



Queensland Government

(Affix patient identification label here)

ACUTE RESUSCITATION PLAN

Facility: _____
Date: ____/____/____

URN: _____
Family name: _____
Given names: _____
Date of birth: _____ Sex: M F

Good medical practice should guide clinical assessment and the treatment options discussed with the patient (or other person—see below). If unsure, consult with a senior medical officer or consultant.

If there is insufficient room on this form to record information, please record further details in the progress notes and cross-reference

1. Clinical assessment

Include details/assessment of **relevant medical conditions**, mental health assessment (if required), details of discussion with patient and/or substitute decision-maker (see Sections 4 and 5) about relevant health care plans and resuscitation management

2. Capacity assessment

- I believe that the patient **has capacity*** to consent to and/or refuse medical treatment
 - I believe that the patient **does not have capacity** to consent to and/or refuse medical treatment
- If the patient regains capacity, this form must be voided and a new *Acute Resuscitation Plan* must be completed

Details of assessment:

*A patient with capacity can understand information about their illness and treatment options, weigh up the benefits, risks and burdens of each choice and freely and voluntarily make and communicate a decision. A patient with capacity may refuse treatment (see the section *Legal Considerations* in the quick guide). **If unsure about the patient's capacity, seek a second opinion and/or arrange a mental health assessment, if necessary.**

3. Resuscitation management plan

In the event of an acute deterioration, it is clinically indicated to:

Provide eg. intubation, IV fluids, supportive therapies

Not provide eg. defibrillation, intubation

There is further documentation in the progress notes on the following dates: _____

In the event of a cardiac or respiratory arrest, it is clinically appropriate to:

CPR

Provide
 Do not provide

A decision not to provide CPR does not limit other treatment

If the resuscitation management plan differs from the choices of the patient/substitute decision-maker regarding future medical treatment, details must be recorded in either the progress notes or on this form and, where possible, a second opinion obtained.

Form continues over page

Perforate / Fold

General

- The ARP form applies to adult patients only.
- The ARP replaces not for resuscitation (NFR) orders and its purpose is to improve documentation of resuscitation planning.
- This form should be completed where it can be reasonably expected that an adult patient might suffer an acute event in hospital in the foreseeable future necessitating the process of resuscitation planning.
- If changes are required to the form, it must be voided and a new ARP form completed. To void a form, draw two lines diagonally across the front page, write "VOID" between the lines and sign and date this annotation. The voided form should be retained on the patient file.
- The ARP form applies to the emergent resuscitation of the patient with cardiac or respiratory arrest. If the patient is successfully resuscitated, the patient's condition should be re-evaluated to determine a management plan consistent with good medical practice. Ongoing organ support may or may not be indicated, depending on the cause for the deterioration and the patient's clinical status.
- Completion of an ARP form, particularly where CPR and other medical treatment are indicated, is not a commitment, nor prerequisite, to admit a patient to an intensive care or critical care unit.

Legal considerations

- An ARP form is a clinical record and does not provide legal consent to withhold or withdraw life-sustaining measures.
- An ARP form is different from a patient's Advance Health Directive (AHD). An AHD is a legal document formalising the patient's choices for end of life care. An AHD is only triggered when the patient lacks capacity for decision-making.

Patients with capacity

- Where a patient has capacity to make health care decisions, the patient's consent must be obtained to withhold or withdraw life-sustaining measures. Consent must be recorded in the progress notes.
- A patient with capacity is entitled to refuse any or all medical treatments, even if this results in their death. The authorising medical officer should ensure that the patient has received adequate information about the nature of the proposed medical treatment.

Patients with impaired capacity

- Queensland's legislation refers to 'good medical practice' as something that must underscore all treatment decisions about withholding and/ or withdrawing medical treatment from adult patients who lack capacity.
- In meeting the standards of good medical practice, medical officers are under no obligation to initiate treatments known to be ineffective, nor to continue treatments that have become ineffective. Good medical practice also involves ethical considerations.
- Medical treatment should never be withheld merely on the grounds that it is easier to withhold treatment than to withdraw treatment which has been initiated.
- Consenting details for a patient must be documented on this form, and in the progress notes. Meticulous documentation of the decision-making pathway regarding withholding and withdrawing of life-sustaining measures is required by law.
- Blood transfusions do not qualify under the legislation as a "life-sustaining measure", therefore consent is always required.
- Consent must always be obtained to withhold or withdraw artificial hydration and/or nutrition, even in acute emergency situations.

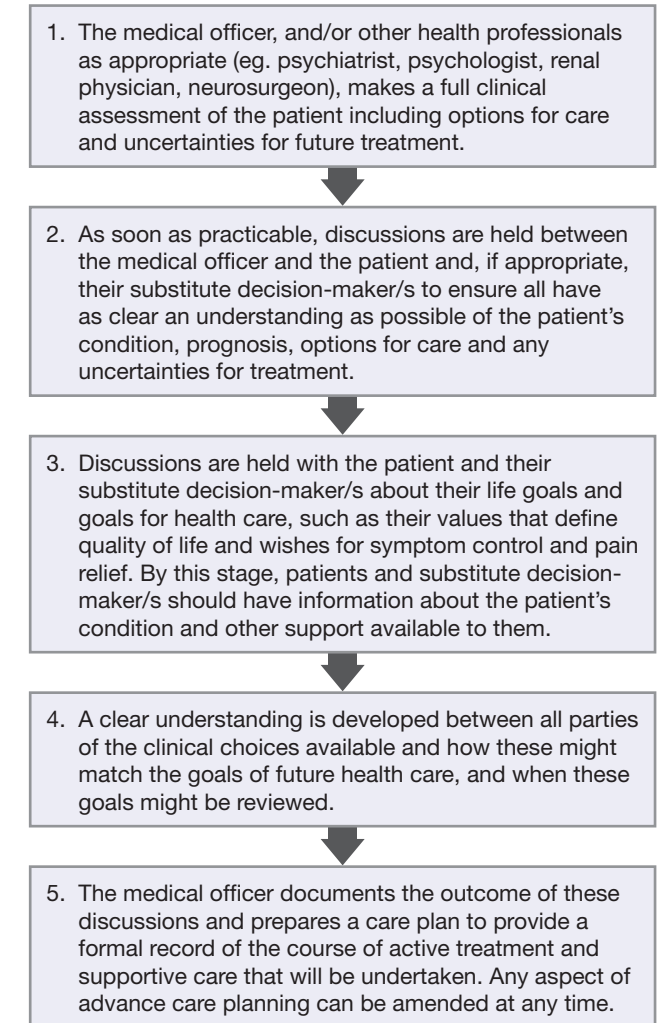
Emergency situations

- Emergency situations are characterised by the need for urgent decisions to maintain the life and health of a patient.
- In providing life-sustaining medical treatment to a patient without capacity, the legislation recognises that it is not always practical to obtain consent in urgent health care situations.
- While all reasonable efforts to obtain consent should be made, in some emergency situations it may be inappropriate to continue to maintain life while attempts are made to obtain consent to withhold or withdraw treatment.
- In acute emergency situations, consent is generally not required to withhold or withdraw life-sustaining medical treatment (with the exception of artificial hydration and/or nutrition).
- Life-sustaining medical treatment may not be withheld or withdrawn without consent, even in an acute emergency, if the medical officer knows the patient has objected to the withholding or withdrawal of treatment (that is, the patient directed the medical officer to prolong their life before losing capacity).

Communicating with patients

- Completing an ARP is only one aspect of the advance care planning process.
- People facing end of life decisions have a right to be informed of their available treatment options and to have their views and wishes for care respected, including choices for resuscitation.
- Open, honest and frank communication with the patient and their family about end of life choices is vital when a patient is diagnosed with a life-threatening illness or condition.

The following five steps provide a broad outline of the communication process for advance care planning for a patient approaching the end of life:



For advice, contact Office of the Adult Guardian:

Phone: 1300 QLD OAG (753 624)
Email: adult.guardian@justice.qld.gov.au

Other resources, contact Clinical Policy Unit:

Email: clinicalpolicy@health.qld.gov.au
Intranet: qheps.health.qld.gov.au/policybranch/html/ethicsteam.htm

DO NOT WRITE IN THIS BINDING MARGIN

ACUTE RESUSCITATION PLAN



SW065 - v1.00 - 02/2010

Quick guide to completing an Acute Resuscitation Plan (ARP)

Remove these instructions before filing this form. It is recommended that the form be filed at the front of the chart, but individual facilities can decide on the most prominent place to file the form.

Section 1. Clinical assessment

- Note the medical conditions relevant to the resuscitation management plan and emergency treatment plan, summarise your clinical assessment relevant to resuscitation planning, and note any discussion/s with the patient and/or family or substitute decision-maker/s about the patient's medical status.

Section 2. Capacity assessment

- If the patient has capacity, it is not necessary to document the "Details of assessment"; however, there may be circumstances where it is appropriate.

Section 3. Resuscitation management plan

- Record the treatment that you recommend should, and should not be, provided to the patient. If the decision is to not provide CPR, this section is intended to clarify which other treatments are to be provided.

Section 4. Patient choices

- This section is to record the patient's choices about end of life care, including the patient's wishes and views regarding resuscitation.
- A patient with capacity is entitled to refuse medical treatment, even if their decision is inconsistent with good medical practice and will result in their death.
- A patient may have already completed an Advance Health Directive (AHD). The authorising medical officer will need to resolve with the patient and/or their substitute decision-maker/s any conflict between a valid AHD and the patient's stated choices.
- Where a patient's choices differ from the resuscitation management plan, this could represent a recognised objection under the statutory regime for withholding and withdrawing medical treatment, even in an acute emergency. Utmost caution should be exercised in these situations.

When patient choices differ from the medical officer's assessment and/or resuscitation management plan

- Medical officers are not obliged to offer or provide medical treatment to a dying patient that confers no benefit and would be considered futile.
- If the patient and/or their family request choices for treatment that differ from the medical officer's assessment and do not meet the standards of good medical practice, medical officers must make all efforts (including involvement of counsellors if this is appropriate) to inform the patient and/or their family of the risks involved. Involvement of all members of the health care team is recommended in these situations. The medical officer may also seek a second opinion from and/or involvement of an experienced clinician.
- If all of these negotiation efforts are unsuccessful, the medical officer must refer the matter to the hospital administration.
- For a patient who lacks capacity, if the medical officer believes the substitute decision-maker/s is not adhering to the Health Care Principle*, the matter can be referred to the Adult Guardian at any stage.
- In these circumstances, it is vital that clear and detailed documentation occurs at all stages of all discussions held.

*Further information can be found in Schedule 1, *Guardianship and Administration Act 2000* and in the *Implementation Guideline - End of Life Care: Decision-Making for Withholding and Withdrawing Life-Sustaining Measures from Adult Patients*.

Section 5. Consent requirements

- Consent can be verbal, however it is good practice to document details in the progress notes. Where a patient lacks capacity, this is a legal requirement.
- Because this form is a clinical record, there is no requirement for the patient and/or their substitute decision-maker/s to sign the ARP or a copy of the ARP.
- Under the law, all patients who lack capacity have a substitute decision-maker. If there is no appointed guardian, attorney or statutory health attorney, the Adult Guardian must be contacted to represent the patient's best interests.
- A patient may have more than one substitute decision maker. Ideally, consent should be obtained from the patient or their substitute decision-maker/s at the time of an acute deterioration. If consent is obtained earlier, at the time of an acute deterioration the medical officer must ensure that the patient or their substitute decision-maker/s continue to understand what they have consented to. This is to ensure that the ARP form remains valid.
- If relevant, cross-reference the dated progress notes about the process of obtaining consent.

Section 6. Clinicians

- Where possible, the most senior medical officer available should sign and/or authorise the ARP form. This is particularly relevant where patient choices differ with the decision of the medical officer about CPR and future medical treatment.
- While junior medical officers should be encouraged to be involved in resuscitation planning with patients, it is not recommended that junior medical officers authorise an ARP. It is highly recommended that junior medical officers seek advice from the most senior medical officer/consultant available before signing an ARP form.
- Other clinicians may also be involved in clinical assessments of the patient, such as GPs, allied health and nursing professionals. For example it may be appropriate to contact the patient's GP when completing an ARP.

Section 7. This plan remains valid

- This section allows for review of the form, and indicates whether changes are required. If changes are required, the form should be voided (see "General" instructions over the page).
- The options allow for circumstances where the patient's resuscitation plan needs to be regularly reviewed. Some patients will have:
 - > one ARP for their admission;
 - > several ARPs completed over their admission; or
 - > an ARP remaining valid across multiple admissions.
- For patients with chronic illnesses, revisiting resuscitation planning on each admission may be unduly distressing or inappropriate.

Patient transfers and copies

- The original ARP must be retained on the patient's records.
- If a patient with an active ARP (that is, it is valid for subsequent admissions or until a future review date) is being transferred to another facility, a copy of the ARP should be accompanied by an ARP Cover Sheet.
- Facilities other than those managed by Queensland Health are responsible for following their own processes and procedures for documenting or acting on resuscitation planning decisions. This includes the Queensland Ambulance Service while the patient is in transit.
- It is recommended that the patient's GP receive a copy of the patient's ARP for their records, even if the ARP is voided.

| | | |
|--------------|--------------|------|
| Family Name: | Given names: | URN: |
|--------------|--------------|------|

4. Patient choices

The patient/substitute decision-maker expressed the following views and wishes about their end of life care: (eg. CPR, pain management, living arrangements, visiting arrangements, spiritual support)

Date of discussion:

Time:

5. Consent requirements

If the patient does not have capacity, consent is required from one of the following in order of priority:

Advance Health Directive (AHD)? Yes No

Tribunal-appointed Guardian? Yes No

Attorney under Enduring Power of Attorney or AHD? Yes No

Statutory Health Attorney*? Yes No

If no to all, the Adult Guardian must be contacted for consent to withhold or withdraw life-sustaining measures should the patient not have or lose capacity:

Phone: 1300 QLD OAG (753 624)
Email: adult.guardian@justice.qld.gov.au

Has consent been discussed with the patient and/or their substitute decision-maker?

Yes No

Date of discussion: Time:

Name of substitute decision-maker / details of discussion:

*A **statutory health attorney** is, in the following order: a spouse (including de facto and same sex partners) in a continuing relationship; an adult who has care of the person (not a paid carer); an adult who is a close friend or relation (not a paid carer). (s. 63 Powers of Attorney Act 1998)

6. Clinicians

Medical officer's name*:

Dr

Medical officer's signature:

Date:

Authorising medical officer's name*: (if applicable)

I have read and understood the instructions in the quick guide

Other clinicians (eg. GPs, allied health and nursing professionals) involved in assessing patient at this hospital or other facility: (if applicable)

*If required, the authorising medical officer will be a more experienced or senior medical officer/consultant and must be involved in all decisions to withhold/withdraw medical treatment.

7. This plan remains valid:

For this admission only Until review date: For this and subsequent admissions

Date reviewed: **Reviewer's signature:** **Discharging ward phone number:**

Has the patient's GP (or other relevant health care providers, eg. residential aged care facility) been notified or provided with a copy of this ARP? Yes No

Details:

If changes are required, this form must be voided and a new Acute Resuscitation Plan must be completed.

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