Resuscitation planning - 7 Step Pathway
A clear path to care

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Today

- Using a case study- Bruce
  - Highlight the Resuscitation Planning – 7 Step pathway
  - Framework for end of life decision-making
  - Importance of ACDs and Substitute Decision-Makers
  - Work through the 7 Steps of the resuscitation planning process and form
  - To facilitate person – centred care

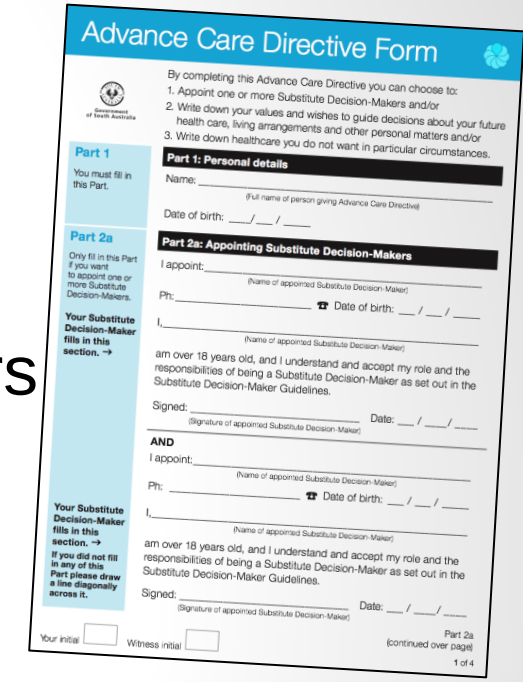
Bruce – life history



- 65 year old man, life-long animal rescue volunteer
- Married to Maria; supportive family
- Values independence and being fit and active
- Loves his dog
- Very private man
- Wants to be home to be with his wife and dog
- He has diabetes.
- He has an Advance Care Directive (ACD) and has appointed his wife, Maria as his substitute decision-maker (SDM)
- His ACD includes the above information about his values and what is important to him.

Advance Care Directive

- One Advance Care Directive Form in which competent adults can:
  - appoint one or more substitute decision-makers (SDMs) for different types of decisions
  - choose to appoint no-one
  - write down their future wishes, care goals, values and levels of acceptable functional ability


Advance Care Directive Form

By completing this Advance Care Directive you can choose to:
1. Appoint one or more Substitute Decision-Makers and/or
2. Write down your values and wishes to guide decisions about your future health care, living arrangements and other personal matters and/or
3. Write down healthcare you do not want in particular circumstances.

Part 1
You must fill in this Part.

Part 1: Personal details
Name:
(Full name of person giving Advance Care Directive)
Date of birth: ___/___/____

Part 2a
Only fill in this Part if you want to appoint one or more Substitute Decision-Makers.

Part 2a: Appointing Substitute Decision-Makers
Your Substitute Decision-Maker fills in this section. →
I appoint:
(Name of appointed Substitute Decision-Maker)
Ph: ☎ Date of birth: ___/___/____
I,
(Name of appointed Substitute Decision-Maker)
am over 18 years old, and I understand and accept my role and the responsibilities of being a Substitute Decision-Maker as set out in the Substitute Decision-Maker Guidelines.
Signed: Date: ___/___/____
(Signature of appointed Substitute Decision-Maker)
AND
I appoint:
(Name of appointed Substitute Decision-Maker)
Ph: ☎ Date of birth: ___/___/____
I,
(Name of appointed Substitute Decision-Maker)
am over 18 years old, and I understand and accept my role and the responsibilities of being a Substitute Decision-Maker as set out in the Substitute Decision-Maker Guidelines.
Signed: Date: ___/___/____
(Signature of appointed Substitute Decision-Maker)
Your Substitute Decision-Maker fills in this section. →
If you did not fill in any of this Part please draw a line diagonally across it.

Your initial Witness initial
Part 2a
(continued over page)
1 of 4

Important note: Enduring Powers of Guardianship, Medical Powers of Attorney and Anticipatory Directions completed prior 1 July still have legal effect

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Substitute Decision-Maker

- Must make the decisions the person would have made -guided by the wishes and values of the person who gave the ACD
  - Stand in Bruce's shoes



- Must produce the ACD or a certified copy
- Must have decision-making capacity
- Can only make lawful decisions on behalf of the person – cannot authorise euthanasia
- Cannot refuse drugs to relieve pain/distress

Health Practitioners' Obligations

- Defined as any professional registered under the National Law (includes nurses, doctors, physiotherapists, psychologists, OTs) and ambulance officers/paramedics
- If relevant/applicable - must comply with refusals of health care (called binding provisions)
- Must seek consent from SDM when the person has impaired decision-making capacity in relation to the decision
- If reasonably practicable, must comply with non-binding provisions - seeking to avoid outcomes or interventions that the person wanted to avoid
- Not obligated to provide treatment which is considered of no medical benefit

No obligation to provide treatment which is of no medical benefit

1) A change to S17(2) of the Consent Act which clarifies that there is:

- no longer a requirement to provide, and the ability to withdraw, treatment
- which a doctor does not think is of benefit to a patient
- in the terminal phase of a terminal illness, persistent vegetative state or minimally responsive state

- Can make decisions based on what is good practice rather than on medico-legally defensive grounds

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Amendment of section 17 (2) The care of people who are dying:

- A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision:

  (a) is under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state (whether or not the patient or the patient's representative has requested that such measures be used or continued); and

  (b) must, if the patient or the patient's representative so directs, withdraw life sustaining measures from the patient.

(Representative = SDM (+EG/MA) or person responsible or parent/guardian of a child)

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Bruce – health history

- Has diabetes
- Was a smoker
- Good relationship with his GP
- Has developed peripheral vascular disease
- R foot has become painful and then numb- cold and blue- and ulcers have developed on his toes and heel
- His GP -
  - has had ongoing discussions with Bruce about his life and care goals
  - suggested he document his wishes in an ACD/appoint a SDM
  - discussed resuscitation with Bruce, but cannot fill out a 7 Step form

Bruce- hospital visit

- Given changes to Bruce's R foot– GP referred him to hospital
- Admitted under General Medical Unit
- Vascular consult
- Has developed ischaemic leg > gangrene
- Only curative option is to amputate
- Bruce has refused this option- '*I do not want my leg amputated- I would rather die' .. 'I want to go home and be with my wife and dog*'
- Family conference held with Bruce and SDM (his wife) and adult children

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The 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.

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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.*

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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.

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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Designation			Designation:
Signature			**Signature:**
Consultant Responsible:		Unit:	

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Triggers – for discussion

1. The patient, family/carer, Substitute Decision-Makers, Person Responsible or members of the interdisciplinary team **express concern or worry that the patient is dying** and/or has unmet end-of-life care needs.
2. Meet criteria of the **Supportive and Palliative Care Indicators Tool (SPICT TM)** which is 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?
4. A **patient has refused life-sustaining treatment** either directly or 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)**.

SPICT

SPICT is a useful **guide** for clinicians, to

- Prompt consistent recognition of patients who are at risk of dying within 12 months

- Trigger a review of patients with advanced conditions, multiple comorbidities or general frailty, especially if they have had multiple hospital admissions



Supportive and Palliative Care Indicators Tool (SPICT™)

NHS Lothian

The SPICT™ is a guide to identifying people at risk of deteriorating and dying. Assess for unmet supportive and palliative care needs.

Look for two or more general indicators of deteriorating health.

- Performance status poor or deteriorating with limited reversibility; is in bed or a chair for 50% or more of the day.
- Dependent on others for most care needs.
- Two or more unplanned hospital admissions in the past 6 months.
- Significant weight loss (5-10%) over the past 3-6 months, and/ or a low body mass index.
- Persistent, troublesome symptoms despite optimal treatment of any underlying condition(s).
- Patient requests supportive and palliative care, or treatment withdrawal.

Look for any clinical indicators of one or more 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; swallowing difficulties; difficulties with 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.

Review supportive and palliative care and 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, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.

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

SPICT™, March 2015

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Decision-Making Capacity

Under the Act, decision-making capacity:

- is presumed
- is not based on a medical diagnosis
- should be supported (eg including a support person)
- residual capacity respected – can understand some things but not others
- fluctuating capacity respected

Impaired decision-making capacity- only relates to a particular decision when consent is required

In respect of a particular decision, impaired decision-making capacity means they cannot:

- understand relevant information (presented to them in a way they can understand)
- retain such information, even if only for a short time
- use information to make the decision- i.e. risks vs benefits
- communicate the decision (in any manner)

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Clinician Confidence and Support :
Essential enablers for resuscitation planning

What supports clinicians and gives them confidence?

- Having the skills to have a therapeutic conversation
- - education, mentoring, assessment, use of a framework
- A clear, consistent policy and process
  - triggers
  - the form and guidelines
  - clinical handover processes and a team approach
  - discharge planning processes



- A facilitator integrated into clinical practice and workflow
  - removal of barriers to sustained intervention eg skills, staff, time, resources, workflow issues

(Lund, Richardson & May, 2015. Systematic review)

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More Information

- ***Fact sheets, FAQ, educational resources for health practitioners***
  - *SA Health (www.sahealth.sa.gov.au/advancecaredirective)*
- ***DIY Kit and online interactive Form***
  - *www.advancecaredirectives.sa.gov.au*
- ***Form and guidelines for all parties (DIY Kit)***
  - *Service SA*
  - *108 North Terrace, Adelaide SA 5000 ph 13 23 24*

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More information

- ***Education and awareness & general advice on ACD***
  - *Legal Services Commission ph 1300 366 424*
- ***Advice about decisions, resolving disputes/mediation, declarations***
  - *Office of the Public Advocate (www.opa.sa.gov.au)*
- ***Determinations and binding declarations***
  - *SACAT (www.sacat.sa.gov.au) (formerly the Guardianship Board)*

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Questions

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