



Health

Facility:

**RESUSCITATION PLAN - PAEDIATRIC**  
For patients aged between 29 days and 18 years  
Refer to PD2014\_030

FAMILY NAME

MRN

GIVEN NAME

☐ MALE ☐ FEMALE

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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 ☐ No ☐

**The Goals of Care** negotiated through conversations with the doctor/patient/family/guardians

**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 ☐

No ☐

No ☐

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 Calls are to be activated**

Yes ☐ No ☐

YELLOW ZONE on Standard Paediatric Observation Chart

**Rapid Response Call are to be activated**

Yes ☐ No ☐

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 ☐ 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 and sign your name and date on the line.

NO WRITING

Page 1 of 2



SMR020055

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

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SMR020.055





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**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 ☐ No ☐ N/A ☐

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: 133 627 available 24/7.

**Rationale for withholding CPR:**

- Following consensus with the patient / parents / guardians, resuscitation is inappropriate. ☐
- 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 / parents / guardians request a change. ☐
- For this admission only (including inter-facility Ambulance transfers). ☐
- For up to 3 months for frequent and routine admissions (e.g. regular immunoglobulin infusions) ☐
- Until review date at ...../...../..... and/or time at..... ☐

**Delegated signatory Medical Officer (the AMO must authorise this decision)**

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PAGER/PHONE ..... DATE ..... SIGNATURE .....

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