TITLE	Resuscitation Plan – Policy and Protocol
TARGET AUDIENCE	All Clinical Staff
SCOPE	Cabrini Brighton, Malvern, Hopetoun and Prahran

PURPOSE

Clear documentation of a patient's Resuscitation Plan allows the patient to be involved in the decision making regarding their treatment and for treatment to be provided in line with patient wishes. A Resuscitation Plan avoids the need for hasty decision making in time-critical situations and unwanted interventions in patients nearing the end of their life.

DEFINITIONS

Admitting Medical Officer: the medical officer under whose name or bed card the patient is admitted to Cabrini Health.

Authorising Medical Officer: A medical officer who is responsible for completing the resuscitation plan but may not be their admitting medical officer, for example Emergency Department Registrar.

Code Blue: as defined by the Code Blue – Rehabilitation, Code Blue/Cardiac Arrest Inpatient- Malvern or Code Blue/Cardiac Arrest Inpatient – Brighton policies.

CPR: Cardiopulmonary resuscitation

Medical Treatment Decision Maker: A person who is identified as having authority over medical treatment decisions when a patient lacks decision-making capacity. Refer Advance Care Planning policy.

Overly burdensome treatment**:** treatment where the benefits hoped for (cure, reversal of a condition, relief of discomfort, appreciable forestalling of death, etc) do not justify the foreseeable burdens of treatment (pain, discomfort, loss of lucidity, breathlessness, extreme agitation, repugnance, cost to the patient, excessive demands on family/carers/healthcare resources, etc)

Therapeutically futile treatment: Treatment that makes no significant contribution to cure or improve the condition of the patient/resident

POLICY

Treatments may be withheld if:

- **i.** There is a medical decision that the treatment would be therapeutically futile or overly burdensome, **or**
- **ii.** The treatment is unwanted by a competent and informed patient or their Medical Treatment Decision Maker, **or**
- **iii.** The treatment is refused in a valid Refusal of Treatment Certificate or an instructional Advance Care Directive

In these situations, a Resuscitation Plan (see Appendix B) should be completed to clearly identify which treatments should not be offered.

In the absence of any of options **i, ii** or **iii** listed above, all emergency treatments should be provided.

An order to withhold CPR does not imply that the patient should not receive other forms of treatment.

- For every patient, an assessment of their resuscitation status should be undertaken on admission
- For those patients at increased risk of deterioration, the Resuscitation Plan MR004 form should be completed ideally within the first 24 hours of admission.
- Validated tools, such as the Supportive and Palliative Care Indicators Tool (SPICT), may be used to assess for increased risk of deterioration. This may include patients with advanced organ failure, advanced age, the diagnosis of a life-limiting illness including malignancy, and any other patient thought to be at risk of deteriorating or dying.
- All patients admitted to the Palliative Care and the Rehabilitation units are required to have a Resuscitation Plan completed upon transfer or admission.

Each Resuscitation Plan applies only to the current hospital admission, and needs to be repeated upon any re-admission or transfer from one Cabrini campus to another.

PROTOCOL

The process for completing the Resuscitation Plan should follow these steps:

a) The healthcare team decides which treatments should be offered to the patient. This should consider the patient's diagnosis and prognosis, and also the patient's preferences and expectations. An understanding of what the patient considers to be an acceptable outcome of treatment is required before deciding whether specific treatments should be offered. This decision-making should include all relevant healthcare staff.

b) Medical staff discuss with the patient what treatments are available to them in the event of a deterioration. The patient is informed of what is involved in these treatments, what the likely outcomes are, and what the alternatives are, so that they may decide whether they want those treatments or not. Also, where appropriate, medical staff may discuss with the patient those relevant treatments which are not being offered and why (see below regarding communication with patients and their families).

c) The Resuscitation Plan and the Resuscitation Plan Discussion Pathway are completed by the Medical Officer to indicate which treatments should be offered in the event of a sudden clinical deterioration. The Discussion Pathway should outline the conversations with the patient and their family and what led to the resuscitation decisions. The Resuscitation Plan must be filed behind the green divider in the patient's medical record, and discussed with the nursing team caring for the patient.

The process for completing a Resuscitation Plan is summarised in Appendix A Flowchart: Completing a Resuscitation Plan

The Resuscitation Plan Form

1. Resuscitation Plan

   Fill in either **Section A**, OR **Section B** OR **Section C** in accordance with the goals of care for the patient's admission.

   SECTION A; Curative treatment with no limitations of treatment: such patients will be offered all treatments which are felt to be potentially beneficial, including CPR, intubation and admission to Intensive Care. Any particular treatments which the patient does not want or which the medical team feels should not be offered should be indicated in the Additional Comments section (e.g. blood transfusion). Note that the patient may be transferred to another facility if required.

SECTION B; Curative or restorative treatment with some treatment limitations: For such patients, it is necessary to specify which treatments should be offered to the patient. It is necessary to select whether the patient should receive CPR or not. In order for CPR to be attempted, it should be medical opinion that there is a chance that CPR will restore life and also that the patient wants CPR to be performed, having been informed of what CPR means, the alternatives (i.e. allowing a natural death), and the possible outcomes of CPR. It is important to inform patients that CPR is almost always coupled with intubation and ventilation, and management in the Intensive Care Unit. Therefore, those patients for whom Intensive Care admission, intubation and ventilation are likely to be non-beneficial should not have CPR attempted. This policy notes that there may be some cases where a patient may wish to have CPR, but not other interventions, such as dialysis.

Section B also documents whether patients should be offered other treatments as listed; again, this should be based on medical opinion of the likely benefit of the treatments and also a discussion with the patient to determine whether they wish for such treatments to be attempted. It is acknowledged that there are some conditions where items in section B may be appropriate and others are not, such as some cardiac arrhythmias which would benefit from defibrillation, however the patient may not benefit from or want CPR and ICU intervention. The additional comments section is used for treatments not listed, such as antibiotics.

SECTION C; Comfort care during dying: such patients are those who should not be offered any of the treatments listed in section B. These patients should not have MET calls other than for uncontrolled symptoms, such as pain or breathlessness. In patients nearing the end of their life where more substantial treatment limitations are in place, other forms of care such as pain relief and physical, spiritual and emotional care must still be provided. Nutrition and hydration must always be provided unless they cannot be assimilated by the person's body or their only mode of delivery imposes a burden on the patient.

2. Resuscitation Plan Discussion Pathway

The reverse-side of the Resuscitation Plan form is a Discussion Pathway where clinicians should document the rationale for treatment decisions and also the extent to which the plan has been discussed with the patient and/or their Medical Treatment Decision Maker and other family members. This should include whether any specified treatment limitations were a result of medical opinion that they are non-beneficial, or patient refusal of treatment.

The rationale should be further clarified with a description of any patient values/wishes that have contributed to the Resuscitation Plan. A description of the factors that have influenced the decisions helps to plan care that is consistent with a patient's values, and assists all members of the health care team to understand the directives.

Patients should routinely be asked about the presence of an Advance Care Directive. If present, the person completing the Resuscitation Plan should ensure that the ACD is copied and available in the patient's notes behind the green medico-legal divider, and also uploaded to PAS (see: Advance Care Planning Policy and Procedure). Patients who wish to receive more information about advance care planning can be referred to the social work department for advice. Patients with significant treatment limitations who do not have an Advance Care Directive should be advised to consider this.

3. Authorising Medical Officer Details

The Resuscitation Plan should be completed by a Medical Officer. If this is not the Admitting Medical Officer, then the Admitting Medical Officer must be informed. It should be documented whether the patient and/or their family were informed of the decisions therein. The nursing staff member caring for the patient must be informed of the decisions documented in the Resuscitation Plan.

4. Phone orders

A phone order may be provided by the patient's admitting Medical Officer if it is clear that certain treatments are therapeutically futile or non-beneficial and should not be offered. Nursing staff completing the form on advice over the phone from the patient's admitting Medical Officer should document the discussion in the Discussion Pathway and also in the patient's notes. The admitting Medical Officer should verify and sign the Resuscitation Plan within 24 hours.

Review of Resuscitation Plan

The Resuscitation Plan should be reviewed whenever there are substantial changes in the patient's diagnosis or prognosis, or whenever requested by the patient. The Resuscitation Plan may only be changed by a Medical Officer. The plan can be reversed or altered at any time. Each Resuscitation Plan is relevant only for the current hospital admission, and needs to be repeated upon any re-admission or transfer from one Cabrini campus to another. In the event of a transfer, the admitting Medical Officer of the receiving facility may refer to the previous facility's Resuscitation Plan to inform appropriate goals of care.

Review during the peri-operative period

It is increasingly common for surgical procedures to be performed for patients with treatment limitations. This poses difficulty as interventions routinely used in the course of anaesthesia may include those that have been withheld. The Resuscitation Plan should be reviewed when a patient with treatment limitations embarks upon an anaesthetic or surgical procedure, during which it may be appropriate to alter or suspend the plan during the peri-operative period.

These patients must be identified early to allow discussion with surgical and anaesthetic staff. Pre-operative discussion should be sensitive, timely and clear, and should include the patient and all other relevant individuals. Decisions should consider the patient's medical condition, the surgical intervention required and the details of the original Resuscitation Plan. These discussions will result in one of four options:

a) Deferment or cancellation of surgery

b) Temporary suspension of any treatment limitations in the Resuscitation Plan – the Resuscitation Plan may then be re-instated when the patient leaves PACU

c) Modification of the Resuscitation Plan with respect to monitoring, intubation and mechanical ventilation, use of vasopressors, inotropes or antiarrhythmic drugs and/or defibrillation/CPR

d) No change to the Resuscitation Plan; patients may wish to undergo a minor surgical procedure with treatment limitations in place. With this option there should be a decision about exactly which interventions are permitted.

There should be very clear documentation in the patient's medical record about discussions leading to modifications of the Resuscitation Plan in the perioperative period. All staff must be made aware of the Resuscitation Plan.

In an emergency requiring surgery, it may not be possible to review the Resuscitation Plan. Reasonable attempts should be made to clarify the patient's wishes by discussion with the patient or their Medical Treatment Decision Maker and other family members. If no information is available, the health care team must act in the best interests of the patient using whatever information is available, including consideration of the existing Resuscitation Plan and the rationale for the decisions therein.

To change a Resuscitation Plan

Amendments to an existing Resuscitation Plan form can lead to confusion; therefore, a new Resuscitation Plan form is to be completed whenever there are changes to a Resuscitation Plan.

To change a Resuscitation Plan, draw a diagonal line across the existing form, and write "Cancelled", with the date and your initials on the line. Record appropriate information in the patient's medical record. Record the new Resuscitation Plan on a new form, and file behind the green divider.

Communication with patients and families regarding the resuscitation plan

The Resuscitation Plan is designed to encourage open, two-way dialogue with the patient and/or their representative in order to establish a treatment plan that is consistent with the beliefs and wishes of that patient. It is important that the healthcare provider completing the plan has spent time to understand the wishes of the patient in order to tailor care to their requirements. Equally, it is important that patients/representatives understand the nature and outcomes of their own diagnosis, prognosis, and any treatment proposed, in order to make an informed decision regarding their treatment preferences. Completing the documentation on the Resuscitation Plan can be done whilst speaking with the patient / MTDM, or it can be completed separate to the discussion. This is often best judged by the clinician completing the form at the time.

Treatments that are considered to be therapeutically futile by the medical team should not be offered to the patient. Rather, it should be explained to the patient what the alternatives are. It is always preferable to talk about what treatments will be offered, rather than what won't be offered. For example, for a patient whose admission to ICU is thought to be non-beneficial, it would be better to describe what would occur with ward based treatment in the event of deterioration rather than focussing on the withholding of ICU treatments.

Treatments that are considered to be potentially of benefit to the patient should be explained, including what is involved, the possible outcomes, and what alternatives are available to the patient, so that the patient can make an informed decision as to whether to accept those treatments or not. Where advice is desired, it is an important role of the healthcare provider to offer that advice.

Discussions with relatives of the patient are important when determining a Resuscitation Plan, especially when the patient is not competent. If the patient is not competent, the Resuscitation Plan is completed with the patient's Medical Treatment Decision Maker. Even when the patient is competent, inclusion of their family in discussions around resuscitation planning can be helpful and should be offered to the patient.

It is also important that the plan is discussed with other members of the healthcare team involved in caring for that patient, particularly the bedside nursing staff and nurse in charge of the ward.

In case of difficulty or disagreement:

In some cases, there will be dispute amongst staff or between staff and the patient/representative, regarding what treatments should be offered to patients.
In such cases:

a) A second clinical opinion from a colleague should be sought
b) Input from the ICU or Palliative Care consultant may be sought
c) The case may be referred to the Group Director Medical Services and Clinical Governance
d) A clinical ethics consultation may be sought

In all cases, open, honest dialogue with the patient and family is of primary importance. Where disputes cannot be settled with the above inputs, it may be appropriate to offer a time-limited trial of therapies to ascertain a patient's response to this.

In cases where dispute persists, referral to the Office of the Public Advocate may be considered.

Where a staff member is concerned that his/her capacity to care for a patient may be negatively impacted by a Resuscitation Plan, he/she should raise the issue with the person in charge of patient allocation on the shift, and the appropriate process followed (see: Guideline for Staff Experiencing Values Conflict).

Occasionally, it may be appropriate for a medical officer to consider transferring the care of a patient to another doctor if disputes cannot be settled.

EVALUATION
Audit of the Resuscitation Plan as per Cabrini Clinical Audit schedule.

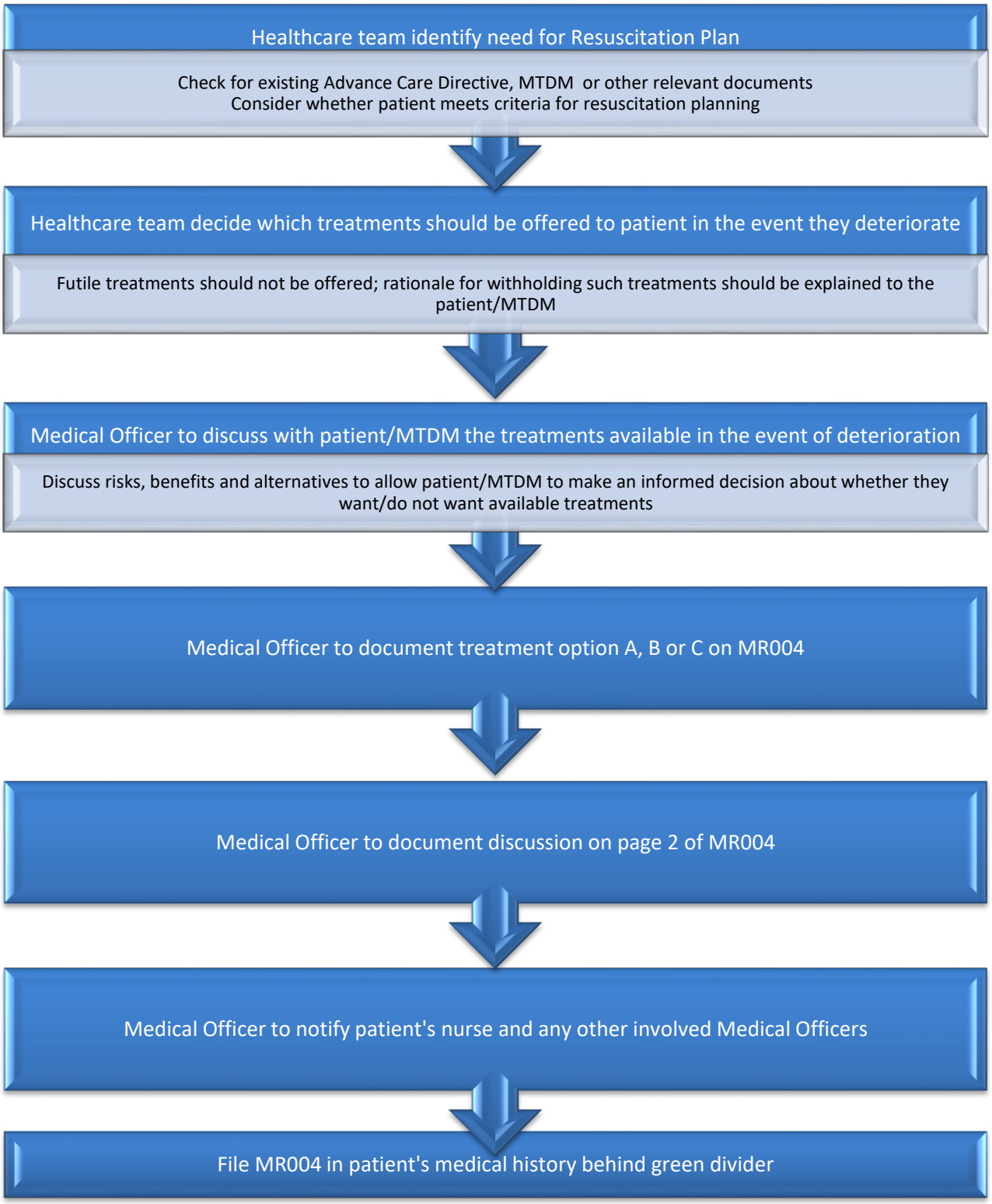
REFERENCES and ASSOCIATED DOCUMENTS
Cabrini Health Policies Procedures & Protocols
Clinical Ethics Consultation Service
Staff Experiencing Values Conflict
Withholding, withdrawing and refusing treatment
Resuscitation Plan MR004 form

Supportive and Palliative Care Indicators Tool (SPICT) (Website link)

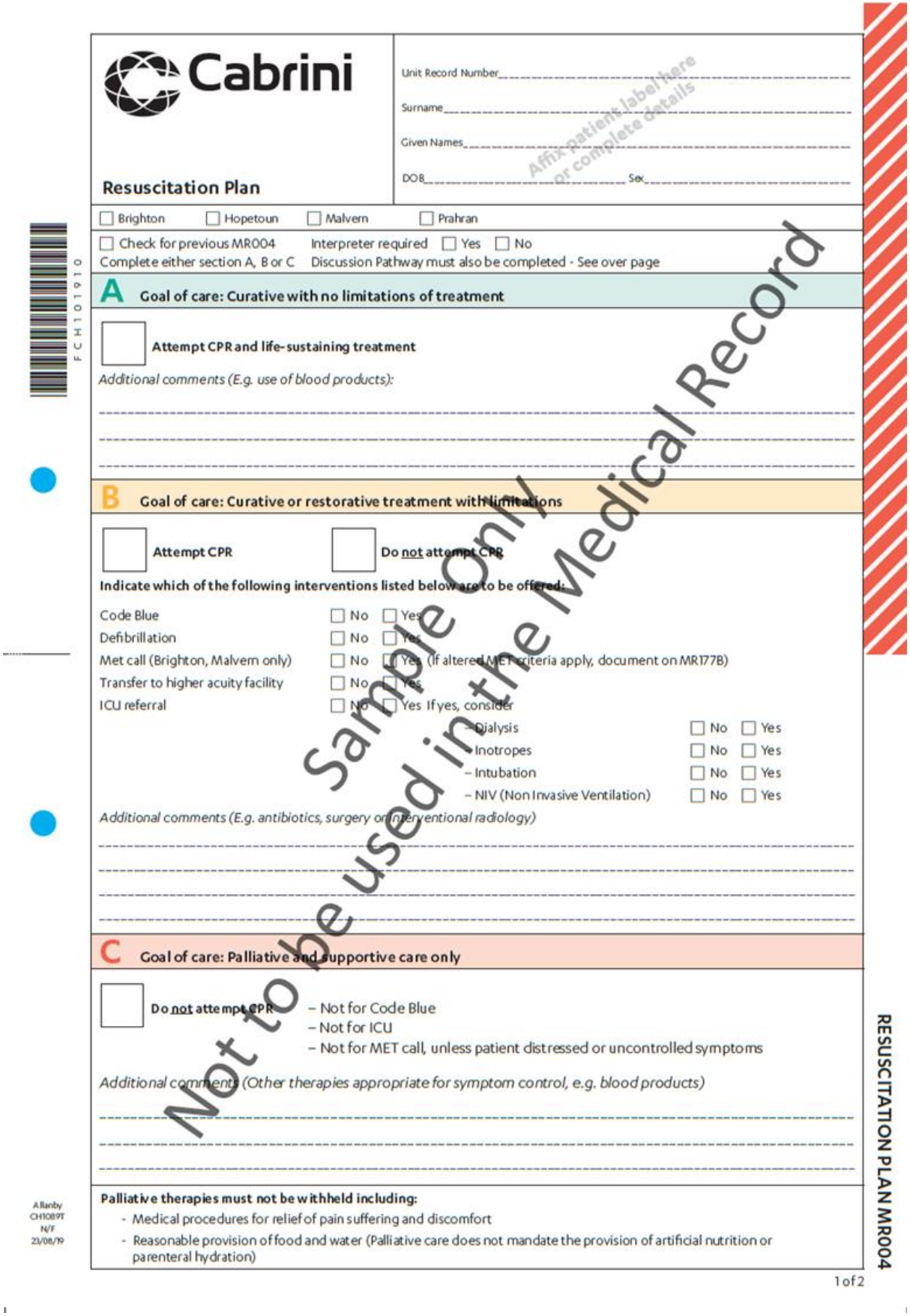
Key Legislation & Standards
Medical Treatment Planning and Decisions Act 2016
Enduring Power of Attorney Act 1990
Code of Ethical Standards for Catholic Health & Aged Care Services in Australia

Executive Sponsor	**Group Director Medical Services and Clinical Governance**	
Content Approved By:	End of Life Care Sub-committee	**Date:** 14th August 2018
Authorised to Publish By:	Group Director Medical Services and Clinical Governance	**Date:** 30th August 2019

Appendix A – Flowchart: Completing a Resuscitation Plan



Appendix B – Resuscitation Plan MR004 form



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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RESUSCITATION PLAN MR004

FCH101910

Allanby CH1089T N/F 21/08/19

Sample Only Not to be used in the Medical Record

Cabrini

Cabrini

Unit Record Number_____

Surname_____

Given Names_____

DOB_____ Sex_____

Affix patient label here or complete details

Resuscitation Plan

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.

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