Cabrini

Unit Record Number_____

Surname_____

Given Names_____

DOB_____ Sex_____

Affix patient label here or complete details

Resuscitation Plan

☐ Brighton ☐ Hopetoun ☐ Malvern ☐ Prahran

☐ Check for previous MR004 Interpreter required ☐ Yes ☐ No

Complete either section A, B or C Discussion Pathway must also be completed - See over page

A Goal of care: Curative with no limitations of treatment

☐ **Attempt CPR and life-sustaining treatment**

Additional comments (E.g. use of blood products):

_____

_____

_____

B Goal of care: Curative or restorative treatment with limitations

☐ **Attempt CPR** ☐ **Do not attempt CPR**

Indicate which of the following interventions listed below are to be offered:

Code Blue	☐ No	☐ Yes
Defibrillation	☐ No	☐ Yes
Met call (Brighton, Malvern only)	☐ No	☐ Yes (If altered MET criteria apply, document on MR177B)
Transfer to higher acuity facility	☐ No	☐ Yes
ICU referral	☐ No	☐ Yes If yes, consider
– Dialysis	☐ No	☐ Yes
– Inotropes	☐ No	☐ Yes
– Intubation	☐ No	☐ Yes
– NIV (Non Invasive Ventilation)	☐ No	☐ Yes

Additional comments (E.g. antibiotics, surgery or interventional radiology)

_____

_____

_____

_____

C Goal of care: Palliative and supportive care only

☐ **Do not attempt CPR**

– Not for Code Blue
– Not for ICU
– Not for MET call, unless patient distressed or uncontrolled symptoms

Additional comments (Other therapies appropriate for symptom control, e.g. blood products)

_____

_____

_____

Palliative therapies must not be withheld including:

- Medical procedures for relief of pain suffering and discomfort
- Reasonable provision of food and water (Palliative care does not mandate the provision of artificial nutrition or parenteral hydration)

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CH1089T
N/F
23/08/19

RESUSCITATION PLAN MR004

Cabrini

Resuscitation Plan

Unit Record Number_____

Affix patient label here or complete details

Surname_____

Given Names_____

DOB_____ Sex_____

Discussion Pathway

Patients for whom this form should be considered

- Patients with care directives (E.g. Advance Care Directives, Refusal of Treatment Certificates)
- Patients for whom advanced life-support therapies will neither significantly prolong life expectancy nor provide other benefits
- Patients for whom the distress likely to result from treatment would be disproportionate to the benefit
- Patients whose condition or treatment plans have changed significantly since the creation of an earlier Resuscitation Plan

Advance Care Directive (ACD) available for this patient ☐ **Yes** ☐ **No** ☐ **Referred for ACD advice**

I have discussed this plan with:

☐ Patient ☐ Patient's family _____

☐ Medical treatment decision maker _____

☐ Registered Nurse caring for patient _____

☐ Other _____

Record of discussion about treatment goals and any limitations to treatments

Include notes about how the patient is currently affected by their health, outcomes of particular value to the patient, and outcomes that would not be acceptable to the patient

Date / time	Notes

Authorising Medical Officer to complete this section

Print name: _____ Position:_____ Contact no. _____

Signature: _____ Date: DD/MM/YYYY Time: _____

Notified admitting Medical Officer: _____ Date: DD/MM/YYYY Time: _____

Notified Registered Nurse: _____ Date: DD/MM/YYYY Time: _____

If the patient's admitting Medical Officer is unavailable, this form can be completed as a phone order by nursing staff on advice from the admitting Medical Officer. The phone order must be documented in the Discussion pathway above, as well as in the patient's nursing notes. The Medical Officer must verify and sign this form within 24 hours.