Acute Resuscitation Plan

Queensland Health Clinical Guidelines
April 2020

Acute Resuscitation Plan: Queensland Health Clinical Guidelines

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2.0	September 2020	*To be reviewed*

Contents

Part 1: Overview

Purpose

This document provides guidance for Queensland Health (QH) practitioners in relation to the QH Acute Resuscitation Plan (ARP) for adult patients aged 18 years and over.

Introduction

The introduction of a formal substitute decision-making scheme in the *Guardianship and Administration Act 2000* (Qld) confirmed that 'Not for Resuscitation' (NFR) Orders have no legal status and cannot be relied upon in the absence of other forms of consent to withhold or withdraw medical treatment.

In 2009, NFR Orders in QH services were replaced by a standardised ARP form. The ARP was developed in consultation with a range of government agencies, including the Queensland Coroners, public health professionals and health administrators and was developed to promote:

- resuscitation planning commencing earlier to avoid decisions being made in a crisis;
- greater attention to communicating effectively with patients and their families; and
- clearer documentation of the decision-making pathway recorded in a patient's medical record, as required by law.

The ARP is not a legal document, nor does it substitute for legal consent; however, it is a medical order and if completed provides clinical authority to act on the order when urgent decisions are required.

The QH Director-General has authorised the use of the ARP form in services and facilities that are not public sector health services or public sector health facilities as defined by the *Hospital and Health Boards Act 2011* (Qld). The updated ARP form now reflects this authority and as of November 2019, an ARP form can now be used in any health setting in Queensland, including but not limited to:

- public sector health services and facilities;
- private health services and facilities;
- residential aged care and disability facilities;
- general practice and primary care; and
- the patient's home.

While non-QH organisations can use the ARP form, the ARP form has been developed as a clinical support tool for use in 'public sector health services' and 'public sector health facilities'. The ARP 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'. These considerations may or may not apply when using the ARP in non-QH services and facilities, and independent legal advice or other professional advice is recommended.

As such, while non-QH organisations can use the ARP form, its usage is subject to that service's policies and procedures. It is the responsibility of medical practitioners and other health professionals completing the ARP form or using a previously completed ARP form, without limitation, to independently and adequately satisfy themselves of all relevant matters to the standards applicable at law.

QH will not take responsibility for the use or consequences of the ARP form in non-QH facilities. To the

fullest extent permissible by law, QH excludes all warranties, representations and liability in relation to the use of the ARP form by non-QH facilities.

Scope

These clinical guidelines only apply to:

- QH staff (permanent, temporary and casual) including Queensland Ambulance Staff (QAS); and
- organisations and individuals acting as QH agents (including Visiting Medical Practitioners and other partners, contractors, consultants and students).

It provides clarification about the practical usage of the ARP form in QH services, its link to advance care planning (ACP), the legislation regarding withholding/withdrawing life sustaining measures, administrative processes to support access and use of the ARP form and Hospital and Health Service (HHS) responsibilities in implementation of the ARP form.

The *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients* are also available to support health professionals in decision-making about life sustaining measures.

What is an ARP?

An ARP is a medical order made by a medical practitioner that, if appropriately completed, provides documentation of:

- discussions regarding life sustaining measures including Cardiopulmonary Resuscitation (CPR) and ventilation;
- clinical authority for attending clinical teams to act on the order in an acute emergency; and
- treatment that is available and recommended.

The ARP (SW065 Acute Resuscitation Plan):

- is not a consent form
- is not a legal document and does not substitute for legal consent
- is a medical record designed to document the decision-making pathway around life-sustaining measures
- provides for consistent documentation of clinical recommendations to provide, withhold or withdraw medical treatment in an acute emergency
- is intended to prompt discussion with patients and/or their substitute decision-maker/s about resuscitation planning in the event of an acute event, such as cardiac or respiratory arrest
- should be completed where it can be reasonably expected that an adult patient may suffer an acute event in the foreseeable future and require resuscitation
- is initiated and completed by a medical practitioner and is authorised by the most senior medical practitioner available
- requires consideration of a person's existing ACP discussions and documents, and can also trigger initiation and review of ACP documents
- can be 'active' for (i) this admission/attendance, (ii) until a specified date (not longer than 12 months) or (iii) for 12 months

- should be reviewed clinically for its applicability and appropriateness at each admission, or every 12-months, whichever is sooner to ensure it remains relevant and clinically appropriate
- can be used in **non-acute clinical situations** to inform the consent process to provide/ withdraw/withhold medical treatment
- can be used in an acute emergency without consent, unless there is a known objection to the provision/withholding/withdrawing of medical treatment by the person.

Triggers to complete an ARP

Resuscitation planning in these guidelines refers to advance discussions regarding actions to be taken for a patient in the event of organ failure, more specifically a cardiac and/or respiratory arrest. In all instances this will involve consideration of CPR. However, other life-sustaining measures may also be appropriate in acute settings, depending upon the circumstances.

Resuscitation planning should occur as part of the ACP process. People approaching end-of-life care 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.

Preferably, patients should be able to express views, wishes and preferences regarding end-of-life care when their health is stable, and they have time and capacity to contemplate such matters. Sharing of ACP wishes with substitute decision-makers and medical practitioners involved in the person's care can avoid decisions being made on their behalf without knowing what they would have wanted.

Initiation of an ARP is intended for those patients who are at risk of cardiac and/or respiratory arrest in the foreseeable future, and/or death can reasonably be expected within 12 months.

Triggers that suggest a person may benefit from an ARP include:

- the "surprise question"– Would I be surprised if the person were to die in the next year?
- the person is experiencing symptoms and signs that indicate declining general health
- the person is experiencing indicators of decline related to their specific disease or conditions
- the person, family member or carer raises resuscitation planning with a health professional.

The Queensland Health ACP Quick Guide includes prognostic indicators and can help to identify those who may benefit from ACP or resuscitation planning.

In anticipation of the patient's deteriorating condition, discussions about end-of-life decision making are best initiated as soon as practicable. This supports identification of unmet needs and preferences, guides medical treatment plans and provides a decision pathway for members of the health care team in the case of an acute emergency.

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.

Who can complete an ARP?

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 form. Note that this carries an element of risk.

When completing an ARP:

- the form should be discussed with the person/substitute decision-maker(s) in the context of the person's prognosis, goals of care and treatment choices
- Translator Interpreter Services should be engaged when the person's English skills are assessed to be inadequate to properly understand the situation or participate in the conversation, the person has a Queensland Government interpreter card, or the person requests an interpreter
- Indigenous Health Workers should be engaged for discussions with Aboriginal and Torres Strait Islander persons to support cultural needs
- all attempts should be made to support communication with people who have physical, intellectual or cognitive impairments including:
  - providing information in a format that can be easily understood by the person
  - allowing for informal assistance from family and friends
  - arrange an interpreter (for a person who is deaf for example) or another suitable person (for example a speech pathologist for a person with communication difficulties) to assist with communication
  - recognising and accommodating supported decision-making representatives (both formal and informal).

Part 2: The ARP form

ARP components

The SW065 ARP form is comprised of a:

- Quick Guide, and
- ARP Form containing six sections:
  1. Clinical assessment
  2. Capacity assessment
  3. Resuscitation management plan
  4. Patient choices
  5. Consenting details
  6. Clinician authorisation.

The following sections provides information about each of these components and guidance for ARP usage.

Quick Guide

The Quick Guide is a tear-off section attached to the ARP form that assists medical practitioners to complete the form. It contains:

- a set of instructions that can be used to complete the form,
- important general information about communicating with patients, legal considerations, capacity and patient objections including a flowchart for withholding and withdrawing life-sustaining measures.

Medical practitioners should be familiar with the Quick Guide before completing an ARP.

ARP form

The introduction/disclaimer on the ARP form reminds the user that:

- clinical assessment and appropriate treatment options should be guided by good medical practice (see Box 1), which include discussions with the patient and/or their substitute decision-maker(s) (see Box 2)
- the ARP 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) and it includes references to legal considerations, policies, indemnities and conditions of use which may only apply in public sector health services and public sector health facilities and a disclaimer in relation to use of the ARP form by non-QH services which requires non-QH services to independently and adequately satisfy themselves of all relevant matters to the standards applicable at law
- the Quick Guide contains important information and should be read prior to completing the form
- section content can be cross referenced with the progress notes if there is insufficient room on the ARP form to record information.

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.

Box 1: Good medical practice is good medical practice for the medical profession in Australia having regard to—

a. the recognised medical standards, practices and procedures of the medical profession in Australia; and

b. the recognised ethical standards of the medical profession in Australia.

Guardianship and Administration Act 2000, Schedule 2, 5B.

Box 2: Substitute decision-maker(s)

A person appointed or identified by law to make substitute decisions on behalf of a person whose decision-making capacity is impaired. Substituted decision-making comes into effect when consent is required to provide health care to an adult with impaired capacity. The *Guardianship and Administration Act 2000* (s. 66 – Adult with impaired capacity-order of priority in dealing with health matter) provides a priority list of substitute decision-makers when consent is required:

1. a valid Advance Health Directive
2. Tribunal-appointed Guardian
3. Attorney appointed under most recent enduring document (e.g. an Enduring Power of Attorney)
4. the person's statutory health attorney
5. the Public Guardian.

More than one substitute decision-maker may be appointed under an enduring document**.**

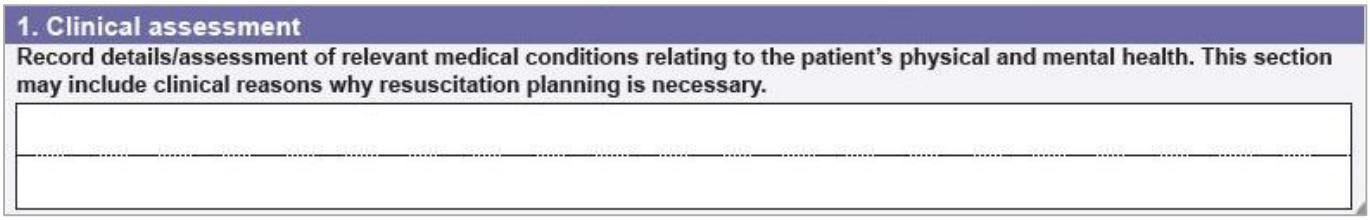
There are essentially three categories of substitute decision-makers:

- substitute decision-makers chosen by the person (e.g. one or more attorneys appointed under a statutory advance health directive or enduring power of attorney)
- substitute decision-makers assigned to the person by the law in the absence of an appointed substitute decision-maker, (e.g. statutory health attorney which could be a family member or carer or close friend)
- substitute decision-makers appointed for the person (e.g. a guardian appointed by a guardianship tribunal).

Section 1: Clinical assessment

This section of the ARP:

- records details/assessment of relevant medical conditions relating to the patient's physical and mental health
- may include clinical reasons why resuscitation planning is necessary, or reasons why the patient is suitable for cardiopulmonary resuscitation (CPR) or not.



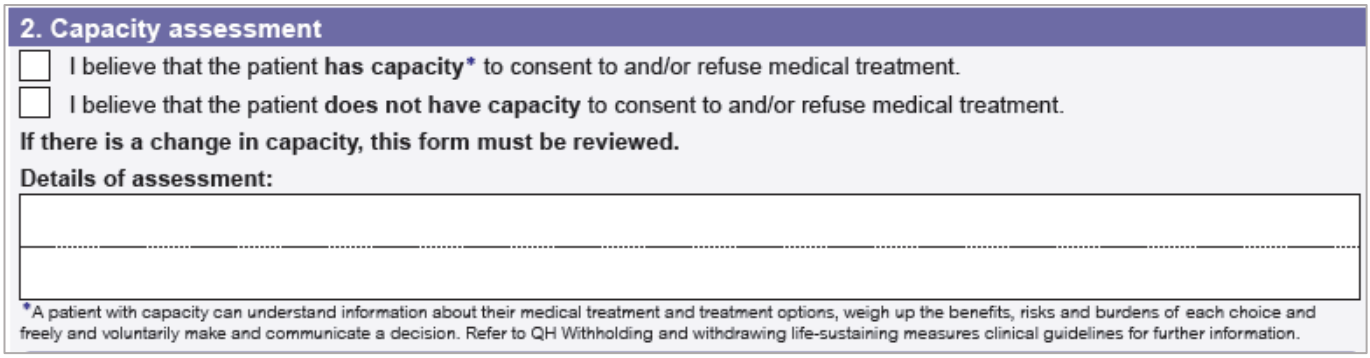
Note:

- If there are doubts or uncertainties about the patient's medical condition, a second opinion should be obtained.
- If there is insufficient room on the form to record all relevant details, information can be cross-referenced in the patient's medical record.
- Any discussions held with the patient and/or their substitute decision-maker(s) about the patient's medical status should also be recorded in this section.

Section 2: Capacity assessment

This section of the ARP:

- is where details about a patient's capacity and whether they have the capacity to consent to, or refuse, medical treatment are recorded (see Box 3).



Note:

- If the patient has capacity, it is not mandatory to document the 'Details of assessment'. However, there may be circumstances where it is appropriate, such as where there is potential for fluctuating capacity. If there has been any dispute over a patient's capacity, or if a second opinion has been sought, it may be appropriate to note this in this section of the ARP. It may also be useful to note the method of capacity assessment that was used.

- If there are doubts or uncertainties about the patient's capacity for decision-making (e.g. fluctuating or episodic capacity), seek a second opinion or a review by a specialist such as a geriatrician, psychiatrist or psychologist.

Further information can be found in Section 1.4 Capacity of the *End-of-Life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients*.

Box 3: Capacity for a person, for a matter, means the person is capable of:

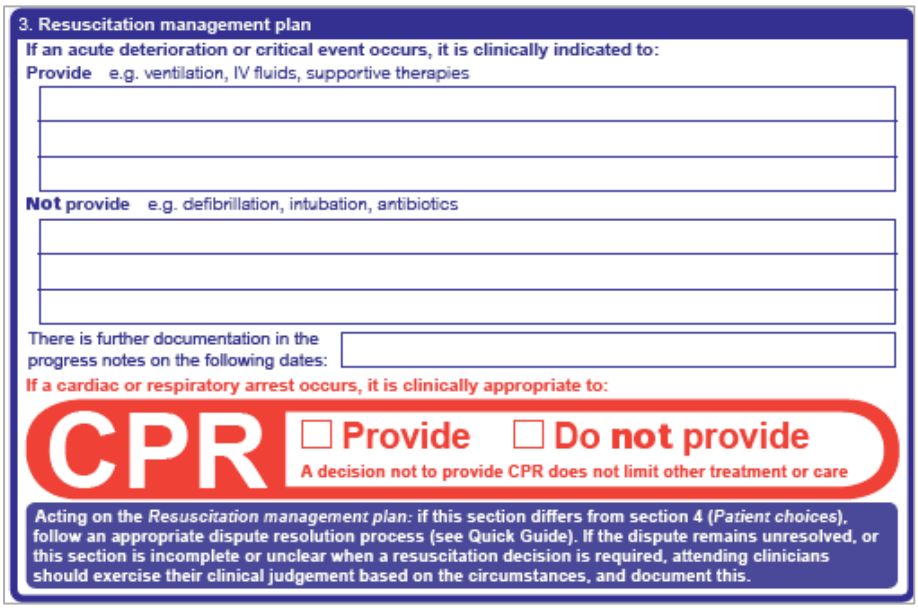
1. understanding the nature and effect of decisions about the matter, and
2. freely and voluntarily making decisions about the matter, and
3. communicating the decisions in some way.

Guardianship and Administration Act 2000, Schedule 4

Section 3: Resuscitation management plan

This section of the ARP:

- records the medical treatment and care that should and should not be provided
- records the date(s) where further documentation is available in the progress notes of the patient's medical record
- the 'Provide' and 'Do not provide' free text boxes indicate if CPR is clinically appropriate.



Note:

- The Resuscitation management plan represents what is clinically appropriate in an acute emergency. This authority is intended for use by attending teams and should give clear direction to staff who are present if the patient arrests (or in the event of an acute deterioration).

- If the Resuscitation management plan is incomplete or unclear at the time of an acute deterioration, attending clinicians must exercise their clinical judgement in accordance with good medical practice, document what they did and why and be prepared to stand by that decision.
- Life sustaining measures can be withheld or withdrawn in an acute emergency without consent, unless there is a known objection to the withholding and withdrawal by the person (see Box 4). In such cases, clinicians must document what they did and why, and be prepared to stand by this decision. Where time permits, second opinions in these circumstances are highly recommended.
- It is important to recognise that a direction to not provide CPR does not mean 'do not provide any treatment'. Completion of this section does not exclude the provision of other medical interventions and treatments which are not specifically mentioned. For example, it is always appropriate to provide medication and other therapies to manage pain, suffering and discomfort, even if they are not mentioned on the ARP form e.g. palliative therapies, management of pain, suffering and discomfort).

In an emergency, good medical practice and clinical judgement must always prevail.

Box 4: 63A Life-sustaining measure in an acute emergency:

1. A life-sustaining measure may be withheld or withdrawn for an adult without consent if the adult's health provider reasonably considers—
   a. the adult has impaired capacity for the health matter concerned; and
   b. the commencement or continuation of the measure for the adult would be inconsistent with good medical practice; and
   c. consistent with good medical practice, the decision to withhold or withdraw the measure must be taken immediately.
2. However, the measure may not be withheld or withdrawn without consent if the health provider knows the adult objects to the withholding or withdrawal.
3. The health provider must certify in the adult's clinical records as to the various things enabling the measure to be withheld or withdrawn because of this section.
4. For this section, artificial nutrition and hydration is not a ***life-sustaining measure***.

Guardianship and Administration Act QLD 2000, section 63(a)

Section 4: Patient choices

This section of the ARP:

- records patient views, wishes and preferences about their end-of-life care, e.g. CPR, pain management options, living and visiting arrangements, spiritual and/or cultural support
- the 'tick boxes' should be completed to indicate patient participation in ACP, and any existing document details e.g. Advance Health Directive (AHD), Statement of Choices (SoC) (see Box 5).

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:

Note:

- If there is insufficient room on the form to record all relevant details, information can be cross-referenced in the patient's medical record
- A patient with capacity is entitled to refuse medical treatment, even if their decision is not agreed to by any other person, is inconsistent with good medical practice and will result in their death or cause it to happen sooner
- Where patients feel strongly about treatment and care at the end-of-life, they should be encouraged to complete an AHD as part of their ACP
- A patient may have already completed an AHD. Any inconsistency between a valid AHD and the patient's stated choices will need to be resolved with the patient and/or their potential substitute decision-maker. If the patient does not have capacity, their valid AHD takes precedence, but this should be discussed with their substitute decision-maker
- Where the patient has or regains capacity and expresses decisions contrary to what is recorded in their AHD, they should be encouraged to review their AHD
- A 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 legally binding document, unlike an AHD
- Refer to Consenting details (Section 5, ARP) for the order of priority in dealing with a health matter if a person has impaired capacity.

Box 5: ACP Tracker in The Viewer

The ACP Tracker enables information regarding ACP of the patient to be shared and available to other clinical staff at all QH sites to enable continuity and progression of ACP and patient care.

ACP documents uploaded by the Office of ACP are accessible by clicking on the ACP Tracker icon in The Viewer. QH clinicians can add comments into the ACP Tracker about ACP discussions, review existing documents, completion of ACP documents, or approaches about ACP that have been declined. To alert clinicians about ACP document issues, where relevant, the Office of ACP also adds comments to the ACP Tracker.

When completing Section 4:

- check the ACP Tracker for existing ACP documents/comments
- add comments to the ACP Tracker about ACP discussions/review/completion/declines
- request patient/substitute decision-maker(s) show current ACP documents not on The Viewer
- retain a copy of the ACP document on the local medical record as per local policy
- send a copy of ACP documents that are not on The Viewer to the Office of ACP via:

Email: acp@health.qld.gov.au **Fax:** 1300 008 227

Post: PO Box 2274, RUNCORN, QLD 4113

ACP Documents that can be uploaded to The Viewer

Advance Health Directive (AHD)	A legal document which provides directions about future health care if the person has impaired capacity. It can also be used to appoint an attorney (substitute decision-maker) for health and personal matters.
Queensland Civil and Administrative Tribunal (QCAT) Decisions	A legal document which sets out the decision made by QCAT to appoint a substitute decision-maker (Guardian and/or Administrator) in accordance with the provisions of the *Guardianship and Administration Act 2000*.
Enduring Power of Attorney (EPOA)	A legal document used to appoint attorney(s) (substitute decision-maker) for health/personal matters and/or financial matters
Revocation documents	Legal documents used to revoke an enduring document
Statement of Choices (SoC)	A values-based document that records a person's wishes, choices and preferences for health care. Although the Statement of Choices is not included in Queensland legislation, the content can still have guiding effect by assisting substitute decision-makers and clinicians to plan treatment and care if a person is unable to communicate their choices.

Patient objections

- Where a patient's choices differ to the recommendations of the health care team (that is, what has been indicated in the Resuscitation management plan), this could represent a recognised objection under the law, even in an acute emergency (see Box 6). In these situations, the laws in Queensland require thorough documentation of the decision-making pathway.
- The patient choices section should also be used to initiate or escalate any discussions or counselling about resuscitation planning if the choices of either the patient (if they have capacity) or their substitute decision-maker(s) (if the patient has impaired capacity) differ from the clinical decision

about the appropriateness of resuscitation. In these situations, involvement of all members of the healthcare team is recommended.

- If need be, a new ARP can be initiated as the health care team works through and resolves communication issues. The current ARP form and voided ARP forms should be able to 'tell the story' about how the healthcare team has attempted to address any conflict situations that arise.
- Figure 1 shows the effect of objection by patient to the withholding/withdrawing of Life sustaining measures.

Box 6: Patient Objections

Object, by an adult, to health care means—

a. the adult indicates the adult does not wish to have the health care; or

b. the adult previously indicated, in similar circumstances, the adult did not then wish to have the health care and since then the adult has not indicated otherwise.

Example—

An indication may be given in an enduring power of attorney or advance health directive or in another way, including, for example, orally or by conduct.

Guardianship and Administration Act 2000, Schedule 4

The law recognises that a person can object to life-sustaining measures being provided, withheld or withdrawn. QH's position is that direct knowledge of an objection is required from the patient, rather than hearsay (e.g. from a family member). The patient's objection should have been expressed directly to the treating medical practitioner as close as possible to the acute deterioration or event.

For example, it may not be appropriate for members of the health care team to try to establish the authenticity of 'hearsay' in acute emergency situations while attempts are being made to save the life and health of the patient. For the withholding or withdrawal of medical treatment, an objection may be expressed by the patient as a verbal request to "do everything" or "keep me alive" or "don't let me die", or by their conduct, or in formal terms through an AHD.

Figure 1: ***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

GMP = Good Medical Practice, SDM = Substitute Decision-Maker, LSM = Life Sustaining Measure.

Note: Only consider a trial of treatment that is consistent with Good Medical Practice (GMP). This does not mean automatically trialling emergency treatment unless it is consistent with GMP (see Box 4).

Dispute resolution

When patient choices differ from the medical practitioner's assessment and/or Resuscitation management plan, a dispute resolution process should be initiated, as circumstances permit:

- Medical practitioners are not obliged to offer nor provide medical treatment that has no benefit, would cause harm and would, in all reasonable respects, be considered futile.
- If patients and/or their families request choices for treatment that do not meet the standards of good medical practice, medical practitioners must make all efforts (including involvement of counsellors, if this is appropriate) to inform the patient and/or the family of the risks involved, why the treatment will not be in the patient's best interests, and what treatment and care is clinically appropriate for the patient.
- Depending upon the urgency of decisions required at the time, it may also be appropriate to allow more time and arrange further family discussions/conferences for the patient and/or their family to come to terms with the gravity of decisions around withholding or withdrawal of life-sustaining measures.
- If, despite all efforts to resolve the conflict, the situation fails and requests for inappropriate and/or unwanted treatment continue, the medical practitioner must:
  - seek a second opinion from and/or involvement of an experienced clinician, as circumstances permit
  - refer the matter to Executive, or hospital management, as soon as practicable, as per local arrangements.

- where the patient lacks capacity, if the medical practitioner believes the substitute decision-maker(s) are not adhering to the Health Care Principle, a decision is required and reasonable attempts by the hospital to resolve the matter have been unsuccessful, the Public Guardian can be contacted to consider further action, or to make the decision, if it is not an emergency situation.
- In dispute circumstances, it is vital that clear and detailed documentation occurs at all stages of all discussions held.
- If the dispute remains unresolved despite reasonable attempts, and the patient suffers an acute deterioration, attending clinicians should exercise their clinical judgement based on the circumstances, and document the decision-making pathway. Except in acute emergency situations, consent is required to withhold or withdraw life-sustaining measures.

See Section 1: Legislative Framework and Section 2.6: Disputes of the *End-of-Life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients for more information.*

When the patient's choices disagree with the medical opinion:

Tips following discussions with the Queensland Coroners Court

What should the attending team do in situations where the Resuscitation management plan indicates "DO NOT PROVIDE CPR", and the ARP (and/or medical record) also contains evidence of efforts made to resolve the dispute?

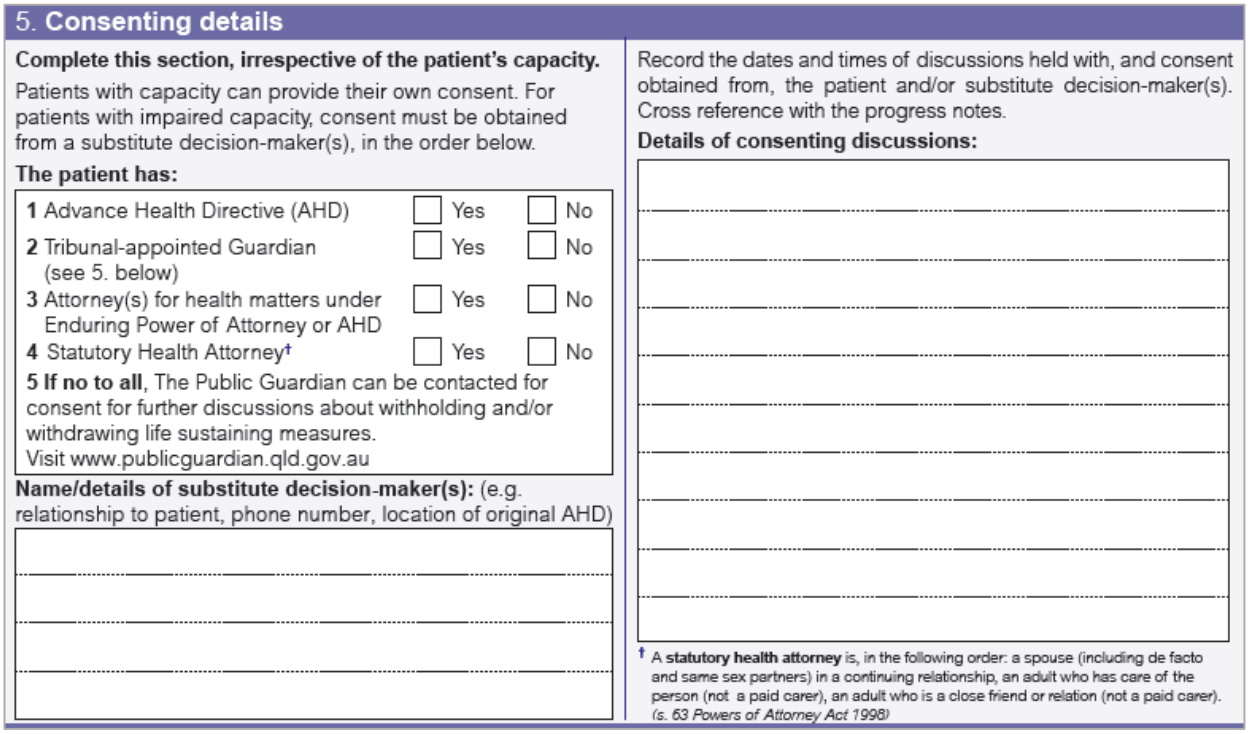
1. If there is time, escalate the matter to more senior medical practitioners or to hospital administration, as guided by local practice.
2. If there is no time, the attending team must exercise clinical judgement based on the "acute emergency" circumstances. This may involve choosing to follow the instruction in the Resuscitation management plan in the knowledge that the dispute remains unresolved.
3. If the patient's death is reportable, the Office of the State Coroner has indicated that it will be looking for the appropriateness of the clinical decision-making and best efforts made to resolve the dispute in the circumstances – all recorded (or cross referenced) on the ARP. In other words, the relevant Coroners would be looking for evidence of appropriately completed ARPs, where they apply and where there has been time to complete one.
4. There is strictly no suggestion from the Office of the State Coroner that an inability to obtain consent requires the attending team to compromise the standards of good medical practice by providing "futile" life-sustaining measures causing harm to the patient.
5. Good medical practice and clinical judgement should prevail in all circumstances, which includes obtaining consent and documenting all stages of decision-making, with the medical practitioner in charge being prepared to stand behind their decision/s.

Section 5: Consenting details

This section of the ARP form:

- records consenting details for the patient Resuscitation management plan, irrespective of the patient's capacity
- the 'tick boxes' should be completed to indicate the existence of formal decision-making documents (see Box 7 and 8) or statutory health attorney (see Box 9)

- records the details of the substitute decision-maker(s)
- records the dates and times of discussions held with, and consent obtained from, the patient and/or substitute decision-maker(s).



5. Consenting details

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:

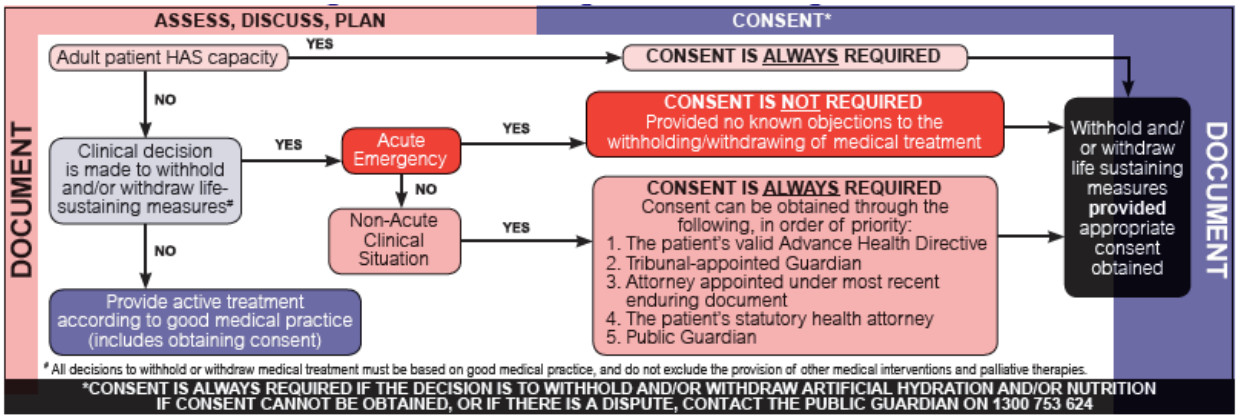
† A **statutory health attorney** is, in the following order: a spouse (including de facto and same sex partners) in a continuing relationship, an adult who has care of the person (not a paid carer), an adult who is a close friend or relation (not a paid carer). *(s. 63 Powers of Attorney Act 1998)*

Note:

- The ARP form is not a consent form.
- It is the position of QH that there is no legal, ethical or practical requirement for patients and/or the substitute decision-maker(s) to sign the ARP form.
- A properly completed ARP form provides documented evidence of discussion outcomes with a patient or their substitute decision-maker(s) concerning end-of-life care/life sustaining measures.
- Except in emergency situations, consent must be obtained to act on the Resuscitation management plan (see Figure 2). This may involve dispute resolution.
- Consent from a patient or their substitute decision-maker(s) can be verbal and must be documented in the notes and cross-referenced in the ARP.
- Under the guardianship scheme in Queensland, all patients who lack capacity have a substitute decision-maker(s). Sometimes there can be more than one substitute decision-maker(s). If there is no appointed guardian, attorney or statutory health attorney (see Box 8) available, the Public Guardian becomes the statutory health attorney and can be contacted to represent the patient's best interests.
- Consent should be obtained from the patient/their substitute decision-maker(s) 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.
- Anything recorded in an ARP for a patient who holds enduring legal documents (such as a valid AHD or EPOA) should reflect the choices documented in these formal documents. However, AHDs do have some limitations. For example, the directions in an AHD must relate to the clinical situation at

the time a decision is required. Also, if the directions in an AHD are uncertain or inconsistent with the standards of good medical practice, medical practitioners may override them, even though they are a legal document. It is vital that the reasons for overriding AHDs are thoroughly documented, and the medical practitioner is prepared to stand behind that decision, if required to do so. For further information, see Section 1.5.5 Deciding not to follow an AHD of the *End-of-Life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients for more information*.

Figure 2: *Flowchart Withholding and Withdrawing Life-Sustaining Measures*



See Appendix 2: Consent flowcharts for providing healthcare and withholding/ withdrawing life-sustaining measures for more information.

Box 7: Citing of decision-making documents

Citing of formal decision-making documents i.e. AHDs, EPOAs, QCAT Decisions (Tribunal appointed guardians for health care) is required to confirm their directions and terms.

When completing Section 5:

- check the ACP Tracker (in The Viewer) for existing ACP documents/comments
- add comments to the ACP Tracker about ACP discussions/review/completion/declines
- request patient/substitute decision-maker(s) show current ACP documents that are not on The Viewer
- send a copy of ACP documents not on The Viewer to the Office of ACP for upload to The Viewer
- retain a copy of the ACP document on the local medical record as per local policy.

Non-statutory ACP documents should also be cited.

Box 8: Adult with impaired capacity—order of priority in dealing with a health matter

1. If an adult has impaired capacity for a health matter, the matter may only be dealt with under the first of the following subsections to apply.
2. If the adult has made an advance health directive giving a direction about the matter, the matter may only be dealt with under the direction.
3. If subsection (2) does not apply and the tribunal has appointed one or more guardians for the matter or made an order about the matter, the matter may only be dealt with by the guardian or guardians or under the order.

Note—

If, when appointing the guardian or guardians, the tribunal was unaware of the existence of an enduring document giving power for the matter to an attorney, see section 23 (Appointment without knowledge of enduring document), particularly subsection (2).

4. If subsections (2) and (3) do not apply and the adult has made one or more enduring documents appointing one or more attorneys for the matter, the matter may only be dealt with by the
5. attorney or attorneys for the matter appointed by the most recent enduring document.
6. If subsections (2) to (4) do not apply, the matter may only be dealt with by the statutory health attorney.
7. This section does not apply to a health matter relating to health care that may be carried out without consent under division 1.

Guardianship and Administration Act 2000 (Qld), section 66.

Box 9: Statutory Health Attorney definition

1. For a health matter, an adult's statutory health attorney is the first, in listed order, of the following people who is readily available and culturally appropriate to exercise power for the matter—
   a. a spouse of the adult if the relationship between the adult and the spouse is close and continuing;
   b. a person who is 18 years or more and who has the care of the adult and is not a paid carer for the adult;
   c. a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult.

Note—

If there is a disagreement about which of two or more eligible people should be the statutory health attorney or how the power should be exercised, see the *Guardianship and Administration Act 2000*, section 42 (Disagreement about health matter).

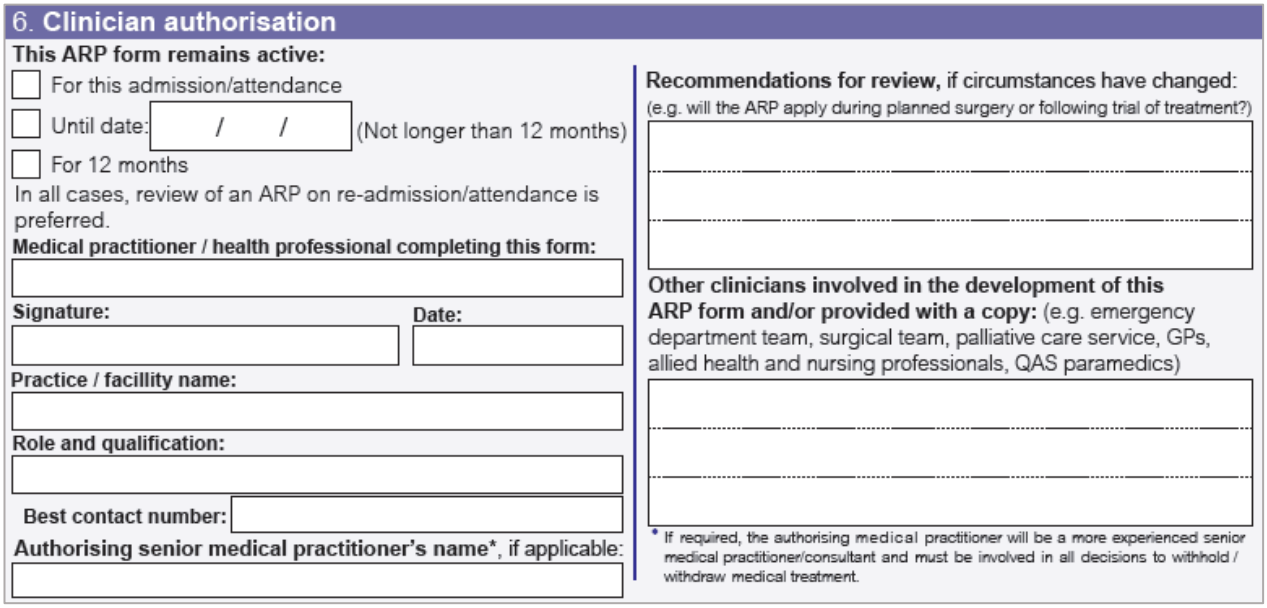
2. If no-one listed in subsection (1) is readily available and culturally appropriate to exercise power for a matter, the public guardian is the adult's ***statutory health attorney*** for the matter.

Powers of Attorney Act 1998 (Qld), section 63

Section 6: Clinician authorisation

This section of the ARP records:

- the time period the ARP is active for i.e. this admission/attendance, until a specified date (not longer than 12 months) or for 12 months.
- the details of the medical practitioner/health professional completing the form including their name, role and qualification, best contact number and practice/facility name.
- the authorising senior medical practitioner's name (if required).
- recommendations for review
- other clinicians involved in the development of the ARP form and/or provided with a copy.



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 / facillity 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.

Note:

- Active ARP forms have a maximum lifespan of 12 months.
- The best contact phone number of the authorising medical practitioner must be recorded to enable other clinicians and QAS paramedics access to the most current medical advice about the patient.
- Contact with the patient's GP when completing an ARP may provide additional information/ advice.
- A complete ARP provides clinical authority to act on the instructions documented on the form in an acute emergency.

Part 3: Completion, administration and quality assurance

Required criteria for a completed ARP

A completed ARP SW065 form requires the authorising clinician to ensure that the following is met.

Content	Criteria
The ARP	Is an original form or is an authentic copy of a completed original form Is legible
Section 1: **Clinical assessment**	Details/assessment of relevant medical conditions are recorded
Section 2: **Capacity assessment**	A box indicating patient capacity is ticked If patient does not have capacity, the details of assessment are recorded
Section 3: **Resuscitation management plan**	Clinically indicated treatment to provide/not provide in an acute deterioration or critical event is recorded Dates of further documentation in medical records/progress notes added
Section 4: **Patient choices**	Dates and times of discussions held with the patient and/or their substitute decision-maker(s) regarding views, wishes and preferences about end-of-life care are recorded Patient ACP documents are recorded
Section 5: **Consenting details**	Substitute decision-maker(s) details - first name, surname, best contact phone number and their relationship to the patient (if applicable) are recorded Dates and times of consenting discussions held with the patient and/or if applicable, their substitute decision-maker(s) Date and time of health care consents (documented in the medical records /progress notes) obtained from the patient and/or their substitute decision-maker(s)
Section 6: **Clinician authorisation**	Time period the ARP form is active is recorded Medical practitioner/health professional has recorded their first name, surname, best contact phone number and signed and dated the ARP form If applicable, an authorising senior medical practitioner's name is recorded

Review of an ARP

It is the responsibility of all health facilities/services in receipt of the patient's ARP form to:

1. verify that the ARP form is active, applicable to the patient's current situation and correctly completed (see Box 10); and
2. verify that the consenting details documented on the ARP form are current; and
3. ensure the ARP form is prominently stored/located in the patient's medical record.

It is best practice for QH facilities to rely on an original ARP form. However, if a copy of the patient's ARP form is received by a health facility / service, the requirement to verify that the ARP form is active, applicable to the patient's current situation and correctly completed must include an assessment of the authenticity of the copy of a completed ARP form.

Enquiries and actions to ascertain the clinical applicability of the copy of the completed ARP form must be thoroughly documented.

If there is any doubt as to the clinical applicability or authenticity of a copy of the ARP form, QH clinicians should treat the ARP form as if it were not properly signed or authorised. That ARP form should not be relied upon, should be marked as void and a new ARP form should be completed for the patient, if resuscitation planning is appropriate.

The most senior registered medical practitioner, at the earliest and most appropriate opportunity, must review a patient's ARP form. This includes:

- when a patient presents to a QH service with an ARP form (original or authentic copy) completed in a non-QH facility or another QH facility on admission to a QH service
- following an attendance by Queensland Ambulance Service (QAS)
- if the patient regains capacity for decision-making, changes their preferences for resuscitation, has changes to personal circumstances (e.g. a different substitute decision-maker), health status or nature of intended health care or outcome. This could include surgical interventions, which should be discussed with the relevant surgeon/anaesthetist.

Note: for some patients (e.g. palliative patients or patients with chronic illnesses and significant co-morbidities), revisiting resuscitation planning discussions on each admission may be unduly distressing and inappropriate.

Box 10: An ARP may be active:

- for this admission/attendance
- until a specified date (not longer than 12 months)
- for 12 months.

If the ARP is active, applicable to the patient's current situation and appropriately completed it provides clinical authority to act upon directions on the form. Provided that QH medical practitioners comply with QH policies regarding End of Life Care in good faith, seeking legal protections and indemnity would fall within scope of the Indemnity for Queensland Health Medical Practitioners I2(QH-POL-153) or the Queensland Government Indemnity Guideline for other Queensland Health/HHS/QAS staff. Both policies require employees to be working in their official duties, at the direction of Queensland Health and that employees have acted in good faith and without gross negligence and may be indemnified for the costs of legal representation in civil proceedings, inquiries or investigations. The indemnity policies do not apply to those who are not engaged by Queensland Health.

When acting on an ARP, all attending clinicians must exercise their clinical judgment.

If the ARP form is lapsed, 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 in accordance with good medical practice. This will require documentation in the medical records in accordance with s63A of the *Guardianship and Administration Act 2000*.

- Only **ONE active ARP** form should exist for a patient and be placed at the front of the patient's medical record, to limit the potential for confusion between multiple copies.
- An ARP completed on a previous version of the ARP form remains active as indicated, up to a maximum of 12 months.
- Amendments and changes cannot be made on a copy of the patients active ARP form—a new one must be completed.
- All photocopied, lapsed or voided ARP forms should be filed in another part of the patient's medical record, as per local practice.

If the ARP review identifies the ARP is active, applicable to the patient's current situation and correctly completed

- Document the outcomes of the ARP review in the patient's medical record/progress notes.
- Add the date of the medical record/progress note entry into the ARP Section 3 Resuscitation management plan section about further documentation in progress notes.

Note: In this situation, the ARP form remains active for the time period specified in Section 6 of the ARP, and authorised based on completion by the original authorising clinician.

What if the reviewed ARP no longer applies?

The ARP form must be voided should it no longer apply.

If the ARP form is lapsed, uncertain or voided, or there is some doubt as to the authenticity of a copy of an ARP form, the treating medical practitioner at the receiving facility may, at their discretion:

- contact the previous authorising medical practitioner where the original ARP form was completed to assist with confirming the clinical applicability to the current situation of the existing ARP; and/or
- complete a new ARP form;
- void the copy received.

A new ARP form must be completed for the patient if the medical practitioner identifies resuscitation planning is appropriate.

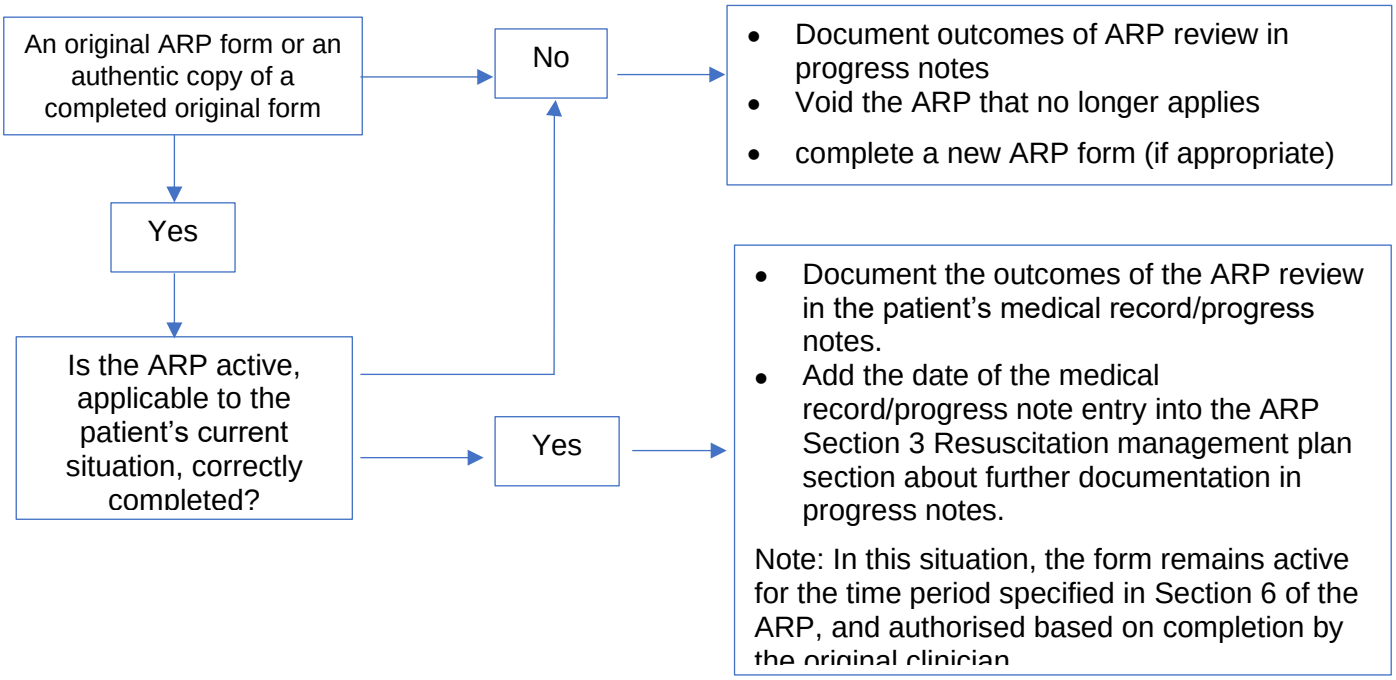
Documentation and communication of changes and the existence of an active ARP form to those involved in the patient's care is required.

Note: Minor changes such as a) change of phone number or address, b) adding name of substitute decision-maker(s) and c) inclusion of a tick for an AHD may not require a new ARP form to be completed. If major changes (such as extending the date of the active ARP) are required to the ARP form or the form has lapsed, it must be marked as void under the authority of a medical practitioner.

IMPORTANT CONSIDERATIONS: When making amendments or writing a new ARP:

- the ARP may represent a piece of evidence before the Coroners Court or other court of law, so therefore needs to be as clear and unambiguous as possible
- if the ARP form becomes uncertain because it is unable to be deciphered or interpreted by an attending team, unintended actions may occur at the time a decision is required
- the ARP, which includes changes and voided forms, should "tell the full story" of resuscitation planning for the patient.

Figure 3: ***Review of an ARP flowchart***



Voiding of an ARP

Minor changes such as (a) change of phone number or address, (b) adding name of substitute decision-maker(s) and (c) inclusion of a tick for an AHD may not require the form to be marked as void and a new ARP form to be completed.

If major changes (such as extending the date of the active ARP) are required to the ARP form or the form has lapsed, it must be marked as void under the authority of a medical practitioner.

To void the form, draw two lines diagonally across the front and back pages, write 'VOID' between the lines and sign and date this notation. Retain the voided ARP form in the patient's medical record and file as per local practice.

Patient transfers

- When a patient is transferred between health services and facilities (or home) a copy of their active ARP and an ARP Cover Sheet must accompany them (for use during transit, at another healthcare facility or while receiving QH community care services [e.g. in the family home]).
- ARP Cover Sheets can be downloaded from: clinicalexcellence.qld.gov.au/resources/ARP
- Copies of lapsed or voided ARP forms can be provided for information at the discretion of the medical practitioner.
- Caution should be exercised to avoid multiple/potentially conflicting ARP forms.

- Patients and their families should be supported to keep a copy of their most recent 'active' ARP form and encouraged to keep copies of their ARP form (and other important health documentation) in an accessible location—for example, in a Care Alert Kit, or uploaded to their My Health Record. This will assist paramedics, other health professionals, family and other substitute decision-maker(s) to easily locate the ARP form if required.
- It is recommended the health service/facility discharging a patient, provides a copy of the patient's ARP form to their GP for their records.

Queensland Ambulance Services (QAS) responsibilities

- An active ARP form, that is applicable to the patient's current situation and appropriately completed, provides clinical authority for all QAS paramedics to act on the instructions.
- Information on the ARP form may assist QAS paramedics to determine if a lawful direction to withhold or withdraw life-sustaining measures is appropriate.
- Where the ARP is lapsed, uncertain, voided or active only for the current admission/attendance, QAS paramedics must exercise clinical judgement about following the directions on the ARP form, and refer to clinical practice guidance material. Actions must be thoroughly documented. Refer to:
  - Queensland Ambulance Service (2019): Clinical Practice Guidelines: Resuscitation/ Resuscitation – General guidelines
  - Queensland Ambulance Service (2017): Clinical Practice Guidelines: Resuscitation/ Resuscitation - Adult

7 Step ARP Pathway

A 7 Step ARP Pathway (see Appendix 4) has been developed to assist clinicians and consumers to make decisions about resuscitation and other life-sustaining treatment, and to develop and document the clinical plan on an ARP form for a patient.

ARP administration

How to order

The ARP Form SW065 can be ordered by QH and non-QH services in packs of 100 at WINC using the code 1NY31841. The print screen below shows the product information on the WINC website. A WINC Customer Credit Account Application Form is required to be completed before orders can be made.

Use of the ARP form by non-QH services and facilities is subject to that service's policies and procedures. It is the responsibility of medical practitioners and other health professionals in non-QH services and facilities completing the 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 use of this ARP form.

Form ID	Form title	WINC code	Packing unit
SW065	Acute Resuscitation Plan (ARP)	1NY31841	100

Previous ARP versions

Previous versions of the QH ARP form (i.e. versions used pre-November 2019, before the form underwent changes to enable its usage outside of public sector health services and facilities) are in circulation.

Health services and facilities will have the older version as stock on hand. The destruction of old forms held in HHS is an operational decision. However, the use of the current version is encouraged.

Previous versions of a completed ARP remain current for a maximum of 12 months and must be voided when the review of the ARP document identifies this time period has expired.

Filing ARP forms

- The active ARP form (original and/or authentic copy) must be filed prominently in the patient's medical record.
- Any additional copies, lapsed or voided ARP forms should be filed in another part of the patient's medical record, as per local practice. This may include scanned copies of ARP forms filed in Integrated electronic medical record.
- ARP documents are not currently accessible on The Viewer.

Health care team role in supporting resuscitation planning

Non-clinical and clinical members of the health care team have roles in supporting resuscitation planning.

Administration officer responsibilities

- Locate any existing ARP forms in the patient's chart, specifically noting whether an active ARP is present.
- Notify the appropriate medical practitioner that there is an existing ARP form.
- File ARP form records according to local HHS processes.
- All ARP forms–whether active or void—remain part of the medical record.
- Provide copies of completed ARP documentation when requested—for example, by the hospital, patient, nominated substitute decision-maker(s), appointed power of attorney and general practitioners (GP).
- Enter ARP status in alerts on electronic systems according to local HHS processes.

Nursing responsibilities

- When a patient is admitted, the admitting nurse must check for an active ARP form in the medical record. Inform the treating team at the earliest, most appropriate opportunity and prompt medical practitioners to complete or review an ARP form.
- Participate in ACP discussions, as nurses can provide a valuable perspective and guidance in the decision-making process.
- Ensure that on transfer to another facility/service, a copy of the active ARP form is attached to an ARP coversheet and sent with the patient or to the facility.

Allied Health responsibilities

- Allied Health professionals should be encouraged to participate in resuscitation planning discussions as appropriate.

Indigenous Health Worker responsibilities

- Indigenous Health Workers should assist Aboriginal and Torres Strait Islander patients with ensuring cultural needs are addressed in the decision-making process. It is important that patients and their families are made aware that the services of Indigenous Health Workers are available to them should they wish to utilise the service.

Medical practitioners

- The ARP form is to be reviewed or completed ideally by a senior registered medical practitioner at the earliest and most appropriate opportunity on admission to a QH facility or service.

Hospital and Health Services (HHS) responsibilities

As per the *Hospital and Health Boards Act 2011* (Qld), each HHS has a responsibility to develop local clinical governance arrangements, including service delivery, teaching, quality and performance.

With respect to implementation of the ARP, HHS executive and management should consider the following:

- Ensure there is an HHS-wide system in place to support staff to implement the ARP form. Ensure resources and systems are in place for the provision of safe, high-quality end-of-life care, including provision of appropriate education and training for the medical, nursing, allied health, administration and operational workforce
- Ensure incidents relating to the ARP form are reported and investigated, and outcomes actioned in accordance with the QH Incident Management System.
- Ensure effective local governance structures and processes are in place for the implementation, monitoring and evaluation of resuscitation planning and end-of-life clinical management. This may include auditing patient outcomes to identify opportunities to improve clinical care
- Generate reports about incidents relating to resuscitation planning and other end-of-life issues to analyse trends.
- Monitor trends through benchmarking across time and between services where appropriate
- Provide organisational governance and leadership in relation to the effective implementation of the ARP in partnership with other government and non-government organisations.
- Develop, implement and monitor local processes that support local clinicians and other health care team members providing services in relation to the ARP form. This may include updating local procedures.
- Establish a collaborative approach with other service providers (local residential aged care facilities, GPs, primary health care organisations, private hospitals and community-based services) to enable safe, high quality discharge planning and clinical handover and support continuity in patient-centred resuscitation planning and end-of-life care between QH and other healthcare service providers.

- Ensure that any learning gained from reviews of the resuscitation planning and procedures are reported to the HHS Chief Executive or appropriate delegate and that they are appropriately implemented and monitored.
- Ensure that all incidents and patient/consumer feedback are investigated, and appropriate action taken in accordance with local procedures.

ARP & National Safety and Quality Health Service Standards

In QH, all public hospitals, day procedure services, healthcare centres, residential aged care facilities and mental health services are required to implement the National Safety and Quality Health Service (NSQHS) Standards. This is carried out through accreditation.

Relevant accreditation Standards that address use of the ARP form and resuscitation planning generally include:

Standard 1 – Clinical Governance

Standard 2 – Partnering with Consumers

Standard 5 – Comprehensive Care

Standard 6 – Communicating for Safety

Standard 8 – Recognising and Responding to Acute Deterioration

Monitoring strategy

Measures that HHSs may consider in monitoring and evaluating use of the ARP form.

Measures			Data source
Timely and appropriate use of resuscitation planning	Percentage of patients in a high-risk cohort with an active ARP in place	Numerator: number of patients in a high-risk patient cohort with a valid ARP in place (patients who usually reside in an RACF, of advanced age, with multiple unplanned hospitalisations in the past 12 months, with multimorbidity or high frailty score) Denominator: total number of patients in a high-risk patient cohort	Mortality review data
	Percentage of ARPs in place for patients who died in a QH service/facility	Numerator: number of patients with ARP who died with an active resuscitation plan in place Denominator: total number of patients who died in QH service/facility	Mortality review data
Effective ACP and use of MET teams for patients at end-of-life	Number of MET calls where a patient had an active ARP in place.	Numerator: number of patients with a resuscitation plan in place at the time of a MET call review Denominator: total number of patients reviewed by the MET team	Met call data
Resuscitation planning education	The percentage of health practitioners who completed ARP training	Numerator: number of clinical staff who have completed ARP training Denominator: total number of clinical staff in QH service/facility	HHS data
ARP meeting quality standards of documentation	The number of active ARPs meeting quality standards for completeness	Numerator: number of ARPs meeting quality standards for completeness of each ARP section Denominator: Number of ARPs audited	HHS data

Relevant legislation/guidelines/resources

Legislation/standards/strategies

- *Powers of Attorney Act 1998* (Qld)
- *Guardianship and Administration Act 2000* (Qld)
- *Human Rights Act 2019* (Qld)
- *Mental Health Act 2016* (Qld)
- *Criminal Code 1899* (Qld)
- *National Safety and Quality Health Service (NSQHS) Standards (2nd edition)*
- Statewide strategy for end-of-life care 2015

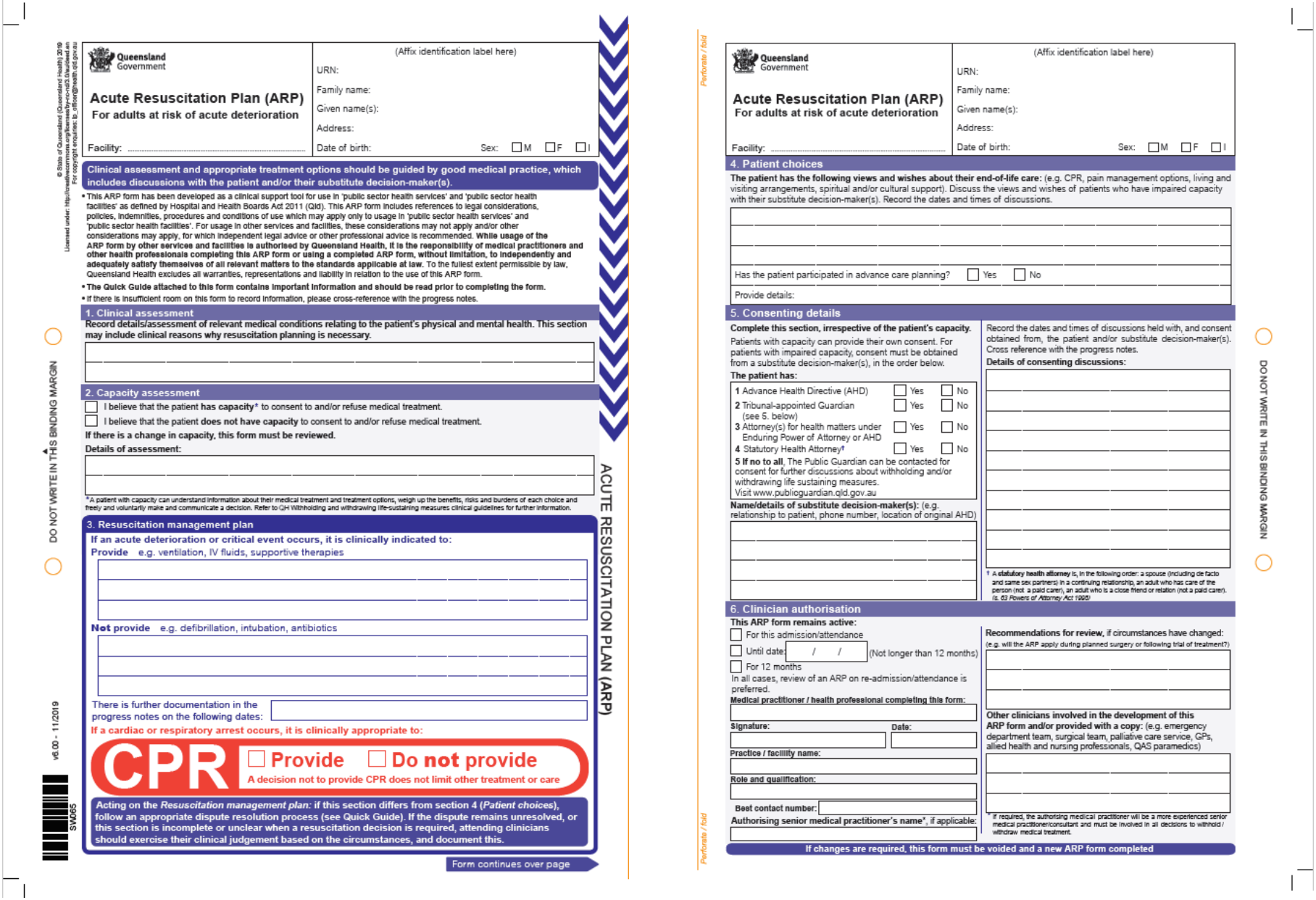
Guidelines

- Queensland Health: Guide to Informed Decision-making in Health Care 2nd edition
- Queensland Health 2018: Advance Care Planning Clinical Guidelines
- Queensland Health 2018: End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients
- Medical Board of Australia 2014: Good medical practice: A code of conduct for doctors in Australia
- Office of the Public Guardian 2018: Withholding and Withdrawal of Life-Sustaining Measures: Decision making framework
- Queensland Health Chief Psychiatrist Policy 2017: Advance Health Directives and 'Less Restrictive Way' of Treatment
- Queensland Ambulance Service 2018: Clinical Practice Guidelines: Resuscitation/ Resuscitation – General guidelines
- Queensland Ambulance Service 2017: Clinical Practice Guidelines: Resuscitation/ Resuscitation - Adult
- HHS service-specific guidance, policies and procedures

Resources

- Acute Resuscitation Plan: Quick Guide
- Acute Resuscitation Plan: Form
- Acute Resuscitation Plan: Cover sheet
- Acute Resuscitation Plan: Frequently asked questions
- 7-Step Acute Resuscitation Plan Pathway
- Flowcharts for providing healthcare and withholding/withdrawing life-sustaining measures
- Withholding and withdrawing life-sustaining measures and legal considerations
- 6 Step Advance Care Planning Process
- Advance Care Planning Quick Guide

Appendix 1: Acute Resuscitation Plan (including Quick Guide)



Queensland Government

Acute Resuscitation Plan (ARP)
For adults at risk of acute deterioration

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Facility: ..... 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.

Form continues over page

DO NOT WRITE IN THIS BINDING MARGIN

ACUTE RESUSCITATION PLAN (ARP)

v6.00 - 11/2019

SW065

Perforate / fold

Queensland Government

Acute Resuscitation Plan (ARP)
For adults at risk of acute deterioration

(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Facility: ..... 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 details

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

Perforate / fold

DO NOT WRITE IN THIS BINDING MARGIN

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

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.

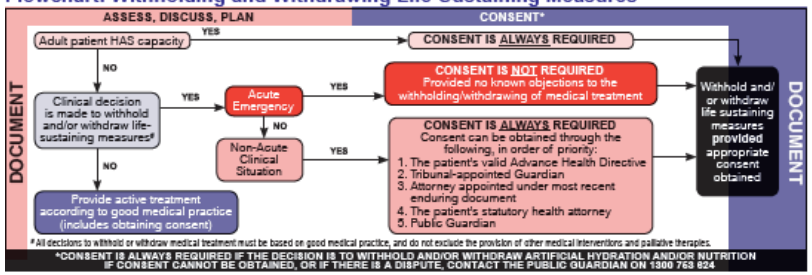
Effect of objection by patient to withholding or withdrawing life-sustaining measures

	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 noliminal 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

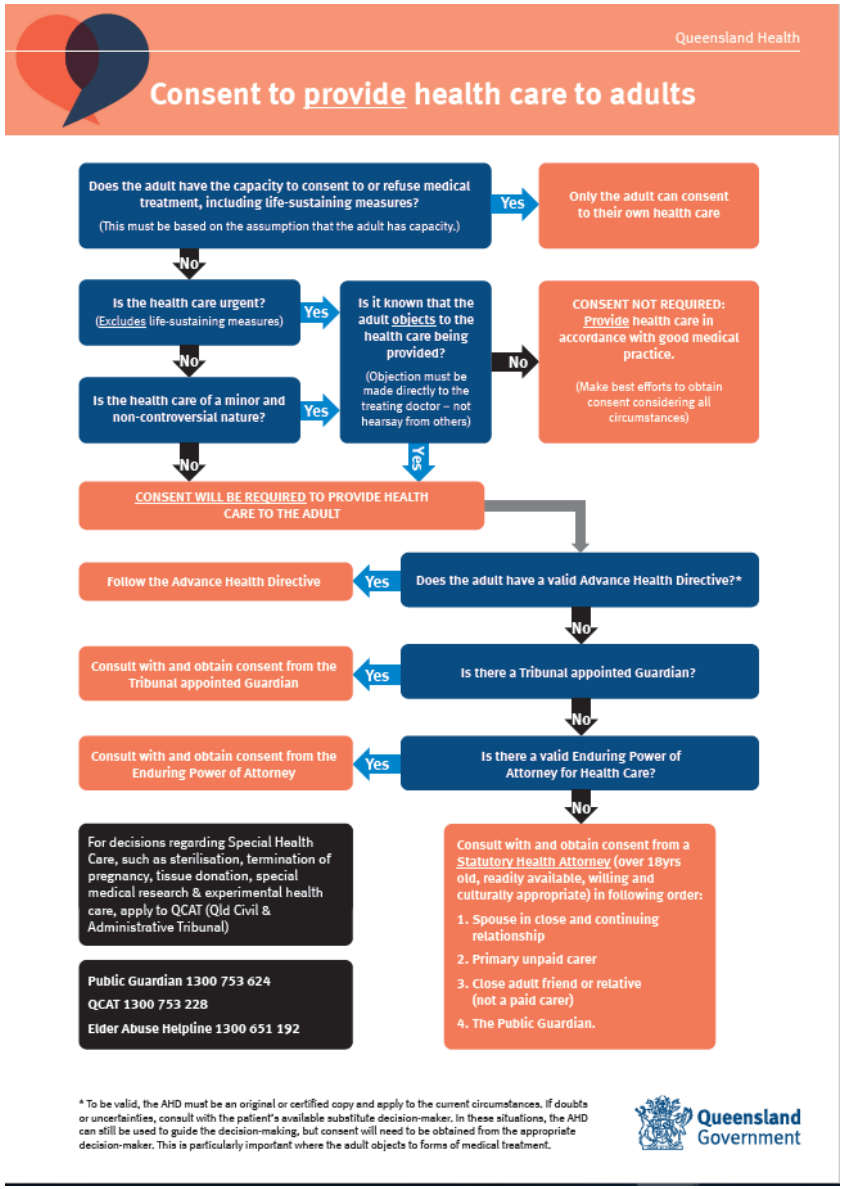
DOCUMENT DECISION-MAKING PATHWAY (legal requirement)

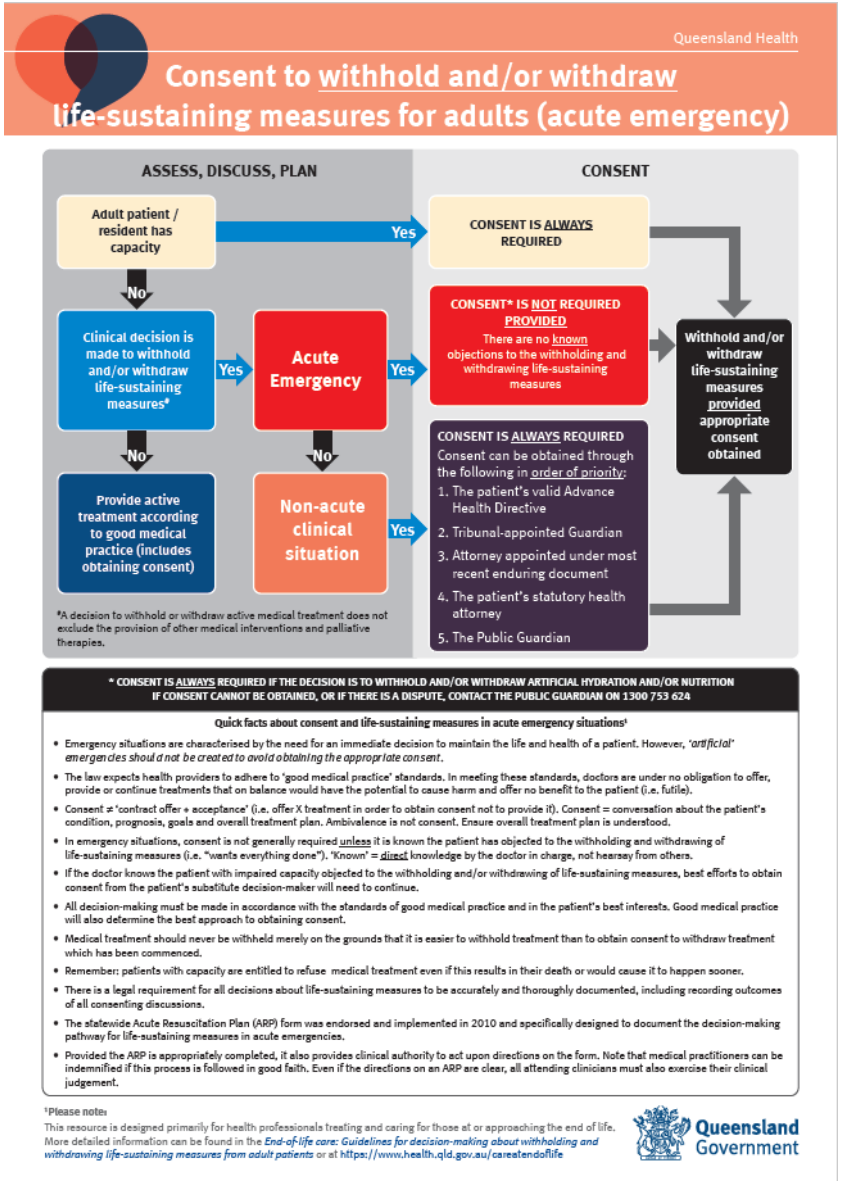
(NB This includes Queensland Health legal and policy positions. Staff from non-Queensland Health facilities and services should refer to the service's policies and procedures and seek their own legal advice)

Flowchart: Withholding and Withdrawing Life-Sustaining Measures



Appendix 2: Consent flowcharts for providing healthcare and withholding/ withdrawing life-sustaining measures





Appendix 3: Withholding and withdrawing life-sustaining measures legal considerations for adult patients fact sheet

Queensland Health

Withholding and withdrawing life-sustaining measures
Legal considerations for adult patients

Consent to withhold/withdraw life-sustaining measures

- Queensland guardianship legislation provides a consenting framework for adults with impaired capacity, through the use of Advance Health Directives (AHD) and substitute decision-makers (SDMs). EXCEPT IN EMERGENCY SITUATIONS, consent is required to withhold and/or withdraw life-sustaining medical treatment (including those measures considered to be "futile").
- Under the law, patients with capacity provide their own consent (and may refuse life-sustaining treatment, even if this results in their death or would cause it to happen sooner).
- The guardianship law provides for a COLLABORATIVE APPROACH to obtaining consent and includes a legal requirement to DOCUMENT the decision-making pathway.
- Good medical practice and clinical judgement will determine the best approach to the consenting process, with the objective of obtaining CONSENT TO THE OVERALL TREATMENT PLAN.
- Consent is NOT A CONTRACT. There is no "legal" offer and acceptance, but rather a CONVERSATION to ensure information is provided and broad understanding is obtained. This is to avoid criminal and civil action (ASSAULT).
- CONVERSATION = (discussion of) CONDITION + PROGNOSIS + OVERALL TREATMENT PLAN.
- COMMUNICATION IS KEY: The overall treatment plan should be discussed in the context of what can and can't be done (within reasonable limits of what is achievable) for the patient in a sensitive, yet honest way. This conversation may include discussion, in broad terms, of AVAILABLE treatment options, palliative care and other support measures. The conversation should occur as early as practicable to avoid decisions being made in a crisis.
- COMMUNICATION IS TWO-WAY: Silence or ambivalence from patients or SDMs is not consent. Ensure overall treatment plan is UNDERSTOOD.
- SDMs MUST adhere to the General Principles and the Health Care Principle, and act in best interests of adult (if not => the facility's dispute resolution process activates and => Public Guardian or court as a last resort).
- If the patient lacks capacity, consent is not required to provide comfort cares (minor/ uncontroversial health care). In these cases, the doctor must reasonably consider this is to promote the patient's health and wellbeing.

CONSENT = CONVERSATION ABOUT THE OVERALL TREATMENT PLAN

Health providers are under no legal or ethical obligation to offer or provide futile medical treatment; that is, treatment that affords no benefit and would cause harm to the patient.

THINK DISPUTE RESOLUTION!

Futile medical treatment

- Concept difficult, controversial and term is best avoided in end-of-life discussions with patients and SDMs. Guardianship law definition linked to "good medical practice" (medical and ethical standards). AHPRA (Medical Board of Australia) provides a *code of conduct for doctors* on good medical practice, with specific guidance on end-of-life care.
- Doctors are only required to OFFER what is clinically appropriate and available to the patient, but doctors must still have the consenting conversation (see above).
- Doctors are only required to PROVIDE what is clinically appropriate and available to the patient in accordance with good medical practice.
- Doctors do NOT have to provide, nor accede to demands by patients and their families for clinically inappropriate medical treatment (i.e. futile treatment). THINK dispute resolution.
- Where no AHD, a consent to the withholding or withdrawal of life-sustaining measures (LSM) by a SDM cannot operate unless the doctor reasonably considers PROVIDING the measures would be INCONSISTENT with good medical practice, that is PROVIDING LSMs would be potentially futile.
- Doctors can override directions in AHDs in very limited circumstances (e.g. different circumstances

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apply to directions in AHD; also, a direction to withhold or withdraw LSMs cannot operate in an AHD unless - the patient is in a coma, or is terminally ill with less than 1 year to live, or has no prospect of regaining capacity for health matters, and the treating doctor believes that PROVIDING the measures would be INCONSISTENT with the standards of good medical practice, in other words providing LSMs would be futile).

- An objection by the patient to withhold and/ or withdraw LSMs is awkwardly dealt with in the guardianship legislation, but is considered rare in reality. An OBJECTION to a clinical decision to withhold and/or withdraw LSMs = DEMAND for futile treatment (see Acute Resuscitation Plan [ARP] Quick Guide). QH policy position is that objections must be expressed directly to the treating doctor (NOT through a family member).
- The position in legislation is that if the objection is expressed to the doctor, consent will be needed to withhold and/or withdraw treatment.

Clinical management, coordination and responsibility

- Medical technology and the medicalisation of dying has increased demands on the health care system, particularly in ICUs. Queensland Health has to respond by ensuring its approach is both practical and capable of balancing competing interests. Shifting the focus to a more realistic expectation of dying and providing patients with appropriate treatment can reduce unnecessary and unwanted invasive measures and transfers to ICUs.
- Starting point is ALWAYS clinical. When completing an ARP, DOCTORS: What is good medical practice in THIS situation? What can realistically be offered? What can YOU provide this patient to improve their life and health? What would YOU do if the patient arrests? What would YOU want an attending team to do if the patient arrests?
- Remember – Clinical is followed by the legal: Legal does NOT determine the clinical.

- Medical treatment should never be withheld merely on the grounds that it is easier to withhold treatment than to withdraw treatment which has commenced.
- Do not create 'artificial' emergencies to avoid obtaining consent, if there is time to do so.
- If clinical doubts or uncertainties, the decision must favour life. Seek a second opinion from an experienced clinician.

Clinical leadership

- Clinical leadership is required to ensure only clinically necessary and available treatment is offered and provided to patients. (DOCTORS: Should the patient be referred to palliative care? If not now, when?)
- If patients are being transferred inappropriately to ICU, must resolve with other specialty.
- Conducting advance care planning (ACP) discussions with the patient and/or their decision-makers as early as appropriate can assist with this process. Ideally, ACP discussions should commence long before a patient has a need for an ARP.
- Documentation of all decisions around life-sustaining measures must be clear & thorough (legal requirement).
- Completing the ARP which was designed to be used in acute emergency situations assists to:
  - identify earlier those patients for whom life-sustaining measures (such as CPR) are clinically inappropriate;
  - identify those patients who refuse medical treatment (e.g. do not want "heroic" LSMs);
  - ensure the appropriate decision-making process is documented and followed (clinical, ethical, legal);
  - initiate dispute resolution when needed; and
  - avoid the "11th hour" crisis and commencement of clinically inappropriate treatment.
- Policy and process compliance => protections under law and indemnity from Queensland Health.

Queensland Health guiding principles for decision-making about life-sustaining measures

Principle 1:	All decision-making must reflect respect for life and the patient's right to know and choose.
Principle 2:	All decision-making must meet the standards of good medical practice.
Principle 3:	All efforts must be made to obtain the appropriate consent through a collaborative approach.
Principle 4:	There must be transparency in and accountability for all decision-making.

Please note:

This resource is designed primarily for health professionals treating and caring for those at or approaching the end of life. More detailed information can be found in the *End-of-life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients* or at https://www.health.qld.gov.au/careatendoflife

Appendix 4: 7-step Acute Resuscitation Plan Pathway

The 7-Step Acute Resuscitation Plan Pathway is a step-by-step process to assist clinicians to make decisions about resuscitation and other life-sustaining treatment, and to develop and document the patient's clinical plan on their ARP form.

STEP 1 - Review

- It is good medical practice to **review** the copy of a patient's ARP form to ensure it is valid, applicable to the patient's current situation, complete; and the consent details are current
- If the ARP copy is lapsed, no longer relevant or voided, a new ARP form must be completed for the patient, if resuscitation planning is appropriate.

STEP 2 - Identify

- Triggers that assist to **identify** a person may benefit from an ARP or advance care planning:
  - the "surprise question" – would you be surprised if the person were to die in the next year?
  - the person is experiencing symptoms and signs that indicate declining general health
  - the person is experiencing indicators of decline related to their specific disease or conditions
  - the person reaches or experiences a significant milestone e.g. advancing age (i.e. aged >65 years or older, or >55 years if an Aboriginal or Torres Strait Islander person), retirement, bereavement, admission to community or aged care facility
  - the person, substitute decision-maker(s) and family members and / or carers raises resuscitation planning with a health professional.

STEP 3 - Assess

- Make a full clinical **assessment** of the patient, considering options and uncertainties for future treatment
- **Assess** the patient's capacity to participate in discussions
- Review existing advance care planning documentation

STEP 4 - Discuss

- **Discuss** the patient's condition, goals of care, prognosis, and uncertainties about treatment with the patient and / or their substitute decision-maker
- **Discussions** should address the person's priorities and goals for life / healthcare (e.g. comfort, symptom relief, function, length of life), in alignment with their values to define quality of life
- If there is disagreement with the resuscitation management plan, all efforts should be made to resolve the situation (see ARP Quick Guide attached to the ARP form for more information). If dispute resolution attempts are unsuccessful, contact the Office of the Public Guardian.

STEP 5 - Document

- **Document** the clinical plan about resuscitation / life-sustaining measures on the ARP.
- Give a copy of the ARP form to the patient; file the original on the patient's health information record.
- Use systems (i.e. electronic flags) to ensure the ARP form can be easily located by health professionals in the event of an acute emergency.
- Support and encourage patients to **document** outcomes from advance care planning discussions on forms (e.g. Statement of Choices, Advance Health Directive, Enduring Power of Attorney forms) with their substitute decision-maker(s) and family members and / or carers.

STEP 6 - Implement

- Take practical steps to **implement** the ARP and to act on the instructions on the form, adhering to good medical practice standards.

STEP 7 - Support

- Offer informational, practical, emotional, cultural and spiritual **support** throughout the process to the patient, substitute decision-maker(s) and family members and / or carers.
- Seek **support** for yourself and / or other health professionals to enable reflection and continual learning.

This resource has been adapted from the SA Health document 7-step Pathway Diagram with permission from Department for Health and Wellbeing.