Resuscitation Plan
7 Step Pathway Instructions (Community Version)

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/residents.

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: This form is intended to be used by registered medical practitioners responsible for coordinating the 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. The SA Health version of this form should be used in SA Health services.
   Interns are not permitted to complete this form.
2. Only 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/resident's Resuscitation Plan** by using a **Tick** to **indicate which decisions about resuscitation apply**. If you are affiliated with an SA Health Hospital, **circle** which option applies: MER Call Yes or No. Alternatively, the Medical Emergency Response (MER) section is to be completed by the hospital admitting doctor (not intern) if the patient/resident is subsequently admitted to hospital. Circle only the option that applies and document name of hospital, doctor's name, date and designation.
6. **Indicate what treatment is to be provided**, including a plan for maintaining comfort and dignity if the patient/resident is not for resuscitation. Consider anticipatory prescribing and other treatments/interventions that may be required.
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, then any necessary care or treatment arrangements must be discussed and agreed to with the health care practitioner/carer who is providing care to ensure the patient/resident's needs in the event of acute distress are met. If the patient is to be transfered to another health facility, the medical officer who will become responsible for the patient's/resident'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/resident'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 contact details.
10. Communicate the plan to health care practitioners/carers involved in the patient's/resident's care.
11. **Document when and if** this **Resuscitation Plan is revoked or whether it is ongoing**.
12. Remember to take all practical steps to **implement** the plan and to **support** the patient/resident and family through the process.
13. Ensure the plan is agreed and understood and provide a copy to the patient/resident and/or family (or their Substitute Decision-Maker, Person Responsible) and care provider (e.g. residential aged care facility), 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

1

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).

2

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.

3

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.

4

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.

5

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.

6

STEP 6: IMPLEMENTATION

Take practical steps to implement the plan and revisit as necessary.

7

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.