A Clear Path to Care

Part 4

Resuscitation and End of Life Care Clinical Planning: The 7 Step Pathway and the Resuscitation Alert – 7 Step Pathway Form
This presentation will:

Introduce the 7 Step Pathway:
- a process
- aids the doctor responsible to make decisions about resuscitation and care including end of life
- in line with ethical and legal standards (incl ACD Act)

Introduce the Resuscitation Alert- 7 Step Pathway (the Form):
- allows decisions to be documented
- standardised
- recognised- particularly in emergencies
- not a separate legal document- really only an extension of the case notes
- replaces “NFR” order
- “One form for the patient”: an ACD or ACP, and “one form for the doctor”: the Pathway Resuscitation Alert- 7 Step Pathway
Clarification of Terms

**Advance Care Directives (ACDs)**
- written by the person
- statutory documents - with specific signing and witnessing requirements expressing a patient’s wishes, or appointing a substitute, to apply when they have impaired capacity to decide.
- Work within a specific set of laws
- e.g. Advance Care Directive Form (*Advance Care Directives Act 2013*), Anticipatory Direction, Medical Power of Attorney or Enduring Power of Guardianship

**Advance Care Plans (ACPs)**
- “informal” documents expressing a patient’s wishes
- have some legal weight within common law, often about refusals of treatment
- e.g. Good Palliative Care Plan (*Palliative Care Council*), Statement of Choices (*Respecting Patient Choices*), Ulysses Agreements

**Clinical Care Plans**
- specific clinical decisions and instructions regarding clinical care
- written by the clinician responsible for the patient’s care, in the context of the prevailing clinical situation
- are basically an extension of the clinical notes
- should be informed by patient’s ACD/ACP/wishes
- e.g. mental health care plan, nursing care plan, resuscitation plan
- (Resuscitation Alert - 7 Step Pathway)
Why is this important?

- Most Australians die in acute care hospitals – over 70%
- Most Australians want to die at home!
- A major area of disputes, complaints and media attention
- 50% of all health care complaints about end of life care
- And also an area of significant health expenditure
  - 30% of Medicare expenditure in the US is for patients in the last year of life-
    with up to 40% of this concentrated on patients in the last month of life
MEDIA RELEASE

Palliative Care Australia
Suite 4, 37 Geils Court, Deakin ACT 2600 | PO Box 24, Deakin West, ACT 2600
t: 02 6232 4433 | f: 02 6232 4434 | w: www.palliativecare.org.au | e: pcainc@palliativecare.org.au

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Australians dying badly

Have you prepared for the end of your life? Whether healthy or ill, an individual, a family, a carer, a healthcare practitioner or a health system reform authority, we all need to talk about dying – because too many people in Australia unnecessarily experience a bad death.

Have you asked yourself:
• How would I want to live in the last few months of my life?
• What do I need to arrange to make my wishes happen?
• What decisions should I make now about my health care at the end of my life?

If you haven’t prepared, then chances are that when your time comes no-one else will ask for your answers to these questions either! This means that your last months, weeks or days may not go the way that you would wish them to. You could miss out on the right care.
How do I make a decision?

- My job is to save lives isn’t it?
- What are the clinical parameters that will tell me that this patient is at the end of their life?
- What’s best for this patient?
- What’s the legal situation if I don’t give treatment? Maybe I’d better keep trying to keep him alive.
- What’s this bit of paper – an Advance Care Directive? And what’s this plan? And who is this person calling themselves a medical power of attorney? Who do I listen to?
- His children are saying that we should let him go. But his wife is saying that we must keep him alive. What do I do?
- What would this patient have wanted if they had been conscious?
- My belief is that life is sacrosanct.
- What is the protocol in this situation? What did the textbook say? What did the consultant do the last time this happened?
- I don’t know how to tell them this bad news. I need to give them hope. Maybe I’ll give them one more round of treatment…
- What’s the legal situation if I don’t give treatment? Maybe I’d better keep trying to keep him alive.
- Maybe I’d better keep trying to keep him alive.
- What’s best for this patient?
- His children are saying that we should let him go. But his wife is saying that we must keep him alive. What do I do?
- What would this patient have wanted if they had been conscious?
- My belief is that life is sacrosanct.
Are Advance Care Directives and Advance Care Plans the only solution?

- often completed a long time before a medical crisis - may not be relevant
- often only vague statements about wishes (e.g. “I do not want to suffer”) - limited use in emergencies
- may be pointless if not converted into clinically useful instructions about resuscitation and care
- 90% of patients presenting don’t have ACDs

So, relying solely upon ACDs and ACPs is common, but fundamentally flawed.
A concern for patients and families

Complaints to Public Advocate and the Health and Community Services Complaints Commissioner from patients and families:

Informal “Not for Cardiopulmonary Resuscitation” and “NFR” orders written in notes and discharge letters without any prior discussion with the patient, family or substitutes.
This led to…

A solution:

ACDs (or ACPs) to tell us the patient’s wishes

plus

Clinical/Resuscitation Plans to convert these wishes into usable clinical instructions about resuscitation and end of life care
Make end of life Clinical/Resuscitation Planning:
• not just a form, but a process
• of logical and commonsense steps for doctors to work through

....The 7 Step Pathway
The SA Health 7 Step Pathway

- Trigger
- Assessment
- Consultation
- Develop and Document the Clinical Plan
- Transparency
- Implementation
- Support the Patient and Family
The Main Improvement

No informal “NFR”, “Not for CPR” or “Not for Cardiopulmonary Resuscitation” orders to be written in the notes

AND

The use of the Resuscitation Alert – 7 Step Pathway for all of these orders
The Form

• incorporates the 7 Steps
• encourages the clinician to work through the correct:
  • clinical
  • legal
  • ethical steps in the correct order
• MUST ask:
  “What are you going to do to maintain the patient’s comfort and dignity?”
• instils an intuitive feel, or “cadence” to the process
The Resuscitation Alert – 7 Step Pathway

1. TRIGGER

Complete this form early if the clinical situation requires decisions about resuscitation or end of life care. Otherwise, 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 end of life care? If Yes, Continue with the plan.

3. CONSULTATION

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

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

4. RESUSCITATION PLAN

Indicate if the following decisions about resuscitation apply:

- Patient is not for any treatment aimed at prolonging life (including CPR)
- Patient has no advance care directive
- Patient has an advance care directive which is not followed
- Patient is in a vegetative state
- Patient is in a persistent vegetative state
- Patient is in a chronic vegetative state
- Patient is in a terminal state

5. TRANSPARENCY

Resuscitation plan explained to:
- Substitute Decision-Maker/Relative
- Patient (if capable and willing)
- Patient (if patient has capacity)

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

SA Health
Created May 2014
Why do we need another form?
Actually, we don’t. The heart of this is a process, not a form

- NFR order with process around it
- Helps doctors make the right decision
- Protects both the patient and the doctor
- Standardised document
- So that everyone recognises and respects it- doctors, nurses, ambulance officers, aged care staff
But, will I have to fill out two forms now?

No!

There is:

• One form for the patient - their ACD (or ACP) - the patient’s responsibility, not the doctor’s

AND

• One form for the doctors - the Resuscitation Alert - 7 Step Pathway - the doctor’s responsibility
Integration of Resuscitation Alert – 7 Step Pathway

With existing systems:
- Medical Record
- EPAS
- Rapid Detection and Response (RDR) Observation Charts

With other health sectors:
- SAAS
- GPs
- Community Nurses
- Aged Care
Resuscitation Alert – 7 Step Pathway Form in transfers across health sectors

- From Hospital to Home/RACF
  → Must contact the GP
- From Home/RACF to Hospital
  → Arguments why a completed form can be respected:
    - “Why would you respect the form?” VS “why shouldn’t you respect the form?”
    - Another doctor has gone through a process consistent with legal and ethical principles
    - ACD Act is clear: no requirement to provide futile treatment
  → Still use clinical judgement
    - Remember, protection if do provide treatment - via the uncertain/urgent provisions
Summary of Part 4
Resuscitation Alert – 7 Step Pathway Part 4

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
• Recognised - particularly in emergencies
• not a separate legal document - really only an extension of the case notes
• Replaces an “NFR” order

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