Mater Misericordiae Ltd

ADULT RESUSCITATION PLAN (ARP)

Unit Record No. _____

Surname _____

Given Names _____

DOB _____ Sex _____

AFFIX PATIENT IDENTIFICATION LABEL HERE

F4362

Read accompanying instructions before completion.
This form must be completed by a Consultant or Registrar. Resident Medical Officers are not permitted to complete this form.

1. Trigger

Consider completing this form if the patient meets any of the following trigger criteria:

1. Answering '**No**' to the '**Surprise Question**': *"Would I be surprised if this patient died in the next 12 months"*.
2. Patient meets criteria using the Supportive and Palliative Care Indicators Tool (SPICT) which is a tool for identifying individuals at risk of deteriorating or dying (see page 4 attached).
3. The patient, family, substitute decision-maker, or multidisciplinary team member expresses concern that the patient is dying.
4. Any patient who has declined life sustaining treatment in an Advance Health Directive or Advance Care Plan, or expresses wishes not to receive specific treatments primarily aimed at prolonging life (e.g. CPR, dialysis).
5. Patient observations likely to meet/ currently meeting Medical Emergency Team call criteria or patient referred to ICU.

2. Patient Wishes

Identify functional outcomes of particular value to the patient and document outcomes that would not be acceptable to the patient (e.g. loss of independence). This will help guide discussions and decisions regarding goals of care and treatment. For patients with impaired decision-making capacity, discuss their wishes/ views with their substitute decision-maker.

3. Goals of Care

- ☐ Curative or restorative with no treatment limitations
- ☐ Curative or restorative with limitations of treatments but with interventions to improve symptoms
- ☐ Palliative symptom management and quality of life without interventions designed to prolong life
- ☐ Terminal care of the dying patient

4. Resuscitation Plan

Indicate if the following decisions about resuscitation apply:

CPR ☐ **FOR CPR** ☐ **NOT for CPR**

☐ **FOR MET calls**	OR	☐ **NOT for MET calls**
Only complete if **FOR** MET		Only complete if **NOT** for MET
CONSIDER REFERRAL TO ICU: ☐ Yes ☐ No		☐ **ACTIVE WARD MANAGEMENT** (this should include comfort cares)
Comment:		Comment:
		☐ **COMFORT CARE ONLY**

Binding margin - do not write. Do not reproduce by photocopying. All clinical form creation and amendments must be conducted through Health Informatics.

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11/17
Ver. 5.00
F4362

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ADULT RESUSCITATION PLAN (ARP)

Unit Record No. _____

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DOB _____ Sex _____

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5. Capacity Assessment and Identification of Decision-Maker

If there is an Advance Care Plan (e.g. Statement of Choices or Palliative Care Plan) it must be referred to by those making decisions.

Does the patient have decision-making capacity to consent to/ or refuse medical treatment? Document assessment in chart.

☐ **YES** **The clinical situation must be discussed with the patient. Identify if any of the below substitute decision-maker(s)/ documents are in place as they may be required in the future (listed in order of priority – tick all that apply and document details below)**

☐ **NO** **This must be documented in the progress notes and at least one of the following documents or individuals should be consulted (listed in order of priority – tick all that apply and document details below)**

a. ☐ Advance Health Directive (AHD)
b. ☐ Tribunal-appointed Guardian
c. ☐ Attorney for health matters under Enduring Power of Attorney (EPOA) or AHD
d. ☐ Statutory Health Attorney (Next of Kin)
e. ☐ If no to all, the Adult Guardian must be contacted for consent, phone: 1300 753 624

Name of substitute decision-maker(s), relationship to patient, and contact number:

6. Transparency and Patient Views

Goals of care and resuscitation plan explained to:

☐ Patient (mandatory if decision making capacity present); ***OR***

☐ Substitute decision-maker/ relative/ carer

Name: ..... Relationship to patient: .....

☐ **Agrees** with resuscitation and treatment plan; ***OR*** ☐ **Disagrees** with resuscitation and treatment plan*

Consent provided to discuss resuscitation decisions with family/ others? ☐ Yes ☐ No

Information regarding above discussions can be found in the progress notes on the following date(s): ..... / ..... / .....

If the patient disagrees with the resuscitation plan, see STEP 6 and Legal Considerations on page 3 attached.

7. Clinician Authorisation

Medical officer (print name):	Designation:
Signature:	Date:
Authorising consultant (print name):	

This Resuscitation Plan remains valid:

☐ **For this admission** ☐ **Until date:** ..... / ..... / ..... ☐ **For 12 months:** ..... / ..... / .....

Cancelling Plan

To **revoke** this Resuscitation Plan strike through the front and back pages, write '**VOID**', and sign and date below. A new form must be completed if the previous form has been revoked.

Medical officer revoking plan (print name):	Designation:
Signature:	Date:

8. Maintaining Patient Wishes

Provide copies of the Resuscitation Plan to the patient (or their substitute decision-maker) and care provider (e.g. GP/ residential aged care facility) if appropriate to ensure patient wishes regarding resuscitation and end of life care are upheld following discharge from hospital and to facilitate completion of an Advance Care Plan with relevant primary care providers. Advise patients that this form should be presented to Ambulance officers if they are contacted to attend the patient.

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Steps

Step 1 – Trigger

This form should be completed early if the patient's condition necessitates decisions about resuscitation or end of life care (i.e. last 6–12 months of life). The readiness of the patient and family to participate in advance care planning needs to be taken into consideration. Obtain adequate information to permit clinical decisions about resuscitation and/ or end of life care. If there is significant uncertainty regarding the patient's current or previous medical condition(s) then a second opinion, further investigations, or collateral history may be required before proceeding.

Step 2 – Patient Wishes

Avoid focusing initially on medical interventions (e.g. CPR) and instead determine patient values and preferences (e.g. preserving mentation and functional status, avoiding residential care, minimising suffering). This will help guide treatment discussions and decisions based on likely outcomes and patient wishes.

Step 3 – Goals of Care

Identify goals of care so that patients receive treatment appropriate for their condition and are not subjected to burdensome or futile treatments. Symptom management (e.g. palliative care) and restorative therapy are not exclusive and can be used concurrently. Goals may change during a patient's illness trajectory and should be reviewed if there is a change in condition.

Step 4 – Resuscitation Plan

Discuss treatment options and likely outcomes. Consider goals of care and patient wishes, particularly with regards to valued functional outcomes, when making decisions regarding resuscitation and other treatments. A decision not to provide resuscitation does not preclude provision of other treatments (e.g. IV antibiotics, blood products) and active ward management does not preclude provision of comfort cares (e.g. pain management with opiates).

Step 5 – Capacity Assessment and Identification of Decision Maker

Make an assessment about the capacity of the patient to participate in discussions about resuscitation (see *Guide to Capacity Assessment*). If it is unclear (e.g. fluctuating capacity) seek a second opinion and/ or arrange a mental health assessment. Legally, all patients with impaired capacity must have a substitute decision-maker. If a substitute decision-maker is required, establish if preferences relevant to the situation have been previously expressed in an Advance Health Directive (AHD), Advance Care Plan (ACP), or in previous discussions to guide decisions. Copies of AHD, ACP, and Enduring Power of Attorney (EPOA) documents need to be obtained and entered into the electronic health record as 'alerts'.

Step 6 – Transparency and Patient Views

Explain the plan to the patient or substitute decision-maker, along with other individuals indicated by the patient/ decision-maker. Allow time for patients to process information and encourage questions. Record details of discussions in the progress notes. When patient choices differ from the clinician's treatment recommendations then all efforts should be made to explain why the request is not in keeping with 'good medical practice' and is not in the patient's best interests. Involvement of the Multi-Disciplinary Team is recommended in these situations and it may be beneficial to obtain a second opinion from a more experienced clinician (i.e a specialist in a specific area). See also *Legal Considerations*.

Step 7 – Clinican Authorisation

The most senior medical officer available should complete and sign the Adult Resuscitation Plan (ARP). If there is a significant change in patient condition, the existing plan should be reviewed and consideration given to revoking it and completing a new form. Reasons for revoking the plan need to be documented in the progress notes.

Step 8 – Maintaining Patient Wishes

If a patient is being transferred to another facility, a copy of the ARP should be provided to assist ongoing care. It is also recommended that the patient's GP receive a copy of the form to aid completion of an ACP.

Guide to Capacity Assessment

Capacity assessment relates to the person's ability to make a specific decision at a specific point in time. To have capacity, a patient must be able to:

1. Understand information about their medical treatment and treatment options;
2. Weigh up the benefits, risks, and burdens of each choice, including the implications of no treatment;
3. Freely and voluntarily make a decision; and
4. Communicate their decision (e.g. by talking, using sign language, or any other means).

Legal Considerations

Based on Australian Common Law, clinicians are not required to attempt medical treatment that could cause harm or would not provide benefit to a patient. The law expects clinicians to comply with 'good medical practice' (GMP) standards and ***for patients with capacity there is no legal obligation to agree to demands for clinically inappropriate treatment***. However, in Queensland, unlike other Australian jurisdictions, the *Guardianship Act 2000* makes it ***an offence to provide, withdraw, or withhold health care for an adult with impaired capacity without consent from a substitute decision-maker***. In emergency situations, consent is not required and the decision to provide or withhold treatment should be based on GMP. In any situation where a patient or their substitute decision-maker requests treatment that differs from the Resuscitation Plan, all efforts should be made to resolve the situation. For patients with impaired capacity, the matter can be referred to the Adult Guardian for resolution if required. Clear and detailed documentation of all discussions is essential.

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THE UNIVERSITY of EDINBURGH

Supportive and Palliative Care Indicators Tool (SPICT-4ALL™)

The SPICT™ helps us to look for people who are less well with one or more health problems. These people need more help and care now, and a plan for care in the future. Ask these questions:

Does this person have signs of poor or worsening health?

- Unplanned (emergency) admission(s) to hospital.
- General health is poor or getting worse; the person never quite recovers from being more unwell. (This can mean the person is less able to manage and often stays in bed or in a chair for more than half the day)
- Needs help from others for care due to increasing physical and/ or mental health problems.
- The person's carer needs more help and support.
- Has lost a noticeable amount of weight over the last few months; or stays underweight.
- Has troublesome symptoms most of the time despite good treatment of their health problems.
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Does this person have any of these health problems?

Cancer

Less able to manage usual activities and getting worse.

Not well enough for cancer treatment or treatment is to help with symptoms.

Dementia/ frailty

Unable to dress, walk or eat without help.

Eating and drinking less; difficulty with swallowing.

Has lost control of bladder and bowel.

Not able to communicate by speaking; not responding much to other people.

Frequent falls; fractured hip.

Frequent infections; pneumonia.

Nervous system problems

(eg Parkinson's, MS, stroke, motor neurone disease)

Physical and mental health are getting worse.

More problems with speaking and communicating; swallowing is getting worse.

Chest infections or pneumonia; breathing problems.

Severe stroke with loss of movement and ongoing disability.

Heart or circulation problems

Heart failure or has bad attacks of chest pain. Short of breath when resting, moving or walking a few steps.

Very poor circulation in the legs; surgery is not possible.

Lung problems

Unwell with long term lung problems. Short of breath when resting, moving or walking a few steps even when the chest at its best.

Needs to use oxygen for most of the day and night.

Has needed treatment with a breathing machine in the hospital.

Kidney problems

Kidneys are failing and general health is getting poorer.

Stopping kidney dialysis or choosing supportive care instead of starting dialysis.

Liver problems

Worsening liver problems in the past year with complications like:

- fluid building up in the belly
- being confused at times
- kidneys not working well
- infections
- bleeding from the gullet

A liver transplant is not possible.

Other conditions

People who are less well and may die from other health problems or complications. There is no treatment available or it will not work well.

What we can do to help this person and their family.

- Start talking with the person and their family about why making plans for care is important.
- Ask for help and advice from a nurse, doctor or other professional who can assess the person and their family and help plan care.
- We can look at the person's medicines and other treatments to make sure we are giving them the best care or get advice from a specialist if problems are complicated or hard to manage.
- We need to plan early if the person might not be able to decide things in the future.
- We make a record of the care plan and share it with people who need to see it.

SPICT-4ALL™, June 2017