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

Clinical assessment and appropriate treatment options should be guided by good medical practice, which includes discussions with the patient and their substitute decision-maker(s). The ARP form can be completed by registered medical practitioners in any setting (e.g. nursing facilities, community residential care, outpatient clinics, GP practices). However, it is completed on the ward by non-Queensland Health facilities. Non-Queensland Health organisations can use this form but must adhere to their policies and procedures.

1. Clinical 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.

2. Capacity assessment
   - The law requires a collaborative approach between health providers and patients and/or their substitute decision-makers (where there is no capacity) to determine whether the patient has capacity.
   - It is clinically appropriate to offer, provide or continue treatments that on balance would have the potential to cause harm if the patient is not able to refuse.

3. Resuscitation management plan
   - An ARP form should be completed where it is reasonably expected that an adult patient may experience an acute deterioration or critical event (e.g. cardiac or respiratory arrest) in the foreseeable future (e.g. within 12 months).
   - If a cardiac or respiratory arrest occurs, it is clinically appropriate to:
     - Provide e.g. ventilation, IV fluids, supportive therapies.
     - Not provide e.g. defibrillation, intubation, antibiotics.

4. Communicating with patients
   - When communicating with patients, health providers should be informed of clinically appropriate treatment options and these and their views and wishes for care respected.

5. Legal considerations
   - The ARP form must reflect the patient's views and wishes for care respected.
   - A decision not to provide CPR does not limit other treatment or care.

6. A decision to withhold or withdraw life-sustaining measures
   - The ARP form replaces 'not for resuscitation' (NFR) orders.
   - It is completed on the ward by non-Queensland Health facilities. Non-Queensland Health organisations can use this form but must adhere to their policies and procedures.

7. documenting the decision-making pathway around LSMs.
   - The law requires a collaborative approach between health providers and patients and/or their substitute decision-makers (where there is no capacity) to determine whether the patient has capacity.

Flowchart: Withholding and Withdrawing Life-Sustaining Measures

**Flowchart**

1. **Assess, Discuss, Plan**
   - Adult patient has capacity
   - Non-Acute Clinical Situation
     - Clinical decision has been made to withhold/withdraw life-sustaining measures
     - Provides active treatment according to plan
   - Non-Acute Clinical Situation
     - Clinical decision has been made to withhold/withdraw life-sustaining measures
     - Provides active treatment according to plan

2. **Consent**
   - Consent is ALWAYS REQUIRED

3. **Document**
   - Consent is ALWAYS REQUIRED

4. **Decision-Making Pathway**
   - In order of priority:
     1. The patient’s advance care plan
     2. Tribunal-appointed Guardian
     3. Attorney who knows patient

5. **Without and/or Withdrawing Life-Sustaining Measures**
   - Withholding and withdrawing life-sustaining measures
   - Non-Acute Clinical Situation
     - Provides active treatment according to plan
     - Consents to withholding and withdrawing life-sustaining measures
   - Non-Acute Clinical Situation
     - Provides active treatment according to plan
     - Consents to withholding and withdrawing life-sustaining measures

6. **Consent not obtained**
   - If there is consent for withholding and withdrawing life-sustaining measures
   - If consent is not obtained, the attending clinician is not required to follow the out-of-hours protocol

7. **Without and/or Withdrawing Life-Sustaining Measures**
   - Withholding and withdrawing life-sustaining measures
   - Non-Acute Clinical Situation
     - Provides active treatment according to plan
     - Consents to withholding and withdrawing life-sustaining measures
   - Non-Acute Clinical Situation
     - Provides active treatment according to plan
     - Consents to withholding and withdrawing life-sustaining measures
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/careattendlife.

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/s is not suitable for an ARP.

Section 2. Capacity assessment
- If a patient has impaired 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 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 of end of life care.
- If 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 dysfunction).

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 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 Capacity (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.A) for a list of SDMs to obtain consent if the patient does not have capacity or 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.
- Excep to some emergency situations, consent must be obtained to act on the Resuscitation management plan (section 3.A). This may involve dispute resolution. (See: Patient selections).
- 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 contract. There is no requirement for the patient or their SDM to sign the ARP form. A properly completed ARP provides documented evidence of discussion outcome with a patient or their SDM concerning end of life care.
- Consent should be obtained from the patient/their SDM as close as possible to an expected acute deterioration or death. 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 case. Patient objections:
- If the patient’s/their SDM’s request 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 interest.
- There is no legal obligation to accede to demands for clinically appropriate medical care (i.e. no benefit, futile).
- Multi-disciplinary team involvement is recommended in resuscitation. The treating medical Practitioner may also seek a second opinion 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 report the matter to facility medical director or the office of the Public Guardian (OGP) as appropriate.
- If a SDM is not adhering to the Health Care Principles and the General Principles, the matter can be referred to the OGP for resolution. An application can also be made to the Queensland 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 patient’s health care.
- Care and detailed description is vital at all stages of discussions.

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