RESUSCITATION ALERT

RESUSCITATION PLAN – 7 STEP PATHWAY

(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.

This form is intended to be used by registered medical practitioners responsible for coordinating medical care of a patient in South Australia. The medical practitioner should be competent in using the Resuscitation Planning - 7 Step Pathway process in accordance with SA Health Resuscitation Planning - 7 Step Pathway Policy, the *South Australian Advance Care Directive Act 2013* and the *Consent to Medical Treatment and Palliative Care Act 1995*, and relevant professional practice standards.

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. Refer to Resuscitation Plan - 7 Step Pathway instructions for the 5 trigger criteria.

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, and/or Person/s Responsible (and where possible, individuals that the patient wishes to be involved in this planning).

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 SA Civil and Administrative Tribunal (formerly 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/resident (the person must be willing to provide consent and follow applicable employer policy)
     Name/s: .....
   - ☐ SA Civil and Administrative Tribunal (SACAT), 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 (e.g. Statement of Choices, Palliative Care Plan), it must be referred to by those making decisions above.

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Hospital .....

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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 medical care (e.g. IV fluids, antibiotics) being provided.*
- *Treatment **must** include a plan (or a contingency plan) to maintain patient/resident 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 palliative care measures fail to maintain the comfort and dignity of the patient/resident in their place of residence.

5. TRANSPARENCY

Resuscitation plan explained to:

☐ Substitute Decision-Makers/Relatives

☐ Patient (mandatory if he/she has capacity) ***or***

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:** / /
Designation			**Name of Doctor revoking the plan:** ..... Designation: .....
Signature			**Signature:** .....
Consultant Responsible		Unit:	

SA Health

Revised November 2018

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

RESUSCITATION ALERT MR-RESUS

Introduction

The Resuscitation Plan - 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 **Resuscitation Plan - 7 Step Pathway** 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.**
   This form is intended to be used by registered medical practitioners responsible for coordinating medical care of a patient in South Australia. The medical practitioner should be competent in using the Resuscitation Planning - 7 Step Pathway process in accordance with SA Health Resuscitation Planning - 7 Step Pathway Policy, the *South Australian Advance Care Directive Act 2013* and the *Consent to Medical Treatment and Palliative Care Act 1995,* and relevant professional practice standards.
2. Only clinicians/medical officers above the level of Intern should complete the **Resuscitation Plan - 7 Step Pathway.** 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 their role as patient/resident, Substitute Decision-Maker, or Person Responsible. Document if the person has an Advance Care Directive and or plan. If others are present, record their names and the details of the consultation in the medical record.
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. Consider anticipatory prescribing and other treatments/interventions. Refer to the SA Health Prescribing Guidelines for the Pharmacological Management of Symptoms for Adults in the Last Days of Life.
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 become responsible for the patient's care should be notified. Appropriate care planning and clinical handover must occur prior to transfer/discharge.
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 medical officer completing the **Resuscitation Plan - 7 Step Pathway** form must include the date the Resuscitation Plan is completed, their name, designation, 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, referrals, tranfers, and in the discharge summary. The Resuscitation status must be 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. Ensure the plan is agreed and understood and provide a copy to the patient (or their Substitute Decision-Maker, Person Responsible) and care provider (e.g. residential aged care facility, ambulance officer), 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.*

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 of 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/carers including offering support and information after the patient has died.