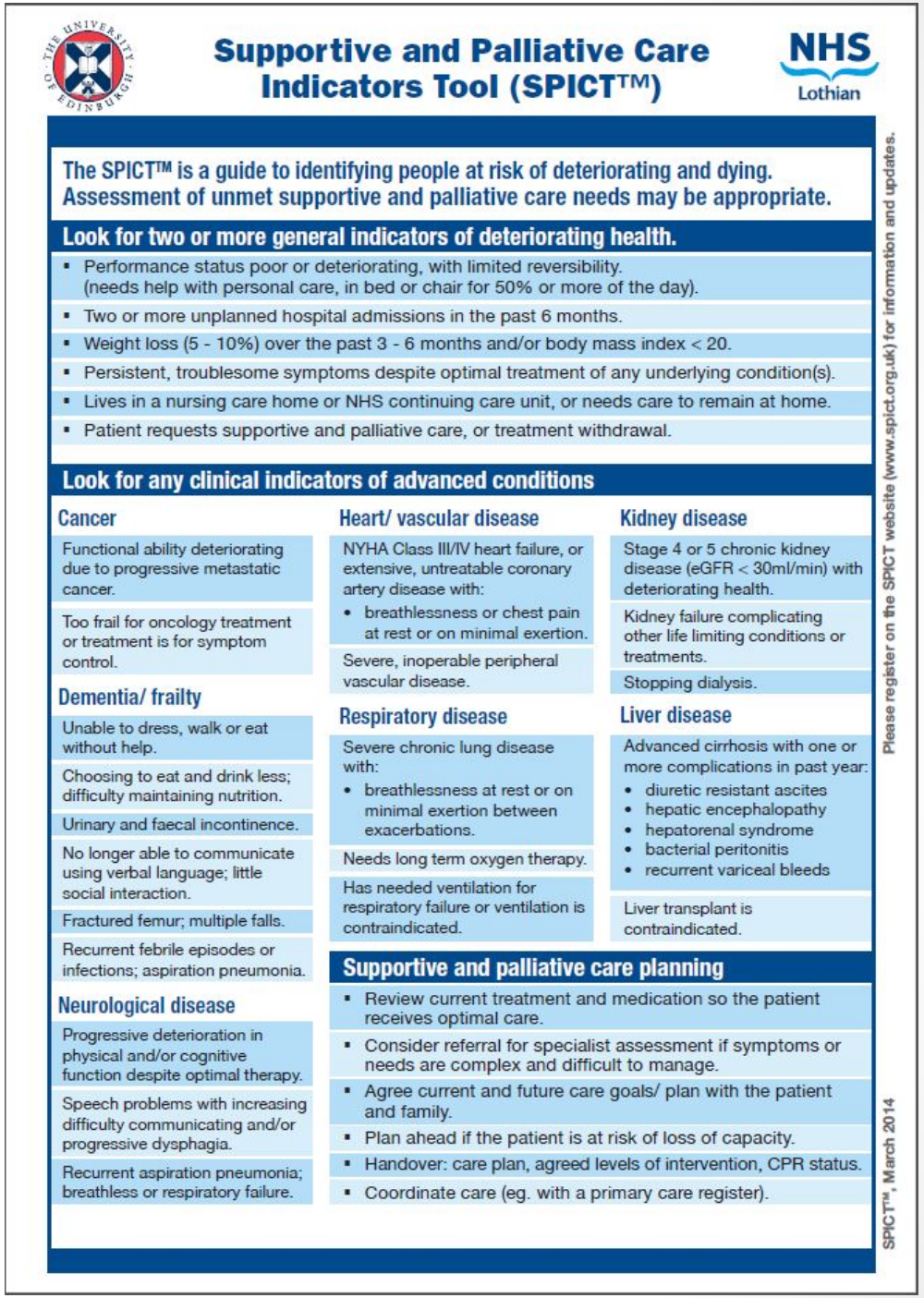
Stage 4: AMBER care bundle cessation

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

The AMBER care bundle NSW – version 1
Localised by the Clinical Excellence Commission 2018

7 Step Pathway: Step 1 Clinical Tools

SPICT



Supportive and Palliative Care Indicators Tool (SPICT™)

NHS Lothian

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assessment of unmet supportive and palliative care needs may be appropriate.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating, with limited reversibility. (needs help with personal care, in bed or chair for 50% or more of the day).
- Two or more unplanned hospital admissions in the past 6 months.
- Weight loss (5 - 10%) over the past 3 - 6 months and/or body mass index < 20.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Lives in a nursing care home or NHS continuing care unit, or needs care to remain at home.
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of advanced conditions

Cancer

Functional ability deteriorating due to progressive metastatic cancer.

Too frail for oncology treatment or treatment is for symptom control.

Dementia/ frailty

Unable to dress, walk or eat without help.

Choosing to eat and drink less; difficulty maintaining nutrition.

Urinary and faecal incontinence.

No longer able to communicate using verbal language; little social interaction.

Fractured femur; multiple falls.

Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

Progressive deterioration in physical and/or cognitive function despite optimal therapy.

Speech problems with increasing difficulty communicating and/or progressive dysphagia.

Recurrent aspiration pneumonia; breathless or respiratory failure.

Heart/ vascular disease

NYHA Class III/IV heart failure, or extensive, untreatable coronary artery disease with:

- breathlessness or chest pain at rest or on minimal exertion.

Severe, inoperable peripheral vascular disease.

Respiratory disease

Severe chronic lung disease with:

- breathlessness at rest or on minimal exertion between exacerbations.

Needs long term oxygen therapy.

Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.

Kidney failure complicating other life limiting conditions or treatments.

Stopping dialysis.

Liver disease

Advanced cirrhosis with one or more complications in past year:

- diuretic resistant ascites
- hepatic encephalopathy
- hepatorenal syndrome
- bacterial peritonitis
- recurrent variceal bleeds

Liver transplant is contraindicated.

Supportive and palliative care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals/ plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Handover: care plan, agreed levels of intervention, CPR status.
- Coordinate care (eg. with a primary care register).

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, March 2014

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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.

7 Step Pathway: Step 2

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.

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7 Step Pathway: Step 2

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.

7 Step Pathway: Step 3

3. CONSULTATION

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

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

Does the patient have decision-making capacity?

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

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

1. *Person with an Advance Care Directive under the Advance Care Directives Act 2013*
   - ☐ Substitute Decision-Maker appointed for health care decisions under an Advance Care Directive
     Name/s: .....
   - ☐ Advance Care Directive with relevant instructions and NO Substitute Decision-Maker

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   - ☐ A Medical Agent or an Enduring Guardian
     Name/s: .....
   - ☐ Anticipatory Direction

3. *If none of the above, a **Person Responsible** in the following legal order:*
   - ☐ Guardian appointed by the Guardianship Board
     Name/s: .....
   - ☐ Prescribed relative (adult with a close and continuing relationship, available and willing, and who is related to the person by blood, marriage, domestic partner, adoption or Aboriginal kinship rules/marriage)
     Name/s:.....
   - ☐ Close adult friend who is available and willing to make a decision
     Name/s:.....

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

OR

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

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

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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.

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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): .....

.....

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

Indicate treatment that will be provided:

Note:

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

.....

.....

.....

.....

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

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7 Step Pathway: Step 4

There are basically 3 steps:

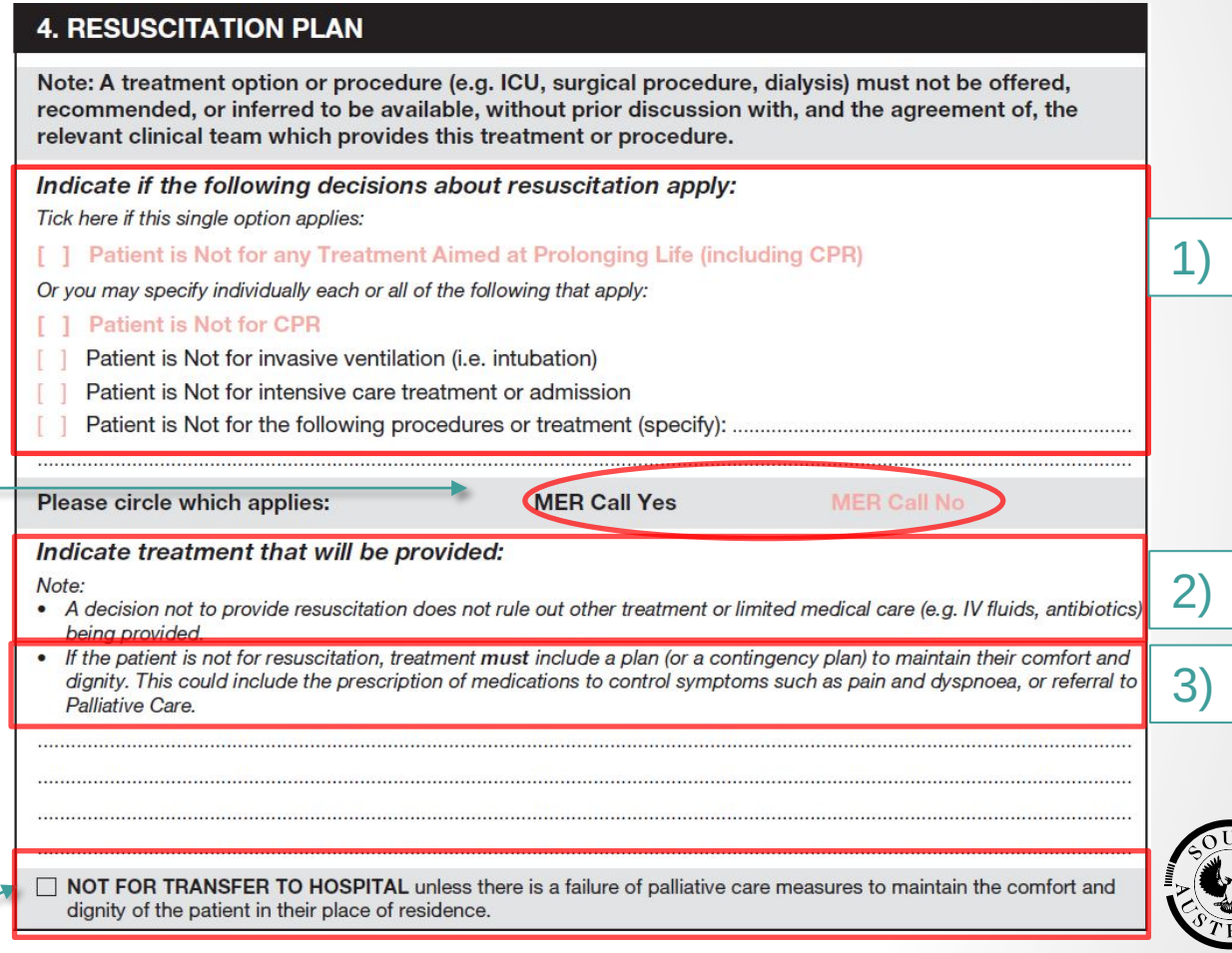
1) Determine treatment that will not be provided
2) Decide on treatment that will be provided
3) If the patient is not for resuscitation, or if resuscitation is likely to fail, ensure that there is a plan to maintain the comfort and dignity of the patient

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



4. RESUSCITATION PLAN

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[ ] Patient is Not for intensive care treatment or admission

[ ] Patient is Not for the following procedures or treatment (specify): .....

.....

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

Indicate treatment that will be provided:

Note:

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

.....

.....

.....

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

1)

2)

3)

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7 Step Pathway: Step 4

- 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.

7 Step Pathway: Step 4

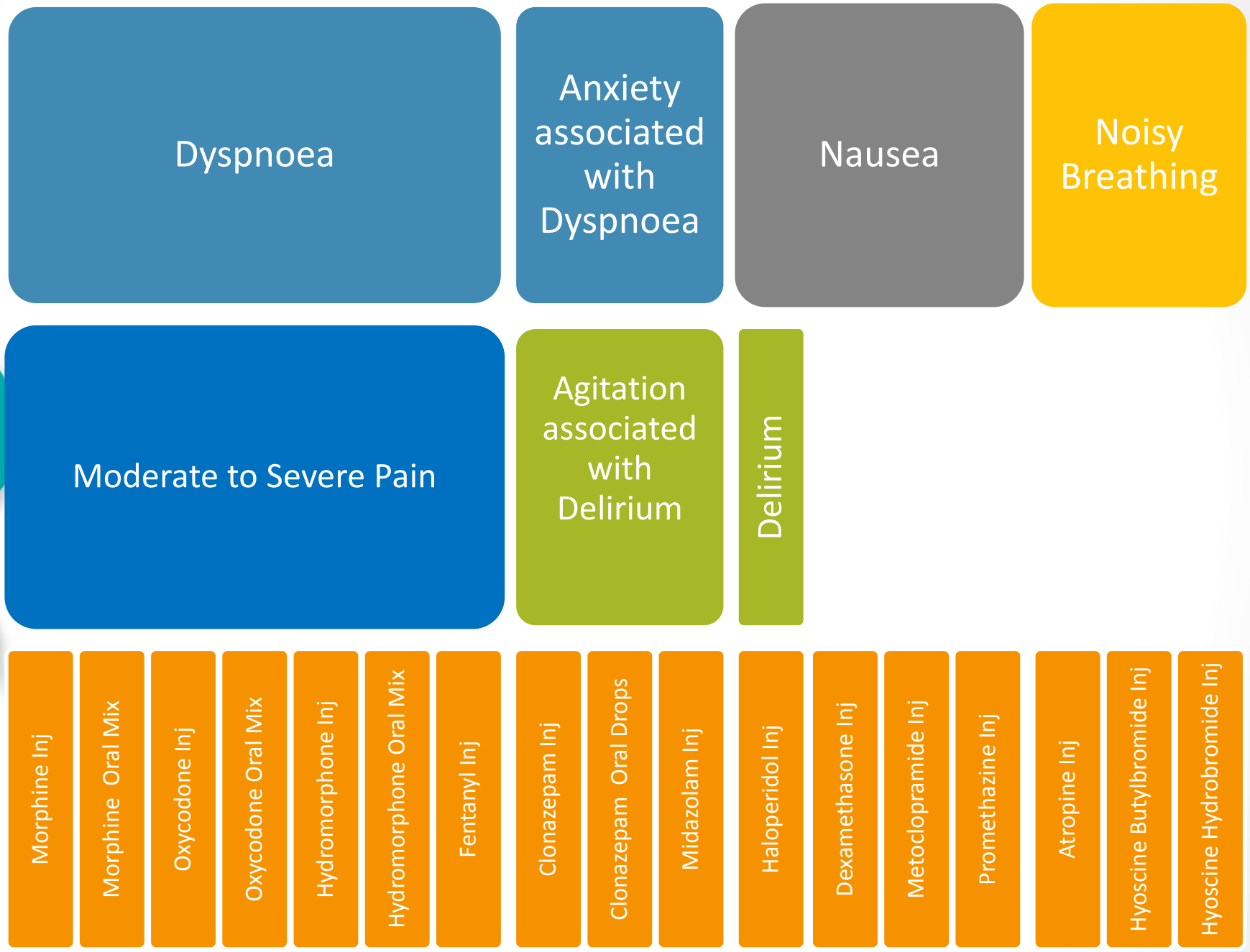
What treatment or referral options are there to prevent the patient suffering pain and distress?

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.



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7 Step Pathway: Step 5

5. TRANSPARENCY

Resuscitation plan explained to: ☐ Patient (mandatory if he/she has capacity) ***or***

☐ Substitute Decision-Makers/Relatives Names: .....

☐ *Tick if an interpreter is used:* *Interpreter's Name:* .....

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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)

7 Step Pathway: Step 6 and Step 7

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

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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

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

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

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Instructions

Introduction

The Resuscitation Alert: 7 Step Pathway establishes a clear and transparent, step-by-step process to assist clinicians to make decisions about resuscitation and other life-sustaining treatment, and/or to develop and document end-of-life clinical care plans for patients.

Before you begin the process of completing the 7 Step Pathway Resuscitation Plan form please read through the instructions and the required 7 Steps.

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 - MER 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 transfered to another health facility, the medical officer who will become 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 (MR59A).**
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 3.12.3: Doctors should understand the limits of medicine in prolonging life, and recognise when efforts to prolong life may not benefit the patient, and, 3.12.4: Doctors do not have a duty to prolong life at all cost. However, they do have a duty to know when to initiate and when to cease attempts at prolonging life, while ensuring that the patient receives appropriate relief from distress.*

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Summary

Resuscitation Alert – 7 Step Pathway Part 5

- 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.

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