



# Advance CPR decision-making in the hospital setting

## A facilitator's guide



Clinical issues – Framework – Communication

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### Acknowledgement and suggested citation

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**Disclaimer:** The terminology and practice of advanced life support teaching depicted in the videos were current at the time of making this guide. The video drama scenes are not intended as a teaching model for Advanced Cardiovascular Life Support.

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## Foreword

*Cardiopulmonary resuscitation (CPR) can prevent premature death and save peoples' lives. However well intentioned, CPR can also prolong inevitable death, increase family duress and extend patient suffering.<sup>1</sup>*

The initiative, context and objective for this facilitator's guide are influenced by such observations. The facilitator's guide is just one component of a suite of teaching resources to support decision-making and effective communication about CPR in the hospital setting. This teaching resource has been developed by a team of clinicians from a range of specialties across Australia. It is one of several initiatives being developed by the Department of Health, WA as part of the End of Life Framework.

It can be difficult to predict a patient's illness trajectory; many patients present with complex co-morbidities and transition in and out of hospital, adding to their complexity and uncertainty. For those patients who are less responsive to treatment, CPR is unlikely to be helpful and survival likely to be uncertain.

As clinicians we owe it to our patients and their families to discuss the potential benefits and risks of performing CPR and to make recommendations. Ongoing conversations with our patients are an important component of best practice in end of life care, and as such are the responsibility of all clinicians.

Talking about death and dying is not easy. We need to take the time to sensitively assist our patients to establish their goals of care, to discuss their needs and values, and to acknowledge their fears. Those of us who have experience in communicating effectively about issues relating to death and dying have a responsibility to share our skills and knowledge with our colleagues, through role modelling and peer guidance.

This teaching resource provides a consistent approach to these principles. It focuses on three main themes – the clinical issues, a decision-making framework and communication. It can be tailored to an individual or health service's needs and applied through reflective practice and the use of tools and workshops.

Thank you to everyone who has contributed to this invaluable teaching resource, in particular the clinicians from around the country who provided their expertise and advice. I would also like to thank the members of the Working Group and the Department of Health WA staff who willingly provided their time in the development of this important teaching resource.



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1 Brindley PG, Beed M. Adult cardiopulmonary resuscitation: 'who' rather than 'how'. Br J Anaesth [Internet]. 2014 [cited 2015 Aug 5]; 3 p. Available from: <http://bj.oxfordjournals.org/content/112/5/777>

## A clinical reflection

Reflecting on my years of clinical practice and in particular the issue of the clinical deterioration of patients, I realised I was frustrated and concerned. I started to question 'why are clinicians providing treatments to patients that have no benefit and avoiding difficult conversations'. In talking to my colleagues I discovered that many of them felt the same way.

The inspiration which finally moved me from frustration to action was the viral TED talk by Intensivist – Dr Peter Saul. Watching Dr Saul's talk, I realised that the 'problem is us' – doctors – and as a Consultant this included me. Like many, however, I was never taught or mentored in the skill of communication in end of life issues and shared decision-making with patients, families and carers – I just picked it up on the job.

On reviewing the literature it was clear I was not alone. A gap existed, with little published about education on advance CPR decision-making. To understand this deeper I ran focus groups, networked, reviewed policies and engaged leaders. A narrative was developed then filming commenced. The rough cuts of the videos were then peer reviewed by many generous and skilled experts across Australia and New Zealand.

Three training videos and the *Advance CPR decision-making in the hospital setting facilitator's guide* are the end result; they have been developed by clinicians for clinicians. The faces and voices are captured not to teach didactically, but so that those who are willing to learn, teach and mentor, are resourced to do this work and have the capacity to change our medical culture.

Although education is essential, leadership and system change is also required. The training videos can assist in building clinician consensus, creating shared responsibility across health services and, ultimately, adopting a goals of patient care approach. In this way, clinicians can routinely seek patient preferences, so that treatments are always beneficial and desired by clinicians and patients alike.



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# Overview

## Background

CPR was originally designed to save 'hearts too good to die'.<sup>1,2,3</sup> The clinicians who pioneered CPR never intended for it to be used universally. CPR is usually an appropriate first aid response to cardiac arrest in a community setting but it is not always appropriate in a hospital setting.

Despite the widely held community view that CPR should be provided for all people who experience cardiac arrest, communication about the potential benefits and risks of performing CPR in the hospital setting should usually be discussed with each patient on a case by case basis.

CPR decision-making is one of the most difficult clinical decisions doctors need to make in collaboration with the patient and their family/carer(s). CPR decision-making is a clinical skill that should be systematically taught and practiced in all hospital settings. Despite this, the provision of medical education in CPR decision-making remains an identified gap in the literature and practice.

No legal consent is required to provide emergency medical treatment such as CPR.<sup>4</sup> However, the decision about whether to initiate CPR in the event of cardiac arrest should be discussed with patients and their families. The way that this is communicated to patients and families must be tailored to their circumstances. Patients and families/carer(s) may have unrealistic expectations about CPR and other treatments at the end of life. They may over-estimate the effectiveness of CPR and underestimate the potential harms.<sup>4,5,6</sup> In some cases CPR may be provided, despite the likelihood of little or no benefit.<sup>7,8</sup> Patients at the end of life are particularly at risk of inappropriately receiving CPR as cessation of heartbeat and breathing may be construed as cardiac arrest as opposed to the normal dying process. In this circumstance providing CPR may result in unnecessary harm.

Communication about the outcomes, including expected benefits and potential harms of performing CPR, should be provided to patients and families. Doctors may be concerned that initiating a discussion about end of life care will remove hope or create distress for the patient and their family/carer(s).

However, in the absence of a discussion, the patient and family/carer(s) may be unrealistically optimistic about treatment outcomes. Poor communication, like any other medical intervention, can cause harm. Quality communication between doctors and patients is vital.

CPR decision-making should be considered a component of best practice for end of life care and is the responsibility of all clinicians who are part of the treating team. Using a systematic approach to quality improvement in this vital aspect of clinical practice responds to the *National Safety and Quality Health Service Standards*, in particular Standard 9 – Recognising and Responding to Clinical Deterioration.

Studies about CPR outcomes describe a range of survival rates, depending on the cardiac arrest circumstances, the cause of the arrest and the patient's underlying medical condition. Estimates range from 7–26 per cent survival through to discharge<sup>1,12,13,14</sup> and 6 per cent for patients with metastatic cancer.<sup>15</sup> For those who survive CPR, between 30 and 50 per cent will have a spectrum of impairment from minimal damage to severe hypoxic brain damage.<sup>4</sup>

An important clinical skill for every doctor is the ability to identify when a patient is approaching death. This skill is enhanced through comprehensive assessment, critical thinking and reflective practice. Despite this, uncertainty in prognostication is common. Good communication initiated by the doctor at this time will help the patient to know when death is expected, what to expect, to be comfortable, to have time to say goodbye and to participate in decision-making to limit medically inappropriate life prolonging treatment.<sup>9,10</sup>

### The facilitator's role

As a facilitator, your role is to stimulate and encourage discussion about CPR decision-making with your colleagues in a trusted environment with the goal of promoting and improving conversations between medical staff, patients and their \*family/carer(s). An adult learning approach will encourage reflection and critical thinking. It is important to respect individual learning styles and encourage constructive group dynamics.

This guide is designed to help medical staff to develop essential knowledge, skills and confidence to initiate and engage in patient-centred conversations, particularly about CPR decision-making. Taking this approach will ensure patients are actively involved in determining the goals of patient care and preferences for appropriate intervention and treatment, in the event of their deterioration.

The role of the facilitator is to assist participants to learn, to gain from each other's experience and gather new information. Ideally the facilitator will:

- use a variety of methods to introduce and reinforce information
- provide opportunities to share relevant information and experiences
- encourage active participation through reflective practice.

This *facilitator's guide* is not prescriptive, rather it is based on a multi-modal learning approach and includes videos and suggested readings. The content may be delivered flexibly, according to the audiences' experience and needs, and the time available.

### Guide at a glance

This guide is organised into three learning parts and includes sample session plans, a suite of video presentations, essential and additional readings and links to other resources. The videos present clinical scenarios and examples of CPR decision-making discussions. Each video may be watched in full or in smaller sections interspersed with audience discussion.

#### Part A

The clinical issues

#### Part B

The decision-making framework

#### Part C

Communication tips and examples

The content is particularly focused on patients with progressive, deteriorating illness.

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\* For simplicity, this guide will use the term 'family/carer(s)' to also include the patient's legal medical substitute decision-maker because it is important to correctly identify the person who has this role.



## The use of videos

By using videos in a group setting with discussion, the social aspects of learning with peers and consensus building can be emphasised. The goal of the facilitator is to allow adult learners to develop their understanding and own meaningful interpretation of the material, in order to layer new knowledge upon their existing experience.

Pragmatically, finding time for education sessions can be difficult. The videos can also be used in a *flipped* classroom context where parts of the material are viewed before or after an education session or used as a resource to refer to for future learning needs.

Overview of video content			
Video part	Subsection	Time*	Content
<b>A. The clinical issues</b>  Total time: 11 mins, 24 secs	1. The current situation	2:47	Frustration; CPR overuse; lack of decisions; variable approaches.
	2. Why has this situation arisen?	5:09	CPR history; expectations; lack of training; clinical uncertainty; 'do everything'.
	3. How can we improve clinical care?	3:29	CPR decision-making framework; normalise discussion; honesty; shared responsibility; scripted questions; involve team; 'systematise' not 'protocolise'.
<b>B. The decision-making framework</b>  Total time: 13 mins, 6 secs	1. Is CPR decision-making different?	3:09	Patient expectation; life and death; trust; part of overall care and ongoing.
	2. The medical assessment	3:28	Answer 'will this patient survive CPR'; how to make the decision.
	3. Four clinical categories and discussion aim	4:38	Clinical framework presented in interview style; animation of framework; deliberative and interpretive communication.
	3.1 Documentation	1:59	Capture escalation plan, and value and preferences of patient; follow local policy.
<b>C. Communication tips and examples</b>  Total time: 13 mins, 34 secs	1. Improving communication	5:13	Communication overview; clinician tips for CPR decision-making; improving communication; introduces tools 'ask-tell-ask' and 'NURSE'.
	2. Patient/doctor scenarios		
	2.1 Dot and Dr Nick	2:52	Poor conversation (tools annotated); Dot dies 'bad death'; healthy view of death.
	2.2 Dot and Dr Eng	5:29	Good conversation (tools annotated); Dot dies 'good death'; consumer voice.
Overview video  Total time: 5 mins, 35 secs	Additional material	5:35	Promotional style overview of narrative and video suite.

\* (minutes:seconds)

### Target audience

The primary target group includes:

- consultants, senior and junior medical staff
- medical students
- other clinicians, such as nursing and allied health staff may also find this guide useful.

Ideally this guide should be incorporated into formal hospital in-service education programs and may also be used flexibly to accommodate other training opportunities, for example grand rounds, journal clubs, case reviews and self-directed learning.

### How to get the best out of the facilitator's guide

It is recommended that the facilitator:

- considers how the content relates to your audience and their specialty(s), for example ICU, geriatricians, general medicine
- reads the guide and is well informed about the videos and readings
- starts and finishes on time
- meets the aims of each session
- keeps participants on track and on topic
- is familiar with the topic and audience - pitches the session appropriately and anticipates the questions that might arise
- allows time for group reflection including sharing clinical experiences
- provides evidence to back up claims, e.g. uses the statistics slides
- is open to questions – if you can't answer the question, ask the group for their thoughts
- respects the range of participants' experiences and builds their knowledge accordingly
- includes small breakout sessions for larger groups.

Conducting a successful learning session will require you to be aware of what might undermine the group's progress. Planning your session and anticipating what might not work for your group will help ensure a productive session, increase your confidence and achieve the aims of this guide. Consider the following points:

- A participant might say 'this is not my responsibility'. Some doctors may have their own personal beliefs that conflict with the contents of this guide. Accept that some participants may not see CPR decision-making as part of their role. If this is the case, explore the following questions:
  - Whose role should it be?
  - Does anyone in the audience see it as their role? Why?
  - Would it be okay if someone other than a senior doctor initiated the conversation? For example, a junior team member, in the presence of the senior doctor, may be better placed within the team to have the discussion.
- Provide an opportunity for all views to be heard, for example 'I don't agree with the content!' Ask others if they feel the same?
- Acknowledge that CPR decision-making is everybody's business. Decisions need to be made on wards every day. Sometimes these decisions are straightforward; at other times they are more complex and may require other opinions, for example input from an Intensive Care Physician.
- Consider how you will support participants who may require follow up/support or the opportunity to debrief with an appropriately qualified professional.
- Acknowledge that you are not teaching but facilitating.

## Resources for each session

Suggested resources and materials include:

- book a venue
- poster/flyer or website to advertise session
- computer
- data projector
- PowerPoint slides
- whiteboard and/or butchers paper and markers
- reading materials and other handouts.

**Please note:** Internet access will be required unless you have an electronic copy of the videos.

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# Part A: The clinical issues

## Part A: The clinical issues

### Aims

- A.1 Identify current practices and challenges facing clinicians in CPR decision-making.
- A.2 Explore ways in which communication can be improved with patients who have a progressive/deteriorating illness, and their families/carers.
- A.3 Investigate strategies for improving CPR decision-making in the hospital setting.

### Video summary

The video takes the participants through the hospital journey of a patient who most likely would not survive CPR; yet as a result of poor communication, receives attempts at CPR. It highlights issues around CPR decision-making, identifying problematic areas and potential solutions. It also provides a range of observations and comments from clinicians which the participants can discuss in the context of their own experiences.

### **Part A**

1. The current situation
2. Why has this situation arisen?
3. How can we improve our clinical care?

## Part A: The clinical issues sample session plan

Duration: 45 minutes.

The session plan is provided as a guide. All activities can be used flexibly.

Part A: The clinical issues			
Time	Video	Activity	Considerations
20 mins	<p><b>A.1 The current situation</b> (2 mins 47 secs)</p> <ul style="list-style-type: none"> <li>• CPR was designed for a selected population and has now been applied to a broader hospital group.</li> <li>• A patient with advanced progressive illness or frailty may not survive or benefit from CPR.</li> <li>• Identify how poor communication and lack of training contributes to poor end of life decision-making</li> </ul>	<p><b>A.1.1</b> Introduce the session and background briefing.</p> <p><b>A.1.2</b> Ask participants if CPR decision-making is an important issue for them?</p> <p><b>A.1.3</b> Invite participants to discuss past experiences – good and bad.</p> <p><b>A.1.4</b> Give an overview of the video content.</p> <p><b>A.1.5</b> Invite group discussion by asking if the video reflects their own clinical experience?</p>	<p>The participants will have had a variety of clinical experiences in CPR decision-making.</p> <p>It is important to create an environment where they will want to share their stories. It is important to note that past experiences may continue to impact upon them and affect their decision making.</p> <p>Acknowledge participants' engagement and emotions expressed.</p>

Part A: The clinical issues			
Time	Video	Activity	Considerations
10 mins	<p><b>A.2 Why has this situation arisen?</b> (5 mins 9 secs)</p> <p>Consider the implications of:</p> <ul style="list-style-type: none"> <li>• Poor engagement with end of life discussions and decision-making.</li> <li>• Providing treatment that is not likely to benefit the patient, is excessively burdensome, or may cause unnecessary suffering.</li> <li>• Not seeking input from patients, in a timely manner, about their preferences. For example, wanting or not wanting treatment, providing treatment that the patient would refuse if they were fully informed about their illness trajectory, and about CPR or other life prolonging treatment.</li> <li>• The Clinical team providing inconsistent or ambiguous advice.</li> <li>• Avoiding difficult conversations which lead to default treatment.</li> </ul>	<p><b>A.2.1</b> Ask the participants why we sometimes fail to make proactive decisions including escalation and limitations to treatment, e.g. making decisions to withhold CPR.</p> <p><b>A.2.2</b> Consider stopping the video after Dr Nick’s discussion and asking: Has anyone in the group been formally taught CPR decision-making?</p> <p><b>A.2.3</b> Do you feel that poor communication can lead to poor treatment outcomes?</p> <p><b>A.2.4</b> Ask the group to share their reflections on the video. What further help would you need to undertake these decisions/ discussions/actions in the context of your specialty?</p> <p><b>A.2.5</b> How does this activity fit within the quality improvement agenda of your health service?</p> <p><b>A.2.6</b> Is the depiction of CPR in the video realistic? Can the participants describe any flaws (acknowledging that clinical practice is often imperfect)?</p>	<p>This will enable the facilitator to better understand the participants, their specialty and prior learning on CPR decision-making.</p> <p>It is likely that they have not been taught CPR decision-making specifically, but have received some teaching in the area of communication skills.</p> <p>Participants are more likely to engage in CPR decision-making conversations with patients and their families if they know that they are supported by:</p> <ul style="list-style-type: none"> <li>• local clinical governance, policy and quality improvement</li> <li>• endorsement by the hospital executive and the Department of Health and current legislation.</li> </ul> <p>Clinical uncertainty is part of decision-making, and the illness process is changeable and dynamic. There is no single solution to this complex problem.</p> <p>Emphasise high quality medical care is not about always ‘doing everything’ that is technically possible, rather it is about doing everything that is technically appropriate and wanted by the patient. For some, this may mean a palliative approach to care.</p>



Part A: The clinical issues			
Time	Video	Activity	Considerations
10 mins	<p><b>A.3 How can we improve clinical care?</b> (3 mins 29 secs)</p> <p>Include opportunities for improvement in CPR decision-making through systems based approaches including:</p> <ul style="list-style-type: none"> <li>• Use of training to improve clinician communication practices.</li> <li>• Recognition of the importance of discussions about goals of patient care and resuscitation especially for patients with progressive deteriorating illness.</li> <li>• Shared responsibility by all medical staff.</li> </ul>	<p>Invite group discussion by asking:</p> <p><b>A.3.1</b> Is the depiction of CPR in the video realistic?</p> <p><b>A.3.2</b> Support the participants to reflect and critique the content of the video.</p> <p><b>A.3.3</b> Do you feel that the two questions posed would be useful in clinical practice?</p> <ul style="list-style-type: none"> <li>• Who do you want to speak for you?</li> <li>• Have you spoken to that person?</li> </ul> <p><b>A.3.4</b> Can they be applied in current practice?</p> <p><b>A.3.5</b> Discuss the characteristics of effective communication for CPR decision-making discussions.</p>	<p>Collaboration between patient, family/carer(s) and clinician is essential for good clinical care.</p> <p>Shared decision-making means that:</p> <ul style="list-style-type: none"> <li>• clinicians bring the necessary medical expertise</li> <li>• patient/family/carer(s) bring necessary expertise about the patient's values/priorities</li> <li>• collaborative decision-making occurs within the context of available medical options</li> <li>• ethical processes will be upheld.</li> </ul> <p>Exploring a range of accepted communication techniques will enable:</p> <ul style="list-style-type: none"> <li>• the adoption of specific change strategies for individuals, supported by the specialty and hospital</li> <li>• improvements in clinical decision-making and performance outcomes.</li> </ul>
5 mins	<p><b>Conclusion</b></p> <ul style="list-style-type: none"> <li>• Recap session aims consider what has been learnt by the group.</li> <li>• Where to from here?</li> </ul>	<p>Remind participants of the availability of further training especially Parts B and C within the guide.</p>	

## Facilitator's tips

- *Futility* is a term that is likely to arise in discussion and best avoided as:
  - it is a highly subjective and ambiguous term open to misinterpretation
  - is influenced by the clinicians' own values
  - may imply that the person rather than the condition is not worthwhile treating.
- Show the following PowerPoint slides:
  - Dr Barbara Hayes' decision-making framework slides (Appendix 1)
  - Survival rates (Appendix 2)
  - Two questions (Appendix 3)
  - slides that support your local initiative/quality improvement initiatives.

## Essential reading

*(essential reading for facilitator, recommended reading for participants)*

1. Williams A, Griffiths D, Darbyshire P. When is it our time to die? [editorial]. J Clin Nurs [Internet]. 2013 Jan [cited 2015 June 8];22(1-2):1-3. Available from: <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2012.04265.x/abstract>
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## Additional reading

1. Australian Commission on Safety and Quality in Health Care. Safety and quality of care in acute hospitals: a background paper [Internet]. Sydney: ACSQHC; 2013 [cited 2014 Nov 7]. 62 p. Available from: [http://www.safetyandquality.gov.au/wp-content/uploads/2013/09/SAQ083\\_End\\_of\\_life\\_care\\_V15\\_FILM\\_REVISIED\\_TAGGED.pdf](http://www.safetyandquality.gov.au/wp-content/uploads/2013/09/SAQ083_End_of_life_care_V15_FILM_REVISIED_TAGGED.pdf)
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# Part B:

## The decision-making framework

## Part B: The decision-making framework

### Aims

- B.1 Consider the importance of quality CPR discussions and the risks of inadequate discussion, for example inappropriate use of CPR.
- B.2 Explore clinical situations where it is not appropriate to offer CPR.
- B.3 Describe how discussions should be framed in the following circumstances, considering:
  - that the patient might die or live following CPR
  - the potential benefits and harms of CPR/no CPR
  - why CPR might not be provided
  - planning care for a comfortable death.

### Video summary

The video presents information and guidance for CPR decision-making and communication using a structured decision-making framework (Appendix 1) and aims to provide clinical insight into this decision-making process.

### **Part B**

#### The decision-making framework

1. Is CPR decision-making different?
2. The medical assessment
3. Four clinical categories and discussion aim

## Part B: The decision-making framework sample session plan

Duration: 45 minutes.

The session plan is provided as a guide. All activities can be used flexibly.

Part B: The decision-making framework			
Time	Content	Activity	Considerations
10 mins	<p><b>B.1 Is CPR decision-making different?</b> (3 mins 9 secs)</p> <p>It is different because:</p> <ul style="list-style-type: none"> <li>• CPR is first aid treatment in the community for ALL cardiac arrests</li> <li>• expectations and perceptions vary between the community and clinicians</li> <li>• it is a high stakes (life and death) decision</li> <li>• unless there is an order to not provide CPR, it is provided.</li> </ul> <p>The CPR decision is embedded in an individual's life, values, illness, expectations and part of an ongoing discussion.</p>	<p><b>B.1.1</b> Open the session – give an overview of the session and the video content.</p> <p><b>B.1.2</b> Invite past personal experiences and the sharing of clinical approaches.</p> <p><b>B.1.3</b> Invite group discussion by asking:</p> <ul style="list-style-type: none"> <li>• Is CPR decision-making different or the same as other treatment decisions?</li> <li>• How do we decide whether someone is likely to survive CPR?</li> </ul> <p><b>B.1.4</b> Suggest use of the Decision-making Framework (Appendix 1). Also include discussion about local forms and documentation. The session should align with hospital policy and quality improvement initiatives.</p>	<p>There is no one tool which adequately captures each patient/situation. Clinicians should use:</p> <ul style="list-style-type: none"> <li>• a structured approach to CPR decision-making</li> <li>• a combination of tools, for example Supportive and Palliative Care Indicators Tools (SPICT™) and 'The Surprise Question'* to cover all scenarios to help identify patients for whom CPR may not be of benefit.</li> </ul> <p>(*Would I be surprised if this patient was to die in the next 6-12 months?)</p> <ul style="list-style-type: none"> <li>• Tools as an aid to memory.</li> <li>• A considered approach, exploring the patient's medical condition, their wishes and values.</li> </ul>

Part B: The decision-making framework			
Time	Content	Activity	Considerations
10 mins	<p><b>B.2 The medical assessment</b> (3 mins 28 secs)</p> <p>CPR decision-making is a two stage process:</p> <ol style="list-style-type: none"> <li>1. A technical assessment and decision about the patient's potential to survive CPR; and</li> <li>2. A discussion.</li> </ol> <p>Identifying patients who are likely to survive CPR is challenging. There is little discrete clinical research on the topic.</p> <p>Considerations include:</p> <ul style="list-style-type: none"> <li>• What is wrong with them now?</li> <li>• Do they have chronic progressive illness?</li> <li>• What are their co-morbidities, lifestyle, function, frailty and physiological reserve?</li> <li>• Less experienced doctors may need advice from more senior doctors to help them answer this question about likely survival.</li> </ul> <p>CPR discussions should be considered, rather than just providing default CPR without discussion.</p> <p>Clinical tools such as the SPICT™ Tool and 'The Surprise Question' are useful in assessing the patient.</p>	<p><b>B.2.1</b> It is important for clinicians to ask:</p> <ul style="list-style-type: none"> <li>• What are the likely consequences if the patient survives CPR?</li> <li>• How they will be afterwards?</li> </ul> <p><b>B.2.2</b> Have the slide available on the illness trajectories and the link for further reading.</p> <p><b>B.2.3</b> Have the clinicians seen the trajectories and do they use them to assist in decision-making?</p> <p><b>B.2.4</b> Do you find it difficult to establish when someone is dying?</p>	<p>The decision to use CPR is likely to have other implications for the patient, for example ventilation, prolonged hospitalisation, or disability.</p> <p>ICU admission is a second decision made at the time of cardiac arrest by the intensivists.</p> <p>It may be very helpful to obtain an ICU opinion prior to initiating any CPR discussion.</p> <p>These factors are important inclusions in the discussion about goals of care.</p> <p>There are no easy answers. Clinical experience will assist and for that reason consultants should be involved in these decisions.</p> <p>Junior staff will benefit from support as they are more likely to overestimate the patient's outcomes and ability to recover.</p>

Part B: The decision-making framework			
Time	Content	Activity	Considerations
10 mins	<p><b>B.3 Four clinical categories of patients being considered for an order to withhold CPR – each with its own discussion aim (4 mins 38 secs)</b></p> <p><b>Describes a framework which can be used to guide decision making.</b></p> <p><b>Each category contains discussion aims.</b></p> <ol style="list-style-type: none"> <li>1. Dying patient</li> <li>2. Medically unwell-not imminently dying</li> <li>3. Very poor outcome likely from CPR</li> <li>4. Uncertain outcome from CPR.</li> </ol> <p>There will be another group of patients for whom default CPR without specific discussion is entirely appropriate (in the absence of any advance care planning refusing CPR).</p>	<p><b>B.3.1</b> Invite discussion about the decision-making framework handout (Appendix 1) and ask the participants to consider:</p> <p><b>B.3.2</b> Are 'unilateral decisions' commonly made in clinical practice?</p> <p><b>B.3.3</b> Facilitate a discussion about why this may not be appropriate.</p> <p><b>B.3.4</b> Would you currently discuss CPR if you believed the patient would not survive?</p> <p><b>B.3.5</b> Discuss category 3 and 4.</p> <p><b>B.3.6</b> How do these categories fit with patients currently in your care?</p> <p><b>B.3.7</b> Can you see how these principles might apply to other medical treatment decisions?</p>	<p>A conversation about CPR fits into a broader conversation and decision-making about:</p> <ul style="list-style-type: none"> <li>• where the patient is on their illness trajectory and overall goals of care</li> <li>• what the patient's expectations are regarding ongoing treatment including CPR.</li> </ul> <p>Asking about prior Advance Care Planning is a way to also identify those patients, who might be considered medically appropriate to receive default CPR, but where the patient has their own CPR preferences.</p> <p>Unlike CPR, other treatments may have palliative benefit, independent of any life-prolonging intent. For example, surgery to fix an unstable fracture or antibiotics for a symptomatic urine infection.</p>

Part B: The decision-making framework			
Time	Content	Activity	Considerations
10 mins	<p><b>B.4 Importance of documentation</b> (1 min 59 secs)</p> <p>The video alludes to, but does not describe, strategies for dealing with disagreement.</p> <p>B. Hayes (2013) article, <i>Clinical model for ethical cardiopulmonary resuscitation decision-making</i> describes strategies for disagreement in each of the four CPR discussion categories.</p>	<p><b>A strategy to deal with disagreement</b></p> <p>CPR decision-making requires clear verbal/written communication, including clinical handover.</p> <p><b>B.4.1</b> Invite participants to discuss examples of disagreement/conflict regarding CPR (or other end of life) decisions.</p> <p><b>B.4.2</b> What happened and how did you address it as an individual/ team and with the patient and family/ carer(s)?</p> <p><b>B.4.3</b> Discuss the Framework and its specific applications in practice which include:</p> <ul style="list-style-type: none"> <li>• to build quality practice</li> <li>• as a teaching tool</li> <li>• to aid decision-making in difficult cases.</li> </ul> <p><b>B.4.4</b> Explore common questions as they arise. Ensure that the participants understand that the Framework is a tool which should be used together with the participant's professional judgment.</p>	<p>Every effort should be made to maintain working clinical and therapeutic relationships. Conflict should be avoided wherever possible during CPR decision-making; good communication will assist. For example, on occasions it may be judged ethically be better to provide CPR when it is not expected to be clinically beneficial to the patient rather than fall into a dispute with the patient and family/carer(s).</p> <p>The Framework will be specifically useful for clinicians who are inexperienced.</p> <p>As doctors gain experience in a systematic approach to CPR decision-making they will apply the principles of the Framework but will be less likely to rely on the document.</p>
5 mins	<p><b>Conclusion</b> Where to from here?</p>	<p>Remind the participants of the availability of Part C within the guide.</p>	



## Facilitator's tips

- Provide copies of the decision-making framework to the participants (Appendix 1).
- Show slides that support your local initiative/quality improvement initiatives.
- Show survival rates slide. Figures used for a poor outcome/uncertain outcome are a theoretical guide, based on estimated survival along the 0-18 per cent survival continuum:
  - poor outcome is approximately < 6 per cent but not zero
  - uncertain outcome is approximately 6-12 per cent.
- Note: Figures used in this guide are based on an overall in-hospital cardiac arrest survival for unselected patients of 18 per cent. These statistics may vary between settings and may change over time.
- Note: Corrections for Video B:
  - Video time (9 mins 55 secs): 2 per cent survival to same level of function should be 3-4 per cent.
  - Video time (10 mins 22 secs): 4-5 per cent survival, technically should be 6-7 per cent.

## Essential reading

*(essential reading for facilitator, recommended reading for participants)*

1. Hayes B. Clinical model for ethical cardiopulmonary resuscitation decision-making. Intern Med J [Internet]. 2013 Jan [cited 2015 June 8];43(1):77-83. Available from: [http://advancecareplanning.org.au/library/uploads/documents/B\\_Hayes\\_etchical\\_cpr\\_decision.pdf](http://advancecareplanning.org.au/library/uploads/documents/B_Hayes_etchical_cpr_decision.pdf)
2. Brindley PG, Beed M. Adult cardiopulmonary resuscitation: 'who' rather than 'how'. Br J Anaesth [Internet]. 2014 [cited 2015 June 8]; 3 p. Available from: <http://bjaoxfordjournals.org/content/112/5/777>
3. Boyd KJ. Supportive and Palliative Care Indicators Tool (SPICT™) [Internet]. Edinburgh: NHS Lothian. Current version available from: [www.spict.org.uk](http://www.spict.org.uk)

## Additional reading

1. Emanuel EJ & Emanuel LL. Four models of the physician-patient relationship. JAMA [Internet]. 1992 Apr; 22;267(16):2221-6.  
*Note – readers will need to: 1) Right click on the PDF link, then 2) select Open (or Open in New Tab or Open in New Window) then 3) Select Open (or Save) to get the free copy from this link.*
2. Hayes B. Trust and distrust in CPR decisions. J Bioeth Inq. 2010;7(1):111-22. DOI: 10.1007/s11673-010-9213-y  
**NB: ACCESS BY PURCHASE ONLY**
3. Hurst SA, Becerra M, Perrier A, Perron NJ, Cochet S, Elger B. Including patients in resuscitation decisions in Switzerland: from doing more to doing better. J Med Ethics [Internet]. 2013 Mar [cited 2014 Nov 7];39(3):158-65. Available from: <http://jme.bmj.com/content/39/3/158.full.pdf+html> DOI: 10.1136/medethics-2012-100699
4. Spotlight: Palliative care beyond cancer. BMJ [Internet]. 2010 Sep 16 [cited 2015 June 8]; 341:645-662. ARTN c4863. Available from: <http://www.bmj.com/content/bmj/341/7774/Spotlight.full.pdf>



# Part C: Communication tips and examples

## Part C: Communication tips and examples

### Aims

- C.1 Discuss the importance of communication in the provision of medical care including CPR decision-making.
- C.2 Explore how communication for quality patient care can be improved with training and practice.
- C.3 Consider communication strategies and clinical tools that can be used by doctors to enhance CPR decision-making discussions.

### Video summary

The video presents a broad overview of communication and provides clinicians with tools and tips to aid communication. It illustrates the application of the tools through the use of clinical scenarios.

### **Part C**

- 1. Improving communication
- 2. Patient/Doctor scenarios
  - i. Dot and Dr Nick
  - ii. Dot and Dr EngAdditional scenario – Jo and Dr Eng

## Part C: Communication tips and examples sample session plan

Duration: 45 minutes.

The session plan is provided as a guide. All activities can be used flexibly.

Part C: Communication tips and examples			
Time	Content	Activity	Considerations
15 mins	<p><b>C.1 Improving communication</b> (5 mins 13 secs)</p> <p>Communication in medical care including:</p> <ul style="list-style-type: none"> <li>• strategies, tips and tools that can be used to enhance CPR decision-making</li> <li>• exploring CPR decision-making within a broader discussion about the goals of medical treatment</li> <li>• the importance of enquiring and listening before offering information</li> <li>• how to recognise and respond to emotions during CPR decision-making.</li> </ul>	<p><b>C.1.1</b> Open the session – give an overview of the session and the video content and invite past personal experiences.</p> <p><b>C.1.2</b> Do you use any communication tools in your clinical practice?</p> <p><b>C.1.3</b> Emphasise the group's suggestions and recommendations about what can and will be done to improve CPR decision-making.</p> <p><b>C.1.4</b> Are there suggestions for improving communication?</p> <p><b>C.1.5</b> What have you found particularly useful in your own practice?</p>	<p>The doctor patient relationship is the cornerstone of good medical care.</p> <p>Good communication improves accuracy and efficiency of clinical practice as well as patient satisfaction.</p> <p>Good communication skills can be taught and learnt.</p> <p>Successful communication is prefaced on spending more time listening than talking.</p> <p>CPR decisions are contingent on the decision-making discussion; different conversations can lead to very different patient outcomes.</p> <p>Advance Care Planning will inform doctors of the patient's preferences in the event of deterioration even for those who may be considered medically appropriate to receive default CPR.</p>

Part C: Communication tips and examples			
Time	Content	Activity	Considerations
25 mins	<p><b>C.2 Patient/Doctor scenarios</b></p> <p><b>Scenario 1</b> <b>Dot and Dr Nick</b> (2 mins 52 secs)</p> <p><b>Scenario 2</b> <b>Dot and Dr Eng</b> (5 mins 29 secs)</p> <p><b>Scenario 3</b> <b>Jo and Dr Eng</b> (4 mins 43 secs)</p> <p>Provides advice and tips for good communication and identifies tools that can aide communication including:</p> <ul style="list-style-type: none"> <li>• ‘ask-tell-ask’</li> <li>• ‘NURSE’ and demonstrates use of the tools in patient scenarios.</li> </ul> <p>Scenarios which give examples of communication practice including:</p> <p>What is done well?</p> <ul style="list-style-type: none"> <li>• introduction, sits down, is polite</li> <li>• identifies patient is upset</li> <li>• provides reassurance ‘everything will be done’.</li> </ul> <p>What is done poorly?</p> <ul style="list-style-type: none"> <li>• leads with closed question</li> <li>• uses ‘Tell-Ask-Tell’ rather than ‘Ask-Tell-Ask’</li> <li>• doesn’t ascertain the patient’s level of knowledge or wishes for information</li> <li>• doesn’t engage with the patient’s emotions.</li> <li>• doesn’t consider whether the patient’s plan aligns with the doctor’s own judgment.</li> </ul>	<p><b>C.2.1 Play scenario 1:</b> Remind the group of the acronyms for the two tools and what they stand for:</p> <p><b>C.2.2</b> How might the two tools be usefully applied?</p> <p><b>C.2.3</b> What was done well and how could it be improved?</p> <p><b>C.2.4</b> Do you think that Dot had a good or bad death?</p> <p><b>C.2.5 Play scenario 2:</b></p> <p><b>C.2.6</b> Do you think that this was a good death or bad death? List the reasons why.</p> <p><b>C.2.7</b> What is done differently in this scenario?</p> <p><b>C.2.8</b> What ways, other than being a fighter, might patients use to describe how they cope with their illness? Be cautious about imposing on the patient a perception about how they should cope with illness. For example, ‘fighting’ or ‘giving up’.</p> <p><b>C.2.9 Play scenario 3:</b> Discuss the scenario with the participants:</p> <p><b>C.2.10</b> What was done well?</p> <p><b>C.2.11</b> Were there aspects of the communication that you would do differently? And why?</p>	<p>The better our communication skills, the better we will care for patients.</p> <p>Dying itself is not a failure; the failure is in managing the dying process poorly.</p> <p>Discussions are dynamic and at times challenging. Like all human experiences they are imperfect and as such will at times be flawed. Relationships are established with trust and a shared understanding.</p> <p>Patients with decision-making capacity should be invited to be involved in CPR discussions. A patient may request that another person also be involved, or may even delegate the discussion and/or decision-making to someone else.</p> <p>Patients may pick up messages from others about how they should deal with illness and can feel bad, or that they are letting others down, if this is not how they want to manage their illness. It can require significant courage to forgo treatment and accept what can’t be changed. This is not weakness or failure.</p> <p>This scenario describes a patient who might survive CPR but with a poor outcome expected.</p> <p>Not every communication will be perfect all of the time. However, establishing a caring and trusted relationship will go a long way towards creating a quality discussion.</p>

Part C: Communication tips and examples			
Time	Content	Activity	Considerations
		<p><b>C.2.12</b> How did the doctor's communication fit with the CPR Framework?</p> <p><b>C.2.13</b> Consider how the patient's condition might change over time – moving between discussion categories in the CPR Framework.</p> <p><b>C.2.14</b> How do you approach this and open a CPR discussion with a patient and family/carer(s)?</p>	
5 mins	<p><b>Conclusion</b> Where to from here?</p>		

## Facilitator's tips

Provide relevant handouts to the participants:

- recommended language for communicating end-of-life concepts (Appendix 4).

Show the following PowerPoint slides:

- Dr Barbara Hayes' Decision-Making Framework slides (Appendix 1)
- discussing end of life care preferences: Tools for communication (Appendix 5)
- slides that support your local initiative/quality improvement initiatives.

## Essential reading

*(essential reading for facilitator, recommended reading for participants)*

1. Tulsky JA, Chesney MA, Lo B. See one, do one, teach one?: house staff experience discussing do-not-resuscitate orders. Arch Intern Med [Internet]. 1996 Jun 24 [cited 2015 June 8];156(12):1285-9. Available from: <http://archinte.jamanetwork.com/article.aspx?articleid=622047>

*Note – readers will need to: 1) Right click on the PDF link, then 2) select Open (or Open in New Tab or Open in New Window) then 3) Select Open (or Save) to get the free copy from this link.*

2. Thomas K, et al. Prognostic Indicator Guidance (PIG): the National GSF Centre's guidance for clinicians to support earlier recognition of patients nearing the end of life [Internet]. 4th ed. National Gold Standards Framework Centre in End of Life Care CIC; 2011 Oct. The surprise question: [cited 2014 Nov 7]. 6 p. Available from: <http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf>

## Additional reading

1. Clayton JM, Hancock KM, Butow PN, Tattersall MH, Currow DC. Clinical practice guidelines for communicating prognosis and issues with adults in the advanced stages of a life-limiting illness, and their caregivers. Med J Aust [Internet]. 2007 Jun 18 Suppl [cited 2014 Nov 7];186(12):S77-S108. Available from: <https://www.mja.com.au/journal/2007/186/12/clinical-practice-guidelines-communicating-prognosis-and-end-life-issues-adults>

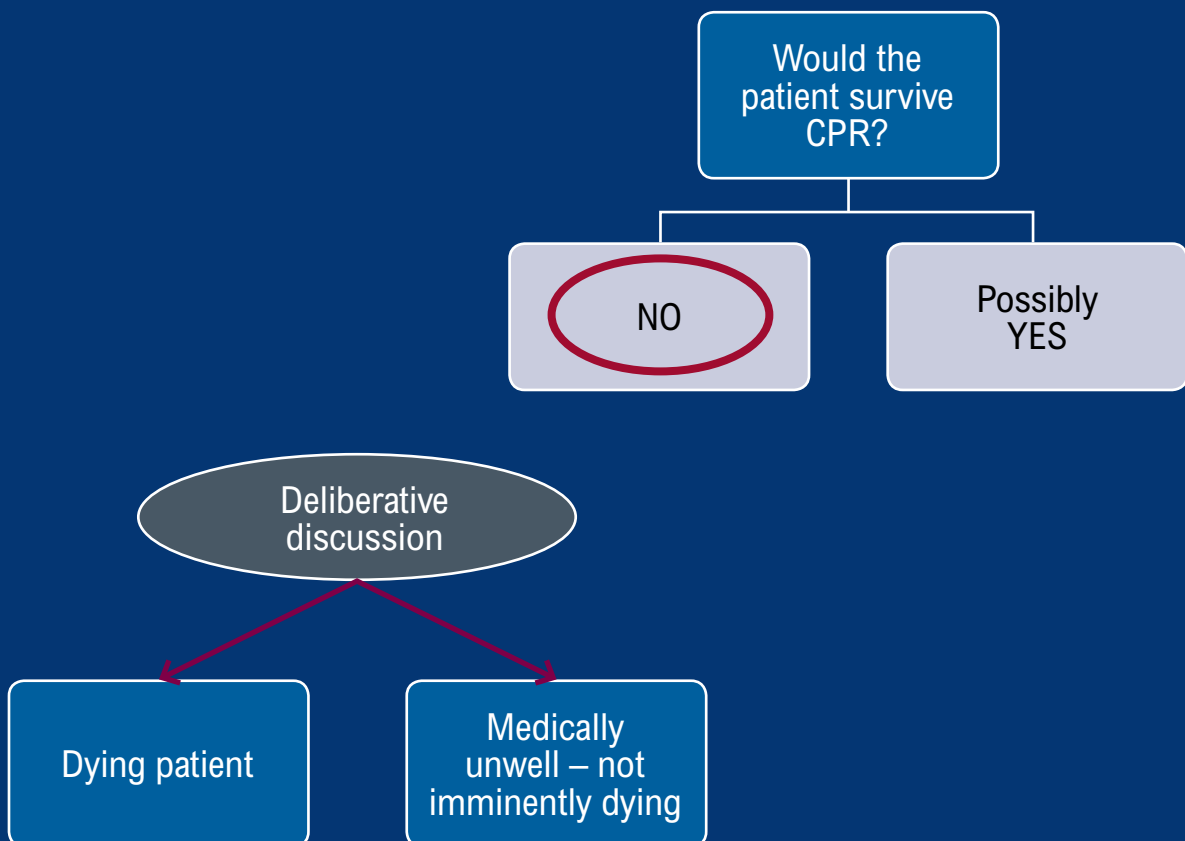
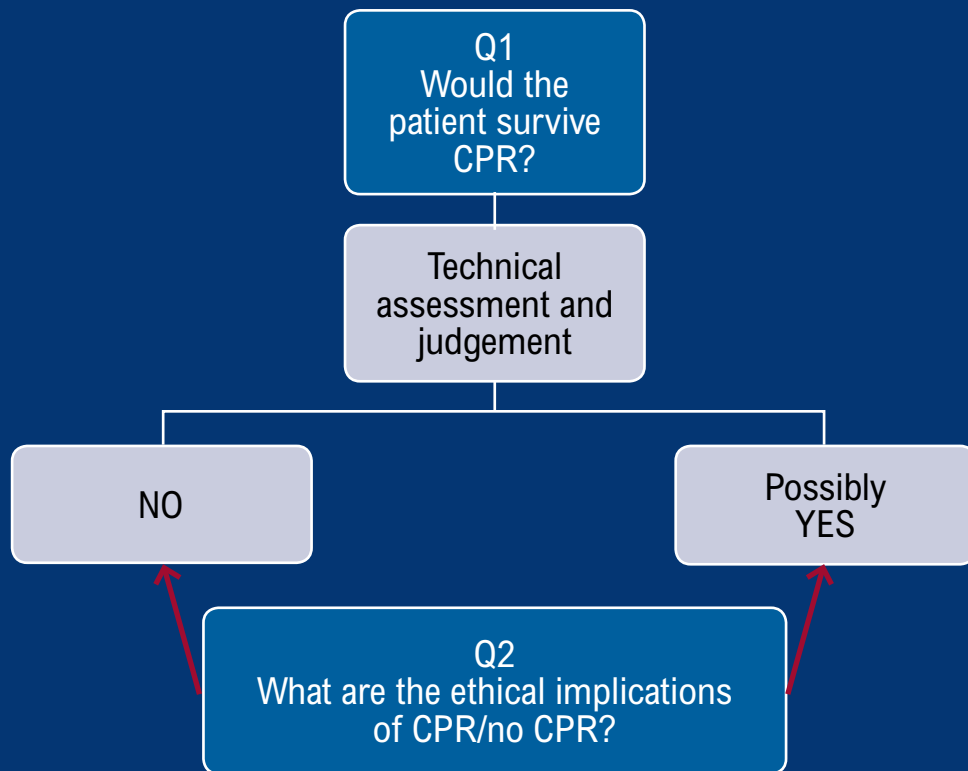
*Note: To access this article, you will need to click on the Download PDF link at the top right hand side of the list of Article – Contents. It takes time to download the 22 pages and large graphic.*

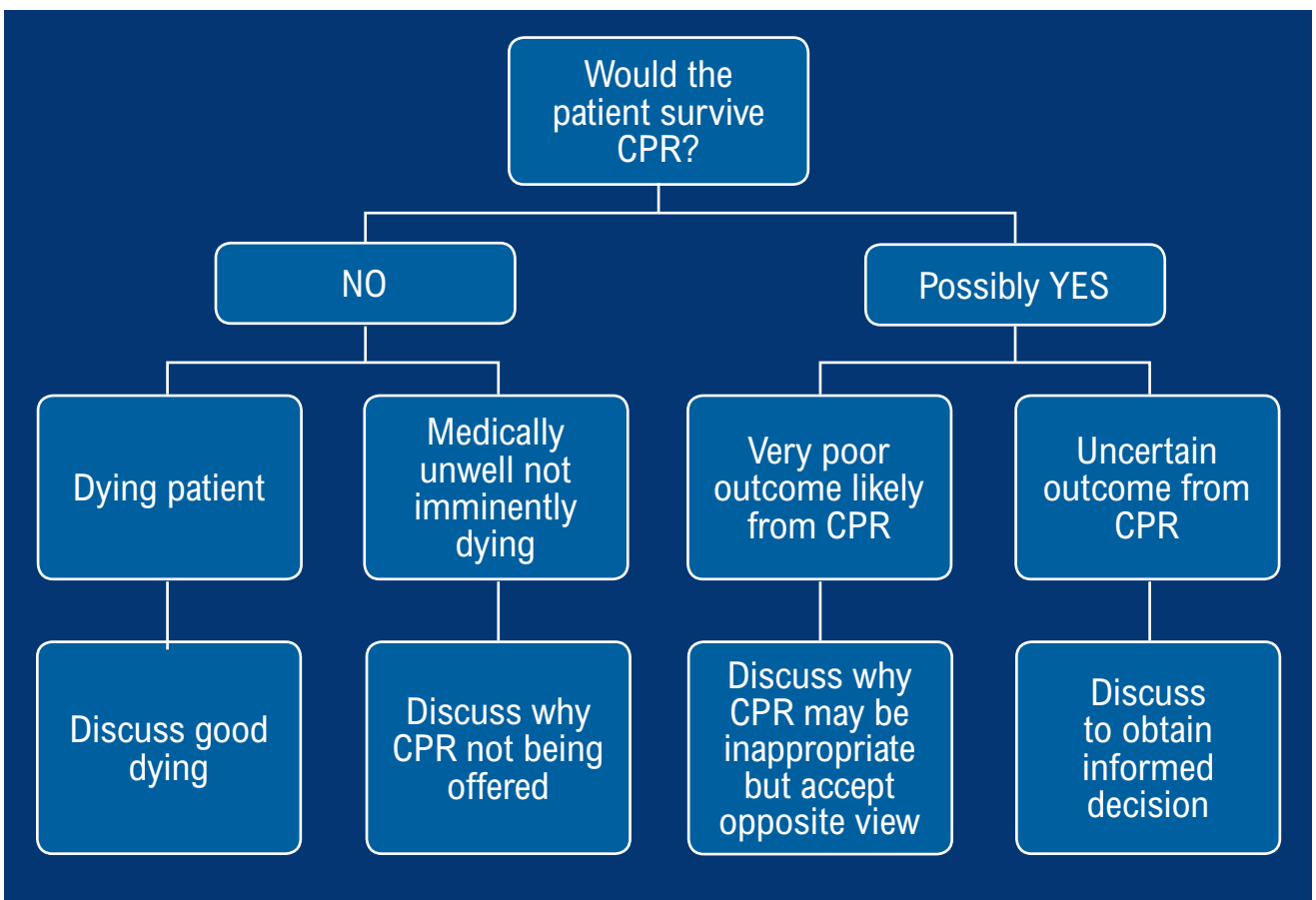
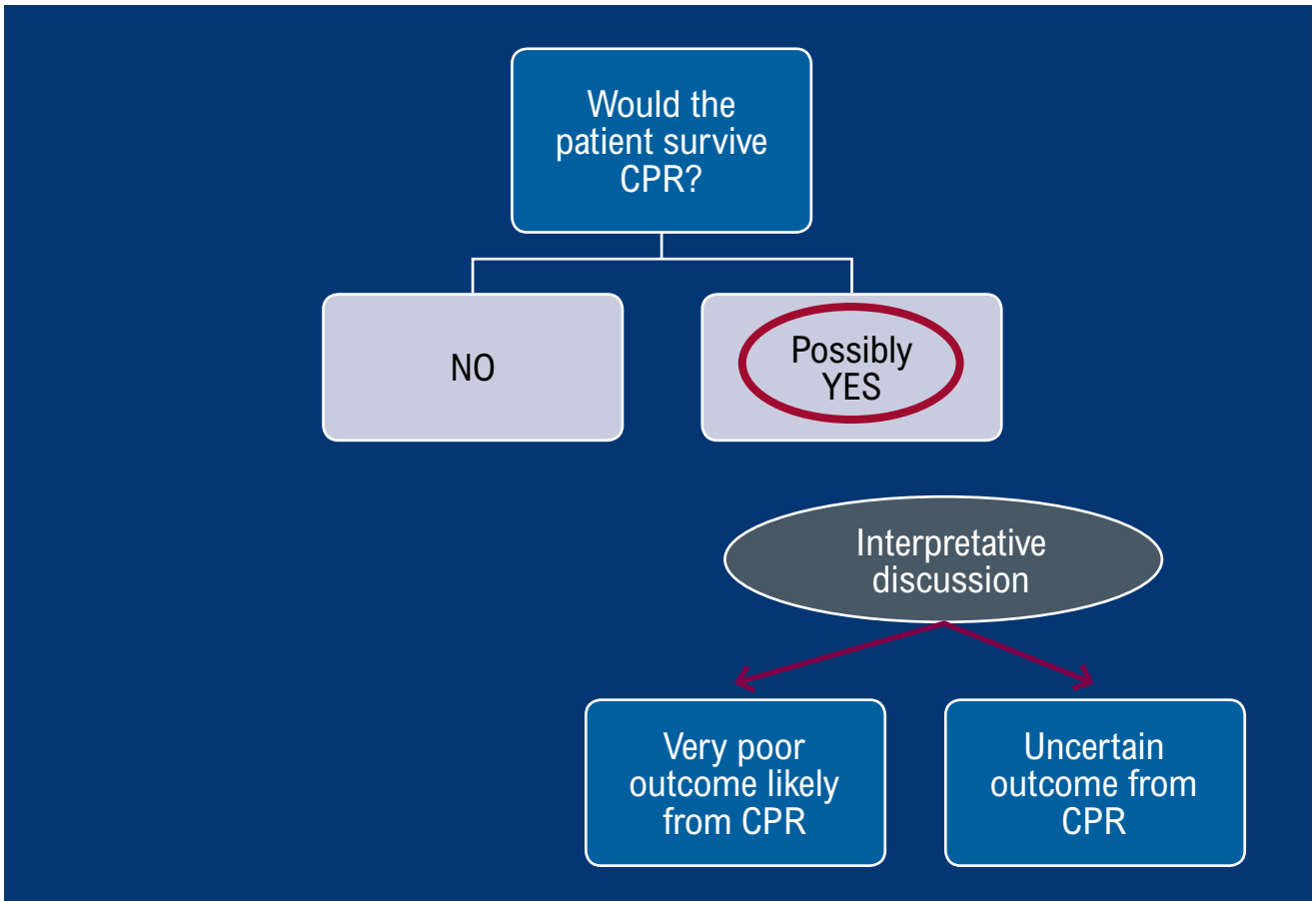
2. Boyd K, Murray SA. Spotlight: Palliative care beyond cancer recognising and managing key transitions in end of life care. BMJ [Internet]. 2010 Sep 16 [Cited 2015 June 8];341. ARTN c4863. Available from: <http://www.bmj.com/content/341/bmj.c4863>



# Appendix 1: Decision-making framework slides

# CPR decisions are both technical and moral





Source: B Hayes PhD 2011 ©



# Appendix 2: Treated cardiac arrest survival rates

# Treated cardiac arrest survival

~ 100 per cent with coronary angiography (elective)

~ 60 per cent for VF in CCU after myocardial infarct

~ 18 per cent for general hospital patients\*

< 5 per cent for advanced illness – cancer, dementia etc.

\* ~ 30–50 per cent of these survivors will have further impairment

Examples to illustrate the wide range of survival outcomes of CPR treated cardiac arrest. Reported survival outcomes also vary considerably between studies. This may, in part, relate to who is excluded from receiving CPR. It will be important to be aware of CPR outcomes in your own setting.

# Appendix 3: Two questions

## Two questions to ask when discussing a patient's future clinical care

1. If you were so unwell that you could not talk about your treatment with your doctor, is there someone you would want to speak for you?
2. Have you discussed this with that person?



# Appendix 4: Recommended language for communicating end-of-life concepts

Poor statement	Possible interpretation by family	Better statement
<i>Do you want us to do everything?</i>	Do you care whether they live or die?  Do you want us to try?	<i>We want to work out what is the right thing to do.</i>
<i>What do you want us to do?</i>	It is the family's responsibility to decide medical treatment – not the patient or doctor.	<i>What would he or she want?</i> OR <i>What do you think he would want us to do?</i>
<i>We need your permission or consent to stop.</i>	The family have total control of decision-making.	<i>I would like to discuss with you whether it is appropriate to keep on...</i>
<i>There is nothing more we can do.</i>  <i>We are withdrawing treatment.</i>	Abandonment.	<i>We will do everything we can to ensure his or her last days are as comfortable and dignified as possible.</i>
<i>We are going to withdraw care.</i>	The medical staff do not care.	<i>We are recommending making comfort a priority and to stop doing unpleasant things that are not helping.</i> OR <i>We are recommending continuing good care while stopping treatments that are distressing and not helpful.</i>
<i>Futile treatment</i>	Your relative's life is futile/worthless.	<i>Overly burdensome or ineffective treatment.</i> OR <i>Treatment that is ineffective and distressing.</i> OR <i>Treatment that is worse than the disease itself.</i>

Poor statement	Possible interpretation by family	Better statement
<i>We can't be certain...</i>	Things are too uncertain for important decision-making.	<i>We are as certain as we can be.</i> OR <i>There are some things that we can't be sure about but other things that are very clear. (i.e. focus on the most certain facts rather than on the least certain).</i>
<i>The medical team have decided...</i>	The family and their views do not matter at all.	<i>We are becoming concerned that the burden of continuing this sort of treatment outweighs the benefit. I am afraid the treatment is not working.</i>
<i>We could do this or this or that... (the 'shopping list').</i>	The family have the power and responsibility to decide. Continued treatment is being offered and advocated by the doctor.	<i>There are lots of treatments that we could do but it is important for us to discuss what we should do.</i> OR <i>We could theoretically do a number of things but I should like to discuss what we should actually do.</i>
<i>Terminal care.</i> OR <i>Comfort care.</i>	Clichés that obscure meaning.	<i>Reset our focus to ensure his or her end is as comfortable and dignified as we can make it.</i> OR <i>Reconsider our goals to make comfort the priority.</i>
<i>There is a lot of misinformation on the internet.</i>	Family efforts to get information are being derided.	<i>Can you show me what you have found so we can discuss it?</i>
<i>This is not euthanasia.</i>	He is talking about euthanasia and using a controversial, highly emotional, weighted word.	<i>Permitting to die (with a specific explanation of what is proposed).</i>

Reproduced with permission from the Australian and New Zealand Intensive Care Society, 2014 (extract from Table 5.1: Recommended language for communicating end-of-life concepts).



# Appendix 5: Discussing end-of-life care preferences: tools for communication

# Discussing End of Life Care Preferences

Tools for Communication

Dr Derek Eng

April 2015

## Key skills

- Exploring the patient's concerns about their end of life preferences/care – (their agenda)
- Raising your concerns – (your agenda)
- Responding to emotional cues – the NURSE acronym

## Exploring the patient's concerns about their end of life preferences/care: key skills

- Ask-Tell-Ask AND Tell me more... :
  - Explore their hopes and fears/concerns
  - Clarify their goals and expectations **before** any decision making discussion
- Capitalise on *opportunities to align* their goals with ours:
  - “It sounds like you are fed up with hospitals, perhaps when this happens again, we can have the care come to you at home...”

## Exploring the patient's concerns about their end of life preferences/care: key skills

- **If the patient does not want to discuss the future** you could try these skills:
  - A hypothetical situation
    - “I know that you're a very positive person and things will probably go well this time around. If things don't go so smoothly, we would like to know your thoughts?”
  - Hoping for the best, preparing for the rest
    - ‘What are you hoping for at the moment? Would it be okay to talk about your concerns for the future in case things don't go as well as we hope?’
  - An ‘I wish’ statement
    - ‘I wish I could guarantee that the antibiotics will work every time. What would be important to you if things were clearly getting worse?’

## Raising your concerns

- Catastrophic events at the end of life (e.g. major bleed, airways obstruction, cardiac arrest) need to be discussed with patient and with family carers.
- Not for CPR and MET call
  - Reassure that appropriate medical care WILL continue (eg. IVAB's, IV Fluids etc)
  - Make a recommendation based on best evidence

## Responding to emotional cues

**N: Name it:** "...it sounds like you've been worried about what's going on..."

**U: Understand the core message:** "...if I understand you correctly, you are worried about what to say to your family and how they will react..."

**R: Respect /Reassurance at the right time:** "...I'm really impressed that you've continued to be independent ...".

**S: Support:** "... would you like me to talk to your family about this..."

**E: Explore:** "... I notice that you're upset, can you tell me what you're thinking?"

❖Back, Arnold, Tulsky – Mastering Communication with Seriously Ill Patients



## Remember:

- Respect the patient by listening to their concerns in a non-judgmental way
- Acknowledge patient's emotions and allow this to settle before trying to give information
- You are the medical expert - make a recommendation based on best evidence
- Experiential workshops are the best way to learn and practice the communication skills.



Appendix 6:  
Needs analysis and  
proposed behaviour changes  
for improving routine advance  
CPR decision-making  
in hospitals

## Appendix 6: Needs Analysis and proposed behaviour changes for improving routine advance CPR decision-making in hospitals

Before developing this teaching resource, a Needs Analysis was undertaken to evaluate issues associated with advance CPR decision-making in the hospital setting. This included: (i) reviewing the current literature; (ii) focus groups with junior medical staff; and (iii) focus groups with senior medical staff.

A range of themes were identified from both the literature and the focus groups. These have been grouped together under three major themes:

1. Knowing what to say
2. Knowing how to say it
3. Wanting to say it.

In the following table, columns 1 and 2 list the themes related to CPR decision-making barriers; column 3 lists the source/s for that theme; and column 4 lists recommended interventions, which have been incorporated into this educational video resource.

Themes	Description	Source*	Video education
<b>(i) Knowing what to say</b>			
Lack of knowledge	<p>Uncertain how to medically assess and predict prognosis from CPR:</p> <ul style="list-style-type: none"> <li>• variable experience of CPR outcomes</li> <li>• wanting a predictive tool</li> </ul> <p>Poor understanding of difference between active and palliative management. (Weil et al. 2015)</p>	LI, JFG, SFG	<p>Guidance for assessing medically, including statistics, uncertainty and how CPR decision relates to overall treatment plan.</p> <p>Promotes palliative care as an active treatment option.</p>
Lack of skill/expertise	<p>Difficulty predicting patient's likely illness trajectory.</p> <p>Juniors use intuition to assess prognosis (Becerra, Hurst et al. 2011)</p> <p>Significant variation in CPR decision-making approach being modelled by Consultants.</p>	LI, JFG, SFG	<p>Patterns of illness trajectories described.</p> <p>Frailty and lack of physical reserve discussed as poor prognostic indicators for CPR.</p> <p>'Surprise question' and tools for assessing frailty discussed.</p>
Lack of evidence/guidelines for CPR outcomes	<p>Guidelines only address technical aspects of providing CPR. (Brindley and Beed. 2014)</p> <p>Difficulty relating theory to individual patient.</p>	LI, SFG	<p>Explains gaps in research evidence for who should receive CPR.</p> <p>Importance of shared decision-making.</p>

Themes	Description	Source*	Video education
<b>(ii) Knowing how to say it</b>			
Lack of knowledge	Range of views about role of family and patient in CPR decision.	LI, JFG, SFG	CPR decision-making framework supports routine involvement of patient/family.
Lack of confidence in ability to discuss CPR	<p>Patients have falsely high expectations of CPR.</p> <p>Patient and family may have different desire for CPR.</p> <p>Concerns about upsetting patients.</p> <p>Juniors experience discomfort or embarrassment with these discussions. (Becerra, Hurst et al. 2011; Hurst, Becerra et al. 2013)</p> <p>Poor training for decision-making and communication. (Deep, Green et al. 2007; Siddiqui and Holley. 2011)</p>	LI, JFG, SFG	<p>Good communication is promoted as cornerstone of quality medical care.</p> <ul style="list-style-type: none"> <li>introduces communication tool, 'Ask-Tell-Ask'</li> <li>importance of acknowledging emotions is discussed using 'NURSE' tool.</li> </ul>
Lack of role modelling and peer guidance	Described lack of modelling and mentoring by Consultants.	LI, JFG, SFG	<p>'Goals of patient care' form and process is discussed:</p> <ul style="list-style-type: none"> <li>requires Consultant leadership to promote CPR decision-making as routine part of an overall treatment plan</li> <li>includes scripted questions.</li> </ul>

Appendix 6: Needs Analysis and proposed behaviour changes for improving routine advance CPR decision-making in hospitals

Themes	Description	Source*	Video education
<b>(iii) Wanting to say it</b>			
Awareness	<p>Clinicians under-estimate patients willingness to engage in these discussions. (Hurst, Becerra et al. 2013; Elo, Dioszeghy et al. 2005)</p> <p>Families can be unaware of terminal status of patient. (Hilden, Louhiala et al. 2004)</p>	LI	<p>Promotes ownership of decision-making by all doctors.</p> <p>Repeated conversations may be required.</p>
Authority for decision-making	<p>Juniors feel they don't have decision-making authority and feel frustrated when decisions are not made.</p> <p>Seniors feel frustrated by inaction of others in making decisions.</p> <p>Fear of complaint. (Myint, Miles et al. 2006)</p>	LI, JFG, SFG	Promotes local consensus approach and shared responsibility for decision as part of routine hospital care.
Maturity of practice	<p>Junior staff may lack experience to make decisions</p> <p>Poor insight into sub-optimal communication. (Deep, Griffith et al. 2008)</p>	LI	<p>Role delineation, mentoring and support.</p> <p>Decision-making needs to be overt.</p> <p>Involve whole team in decisions.</p>
Resources	<p>Time pressures to complete rounds.</p> <p>Inadequate time to establish rapport with patients and to co-ordinate family meetings.</p>	SFG	Shared responsibility across system, depending on patient's health needs.
The system	<p>Policies not reflecting contemporary practice.</p> <p>Potential for worse care with NFR decision. (Cohn, Fritz et al. 2013)</p>	LI	<p>Need for local consensus approach to decision-making.</p> <p>Emphasises that CPR decisions are part of an overall management plan.</p> <p>Audit and feedback on performance.</p>

\*JFG = Junior doctor focus group; SFG = Senior doctor focus group; LI = Literature

# Appendix 7: Supplementary resources

## Supplementary resources

The supplementary resources listed below are provided for your interest:

Alfred Health. Palliative care education and training modules for medical professionals (doctors only) [Internet]. Melbourne: Victoria; c2007 [cited 2014 Nov 7]. Available from: <http://www.alfredhealth.org.au/pallcaremodules/>

Arnold R. [Internet]. [Video], Ask, tell, ask (physicians). Pittsburgh: University of Pittsburgh Medical Centre; 2013 Nov 19 [cited 2014 Nov 7]; [4 min., 03 sec]. Available from: <https://www.youtube.com/watch?v=Bwq0qAFRct8>

Arnold R. [Internet]. [Video], Ask, tell, ask. Pittsburgh: University of Pittsburgh Medical Centre; 2013 Nov 19 [cited 2014 Nov 7]; [3 min., 23 sec]. Available from: <https://www.youtube.com/watch?v=-vd2daCOPJA>

Arnold R. [Internet]. [Video], Naming emotions (physicians). Pittsburgh: University of Pittsburgh Medical Centre; 2013 Nov 19 [cited 2014 Nov 7]; [2 min., 31 sec]. Available from: <https://www.youtube.com/watch?v=-PYmEaVme1Q>

Arnold R. [Internet]. [Video], Surrogate decision makers (physicians). Pittsburgh: University of Pittsburgh Medical Centre; 2013 Nov 19 [cited 2014 Nov 7]; [1 min., 54 sec]. Available from: <https://www.youtube.com/watch?v=IwjtpONoo3c>

Northern Health. Advance care planning [Internet]. Melbourne: Northern Health. c2014 [cited 2014 Nov 7]. Available from: <http://www.nh.org.au/services/advance-care-planning>

Parker C. [Internet]. Ethical CPR decisions [place unknown]: Emergency Medicine and Paediatric Emergency Medication Webucation;. 2014 Jun 9 [cited 2014 Nov 7]. Available from: <http://empem.org/2014/06/ethical-cpr-decisions/>

Prof Joe. [Internet]. [Video], Discussion – to resuscitate or not? Melbourne: Alfred Health; c2014 [reviewed 2014 Nov 7]. c2014 [cited 2014 Nov 7]; [9 min., 10 sec]. Available from: <http://www.profjoe.com.au/all-cases-list/to-resuscitate-or-not/>

Workman, S, writer. Int J Clin Prac [Internet]. [Video], Accompaniment to Never say die? – as treatments fail doctors' words must not [Internet]. 2011 Mar 3 [cited 2014 Nov 7]; [3 min., 34 sec]. Available from: <http://www.youtube.com/watch?v=rifTBDgAzzg>

*Video example of a good discussion based on the paper published by Stephen Workman in International Journal of Clinical Practice 'Never say die? – as treatments fail doctors' words must not'.*

Workman SR, writer. Int J Clin Prac [Internet]. [Video], Never say die? – as treatments fail doctors' words must not. 2011 Jan 17 [cited 2014 Nov 7]; [3 min., 37 sec]. Available from: <http://www.youtube.com/watch?v=BdXwex3FzHY>

*Video example of a bad discussion based on the paper published by Stephen Workman in International Journal of Clinical Practice 'Never say die? – as treatments fail doctors' words must not'.*

Victoria and Tasmania Dementia Training Study Centre. [Internet]. Limitation of care orders: making an informed choice. Melbourne: Vic/Tas DTSC 2015 [cited 2015 June 8]. Available from: <http://web.dtsc.com.au/limitation-of-care-orders-making-an-informed-choice/>  
Jointly published by the Tasmania Dementia Training Study Centre (TAS DTSC).

*Note: Includes a link to video developed by Prof Joe Ibrahim.*



# Appendix 8: Contributors to the consultation process and video production

## Appendix 8: Contributors to the consultation process and video production

The Palliative Care Program, Department of Health, would like to thank the following people who were involved in the consultation process and video production:

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This document can be made available in alternative formats on request for a person with a disability.

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