Acute Resuscitation Plan Cover Sheet

A copy of this patient’s Acute Resuscitation Plan is attached

(Affix patient identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐ M ☐ F ☐ I

An original ARP form contains important information and its purple/red colour scheme allows it to be easily located when needed. A copy of the patient's active ARP form should be provided to a receiving health care facility if the patient is transferred. Voided or lapsed ARP forms can also be provided for information purposes. This Cover Sheet should accompany a copy of the form(s).

It may also be appropriate to provide a copy of the ARP form (active, voided or lapsed) to the patient's GP.

An ACTIVE ARP means that it is:
1. Valid until a specified (future) date; or
2. Valid "for this and subsequent admissions".
(this information is in Section 6 on page 2 of the ARP form)

For Queensland Health Facilities

- The receiving facility should complete an original ARP form for use in that facility, if resuscitation planning is required for the patient.
- If the facility receives a copy of a patient's ACTIVE ARP form and there has been insufficient time to complete an original ARP form, the health care team may act on its information and clinical instructions based on clinical judgement at the time a decision is required.
- When a facility completes an original ARP form, relying on some or all of the information in a copy of a patient's ACTIVE ARP form, the facility must:
  1. Verify that both pages (sections 1 to 6) of the ARP copy are attached;
  2. Check that the ARP copy is the most recent version;
  3. Check the validity of the ARP form in Section 6 on page 2 of the form;
  4. Verify that the consenting details documented on the copy are current; and
  5. Pending the completion of an original ARP form, file the copy of the ARP form at the front of the patient's record, or in the most prominent position, according to facility practice.
- When creating an original ARP form, the medical officer or the patient’s treating doctor at the receiving facility should review any copies of forms received, and may:
  1. Contact the previous signing/authorising medical officer or treating team from the facility where the original ARP was completed;
  2. Conduct any re-assessments of the patient, as appropriate; and/or
  3. Discuss the patient's choices, appropriate to the circumstances.*

For Non-Queensland Health Facilities

- A copy of a patient’s ARP form is provided for information purposes only. Facilities other than those managed by Queensland Health are responsible for following their own procedures and processes for documenting or acting on resuscitation planning decisions. This includes the Queensland Ambulance Service while the patient is in transit.

* In some cases it may be distressing for a patient and/or their substitute decision-maker to revisit resuscitation planning discussions already held at the previous facility.
Acute Resuscitation Plan Form – Information Sheet

General
- The ARP form replaces ‘not for resuscitation’ (NFR) orders and documents resuscitation planning.
- An ARP form should be completed where it is reasonably expected that an adult patient (≥18) may suffer an acute deterioration or critical event (e.g. cardiac or respiratory arrest) in the foreseeable future and require resuscitation planning. Particular consideration should be given to adult patients who are terminally ill and/or are expected to die within 12 months. For further information on prognostic indicators, please refer to the Implementation Guidelines Part 1.

Legal considerations
- The law requires a collaborative approach between health providers and patients and/or their substitute decision-maker(s) about providing, withholding or withdrawing life-sustaining measures, and appropriate documenting of this. The ARP form prompts this approach.
- An ARP form is a clinical record and does not in itself give consent to provide, withhold or withdraw, life-sustaining measures. Legal authority comes from obtaining consent to the Resuscitation management plan from the appropriate decision-maker. The ARP form does, however, provide clinical authority to act on its resuscitation planning instructions, provided those instructions are clear.
- An ARP form is not the same as, nor does it replace, an AHD.
- The law expects health providers to adhere to clinical and ethical standards through ‘good medical practice’ (GMP). In meeting these standards, medical officers are under no 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 also requires informed consent. When active treatments are no longer appropriate, this should be sensitively explained (in specific or broad terms) to patients and/or their substitute decision-maker(s), and available end-of-life treatment and care options discussed.
- In some emergency situations, while all reasonable efforts should be made to obtain consent, it may be inappropriate to continue to maintain life while attempts are made to obtain consent. Emergency situations are characterised by the need for an immediate decision to be made about maintaining the life and health of a patient.
- 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 staff who comply with Queensland Health policy on the withholding and withdrawal of life-sustaining measures.
- See Flowchart: Withholding and Withdrawing Life-sustaining Measures.

Capacity
- Under the law, all patients are presumed to have capacity. The law differentiates between patients with capacity and without capacity in terms of consenting to health care.
- A patient with capacity is entitled to refuse any or all medical treatment, even if this results in their death. The treating medical officer should ensure the patient receives adequate information about the nature of the proposed treatment measures.
- 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).

- A substitute decision-maker(s) must consider the patient’s best interests, the patient’s views and wishes and 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 life-sustaining measures being provided, withheld or withdrawn. Queensland Health’s policy 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 officer as close as possible to the acute deterioration or event.
- For the withholding or withdrawal of medical treatment, an objection 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 Advance Health Directive.

Effect of objection by patient to withhold/withdraw life-sustaining measures

<table>
<thead>
<tr>
<th>Emergency</th>
<th>Non-emergency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity</strong></td>
<td><strong>Capacity</strong></td>
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<tr>
<td>- Objection = demand for treatment</td>
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<tr>
<td>- Patient cannot demand clinically inappropriate treatment</td>
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<tr>
<td>- Discuss with patient, if time permits</td>
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<tr>
<td>- Provide treatment at discretion with consent; or</td>
<td></td>
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<tr>
<td>- Withhold/withdraw treatment without consent</td>
<td></td>
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<tr>
<td>- Document decision-making pathway</td>
<td></td>
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<tr>
<td><strong>Time to manage objection/demand for treatment</strong></td>
<td></td>
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<tr>
<td><strong>Time to manage objection/demand for treatment</strong></td>
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<tr>
<td><strong>Non-Acute</strong></td>
<td><strong>Non-Acute</strong></td>
</tr>
<tr>
<td><strong>Impaired capacity</strong></td>
<td><strong>Impaired capacity</strong></td>
</tr>
<tr>
<td>- Medical officers cannot override patient objection. Need consent from substitute decision-maker (legal position)</td>
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<tr>
<td>- All reasonable efforts should be made to obtain consent</td>
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<tr>
<td>- If consent cannot be obtained in time available, or decision-maker(s) demands clinically inappropriate treatment, withhold/withdraw medical treatment if consistent with GMP (policy position)</td>
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<tr>
<td>- Document decision-making pathway (legal requirement).</td>
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<tr>
<td><strong>Time to make decision</strong></td>
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<tr>
<td><strong>Time to make decision</strong></td>
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For further information and resources, contact Access Improvement Service:
Email: QHclinicalethics@health.qld.gov.au

Flowchart: Withholding and Withdrawing Life-Sustaining Measures

*CONSENT IS ALWAYS REQUIRED*