Queensland Government

Acute Resuscitation Plan (ARP)

For adults at risk of acute deterioration

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Clinical assessment and appropriate treatment options should be guided by good medical practice, which includes discussions with the patient and/or their substitute decision-maker(s).

- This ARP form has been developed as a clinical support tool for use in 'public sector health services' and 'public sector health facilities' as defined by Hospital and Health Boards Act 2011 (Qld). This ARP form includes references to legal considerations, policies, indemnities, procedures and conditions of use which may apply only to usage in 'public sector health services' and 'public sector health facilities'. For usage in other services and facilities, these considerations may not apply and/or other considerations may apply, for which independent legal advice or other professional advice is recommended. **While usage of the ARP form by other services and facilities is authorised by Queensland Health, it is the responsibility of medical practitioners and other health professionals completing this ARP form or using a completed ARP form, without limitation, to independently and adequately satisfy themselves of all relevant matters to the standards applicable at law.** To the fullest extent permissible by law, Queensland Health excludes all warranties, representations and liability in relation to the use of this ARP form.
- **The Quick Guide attached to this form contains important information and should be read prior to completing the form.**
- If there is insufficient room on this form to record information, please cross-reference with the progress notes.

1. Clinical assessment

Record details/assessment of relevant medical conditions relating to the patient's physical and mental health. This section may include clinical reasons why resuscitation planning is necessary.

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 there is a change in capacity, this form must be reviewed.

Details of assessment:

*A patient with capacity can understand information about their medical treatment and treatment options, weigh up the benefits, risks and burdens of each choice and freely and voluntarily make and communicate a decision. Refer to QH Withholding and withdrawing life-sustaining measures clinical guidelines for further information.

3. Resuscitation management plan

If an acute deterioration or critical event occurs, it is clinically indicated to:

Provide e.g. ventilation, IV fluids, supportive therapies

Not **provide** e.g. defibrillation, intubation, antibiotics

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

If a cardiac or respiratory arrest occurs, it is clinically appropriate to:

CPR ☐ **Provide** ☐ **Do not provide**

A decision not to provide CPR does not limit other treatment or care

Acting on the *Resuscitation management plan:* if this section differs from section 4 (*Patient choices*), follow an appropriate dispute resolution process (see Quick Guide). If the dispute remains unresolved, or this section is incomplete or unclear when a resuscitation decision is required, attending clinicians should exercise their clinical judgement based on the circumstances, and document this.

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v6.00 - 11/2019
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ACUTE RESUSCITATION PLAN (ARP)

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General

- The ARP form replaces 'not for resuscitation' (NFR) orders. It documents resuscitation planning, where there is time to do so. An ARP form can remain active for a maximum of 12 months.
- ARPs have been designed for use in Queensland Health facilities and services, including hospitals, outpatient clinics and other public sector health services. ARPs can be completed by registered medical practitioners in any health setting (e.g. nursing homes, community residential care, outpatient clinics, GP practices or the patient's home). Queensland Health will not take responsibility for the use or consequences of the ARP in non-Queensland Health facilities and to the fullest extent permissible by law, Queensland Health excludes all warranties, representations and liability in relation to the use of this ARP form by non-Queensland Health facilities. Non-Queensland Health organisations can use this form but are subject to that service's policies and procedures.
- A properly completed ARP form documents patient consent to an overall treatment plan for acute deterioration. While the ARP is not a legal document, it provides medical authority for attending clinicians to act in emergency situations when the treating medical practitioner who signed the form is not available.
- An ARP form should be completed where it is reasonably expected that an adult patient (≥18) may experience an acute deterioration or critical event (e.g. cardiac or respiratory arrest) in the foreseeable future (e.g. within 12 months).
- For information on prognostic indicators, Queensland Health / Hospital and Health Service staff should refer to the *Advance Care Planning Quick Guide and Withholding and Withdrawing life-sustaining measures clinical guidelines.*
- It may be appropriate for some patients to have an 'active' ARP upon discharge from a Queensland Health facility (see: *Patient transfers*).
- The ARP form can only be authorised by a registered medical practitioner who takes responsibility for the form. Ideally ARP forms should be completed before acute deterioration, when the patient's capacity for decision-making enables them to actively participate.

Communicating with patients

- People approaching the end of life have a right to be informed of clinically appropriate and available treatment options and to have their views and wishes for care respected, including choices for resuscitation.
- A discussion of the overall treatment plan should include what can / cannot be provided within the limits of medicine; be open, honest and sensitive; appropriate to the patient's condition; and address consenting requirements.
- Repeating resuscitation planning on each admission may be unduly distressing and inappropriate. However, it is recommended that the ARP be reviewed if there are changes in capacity, health status or nature of intended health care or outcome.

Legal considerations

- The law requires a collaborative approach between health providers and patients and/or their substitute decision-maker(s) (SDM) about providing, withholding or withdrawing life-sustaining measures (LSM), and appropriate documentation of these decisions.
- There is a legal requirement to document the decision-making pathway around LSMs. Completing the ARP form prompts this approach.
- An ARP form is a clinical tool or medical order and does not in itself give consent to provide, withhold or withdraw LSMs. Legal authority comes from obtaining consent to the overall treatment plan. This should be documented.
- An ARP form is not the same as, nor does it replace, an Advance Health Directive (AHD).
- The law expects health providers to adhere to 'good medical practice' (GMP) standards. In meeting these standards, medical practitioners are under no legal or ethical obligation to offer, provide or continue treatments that on balance would have the potential to cause harm and offer no benefit to the patient (i.e. futile).
- GMP will also determine the best approach to obtaining consent. Consent ≠ contract 'offer and acceptance'. Consent = conversation about the patient's condition, prognosis, goals for care and overall treatment plan.
- In acute emergencies, consent is not generally required (see: *Patient objections*). Emergency situations are characterised by the need for an immediate decision about maintaining the life / health of a patient. However, "artificial" emergencies should not be created to avoid obtaining appropriate consent.
- Medical treatment should never be withheld merely on the grounds that it is easier to withhold treatment than to withdraw treatment which has been commenced.
- Legal protections and indemnity are provided to Queensland Health / Hospital and Health Service staff who comply with Queensland Health policy relating to LSMs. Staff from non-Queensland Health facilities and services should refer to their service's policies and procedures and seek legal advice where necessary.
- The law regarding consent for patients without capacity is contained in the *Powers of Attorney Act 1998 and the Guardianship and Administration Act 2000 (GAA).*

Capacity

- Under the law, all adult patients are presumed to have capacity for decision-making relating to their health care. The law differentiates between patients with capacity and without capacity when consenting to health care. However, patients with limited capacity should be supported to participate in decision-making about their treatment to the extent of their ability.
- A patient with capacity is entitled to refuse any or all medical treatment, even if this results in their death or would cause it to happen sooner. The treating medical practitioner should ensure the patient receives adequate information about the nature of the proposed treatment measures.
- A SDM must consider the patient's best interests including the patient's views and wishes, involve the patient to the extent they are able to express those views and wishes, and consider medical opinion when providing consent (see: Health Care Principle and General Principles, Schedule 1, GAA).

Patient objections

- The law recognises that a person can object to LSMs being provided, withheld or withdrawn. The relevant law is complex.
- An objection to a clinical decision to withhold/withdraw LSMs may be expressed by the patient as a verbal request to "do everything" or "don't let me die", or by their conduct, or in formal terms through an AHD.
- Queensland Health's policy position is that the patient's objection should be expressed directly to the treating medical practitioner as close as possible to the acute deterioration or event, rather than through hearsay or second hand (e.g. from a family member). Staff from non-Queensland Health facilities and services should refer to their service's policies and procedures and seek their own legal advice.
- An objection should be managed in accordance with the following, subject to the exercise of clinical judgement.

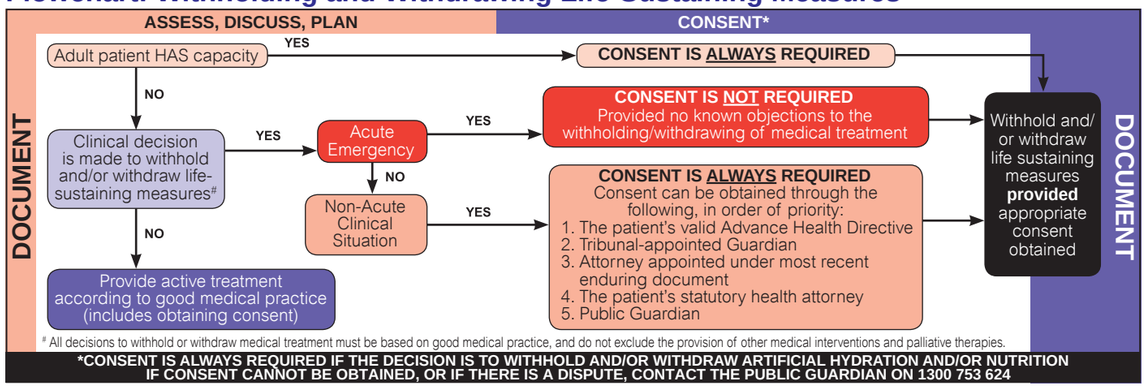
Effect of objection by patient to withholding or withdrawing life-sustaining measures

	Emergency	Non-emergency
Capacity	-Objection = demand for (potentially futile) treatment -Patient cannot demand clinically inappropriate treatment - Discuss with patient, if time permits - Consider trial of treatment if consistent with GMP - Provide treatment at discretion OR withhold/withdraw LSMs in best interests of patient	- Time to manage objection - Discuss with patient - Patient cannot demand clinically inappropriate treatment - Commence dispute resolution, including: second opinion, family conference, referral to facility executive/management
Impaired capacity	- Doctors cannot override patient's known objection. Need consent from SDM (legal position) - All reasonable efforts should be made to obtain consent from SDM - If consent cannot be obtained in time, or SDM demands clinically inappropriate treatment (futile), withhold / withdraw medical treatment if consistent with GMP (policy position)	- Time to manage objection - Objection can be over-ridden by doctors on grounds the patient: › has no/minimal understanding of what is involved; and › will suffer temporary or no distress - Need consent from SDM to withhold/ withdraw treatment - If SDM refuses consent or demands clinically inappropriate treatment, commence dispute resolution processes

DOCUMENT DECISION-MAKING PATHWAY (legal requirement)

(NB This includes Queensland Health legal and policy positions. Staff from non-Queensland Health facilities and services should refer to the service's policies and procedures and seek their own legal advice)

Flowchart: Withholding and Withdrawing Life-Sustaining Measures



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Quick guide to completing an Acute Resuscitation Plan (ARP)

Remove these instructions before filing this ARP form. It is recommended the original ARP form is filed prominently at the front of the patient's medical record. The Quick Guide should be read in conjunction with the *Acute Resuscitation Plan: Queensland Health Clinical Guidelines* at www.health.qld.gov.au/careatendoflife.

Section 1. Clinical assessment

- If there are doubts or uncertainties about the patient's medical condition, a second opinion should be obtained.
- This could include reasons why the patient is / is not suitable for an ARP.

Section 2. Capacity assessment

- If there are doubts or uncertainties about the patient's capacity for decision-making (e.g. fluctuating or episodic capacity), seek a second opinion and/or arrange a mental health assessment.

Section 3. Resuscitation management plan

- Record the treatment and care that should / should not be provided. Examples given on the ARP form are for illustration only and do not substitute for clinical judgement at the time decisions are required.
- Patients may still benefit from treatments and therapies that contribute to quality end of life care.
- If not clinically appropriate to provide CPR, clearly state any other treatments and care to be provided and if a MET call is appropriate.
- Completion of this section does not exclude the provision of other treatments which are not specifically mentioned (e.g. palliative therapies, management of pain, suffering and discomfort).

Section 4. Patient choices

- If a patient with capacity has strong views about their end of life care, encourage completion of an Advance Health Directive (AHD).
- A patient may have already completed an AHD. Any inconsistency between an active AHD and the patient's stated choices will need to be resolved with the patient and/or their potential SDM. If the patient does not have capacity, their active AHD takes precedence, but this should be discussed with their SDM. Where the patient has capacity, they should be encouraged to review their AHD.
- A Statement of Choices (SoC) may exist for the patient. The SoC may be used to guide decision-making but must not be relied upon for consent as it is not a legal document, unlike an AHD. Refer to Consenting details (section 5, ARP) for a list of SDMs to obtain consent if the patient does not have capacity to make decisions about health matters.

Section 5. Consenting details

- Under the law, all patients with impaired capacity have a SDM. This includes the Public Guardian when no other SDM is available.
- For patients with capacity, this section identifies a potential SDM prior to any loss of capacity. There can be more than one SDM.
- Except in some emergency situations, consent must be obtained to act on the Resuscitation management plan (section 3, ARP). This may involve dispute resolution. (See: Patient objections).
- Consent from a patient or their SDM can be verbal. This should be documented. Verbal consent given by the Public Guardian will be confirmed in writing.
- The ARP form is not a consent form. There is no requirement for the patient or their SDM to sign the ARP form. A properly completed ARP provides documented evidence of discussion outcomes with a patient or their SDM concerning end of life care / LSMs.
- Consent should be obtained from the patient / their SDM as close as possible to an expected acute deterioration or event. If consent is obtained earlier (e.g. in another care setting, a patient's home), the attending medical practitioner must be satisfied that the consent remains valid.

Dispute resolution: when patient choices differ from the Resuscitation management plan

- Where a patient's choices differ from the Resuscitation management plan, this could represent a recognised objection under the law, even in an acute emergency (see: Patient objections).
- If the patient / their SDM requests treatment that differs from the Resuscitation management plan, the treating medical practitioner must make all efforts to explain why the request does not meet the standards of good medical practice and is not in the patient's best interests.
- There is no legal or ethical obligation to accede to demands for clinically inappropriate medical treatment (i.e. no benefit, futile).
- Multidisciplinary team involvement is recommended in thesesituations. The treating medical practitioner may also seek a second opinion from and/or involvement of a senior colleague.
- All efforts should be made to resolve the situation. If dispute resolution attempts are unsuccessful, the treating medical practitioner must escalate the matter to facility executive or the Office of the Public Guardian (OPG) as soon as practicable.
- If a SDM is not adhering to the Health Care Principle and the General Principles, the matter can be referred to the OPG for resolution (see: Schedule 1, GAA).
- An application can also be made to the Queensland Civil and Administrative Tribunal or Supreme Court to appoint a guardian for a person with impaired capacity, resolve disputes between decision makers,or otherwise make orders/decisions concerning the impaired person's health care.
- Clear and detailed documentation is vital at all stages of discussions held.

Section 6. Clinical authorisation

- The most senior medical practitioner available should complete and sign the ARP form.
- In very limited circumstances (e.g. in remote communities), it may be appropriate for a more junior medical practitioner or other health professional to complete the form. In these circumstances, the ARP form must be authorised by the most senior medical practitioner available (by phone, fax or email). Details of the authorising medical practitioner must be recorded on the ARP. Note that this carries an element of risk.
- If there are uncertainties (e.g. ARP is not fully completed, signed or authorised, or there is dissent about the Resuscitation management plan), and decisions are required urgently, attending clinicians must exercise their clinical judgement based on the circumstances. This should be thoroughly documented.
- Active ARPs have a maximum lifespan of 12 months. Patients may also have an ARP that is active only for the current admission / attendance, or for a specified time (< 12 months).
- It is recommended the ARP be reviewed if there are changes in capacity, personal circumstances (e.g. a different SDM), health status or nature of intended health care or outcome. This could include surgical interventions, which should be discussed with the relevant surgeon/anaesthetist. It is good medical practice to regularly review a patient's ARP.
- ARPs should be routinely reviewed on re-admission or following attendance by Queensland Ambulance Service (QAS) paramedics. If a patient presents to a Queensland Health service with a non-Queensland Health version of the ARP, the responsible medical practitioner must review the existing ARP upon admission. Documentation and communication of change and the existence of the active ARP to those involved in the patient's care is required. Queensland Health staff should refer to the Acute Resuscitation Planning Guideline for Queensland Health staff.
-The best contact phone number of the treating medical practitioner should be provided to enable other clinicians and QAS paramedics access to the most current medical advice about the patient.

Voiding the ARP form

- If the ARP requires major changes, is revoked or has lapsed, it should be voided by a medical practitioner.
- To void the ARP: draw two lines diagonally across the front and back pages, write 'VOID' between the lines, sign and date this notation. Retain the voided ARP form in the patient's medical record and file as per local practice.
- A medical practitioner is responsible for deciding whether a new ARP form is required.

Patient transfers and copies

- A patient may be transferred between health services and facilities (or home) with a copy of their active ARP and an ARP Cover Sheet. Copies of lapsed or voided ARPs can be provided for information at the discretion of the medical practitioner.
- Download ARP Cover Sheets at: www.health.qld.gov.au/clinical-practice/guidelines-procedures/patient-safety/end-of-life/resuscitation/using-an-arp
- It is good medical practice to undertake a clinical assessment of the patient at the receiving facility and a new ARP form to be completed, if appropriate.
- If an acute emergency occurs with no time to create a new ARP, attending clinicians must exercise clinical judgement according to the circumstances. Document the outcomes.
- Only ONE active original ARP should exist for a patient and be placed at the front of the patient's medical record. This is to limit the potential for confusion between multiple copies. All photocopied, lapsed or voided ARPs should be filed in another part of the patient's medical record, as per local practice.
- Electronic versions of the ARP must be accessible and transferrable between health services, including transfer of hard copies to sites without access to electronic records. Caution should be exercised to avoid multiple /potentially conflicting ARPs.
- Patients and their families should be supported to keep a copy of their current ARP to be used in the event of an acute deterioration.This includes people being cared for at home.
- It is recommended the patient's GP receive a copy of the patient's active ARP form. GP's should void earlier documnets/copies.
- The ARP form can be ordered online via WINC using the WINC code.

Form ID	Form Title	WINC Code	Packing Unit
SW065	Acute Resuscitation Plan	1NY31841	100

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Queensland Government

Acute Resuscitation Plan (ARP)

For adults at risk of acute deterioration

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

4. Patient choices

The patient has the following views and wishes about their end-of-life care: (e.g. CPR, pain management options, living and visiting arrangements, spiritual and/or cultural support). Discuss the views and wishes of patients who have impaired capacity with their substitute decision-maker(s). Record the dates and times of discussions.

Has the patient participated in advance care planning? ☐ Yes ☐ No

Provide details:

5. Consenting deta

Complete this section, irrespective of the patient's capacity.

Patients with capacity can provide their own consent. For patients with impaired capacity, consent must be obtained from a substitute decision-maker(s), in the order below.

The patient has:

1 Advance Health Directive (AHD)	☐ Yes	☐ No
2 Tribunal-appointed Guardian (see 5. below)	☐ Yes	☐ No
3 Attorney(s) for health matters under Enduring Power of Attorney or AHD	☐ Yes	☐ No
4 Statutory Health Attorney†	☐ Yes	☐ No

5 If no to all, The Public Guardian can be contacted for consent for further discussions about withholding and/or withdrawing life sustaining measures. Visit www.publicguardian.qld.gov.au

Name/details of substitute decision-maker(s): (e.g. relationship to patient, phone number, location of original AHD)

Record the dates and times of discussions held with, and consent obtained from, the patient and/or substitute decision-maker(s). Cross reference with the progress notes.

Details of consenting discussions:

† 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. Clinician authorisation

This ARP form remains active:

☐ For this admission/attendance

☐ Until date: / / (Not longer than 12 months)

☐ For 12 months

In all cases, review of an ARP on re-admission/attendance is preferred.

Medical practitioner / health professional completing this form:

Signature: **Date:**

Practice / facility name:

Role and qualification:

Best contact number:

Authorising senior medical practitioner's name*, if applicable:

Recommendations for review, if circumstances have changed: (e.g. will the ARP apply during planned surgery or following trial of treatment?)

Other clinicians involved in the development of this ARP form and/or provided with a copy: (e.g. emergency department team, surgical team, palliative care service, GPs, allied health and nursing professionals, QAS paramedics)

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

If changes are required, this form must be voided and a new ARP form completed

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DO NOT WRITE IN THIS BINDING MARGIN