Acute Resuscitation Plan (ARP)

For adults at risk of an acute deterioration

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).

1. This ARP form is for use in all Queensland Health facilities (e.g., hospitals, aged care and other residential facilities).
2. The Quick Guide attached to this form contains important information and should be read prior to completing the form.
3. 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.

Details of assessment:

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

Flowchart: Withholding and Withdrawing Life-Sustaining Measures

Annex, discuss, plan

Clinical decision is made to withhold and/or withdraw life-sustaining measures

Adult patient has capacity

Yes

No

CPR

Consent IS ALWAYS REQUIRED

Consent can be obtained through the following, in order of priority:
1. The patient’s valid and current Advance Health Directive
2. The patient’s valid and current Public Guardian
3. The patient’s substitute decision-maker(s)
4. The patient’s statutory health attorney

CPR

Consent is NOT REQUIRED

Provided no known objections to the withholding and withdrawing of medical treatment

CPR

Consent IS ALWAYS REQUIRED

Consent can be obtained through the following, in order of priority:
1. A patient with capacity is entitled to refuse any or all medical treatments, and a refusal results in their death. The treating medical officer should ensure the patient receives adequate information about the nature of the proposed treatment measures.
2. The law recognises that the patient’s objections be expressed directly to the treating medical officer as close as possible to the acute deterioration or event.
3. For the withholding or withdrawal of medical treatment, an objection may be expressed by the patient as a verbal request to “do nothing” or “don’t let me die”, or by their conduct, or in formal terms through an Advance Health Directive.

Flowchart: Withholding and Withdrawing Life-Sustaining Measures

Emergency Non-emergency

Capacity

Time to manage objection/pathway

Need consent from substitute decision-maker (if legal position)

Objection can be overridden by time to manage objection/pathway

If no consent, or decision-maker does not provide treatment at discretion

Document decision-making pathway

For patients with chronic terminal illness, discussing resuscitation planning with them on each admission may be unduly distressing and inappropriate. In these situations, it is unlikely that many of the details on the ARP will change, even across admissions.

* A patient with capacity can understand information about their medical treatment and treatment options, weigh the benefits, risks, and burdens of each choice and freely and voluntarily make and communicate a decision.

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Acute Resuscitation Plan (ARP)
Quick guide to completing an Acute Resuscitation Plan (ARP)

Remove these instructions before filing this ARP form. It is recommended that the original form be filed at the front of the patient’s medical record, but individual facilities can decide on the most practical place to file the form.

The Quick Guide should be read in conjunction with the End of life care: Guidelines for decision-making about withholding and withdrawing life-sustaining measures from adult patients - Guidelines for health professionals found at www.health.qld.gov.au/clinical-guidelines

Section 1. Clinical assessment
- If there are doubts or uncertainties about the patient’s medical condition, a second opinion should be obtained.

Section 2. Capacity assessment
- If there are doubts about the patient's capacity (e.g. fluctuating or episodic capacity), seek a second opinion and/or arrange a mental health assessment.
- See the Withholding and withdrawing life-sustaining measures guidelines for further information.

Section 3. Resuscitation management plan
- Record the treatment and care that should be provided, and whether a substitute decision-maker(s) can be involved.
- Cross-reference any previous advance care planning, including relevant details from a SoC, if completed. Resolve any discrepancies between the two documents.
- If it is not clinically appropriate to provide CPR, clearly state any treatments and therapies that contribute to quality end-of-life care.
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Section 4. Patient choices
- Where a patient with capacity has strong views about their end-of-life care, they should complete an Advance Health Directive (AHD).
- 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(s).
- Where a patient with capacity has strong views about their end-of-life care, 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. Refer to the list of substitute decision-makers in section 5 to obtain consent if the patient does not have capacity to make decisions about health matters.
- Cross-reference any previous advance care planning, including relevant details from a SoC, if completed. Resolve any discrepancies between the two documents.
- For more information about resuscitation planning and care at the end of life, visit www.health.qld.gov.au/end-of-life

Dispute resolution: when patient choices differ from the Resuscitation management plan
Where a patient’s choices differ from the Resuscitation management plan, the medical officer 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. futile).

Involvement of all members of the health care team is recommended in these situations. The medical officer may also seek a second opinion from and/or involvement of a more experienced clinician.
- All efforts should be made to resolve the situation. If unsuccessful, the medical officer must refer the matter to executive level.
- If a substitute decision-maker(s) is not adhering to the Health Care Principle and the Clinical Principles, the matter can be referred to the Public Guardian for resolution (see Capacity).
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- Clear and detailed documentation is vital at all stages of discussions held.

Section 5. Consenting details
- Under the law, all patients with impaired capacity have a substitute decision-maker(s). This includes the Public Guardian when no other substitute decision-maker(s) is available.
- For patients with capacity, this section identifies a potential substitute decision-maker(s) prior to any loss of capacity. Consent must be obtained to perform an Acute Resuscitation management plan, except in some emergency situations. This may involve dispute resolution. See Legal considerations and Capacity.
- Consent from patients or their substitute decision-maker(s) 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 substitute decision-maker(s) to sign the ARP form. Consent shall remain in effect from the patient’s or their substitute decision-maker(s) as close as possible to the acute deterioration or event. If consent is obtained earlier (e.g. in the ED), the attending medical officer must be satisfied that the consent remains valid.

Section 6. Clinician authorisation
- This section should be completed by the responsible clinician (e.g. the medical officer responsible for the patient’s medical record). Consent from patients or their substitute decision-maker(s) can be obtained verbally.
- Consent from patients or their substitute decision-maker(s) can be obtained verbally, if there are no objections from the patient’s or their substitute decision-maker(s). In the absence of consent, this section must be completed on behalf of the patient.

Voids the ARP form
- If changes are required or the form has lapsed, it must be marked as void under the authority of a medical officer. A medical officer is responsible for deciding whether a new ARP form is required.
- 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.

6. Clinician authorisation
- This ARP form remains valid:

Consultant / medical officer’s name:

Signature:

Other clinicians involved in the development of this ARP form and/or provided with a copy:
(e.g. Emergency Department team, Palliative Care Service, GPs, allied health and nursing professionals).

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

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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 or their potential substitute decision-maker(s) requests treatment that differs from the Resuscitation management plan, the medical officer 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. futile).

Involvement of all members of the health care team is recommended in these situations. The medical officer may also seek a second opinion from and/or involvement of a more experienced clinician.
- All efforts should be made to resolve the situation. If unsuccessful, the medical officer must refer the matter to executive level.
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