

Using Resuscitation Plans in End of Life Decisions

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Functional Sub group Clinical/ Patient Services - Medical Treatment
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Summary This document describes the standards and principles relating to appropriate use of Resuscitation Plans by NSW Public Health Organisations for patients 29 days and older. A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and which documents other aspects of treatment relevant at end of life.

Replaces Doc. No. CPR - Decisions Relating to No Cardiopulmonary Resuscitation Orders [GL2008_018]

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Applies to Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Affiliated Health Organisations, Community Health Centres, Government Medical Officers, NSW Ambulance Service, Public Health Units, Public Hospitals

Audience Clinical staff involved in decisions about use of resuscitation and other end of life measures

Distributed to Public Health System, Divisions of General Practice, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Review date 08-Sep-2019

Policy Manual Not applicable

File No. 12/5529

Status Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

USING RESUSCITATION PLANS IN END OF LIFE DECISIONS

PURPOSE

This policy directive supersedes GL2008_018 *Decisions relating to No Cardio-Pulmonary Resuscitation (CPR) Orders*.

Planning care for patients who are approaching end of life will generally involve a shift in the focus of care away from aggressive medical intervention and towards a palliative approach, opting out of Rapid Response Systems and/or initiating palliative care.

Making a Resuscitation Plan is one important step in this process of planning quality end of life care. A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and which documents other aspects of treatment relevant at end of life.

This document describes the standards and principles relating to appropriate use of Resuscitation Plans by NSW Public Health Organisations for patients 29 days and older. Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

MANDATORY REQUIREMENTS

Development of standardised Resuscitation Plans and implementation policy is required by the NSW Health *Advance Planning for Quality Care at End of Life: Action Plan 2013-2014* (Action 2.1, 2.2). Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

This policy directive will commence two weeks after release when the state Resuscitation Plans (adult and paediatric) are available.

All Public Health Organisations must:

- Adopt the state Resuscitation Plans (adult and paediatric). These should replace similar existing LHD forms (e.g. No CPR Orders, Not for Resuscitation Orders)
- Incorporate evaluation of whether Resuscitation Plans were completed into death audit protocols.

NSW Health Resuscitation Plans are not valid for community patients under the medical care of a doctor who is not a NSW Health staff member. General Practitioners with admitting rights are considered NSW Health staff.

IMPLEMENTATION

Roles and Responsibilities

NSW Ministry of Health

- Significant developments regarding end of life planning and care are underway in NSW Health that impact use of Resuscitation Plans. These include death audit standards, development of clinical triggers for end of life planning and targeted education for health professionals. However, as these broader implementation

measures are still under development, this Policy Directive has been confined in scope to principles and standards related to usage of the Resuscitation Plan

- Provide current policy to support use of Resuscitation Plans. A guideline will be developed in 18 months addressing how Resuscitation Plans integrate with other state level projects and programs. The Ministry will also evaluate the Resuscitation Plan forms in two years to assess whether they are meeting clinical need given rapid changes in End of Life care in NSW
- Establish an end of life education strategy in partnership with the pillar agencies, that includes best practice approaches to training health professionals in having end of life conversations (relevant to Resuscitation Plans)
- Develop an appropriate service measure for Resuscitation Plans in readiness for the 2015/16 Service Level Agreements.

LHD and Specialty Network Chief Executives

- Identify an appropriate Executive Sponsor for this policy
- Provide an appropriate governance mechanism to oversee implementation planning related to Resuscitation Plans consistent with *Advance Planning for Quality Care at End of Life: Action Plan 2013-2018*
- Establish means of identifying the Person Responsible as a routine part of procedures for all admissions
- Integrate Resuscitation Plans into the electronic Medical Record
- Include assessment of whether Resuscitation Plans have been completed prior to in-hospital deaths as part of death audit standards.

Ambulance Service NSW

- Incorporate Resuscitation Plans into relevant protocols.

REVISION HISTORY

Version	Approved by	Amendment notes
September 2014 (PD2014_030)	Deputy Secretary, Population and Public Health	<ul style="list-style-type: none"> • Emphasising decisions about use/withholding cardiopulmonary resuscitation are one aspect of planning for the clinical deterioration that accompanies dying • Broadening the scope of applicability of Resuscitation Plans to include all patients under the care of NSW Public Health Organisations, including those in care of NSW Ambulance • Providing best practice Resuscitation Plans (adult and neonatal/paediatric) and mandating their use at State Forms • Providing revised standards for reviewing/ rescinding Resuscitation Plans that better accord with clinical need.
November 2008 (GL2008_018)	Deputy Director General	N/A

ATTACHMENTS

1. Resuscitation Plan - Adult
2. Resuscitation Plan - Paediatric
3. Figure 1: *Resuscitation Plans in the context of Advance Care Planning and End of Life*
4. Implementation Checklist

Using Resuscitation Plans in End of Life Decisions



Issue date: September-2014

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1 BACKGROUND

1.1 Purpose

This policy directive supersedes GL2008_018 Decisions relating to No Cardio-Pulmonary Resuscitation (CPR) Orders.

This document describes the standards and principles relating to appropriate use of Resuscitation Plans by NSW Public Health Organisations for patients 29 days and older. A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and which documents other aspects of treatment relevant at end of life.

Development of standardised adult and paediatric Resuscitation Plans and implementation policy is required by the *NSW Health Advance Planning for Quality Care at End of Life: Action Plan 2013-2018* (Action 2.1 and 2.2).

Standardisation of documents in this aspect of end of life planning will assist quality care delivery.

Key terms used in this document are defined in the Glossary.

1.2 Mandatory Requirements

All Public Health Organisations must adopt the NSW Health Resuscitation Plans (adult and paediatric). Resuscitation Plans are intended for use in all NSW Public Health Organisations, including acute facilities, sub-acute facilities, ambulatory and community settings, and NSW Ambulance for patients 29 days and older.

NSW Health Resuscitation Plans are not valid for community patients under the medical care of a doctor that is not a NSW Health staff member. General Practitioners with admitting rights are considered NSW Health staff.

1.3 Legal and legislative framework

The Resuscitation Plan – state forms included in this Policy Directive are legally enforceable medical orders and must be followed by staff.

Interdisciplinary disputes should be managed in accordance with GL2005_057 End-of-Life Care and Decision-Making - Guidelines.

The existing legal framework in NSW supports end of life decisions, including Resuscitation Plans and permits:

- Refusal of any and all life-sustaining treatments by a person with decision making capacity at the end of life
- Advance refusal for a time of future incapacity
- Decisions made by a doctor, in consultation with and preferably agreement of the Person Responsible, where a person has no decision-making capacity to withhold or withdraw life-sustaining measures so as to focus primarily on palliative care. (*Advance Planning for Quality Care at End of Life: Action Plan 2013-2018*).

A Resuscitation Plan must be made:

- With reference to pre-planning by patients (such as Advance Care Plans or Directives)
- In consultation with the patient/Person Responsible
- Taking into account the current clinical status, prognosis, wishes of the patient, and goals of care.

In NSW, common law governs many aspects of end of life decision-making, including use of Advance Care Directives and these must be adhered to when valid. In NSW an Advance Care Directive must be adhered to provided that it is made voluntarily by a capable adult; was made without undue influence; and it is clear and unambiguous in applying to the circumstances at hand.

The NSW *Guardianship Act 1987* governs the legal standards for substitute decision-making i.e. regarding roles and responsibilities of the Person Responsible.

See also web-resource *End of life decisions, the law and clinical practice: legal considerations for health care practitioners in NSW* (2014).

2 WHEN RESUSCITATION PLANS SHOULD BE CONSIDERED

Planning care for patients who are approaching end of life will generally include a shift in the focus of care away from aggressive medical intervention and towards a palliative approach; opting out of Rapid Response Systems; initiating palliative care; and/or making arrangements to facilitate dying in place of choice. Making a Resuscitation Plan is one important step in this process of planning. (See Figure 1)

Improved end of life care will be achieved, in part, if conversations between doctors, patients and families about changing goals of care and appropriate use of life-sustaining measures as end of life approaches are undertaken earlier than currently occurs.

Patients and their families should be genuinely reassured that quality, individualised care consistent with the ongoing goals of treatment will continue to be provided to the patient, regardless of whether or not resuscitation is appropriate.

Decisions to withhold CPR and other resuscitation measures seek to avoid unwanted, excessively burdensome or insufficiently beneficial interventions for patients at the end of life. At some point in the course of life-limiting illness, a shift in the focus of care away from aggressive intervention and towards a palliative approach is often the agreed outcome.

2.1 Triggers for discussing a Resuscitation Plan

Resuscitation Planning is one component of Advance Care Planning and End of Life care (see Figure 1).

Discussing a Resuscitation Plan should be undertaken:

- If the patient's recovery is uncertain
- If the treating clinician asks him or herself, 'Would I be surprised if this patient were to die in 6-12 months?' (so-called 'surprise question') and the answer is 'No'.
- If a patient clinically deteriorates requiring activation of a Rapid Response System, or is anticipated to do so
- If the patient's condition is considered high risk, for example recurrent admission to hospital with severe chronic illness; a diagnosis of metastatic cancer; steady deterioration of a chronic respiratory, cardiac, liver or neurological illness; and other progressive advanced life limiting illnesses e.g. severe end stage dementia or frailty.

2.2 Rationale for withholding resuscitation

In general, the rationales for not instituting CPR are:

2.2.1 Where there is a clearly stated, adequately informed and properly documented or verbally expressed refusal by a person with decision-making capacity.

- Such a person has a lawful right to refuse any medical interventions, including resuscitation and other emergency interventions, even where that refusal will

predictably result in death. This decision legally takes precedence over the contrary wishes of family or treating doctors; or

2.2.2 Where the person has no capacity to make this decision, there is an adequately informed and properly documented decision to withhold resuscitation by the Attending Medical Officer in consultation with the Person Responsible.

- This should be based on any known previous refusal of resuscitation or, in the absence of such refusal, a decision that resuscitation would not be in the patient's best interests. The Attending Medical Officer must also document a reason for overriding a documented decision such as an Advance Care Directive, for example that it does not adequately apply to the clinical situation at hand; or

2.2.3 Where the Attending Medical Officer judges that resuscitation offers no benefit or where the benefits are small and overwhelmed by the burden to the patient.

- Given that judgments about the benefits or otherwise of a therapy ultimately reflect the values, beliefs and hopes/goals of the patient, any decision to withhold resuscitation on clinical grounds alone must be carefully considered, properly justified and documented
- Focussing on patient comfort also entails withholding life-sustaining measures sometimes considered to be of negligible benefit (for example, where the ability to restore spontaneous rhythm or circulation with CPR is highly unlikely)
- A medical practitioner does not need to obtain agreement from the patient or family to withhold interventions considered to be of negligible benefit, but it is still good clinical practice to discuss why these are not being offered in the context of broader end of life goals of care conversation. This includes scenarios that may present at an Emergency Department. If consent is not sought, the reasons why should be documented in the patient record. It is also the case that engaging patients in such discussion does not obligate the treating team to provide treatments that they believe are considered to be of negligible benefit.

2.3 Disagreement about end of life decisions

- Planning end-of-life care is an iterative or cyclic process based on assessment, disclosure, discussion and consensus building with the patient and/or their family and the treatment team. Disagreement within families of patients without decision-making capacity, or between families and the health care team about whether resuscitation is appropriate can generate significant impediments to good patient care planning.
- Use a Resuscitation Plan to record agreement. Efforts to reach consensus and/or resolve disagreement within a family or between the family and the treating team about appropriate use of life-sustaining measures should precede this.
- Where a patient, family or Person Responsible requests a second medical opinion as to the predicted outcome with, or without resuscitation, such requests should always be respected and facilitated.

- These scenarios should be managed sensitively and according to options outlined in GL2005_057 Guidelines for end of life care and decision-making. See also NSW Health Conflict Resolution in End of Life Settings Project Report. http://www0.health.nsw.gov.au/pubs/2010/conflict_resolution.html

3 USE OF THE RESUSCITATION PLAN FORMS

The following section addresses the technical requirements, rationales and related clinical process when completing Resuscitation Plans. These are presented so as to complement the structure of the Resuscitation Plans and the clinical process they are used in.

3.1 Is there evidence of any prior planning?

- Check if the patient has previously prepared an Advance Care Plan (ACP) or Advance Care Directive (ACD). The ACD/ACP reflects the patient's preferences/wishes, often including those relevant to resuscitation. An ACP often becomes a synopsis of previous discussions which will be useful in completing the 'goals of care' section. Where one exists, this must inform decisions recorded in the Resuscitation Plan. This 'translation' or bridging step is critical if patients' prior wishes are to effectively determine how health professionals practically respond to clinical deterioration, most importantly as death approaches.
- If the ACD/ACP is ambiguous or it is unclear if it applies to the situation at hand, conversation should be revisited with the patient and/or Person Responsible, as appropriate.
- Identify the patient's Person Responsible irrespective of whether the patient now has decision capacity. An informed Person Responsible is important to support decision-making where the patient does not have capacity at many times throughout illness, including but not limited to end of life.

3.2 Capacity and participation

- Doctors prescribing medical orders, including 'Resuscitation Plans', hold responsibility for reaching those decisions, in consultation with patients.
- Where the patient does not have decision-making capacity, a consensus building approach to end-of-life decision-making that considers the patient's best interests as paramount is recommended. The patient, Person Responsible and/or family should be informed about the nature of CPR; the likely effects of resuscitation, including CPR, in this particular circumstance; and its' possible adverse outcomes e.g. broken ribs; and the consequences of not instituting CPR. These should be discussed in the context of broader goals of care applicable at that time. As part of such discussions it may be helpful to seek advice from other health professionals who may have been involved in the care of the patient and had conversations about end of life care, such as the patient's General Practitioner. The Attending Medical Officer should recommend a course of action when discussing resuscitation in the context of goals of care with the patient, Person Responsible or family.

3.2.1 Where the patient wishes to discuss resuscitation

- Where the patient has decision capacity and is willing to discuss resuscitation and treatment goals, they should be asked who (if anyone) they would like to be involved in discussions.

- Patients and families from culturally and linguistically diverse groups may have preferences for different decision-making styles, other than involving solely the patient and their doctor. These should be explored and cultural differences respected. For Aboriginal patients, the involvement of an Aboriginal Liaison Officer, where available, is advised.

3.2.2 Where the patient does not wish to discuss resuscitation

- Discussion about diagnosis, prognosis and preferences for care should be encouraged, but not forced. A patient's desire not to discuss resuscitation, or the possibility of his or her own death, should always be respected and emotional support provided, for example through social work or chaplaincy as appropriate.
- In situations where the patient does not want to discuss or decide on resuscitation, the health care professional should establish whether the patient would prefer to have others make resuscitation planning decisions on their behalf.

3.2.3 Where the patient does not have decision-making capacity

- Where decision-making capacity is impaired, reasonable efforts should be considered to maximise his or her capacity to participate in decisions regarding resuscitation.
- If there is any doubt that the patient has sufficient decision-making capacity, their decision-making capacity should be assessed and documented in the patient's records. See *Capacity Toolkit*:
http://www.diversityservices.lawlink.nsw.gov.au/agdbasev7wr/divserv/documents/pdf/capacity_toolkit0609.pdf
- Where the patient lacks decision-making capacity, the Attending Medical Officer or their delegate should identify the Enduring Guardian (or other category of Person Responsible). Enduring Guardians can refuse life sustaining measures if they have been expressly given such a power in their appointment

3.2.4 Where the person's wishes regarding resuscitation are unknown

- Cardiorespiratory arrest may occur before there has been sufficient time to hold discussions regarding resuscitation. Health professionals still need to decide about use of resuscitation without knowing the person's wishes in some circumstances. This is addressed in PD2005_406 *Consent to Medical Treatment - Patient Information* in providing medical treatment in emergency situations.
- Not having a Resuscitation Plan does not necessarily mean that resuscitation is a default action that *must* be applied in all situations. Clinical judgement should be used where resuscitation is manifestly inappropriate and/or the patient is deceased.

3.2.5 Withholding resuscitation without explicit discussion

Where there is time to plan end of life care and to make decisions regarding resuscitation, then the discussion should be had. There are some exceptions to the general requirement to discuss a Resuscitation Plan with the patient, or Person Responsible, or family:

- The patient (Person Responsible/enduring guardian/or family) does not wish to discuss resuscitation. Decisions may then be undertaken by the Attending Medical Officer.
- The patient is aware they are dying and has already expressed a desire for palliative care.
- The health care facility does not provide resuscitation as a matter of course, consistent with the values and practices relevant to their patient population, such as hospices, and this has been made clear to the patient and their family when the facility assumes care; or
- The patient has had a prior therapeutic relationship with a doctor other than the Attending Medical Officer and prior discussion has made the patient's views regarding resuscitation apparent.

3.3 Clinical interventions and monitoring

- Vital sign monitoring should be (re)considered if the patient is in their last days and this should be consistent with monitoring frequency prescribed on the Standard Adult General Observation chart, or equivalent standard observation chart.
- Implantable devices such as defibrillators or pacemakers may need to be deactivated in patients at end of life.
- Nurses may call for medical review of unrelieved symptoms associated with dying, even where activating an urgent Clinical Review call has been considered unnecessary. A plan for monitoring and managing symptoms associated with dying should be put in place if this is the case.

3.4 Referral/Transfer

- 'Referral to palliative care' means referral for specialist palliative care review.
- 'Referral home' may be applicable in some scenarios where discharge to supported care may be feasible and appropriate.
- Careful consideration should be given to the need for, and appropriateness of transfer of an individual with a 'Resuscitation Plan' in place where there is possible need for resuscitation en route, for example if the individual is pre-terminal.
- NSW Health Resuscitation Plans are valid for use by NSW Ambulance staff in all situations involving patient contact.
- A hard copy of the Resuscitation Plan should accompany the patient on inter-facility transfer.
- Where a patient is transferred to a non-NSW Health facility, the receiving medical practitioner should be encouraged to review the Resuscitation Plan's contents and consider whether they authorise a consistent Plan (according to that facility's documentation protocol). Immediate repeat conversation with the patient or family about the decision to use a local Resuscitation Plan is not necessarily required.

3.5 Authorising and Signing the Resuscitation Plan

- Every patient who is admitted to a public hospital is admitted under the bed care of a doctor (Attending Medical Officer) who has medico-legal responsibility for that patient. As part of the AMO's responsibility, it is incumbent that they or their delegate clarify with others including the health practitioners who may have known that patient for many years (such as the patient's General Practitioner), about the patient's background, ongoing management and resuscitation or advance care plans.
- Discussion with the patient/Person Responsible about resuscitation should generally be undertaken by the most experienced clinician.
- Neither the patient, nor their Person Responsible, is required to sign the Resuscitation Plan.
- The 'delegated signatory Medical Officer' e.g. registrar who is not the Attending Medical Officer may undertake the conversation with the patient/Person Responsible and complete and sign the Resuscitation Plan. However, this must be authorised by the responsible Attending Medical Officer at the earliest opportunity.
- Delegation to a junior medical officer should only occur with adequate training, supervision and support. If a junior medical officer is required to discuss and document a Resuscitation Plan (e.g. out of hours) this must be discussed with the Attending Medical Officer at the earliest opportunity.
- Both sides of the form must be completed and signed.
- Consistent with PD2005_406, other health care professionals (including nurses) cannot be delegated the task of informing patients or obtaining consent for resuscitation planning. When requested by a patient, they are permitted to provide information and should document this in the medical record.
- A copy of the form may be provided to the patient or Person Responsible.

3.6 Reviewing the Resuscitation Plan

- A fixed frequency for review is not appropriate for all scenarios. Generally, a Resuscitation Plan needs to be clarified from one acute admission to the next where a change in prognosis is likely.
- A Resuscitation Plan may be valid for up to 3 months for frequent and routine 'admissions' e.g. renal dialysis.
- A Resuscitation Plan should be reviewed prior to elective minor procedures.
- A Resuscitation Plan may be compatible with palliative surgical procedures, and potentially time and goal limited ICU support in some cases.
- Where surgery is planned for someone with a Resuscitation Plan, this should be reviewed in consultation with the patient, Person Responsible, anaesthetist and surgeon as to whether it is appropriate to suspend it during the intra- or post-operative period. This decision should be clearly documented in the medical record.

3.7 Revoking or amending the Resuscitation Plan

- The procedure for revoking the Resuscitation Plan is to rule a diagonal line through both sides, then print and sign your name and date on the line.
- For significant amendments (for example, a change to the CPR order), the Resuscitation Plan must be revoked and a new Plan completed.
- For less significant amendments (for example, a change to the intervention section), the Resuscitation Plan can be amended and initialled. This should be documented in the medical record. It should be noted that this option may not exist if the form is included in an Electronic Medical Record. If this is the case, the Resuscitation Plan must be revoked and reissued – documentation in the medical notes alone is not sufficient.

3.8 Storage of Resuscitation Plans

- The current Resuscitation Plan must be made readily accessible to attending health professionals. It is preferable that multiple copies are not made because of the potential for confusion.
- It is recommended that the current hard copy should be kept at the front of the patient's health record. Details of the Resuscitation Plan should be included in handover between shifts.
- Resuscitation Plans must be integrated into electronic health record systems in appropriate forms e.g. alerts/orders;
- Resuscitation Plans should be incorporated into hospital discharge summaries, where possible.

4 USE OF RESUSCITATION PLANS IN CHILDREN

- The general principles and process guiding the completion of a Resuscitation Plan are the same for children as for adults, with a focus on communication and exploration of goals of care with the person/s responsible, and where appropriate, the child.
- The Paediatric Resuscitation Plan is not intended for use in Neonates (patients under 29 days), although it may be used to guide discussions.
- The Paediatric Resuscitation Plan should be used for patients older than 29 days and up to and including the age of 17 years. The Adult Plan should be used for patients aged 18 years and over.
- Decisions to withhold resuscitation may also be required where a child is in care of the state. The Minister for Family and Community Services is required by the *Children and Young Person's Care and Protection Act* to be responsible for this kind of medical decision. It is the Minister's delegate (the Director-General, NSW Family and Community Services) who authorises a Resuscitation Plan where the Attending Medical Officer considers resuscitation limitation appropriate.
- Refer to PD2005_406 Consent to Medical Treatment - Patient Information for information regarding the potentially complex consent issues for children (persons aged under 16 years) and young people (persons aged 16 or 17).

5 GLOSSARY

Attending Medical Officer

The Attending Medical Officer (AMO) is the senior medical practitioner who has primary responsibility for the patient during admission. This medical officer is a consultant who may be a visiting medical officer or a staff specialist. The AMO may lead a team that includes related medical staff. This team plays a critical role in the clinical review of the patient.

Advance Care Directive

An Advance Care Directive is a type of advance planning tool that can only be completed by a person with decision capacity. These were formerly known, in particular in the US, as “living wills”. They should inform a Resuscitation Plan.

Advance Care Plan

An Advance Care Plan is the outcome of an Advance Care Planning process. Like an Advance Care Directive, an Advance Care Plan also records preferences about health and personal care and treatment goals. However, it may be completed by discussion or in writing and it may be made by, with, or for the individual. It should inform a Resuscitation Plan.

Capacity

In broad terms, when a person has capacity to make a particular decision they can:

- Understand the facts and the choices involved
- Weigh up the consequences
- Communicate the decision.

Clinical review

This is a patient review undertaken within 30 minutes by the attending medical team. Depending on local protocol, the review may be undertaken by a medical officer on call or an appropriately experienced Registered Nurse/Midwife, preferably First Line

Emergency Care accredited or with post graduate qualifications in emergency/critical care nursing or other relevant qualifications.

Enduring Guardian

An Enduring Guardian is someone appointed by a person to make personal (including medical) or lifestyle decisions on their behalf when they are not capable of doing so for themselves. Enduring Guardians and those appointed by the Guardianship Tribunal may make end of life decisions on the person’s behalf. The appointment of an Enduring Guardian comes into effect when the appointing individual loses capacity to make personal or lifestyle decisions. People can choose which decisions (called functions) they want their Enduring Guardian to make. These functions are governed by the *NSW Guardianship Act 1987*

Goals of care

The general goal of medical treatment is the health and wellbeing of the patient. The specific goal of medical treatment may, in the circumstances, be cure of an illness, relief

of the symptoms of an illness, stabilisation of the patient in a satisfactory condition, improvement in the way the patient dies, etc.

Person Responsible

The *NSW Guardianship Act 1987* establishes who can give valid consent for medical treatment to an incompetent patient aged 16 years and over. The Act establishes a hierarchy for determination of who is the Person Responsible as follows:

- The patient's lawfully appointed guardian (including an Enduring Guardian) but only if the order or instrument appointing the guardian extends to medical treatment
- If there is no guardian, a spouse including a de facto spouse and same sex partner with whom the person has a close continuing relationship
- If there is no such person, a person who has the care of the patient (otherwise than for fee and reward)
- If there is no such person, a close friend or relative.

Currently in NSW a Person Responsible who has not been appointed as Enduring Guardian or by the Tribunal does not have the same decision authority in end of life decisions. Guardians (including Enduring Guardians) can consent to treatment being withheld or withdrawn if they have been expressly given such a power in their appointment.

Rapid response

This refers to an immediate review undertaken by an individual or multidisciplinary team of healthcare professionals who have been trained and assessed to hold an advanced level of competence in resuscitation and stabilisation of patients. A Rapid Response call must be made if a patient's observations fall into the 'Red Zone' of NSW Health Standard Observation Charts.

Resuscitation

Resuscitation encompasses a spectrum of emergency interventions such as supplemental oxygen, intravenous fluids and non-invasive ventilation. It is not limited to cardiopulmonary resuscitation.

Resuscitation Plan

A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and document other time critical clinical decisions related to end of life. These were formerly called No CPR Orders. A Resuscitation Plan is made:

- With reference to pre-planning by patients (such as Advance Care Plans or directives)
- In consultation with patients/families
- Taking account of the current clinical status, as well as the wishes and goals of the patient.

Standard observation charts

Observation Charts approved for use by NSW Health System e.g. the Standard Adult General Observation (SAGO) Chart, Standard Paediatric Observation Chart (SPOC), Standard Maternity Observation Chart (SMOC), Adult and Paediatric Emergency Department Observation Charts.

6 LIST OF ATTACHMENTS

1. Resuscitation Plan - Adult
2. Resuscitation Plan - Paediatric
3. Figure 1: *Resuscitation Plans in the context of Advance Care Planning and End of Life*
4. Implementation Checklist

Attachment 1: Resuscitation Plan – Adult (SMR020.056)

 SMR020056	 NSW Health	FAMILY NAME _____ MRN _____ GIVEN NAME _____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE D.O.B. ____/____/____ M.O. _____ ADDRESS _____ LOCATION / WARD _____ COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	RESUSCITATION PLAN - ADULT For patients aged 18 years and over Refer to PD2014_030																		
	Facility: _____																				
	Patient Name: (PRINT)																				
	This Plan was discussed with and authorised by the Attending Medical Officer (PRINT NAME) on ____/____/____ (DATE).																				
	Diagnoses																				
Planning for end of life does not indicate a withdrawal of care, but the provision of symptom management, psychosocial and spiritual support after a compassionate discussion to allow appropriate care in the location of the patient or Person Responsible's* choice. Has the patient's Advance Care Plan/Directive been considered in completing this form? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> The Goals of Care negotiated through conversations with the doctor/patient/family/Person Responsible* are:																					
Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:																					
<ul style="list-style-type: none"> • Respiratory Support: <table style="width:100%; border: none;"> <tr> <td style="width: 30%;">Pharyngeal suction</td> <td style="width: 10%;">Yes <input type="checkbox"/></td> <td style="width: 10%;">No <input type="checkbox"/></td> <td style="width: 30%;">Bag & mask ventilation</td> <td style="width: 10%;">Yes <input type="checkbox"/></td> <td style="width: 10%;">No <input type="checkbox"/></td> </tr> <tr> <td>Supplemental oxygen</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td>Intubation</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>Non-invasive ventilation</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> </table> • Referral to ICU Yes <input type="checkbox"/> No <input type="checkbox"/> • Are other non-urgent interventions appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/> (e.g. Vascular access, blood products, antibiotics, NG feeds/fluids, imaging, Pathology, IV fluids.) Detail in patient record. Additional details, if required: _____				Pharyngeal suction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bag & mask ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Supplemental oxygen	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Intubation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Non-invasive ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>			
Pharyngeal suction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bag & mask ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>																
Supplemental oxygen	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Intubation	Yes <input type="checkbox"/>	No <input type="checkbox"/>																
Non-invasive ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>																			
Clinical Review Call are to be activated Yes <input type="checkbox"/> No <input type="checkbox"/> YELLOW ZONE on Standard Adult General Observation Chart or Maternity Observation Chart																					
Rapid Response Call are to be activated Yes <input type="checkbox"/> No <input type="checkbox"/> RED ZONE on Standard Adult General Observation Chart or Maternity Observation Chart																					
Nurses/midwives may request medical review, even if medical escalation for cardiopulmonary resuscitation (CPR) or other life prolonging treatment is not indicated. • Is a plan in place for monitoring and managing symptoms in anticipated last days of life? Yes <input type="checkbox"/> No <input type="checkbox"/>																					
In the event of cardiopulmonary arrest: <div style="text-align: center; font-size: 2em; font-weight: bold;"> CPR <input type="checkbox"/> No CPR <input type="checkbox"/> </div> (see rationale overleaf)																					
Delegated signatory Medical Officer (the AMO must authorize this decision)																					
PRINT NAME DESIGNATION TIME PAGER/PHONE DATE SIGNATURE																					
Complete and sign both front and back pages. A copy must accompany the patient on all transfers & be included in discharge summary.																					
To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print & sign your name & date on the line.																					

Holes Punched as per AS2828-1: 2012
 BINDING MARGIN - NO WRITING

RESUSCITATION PLAN - ADULT

SMR020.056

NO WRITING

Page 1 of 2

Attachment 2: Resuscitation Plan – Paediatric (SMR020.055)

 <p>SMR020055</p>	 <p>NSW Health</p>	FAMILY NAME _____ MRN _____ GIVEN NAME _____ <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE D.O.B. ____/____/____ M.O. _____ ADDRESS _____ LOCATION / WARD _____ COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE																		
	Facility: _____ RESUSCITATION PLAN - PAEDIATRIC For patients aged between 29 days and 18 years Refer to PD2014_030																			
	Patient Name: (PRINT) This Plan was discussed with and authorised by the Attending Medical Officer (PRINT NAME) on ____/____/____ (DATE). Diagnoses																			
	Planning for end of life does not indicate a withdrawal of care, but the provision of symptom management, psychosocial and spiritual support after a compassionate discussion to allow appropriate care in the location of the patient / parents / guardian's choice. Has the patient's Advance Care Plan/Directive been considered in completing this form? Yes <input type="checkbox"/> No <input type="checkbox"/> The Goals of Care negotiated through conversations with the doctor/patient/family/guardians																			
Holes Punched as per AS2826.1: 2012 BINDING MARGIN - NO WRITING	Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:																			
	<ul style="list-style-type: none"> Respiratory Support: <table border="0"> <tr> <td>Pharyngeal suction</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td>Bag & mask ventilation</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>Supplemental oxygen</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td>Intubation</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> </tr> <tr> <td>Non-invasive ventilation</td> <td>Yes <input type="checkbox"/></td> <td>No <input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> </table> Referral to ICU Yes <input type="checkbox"/> No <input type="checkbox"/> Are other non-urgent interventions appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/> (e.g. Vascular access, blood products, antibiotics, NG feeds/fluids, imaging, Pathology, IV fluids.) Detail in patient record. Additional details, if required: _____ _____ _____	Pharyngeal suction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bag & mask ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Supplemental oxygen	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Intubation	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Non-invasive ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
	Pharyngeal suction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Bag & mask ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>														
	Supplemental oxygen	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Intubation	Yes <input type="checkbox"/>	No <input type="checkbox"/>														
Non-invasive ventilation	Yes <input type="checkbox"/>	No <input type="checkbox"/>																		
Clinical Review Calls are to be activated Yes <input type="checkbox"/> No <input type="checkbox"/> YELLOW ZONE on Standard Paediatric Observation Chart																				
Rapid Response Call are to be activated Yes <input type="checkbox"/> No <input type="checkbox"/> RED ZONE on Standard Paediatric Observation Chart Nurses/midwives may request medical review, even if medical escalation for cardiopulmonary resuscitation (CPR) or other life prolonging treatment is not indicated. • Is a plan in place for monitoring and managing symptoms in anticipated last days of life? Yes <input type="checkbox"/> No <input type="checkbox"/>																				
	In the event of cardiopulmonary arrest: CPR <input type="checkbox"/> No CPR <input type="checkbox"/> (see rationale overleaf)																			
	Delegated signatory Medical Officer (the AMO must authorise this decision)																			
	PRINT NAME DESIGNATION TIME PAGER/PHONE DATE SIGNATURE Complete and sign both front and back pages. A copy must accompany the patient on all transfers & be included in discharge summary. To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print and sign your name and date on the line.																			

RESUSCITATION PLAN - PAEDIATRIC

SMR020.055

NO WRITING

Page 1 of 2

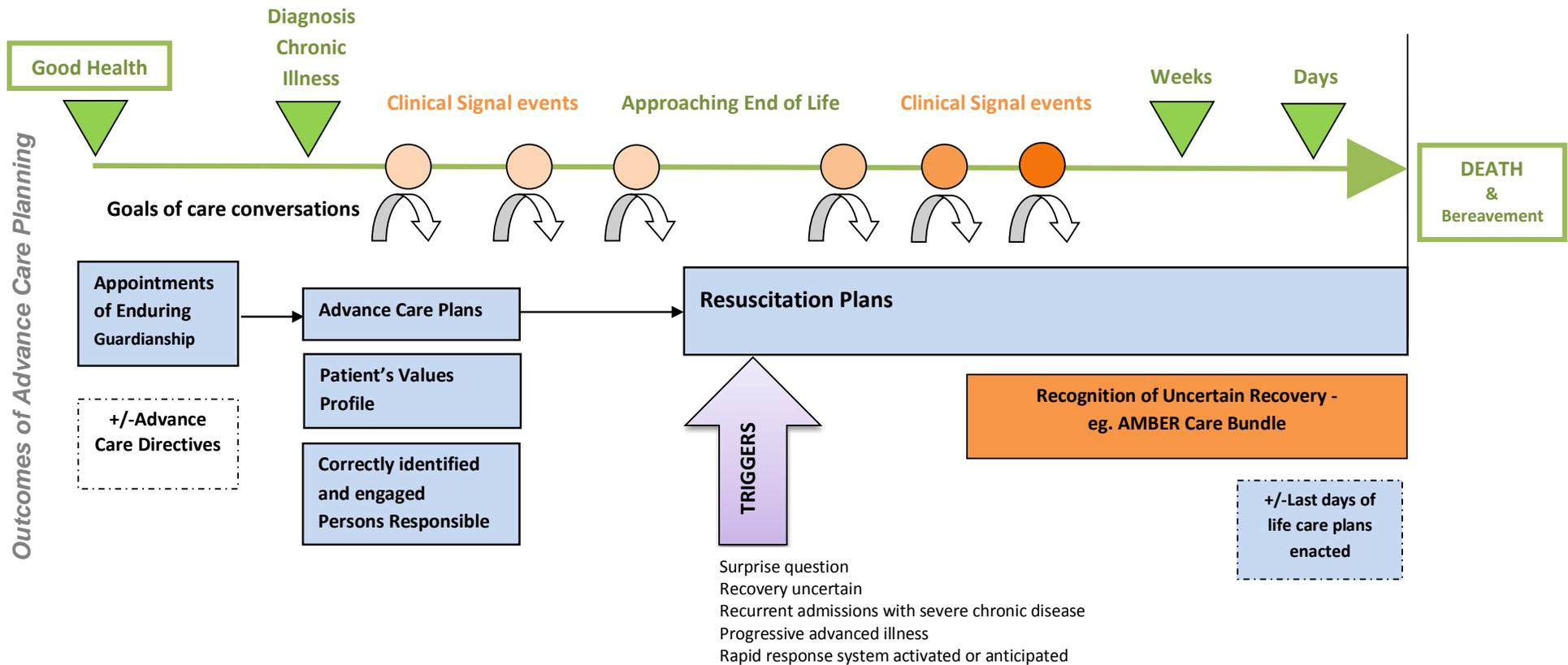
	FAMILY NAME	MRN
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Facility:	D.O.B. ____/____/____	M.O.
RESUSCITATION PLAN - PAEDIATRIC For patients aged between 29 days and 18 years Refer to PD2014_030	ADDRESS	
	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	
Capacity and Participation:		
Use this Resuscitation Plan for minors aged from 29 days up to and including 17 years. For 18 years and above use the Adult Resuscitation Plan. Good practice involves consulting with the family. The patient / parents / guardian have been advised they can revisit these decisions at any time. This Plan was discussed with the patient / parents / guardians (circle which one/s apply) on...../...../..... (date). Include the family in discussions where possible. • An interpreter (if required) was present. Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> If no to any of the above, or the patient / parents / guardian have not been involved in discussions, record details in the patient's health care record. Name of the parents / guardians / family members.....(PRINT) Relationship to patient..... Phone number/s When a child is under the parental responsibility of the Minister, only the Director General of FaCS has the delegated authority to authorise a Resuscitation Plan. Phone the Child Protection Line: 133 827 available 24/7.		
Rationale for withholding CPR:		
• Following consensus with the patient / parents / guardians, resuscitation is inappropriate. <input type="checkbox"/> • The patient's condition is such that CPR is likely to result in negligible clinical benefit. <input type="checkbox"/>		
Referral/Transfer/eMR Alert: (tick as appropriate)		
• Referral to Palliative Care Specialist/Team/Facility <input type="checkbox"/> • Transfer to other facility (specify) <input type="checkbox"/> • Transfer home (if patient/family choice) <input type="checkbox"/> • Has the eMR clinical alert 'Check Resuscitation Plan' been activated <input type="checkbox"/>		
This Resuscitation Plan remains valid:		
• Until a change in prognosis warrants medical review. <input type="checkbox"/> • Until the patient / parents / guardians request a change. <input type="checkbox"/> • For this admission only (including inter-facility Ambulance transfers). <input type="checkbox"/> • For up to 3 months for frequent and routine admissions (e.g. regular immunoglobulin infusions) <input type="checkbox"/> • Until review date at/...../..... and/or time at <input type="checkbox"/>		
Delegated signatory Medical Officer (the AMO must authorize this decision)		
PRINT NAME DESIGNATION TIME PAGER/PHONE DATE SIGNATURE		
Complete and sign both front and back pages. A copy must accompany the patient on all transfers & be included in discharge summary. To revoke this Resuscitation Plan, rule a diagonal line through both sides. Print and sign your name and date on the line.		
Page 2 of 2	NO WRITING	

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 BINDING MARGIN - NO WRITING
 SMR020055



NSW HEALTH RESUSCITATION PLAN PAEDIATRIC 10091.L.indd 2 10/06/2014 10:37:54 AM

Attachment 3: Figure 1: *Resuscitation Plans in the context of Advance Care Planning and End of Life*



Attachment 4: Implementation checklist

LHD/Facility:			
Assessed by:		Date of Assessment:	
IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Notes:</u>		