



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

Facility: ..... URN: (Affix identification label here)

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

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

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

## 1. Clinical assessment

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

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## 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 what resuscitation decision is required, attending clinicians should exercise their clinical judgement based on the circumstances, and document this.

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### General

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

### Communicating with patients

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

### Legal considerations

- The law requires a collaborative approach between health providers and patients and/or their substitute decision-maker(s) (SDM) about providing, withholding or withdrawing life-sustaining measures (LSM), and appropriate documentation of these decisions.
- There is a legal requirement to document the decision-making pathway around LSMs. Completing the ARP form prompts this approach.
- An ARP form is a clinical tool or medical order and does not in itself give consent to provide, withhold or withdraw LSMs. Legal authority comes from obtaining consent to the overall treatment plan. This should be documented.
- An ARP form is not the same as, nor does it replace, an Advance Health Directive (AHD).
- The law expects health providers to adhere to 'good medical practice' (GMP) standards. In meeting these standards, medical practitioners are under no legal or ethical obligation to offer, provide or continue treatments that on balance would have the potential to cause harm and offer no benefit to the patient (i.e. futile).
- GMP will also determine the best approach to obtaining consent. Consent ≠ contract 'offer and acceptance'. Consent = conversation about the patient's condition, prognosis, goals for care and overall treatment plan.
- In acute emergencies, consent is not generally required (see: *Patient objections*). Emergency situations are characterised by the need for an immediate decision about maintaining the life / health of a patient. However, 'artificial' emergencies should not be created to avoid obtaining appropriate consent.
- Medical treatment should never be withheld merely on the grounds that it is easier to withhold treatment than to withdraw treatment which has been commenced.
- Legal protections and indemnity are provided to Queensland Health / Hospital and Health Service staff who comply with Queensland Health policy relating to LSMs. Staff from non-Queensland Health facilities and services should refer to their service's policies and procedures and seek legal advice where necessary.

The law regarding consent for patients without capacity is contained in the *Powers of Attorney Act 1998* and the *Guardianship and Administration Act 2000* (GAA).

### Capacity

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

### Patient objections

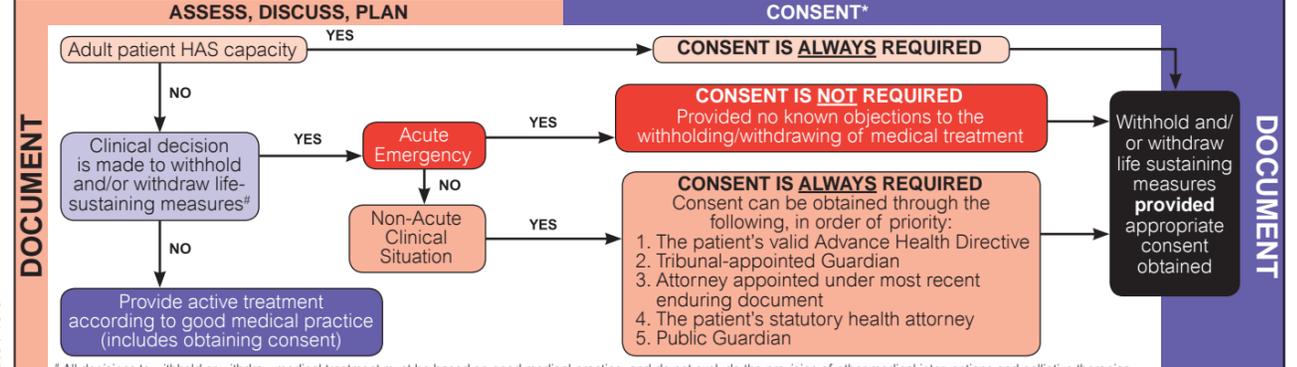
- The law recognises that a person can object to LSMs being provided, withheld or withdrawn. The relevant law is complex.
- An objection to a clinical decision to withhold/withdraw LSMs may be expressed by the patient as a verbal request to 'do everything' or 'don't let me die', or by their conduct,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

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

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

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

## Flowchart: Withholding and Withdrawing Life-Sustaining Measures



\* All decisions to withhold or withdraw medical treatment must be based on good medical practice, and do not exclude the provision of other medical interventions and palliative therapies.  
**\* CONSENT IS ALWAYS REQUIRED IF THE DECISION IS TO WITHHOLD AND/OR WITHDRAW ARTIFICIAL HYDRATION AND/OR NUTRITION IF CONSENT CANNOT BE OBTAINED, OR IF THERE IS A DISPUTE, CONTACT THE PUBLIC GUARDIAN ON 1300 753 624**

DO NOT WRITE IN THIS BINDING MARGIN

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ACUTE RESUSCITATION PLAN (ARP)

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