NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ 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

SMR020056

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 ☐ No ☐ N/A ☐

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:

- **Respiratory Support:**
  - Pharyngeal suction Yes ☐ No ☐
  - Supplemental oxygen Yes ☐ No ☐
  - Non-invasive ventilation Yes ☐ No ☐
  - Bag & mask ventilation Yes ☐ No ☐
  - Intubation Yes ☐ No ☐
- Referral to ICU Yes ☐ No ☐
- Are other non-urgent interventions appropriate? Yes ☐ No ☐

(e.g. Vascular access, blood products, antibiotics, NG feeds/fluids, imaging, Pathology, IV fluids.) Detail in patient record.

Additional details, if required: _____

_____

_____

Clinical Review Call are to be activated **Yes ☐ No ☐**

YELLOW ZONE on Standard Adult General Observation Chart or Maternity Observation Chart

Rapid Response Call are to be activated **Yes ☐ No ☐**

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 ☐ No ☐

In the event of cardiopulmonary arrest:

CPR ☐ **No CPR ☐**

(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 & sign your name & date on the line.

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

RESUSCITATION PLAN - ADULT

SMR020.056

NH606746 100914

NSW GOVERNMENT Health

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RESUSCITATION PLAN - ADULT

For patients aged 18 years and over

Refer to PD2014_030

Capacity and Participation:

Good practice involves consulting with the family. The patient and/or Person Responsible* have been advised they can revisit these decisions at any time.

This Plan was discussed with the patient and/or Person Responsible* (circle which one applies)

on...../...../..... (date).

- **An interpreter (if required) was present.** Yes ☐ No ☐ N/A ☐

If no to any of the above, or the patient and/or Person Responsible* has not been involved in discussions, record details in the patient's health care record.

Name of the Person Responsible* .....(PRINT)

Relationship to patient..... Phone number/s .....

*The *NSW Guardianship Act* establishes the Person Responsible who can give valid consent for medical treatment to an incompetent patient aged 16 years and over according to this hierarchy as:

1. The patient's lawfully appointed guardian (including an enduring guardian) but only if the order or instrument appointing the guardian extends to medical treatment.
2. 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.
3. If there is no such person, a person who has the care of the patient (other than for fee and reward).
4. If there is no such person, a close friend or relative.

Rationale for withholding CPR:

- Withholding CPR complies with the competent patient's verbally expressed wishes. ☐
- Withholding CPR complies with the patient's applicable Advance Care Directive. ☐
- The patient's Enduring Guardian agrees that withholding CPR is consistent with the patient's wishes. ☐
- The patient's condition is such that CPR is likely to result in negligible clinical benefit. ☐

Referral/Transfer/eMR Alert: (tick as appropriate)

- Referral to Palliative Care Specialist/Team/Facility ☐
- Transfer to other facility (specify) ..... ☐
- Transfer home (if patient/family choice) ☐
- Has the eMR clinical alert 'Check Resuscitation Plan' been activated? ☐

This Resuscitation Plan remains valid:

- Until a change in prognosis warrants medical review ☐
- Until the patient and/or Person Responsible* request a change. ☐
- For this admission only (including inter-facility Ambulance transfers). ☐
- For up to 3 months for frequent and routine admissions (e.g. dialysis) ☐
- Until review date at ...../...../..... and/or time at..... ☐

Delegated signatory Medical Officer (must have discussed this decision with the AMO)

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.

NO WRITING