# RESIDENTIAL AGED CARE FACILITIES FOLDER

## Dubbo






LAST UPDATED
November 2017
Please note that the most recent version of the Aged Care Folder can be accessed via the Western NSW PHN website: www.wnswphn.org.au.

## BACKGROUND

This Aged Care Folder is a clinical support tool for Residential Aged Care Facilities (RACFs) and General Practices located in Dubbo, and Dubbo Base Hospital's Emergency Department. It aims to support the delivery of the 'right care, at the right place, and at the right time' for our patients residing in our RACFs. It is designed to be a simple and user-friendly resource that will be kept current via the Western NSW PHN website and can be embedded into routine patient care.

The Folder has been developed by a collaboration between Residential Aged Care Facilities (RACFs), General Practices, Dubbo Base Hospital's Emergency Department, and Western NSW PHN. Representatives from each of the RACFs and General Practices in Dubbo, and from Dubbo Base Hospital Emergency Department, were invited to attend Primary Care – ED (PriCED) Working Party meetings in 2016/2017 and contribute to the development of this Aged Care Folder.

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# RACF patient unwell?

## Assess patient

## Recognise the deteriorating patient:

- *Significant new altered level of consciousness*
- *HR > 120 or < 50*
- *Febrile > 38$^0$C*
- *RR > 28*
- *SBP < 90*
- *Sats > 90*
- *BSL < 4*
- *Other red flags e.g. fallen and on anticoagulants (does not include aspirin), signs of a stroke, witnessed seizure, significant open wound, significant head trauma, significant pain*

## Consider:

- *What are the directions for medical care / Advance Care Plan?*
- *Is this matter an emergency, an urgent matter or a non-urgent matter?*
- *Is it during usual business hours or after hours?*

If in keeping with directions for medical care / Advance Care Plan, **and if this is an *EMERGENCY*, PHONE 000**

For all others, phone or fax Doctor as per ***Doctor Contact Protocol***

Utilise ISBAR communication guide to provide a clinical handover

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# ISBAR Communication Guide

## INTRODUCTION

- Your name, designation and location
- Resident's name, DOB and gender
- Identify whom you are speaking to

## SITUATION

- Explain why you are calling
- What are the resident's main symptoms?

## BACKGROUND

- Resident's relevant medical history
- Current medications
- Allergies
- Resident's GP
- Advance care plan

## ASSESSMENT

- Observations
- It is important to handover not only current observations but also what is usual for the patient e.g. resident is normally confused but they are more confused than normal

## RECOMMENDATION

- I would like:
  - your advice on further management of this resident's problem
  - pathology request
  - medication authorisation
  - transfer to emergency department
- I have / will notify the resident's family

# ISBAR Fax

Acknowledgements to Central Coast NSW Medicare Local

| | | |
|---|---|---|
| **INTRODUCTION** | • Your name, designation and location<br>• Resident's name, DOB and gender<br>• Identify whom you are sending the fax to | |
| **SITUATION** | • Explain why you are sending this fax<br>• What are the resident's main symptoms? | |
| **BACKGROUND** | • Resident's relevant medical history<br>• Current medications<br>• Allergies<br>• Resident's GP<br>• Advance care plan | |
| **ASSESSMENT** | • Observations<br>• It is important to handover not only current observations but also what is usual for the patient e.g. resident is normally confused but they are more confused than normal | |
| **RECOMMENDATION** | • I would like:<br>- your advice on further management of this resident's problem<br>- pathology request<br>- medication authorisation<br>- transfer to emergency department<br>• I have / will notify the resident's family | |

# Checklist for Transfer to and from RACF & Emergency Department

***Please attach this checklist to the outside of envelope containing patient transfer documents***

***Direct line to Emergency Physician in Charge: 6809 7120***

## *From RACF to Emergency Department*

| | | |
|---|---|---|
| *Family / NOK Informed* | | ☐ |
| *GP Name* _____ | *GP Aware* | *Yes / No* |
| *Transfer Letter Completed* | | ☐ |
| *Check Resident Details & GP Details are up to date* | | ☐ |
| *Copy of most recent medical assessment / GP Notes* | | ☐ |
| *Copy of Medication Chart / Blister Pack* | | ☐ |
| *Blank Medication Chart with Addressograph* | | ☐ |
| *Copy of Advance Care Directive* | | ☐ |

## *From Emergency Department to RACF*

| | |
|---|---|
| *Family / NOK Informed* | Yes / No |
| *GP/Practice Called (During Business Hours)* | ☐ |
| *Discharge Summary Completed* | ☐ |
| *Check GP Details have been updated by Ward Clerk* | ☐ |
| *Blister Pack / Hearing Aids / Dentures / Glasses with patient* | ☐ |
| *Scripts given for new medications (inc dispensing first dose)* | ☐ |
| *Advance Care Directive changed* | *Yes / No* |

NSW GOVERNMENT | Health

# MAKING AN ADVANCE CARE DIRECTIVE

## In this package you will find:

- an Advance Care Directive form to complete
- an Information Booklet to help you complete your Advance Care Directive

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May 2017

# Making an Advance Care Directive

**The purpose of this Information Booklet is to provide information to help you complete your Advance Care Directive. An Advance Care Directive form is provided at the end of the booklet, for you to complete and tear off.**

An Advance Care Directive is an important way of letting people know your wishes about your healthcare and treatment should you find yourself in a position where you are seriously ill or injured and not able to make decisions. Having an Advance Care Directive will make it easier for your loved ones and health staff if they need to make decisions for you.

An Advance Care Directive is an important result of Advance Care Planning.

For more information about Advance Care Planning, please see http://www.health.nsw.gov.au/patients/acp/Pages/default.aspx

## What is an Advance Care Directive?

An Advance Care Directive is a way to say what healthcare treatments you would like to have or refuse, should you be in a position where you are seriously ill or injured and unable to make or communicate decisions about your care and treatment.

An **Advance Care Directive** can only be made by you as an adult with decision-making capacity. **If it is valid, it must be followed**. Health professionals and Persons Responsible have no authority to override a valid Advance Care Directive.

An Advance Care Directive may include one or more of the following:

- the person you would like to make medical decisions for you if you are unable to make decisions
- details of what is important to you, such as your values, life goals and preferred outcomes
- the treatments and care you would like or would refuse if you have a life-threatening illness or injury.

**This booklet will help guide you through decisions that you may wish to consider when making an Advance Care Directive.**

## Why is an Advance Care Directive important?

Making an Advance Care Directive is an important part of Advance Care Planning.

None of us know what will happen in the future or can predict what might happen with our health.

Medical advances mean that there are treatments which can keep you alive when you are seriously ill or injured, and which may prolong your life. Some people have firm ideas about how they want to live the rest of their life, including conditions or treatments that they might find unacceptable.

In a crisis your family may find it difficult to decide what treatment is best for you. An Advance Care Directive will help your family and doctors to know what you would want when you are not able to tell them yourself. It's best to write your Advance Care Directive so that your wishes are clearly recorded.

## How do I prepare for making an Advance Care Directive?

The **first step** is to think about what would be important to you at end of life and what matters to you – your values. This may include:

- thinking about what kind of care you would like to receive or refuse
- who you would like to make decisions on your behalf and
- where you would like to be cared for if you were dying.

In the Advance Care Directive form at the back of this booklet, Section 2 includes space for you to write some statements if you wish. There is no right or wrong answer – it is up to you to identify what is important to let others know. This information will help your family and those making decisions for you with understanding what treatment and care you want.

Some examples of statements about values are provided in the **Common Terms** section on page 9. If you're not sure what you would want, or would like to read more, the following websites might be helpful:

- Dying to Talk http://dyingtotalk.org.au/
- MyValues https://www.myvalues.org.au/

The **next step** is to talk with your family, friends and health professionals.

Talking to your family and friends can be difficult. You might start by saying that like writing a will, you are planning ahead for a time when you might not be able to make decisions about your health. Make it clear to your loved ones what treatments you would accept or refuse if you are very unwell.

Your doctors can help by explaining what treatments you could include in your Advance Care Directive based on your current health. They can also make sure that what you write can be understood by a health professional.

Working through the Advance Care Directive form at the back of this booklet will help identify what is important to you, that you would like to let your loved ones and healthcare providers know about.

## How do I make an Advance Care Directive?

In NSW, an Advance Care Directive can be spoken or written.

Unlike in other states, in NSW there isn't a specific form to use for an Advance Care Directive. An Advance Care Directive can simply be written on a piece of paper, not witnessed and still be legally enforceable. However, signed Advance Care Directives are the recommended way to ensure that your wishes are recorded.

If you want to make an Advance Care Directive you can choose to:

- use the Advance Care Directive form developed by NSW Health at the back of this booklet
- use another form, such as one of those available from www.planningaheadtools.com.au
- write a letter or statement about your wishes
- tell someone that you trust and who knows you well.

## Deciding who will make decisions for you if you cannot make them.

It is important to think about who you would like to make healthcare decisions for you if you are seriously ill or injured and can no longer make decisions. Some people choose a family member or close friend or appoint an Enduring Guardian/s.

If it's not clear in your Advance Care Directive who this person or people are, your doctor will ask someone else to make the decision for you. This person is known as the **Person Responsible**. A Person Responsible is not always a relative. You may also hear people use the term Substitute Decision Maker. Further information about these terms is provided in the **Common Terms** section on page 9. The term 'next of kin' isn't used anymore.

## When does my Advance Care Directive apply?

Doctors and health care professionals will only look at your Advance Care Directive if you are unable to make or communicate decisions about your healthcare and treatment.

You can ask that your Person Responsible refer to your Advance Care Directive before making any medical or health decisions.

Before acting on any instructions that your Advance Care Directive may contain about your treatment or care, doctors will assess if it is valid. Part of that assessment is understanding whether it applies to your current situation.

For example, if you were admitted to hospital because you had fallen over and hit your head and had concussion, and were not able to communicate your wishes, you would be expected to get better and your Advance Care Directive may not be considered to apply to that situation.

However, if you had suffered a major stroke or heart attack and were unconscious and not able to communicate, and were not expected to get better, the doctors may consider that your Advance Care Directive may apply in that situation.

Pain relief and managing discomfort are always important. If your Advance Care Directive states you want to die a natural death, you will still be given pain relief if needed.

## When is my Advance Care Directive valid?

An Advance Care Directive will only be used when you do not have capacity to decide for yourself or to communicate your wishes.

Your doctor will consider your Advance Care Directive to be valid if:

- you had capacity when you wrote it
- you made it by choice, it was not forced upon you
- it has clear and specific details about treatments that you would accept or refuse
- it is current
- it applies to the situation you are in at the time.

The NSW Supreme Court has said that valid Advance Care Directives must be followed. This is because they are an extension to a person's right to make decisions about their health. If an Advance Care Directive is valid, it must be followed. Health professionals and Persons Responsible have no authority to override a valid Advance Care Directive.

## Where should I keep my Advance Care Directive?

You should keep your Advance Care Directive in a place that is easy for you or someone else to find it. It is a good idea to keep a copy with you, or to keep a card in your wallet that lets people know that you have an Advance Care Directive and where it can be found.

It is a good idea to leave a copy with your Person Responsible, family and/or carer, doctor and/or healthcare facility.

Make sure you know where all the copies are. If you change your Advance Care Directive, you will need to replace all of the copies.

# Frequently Asked Questions

### Can I record my wishes regarding future healthcare in my will?

No. Your will is only read after your death. Any information about your health in your will not be available to your Person Responsible or doctor(s) while you are alive.

### Can my Power of Attorney consent to medical and dental treatment on my behalf?

No. Their role is to manage your business, property and financial matters.

### Is an Advance Care Directive permission or consent for euthanasia?

No. You cannot request or direct a doctor or any other person to actively and deliberately end your life. Euthanasia or assisted dying is illegal in all Australian States and Territories.

### I prepared an Advance Care Directive when I lived interstate. Is this recognised now that I live in NSW?

Yes. Advance Care Directives made in other Australian states and territories are recognised in NSW.

### I have an Advance Care Directive but have decided that I would like my Enduring Guardian to make the best decision they can at the time. Can I revoke my Advance Care Directive?

Yes, you can retract/cancel/void your Advance Care Directive at any time while you have capacity. It is important to make sure you let people know you have revoked your Advance Care Directive and destroy all copies.

### What if I change my mind about my Advance Care Directive?

You can change your Advance Care Directive as often as you like, as long as you have capacity. It is a good idea to read over anything you have written once a year, to make sure it is still current.

If you change your Advance Care Directive, you should make sure you let people know and replace all of the copies with the new Advance Care Directive.

### What's the difference between an Advance Care Directive and an Advance Care Plan?

An **Advance Care Directive** can only be made by you as an adult with decision-making capacity. If it is valid, it must be followed. No one can override your Advance Care Directive, not even your legally appointed guardian.

An **Advance Care Plan** can be written by you or on your behalf. It documents your values and preferences for healthcare and preferred health outcomes. The plan is prepared from your perspective and used as a guide for future healthcare decision making, if you are unable to speak or otherwise communicate your wishes for yourself.

It may be developed for and with a person with limited capacity (ability to make decisions), so therefore is not a legal document.

## What is capacity?

Capacity refers to an adult's ability to make a decision for him or herself.

Capacity is specific to the particular decision that needs to be made. In some circumstances, the law sets out what tests must be met for capacity to make certain decisions, for example to consent to medical treatment.

Generally, when a person has capacity to make a particular decision they can do all of the following:

- understand and believe the facts involved in making the decision
- understand the main choices
- weigh up the consequences of the choices
- understand how the consequences affect them
- make their decision freely and voluntarily
- communicate their decision.

## Can I insist on being given a particular treatment or procedure?

No. Your health care team will consider your wishes, but does not have to offer you treatment that will not benefit you.

## What about organ and tissue donation for transplantation?

Organ donation is a life-saving and life-transforming medical process. Organ and tissue donation involves removing organs and tissues from someone who has died (a donor) and transplanting them into someone who, in many cases, is very ill or dying (a recipient).

People 16 years of age or older can register their donation decision on the Australian Organ Donor Register at https://www.humanservices.gov.au/customer/services/medicare/australian-organ-donor-register or by contacting their local Centrelink or Medicare Service Centres, myGov shopfront or Access Points.

It is also important that you let your family know your decisions about organ and tissue donation. In Australia your family will always be asked to confirm your donation decisions before organ and tissue donation for transplantation can proceed.

Some patients are so severely injured or ill that they do not respond to lifesaving medical treatments. The doctors caring for that patient may agree that they will not survive and that further medical treatment is no longer of any benefit to them.

The doctors may then ask their family about that person's wishes about organ and tissue donation.

If the person had indicated that they wanted to become an organ and tissue donor after their death, the doctors may also ask the family about several treatments which may be given before that person dies, only for the purpose of improving the function of any donated organs when transplanted. These treatments are of no medical benefit to the patient and are called **antemortem interventions**. Examples include antibiotics, blood thinning drugs or drugs to control blood pressure.

If you want to be an organ donor, the Advance Care Directive asks you to declare your consent to antemortem interventions.

If you do not consent to antemortem interventions, it is still possible to be an organ donor.

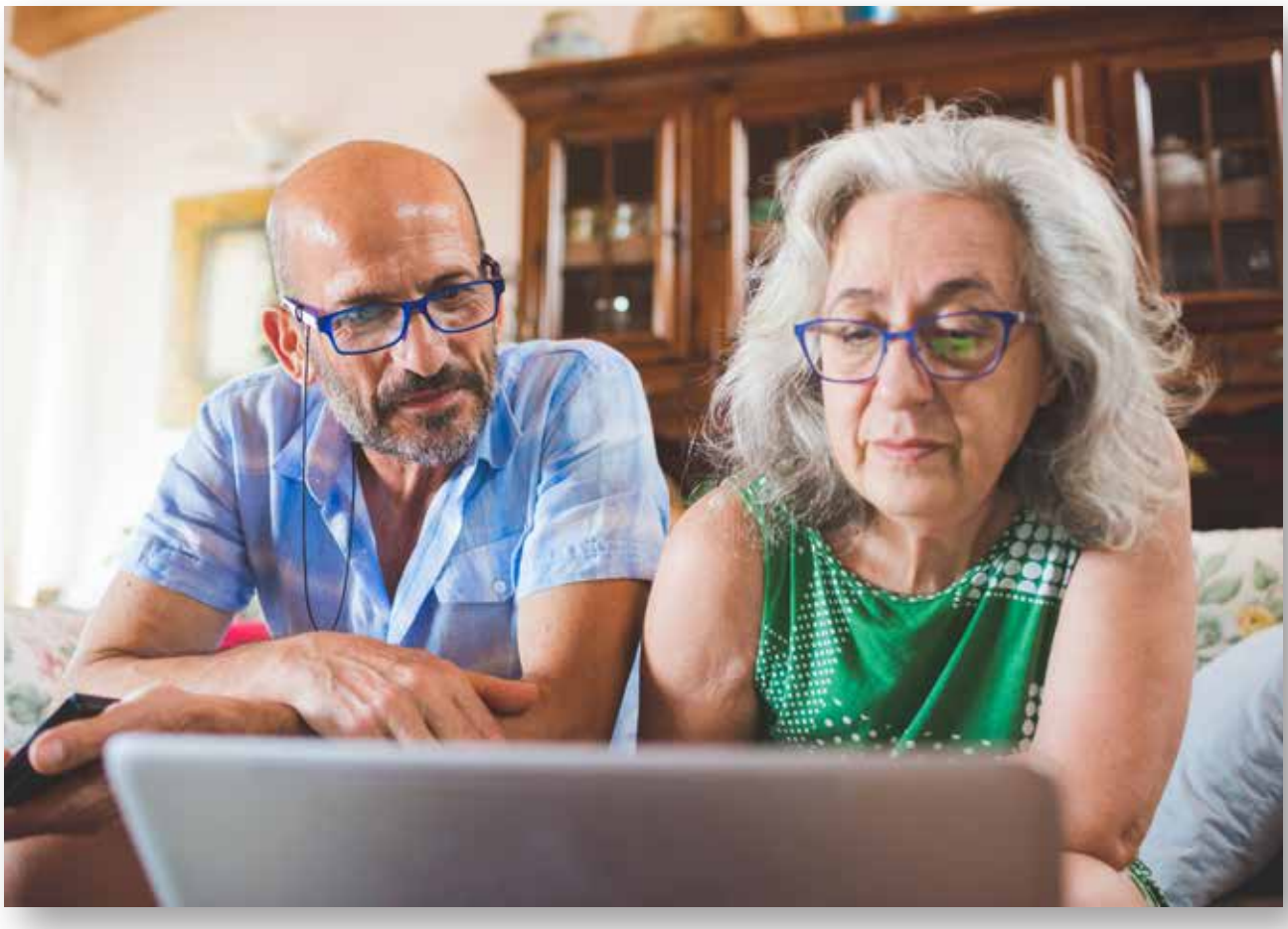
## I've heard about Body donation – what is that?

Body donation is where a person's body is given to a body donor program and / or a licensed anatomical facility either following the person's written consent prior to their death or with the consent of their senior available next of kin after their death. Programs may use bodies for the teaching of medical and health students, training of surgeons in new surgical techniques or for research.

In NSW a body donation program is usually organised through a university or medical research facility.

Most body donation programs encourage people to register to be an organ donor as well as a body donor, if they would like to do so. Where a person has consented to body donation and organ donation, preference is given to organ donation if suitable, because of its life saving benefits.

If you have registered your wish to donate with a body donor program you should make sure that your family knows your decision. That way either your family or hospital staff can contact the program you are registered with when you die.



*An Advance Care Directive is an important way of letting people know your wishes about your healthcare and treatment should you find yourself in a position where you are seriously ill or injured and not able to make decisions.*

# Common Terms

## Advance Care Planning

Advance Care Planning involves thinking about what medical care you would like should you find yourself in a position where you are seriously ill or injured and cannot make or communicate decisions about your care or treatment. It includes thinking about what is important to you - your values, beliefs and wishes.

Advance Care Planning can include one or more of the following:

- talking with your family, carers and/or health professionals
- developing an Advance Care Plan
- making an Advance Care Directive.

Ideally Advance Care Planning happens early, when you are well and are able to understand the choices available to you about your healthcare and treatment. However it can be done at any time.

An Advance Care Plan records preferences about health, personal care and treatment goals. It may be completed by discussion or in writing.

If you are able to make decisions about your future healthcare, you can make an Advance Care Plan by yourself or together with people that you trust and/or who are important to you.

If you are not able to make decisions, an Advance Care Plan can be made for you by a family member or someone who knows you well, together with a health professional. It should include your known wishes about treatment.

## Advance Care Directive

An Advance Care Directive is a way to say what healthcare treatments you would like to have or refuse, should you find yourself in a position where you are seriously ill or injured and unable to make or communicate decisions about your treatment and care.

An Advance Care Directive may include one or more of the following:

- the person or people you would like to make medical decisions for you if you are unable to make decisions
- details of what is important to you, such as your values, life goals and preferred outcomes
- the treatments and care you would like or refuse if you have a life-threatening illness or injury.

## Person Responsible

In *NSW the Guardianship Act 1987 (NSW)* states that the **Person Responsible** is (in order):

**1. Your guardian**

This is a person or people who have been legally appointed to make medical and/or dental decisions for you. In some situations a guardian may be appointed for someone, but most people are able to choose their own guardian.

If you are 18 years of age or older and have capacity, you can appoint an **Enduring Guardian** (you can appoint one or two). When you appoint the Enduring Guardian(s) you can decide what medical and/or dental decisions you would like to be able to make for you, if you do not have the capacity to make the decision yourself.

You can direct your Enduring Guardian to consider your Advance Care Directive before they make a decision.

**2. Your spouse, de facto or same sex partner**

Person with whom you have a close and continuing relationship.

**3. Your carer**

Person who currently provides support to you or did before you entered residential care. This person cannot be a paid carer. The carer support payment is not considered payment.

**4. A close friend or relative**

Person with whom you have an ongoing relationship.

## Substitute decision maker

A substitute decision maker is a person who is appointed or identified by law to make decisions for an individual whose decision-making capacity is impaired. A substitute decision maker may be appointed by the individual (for example appointing an Enduring Guardian or making a Power of Attorney), appointed for the individual (for example a guardian appointed by the Guardianship Division), or identified as a substitute decision-maker for medical and dental treatment by the NSW Guardianship Act 'Person Responsible' hierarchy.

## Values statements

Some people may choose to record general statements about what is important to them - their values, beliefs and wishes - on their Advance Care Directive or in their Advance Care Plan. The following values statements are provided as examples of what you may wish to include in Section 2 of the form (there is no right or wrong – it is entirely up to you what you wish to record to let others know):

**Beliefs and values:**

*It is important for me to be able to communicate in some way, even if I cannot speak.*

*Life has meaning when I can enjoy nature and when I can practise my faith.*

*I value my privacy.*

**Physical or mental health concerns that you may want considered:**

*I do not want to struggle to breathe.*

*I do not want to be in pain.*

*It is important to me that I spend time in my garden.*

**Other information that you would like considered:**

*I would like to stay at home as long as it is not too hard on my family or the people caring for me.*

*I would not like to die at home.*

*I worry that my family or the people caring for me will not know what to do.*

*I want flowers in my room.*

**Cultural, spiritual and/or social care:**

*I would like prayer, religious or spiritual rituals in my own language.*

*I would like my music to be played.*

# NSW Health Advance Care Directive (ACD)

NSW GOVERNMENT Health

## SECTION 1 YOUR DETAILS AND YOUR PERSON RESPONSIBLE

**Family name:** _____

**Given names:** _____

**Date of birth:** _____

**Address:** _____

_____

I have legally appointed one or more people as my Enduring Guardian and they are aware of this Advance Care Directive:

| | ENDURING GUARDIAN 1 | ENDURING GUARDIAN 2 |
|---|---|---|
| **Name:** | | |
| **Home phone number:** | | |
| **Mobile phone number:** | | |
| **Email address:** | | |

I have not appointed an Enduring Guardian.

If, because of my medical condition, I am not able to understand and make decisions about my treatment or can't tell the doctors or my family, my Person Responsible is:

| | PERSON 1 | PERSON 2 |
|---|---|---|
| **Name:** | | |
| **Relationship:** | | |
| **Home phone number:** | | |
| **Mobile phone number:** | | |

## SECTION 2 PERSONAL VALUES ABOUT DYING

**Information about your values is important as it is not possible for this document to cover all medical situations.** Information about what is important to you may help the person who is making decisions on your behalf when they are speaking to the doctors about your care and treatment.

In this section you can include:

- things that are important to you at the end of life (your beliefs and values)
- issues that worry you, and
- personal, religious or spiritual care you would like to receive when you are dying.

**If I am unable to communicate and not expected to get better:**

- I would like my pain and comfort managed; and
- when deciding what treatments to give to me or not to give me, I would like the person/people making health decisions for me to understand how the following would make me feel (initial the box that is your choice):

| VALUES | Acceptable | Unbearable (I would like treatment discontinued and to be allowed to die a natural death) | Unsure |
|---|---|---|---|
| 1. If I can no longer recognise my family and loved ones, I would find life... | ☐ | ☐ | ☐ |
| 2. If I no longer have control my bladder and bowels, I would find life... | ☐ | ☐ | ☐ |
| 3. If I cannot feed, wash or dress myself I would find life... | ☐ | ☐ | ☐ |
| 4. If I cannot move myself around in or out of bed and rely on other people to reposition (shift or move) me, I would find life... | ☐ | ☐ | ☐ |
| 5. If I can no longer eat or drink and need to have food given to me through a tube in my stomach, but can still communicate, I would find life... | ☐ | ☐ | ☐ |
| 6. If I am not able to communicate by talking, reading or writing, I would find life... | ☐ | ☐ | ☐ |
| 7. If I can never have a conversation with others because I do not understand what people are saying, I would find life... | ☐ | ☐ | ☐ |

## SECTION 2 PERSONAL VALUES ABOUT DYING

**At the end of my life when my time comes for natural dying, I would like to be cared for** (initial the box of your choice)

At home or in a home like environment ☐

In a hospital or hospital like environment ☐

Other location (please provide details) _____ ☐

I do not know. I am happy for my family / Person Responsible to decide. ☐

When my Person Responsible is making decisions about care at the end of my life, I would like them to consider the statements below.

If you need extra space please attach an additional page.

**I do not want to complete Section 2:**

_____

(Signature)

# SECTION 3 DIRECTIONS ABOUT MEDICAL CARE

**This section applies to when you are unable to make or communicate decisions about your health care and medical treatment, including CPR.**
If you are able to communicate you will be included in decisions about your care.

## Cardio Pulmonary Resuscitation (CPR)

**CPR refers to medical procedures that may be used to try to start your heart and breathing if your heart or breathing stops. It may involve mouth to mouth resuscitation, very strong pumping on your chest, electric shocks to your heart, medications being injected into your veins and/or a breathing tube being put into your throat.**

**If I am ill or injured and not expected to get better, or if my quality of life is unbearable as indicated in the table on page 3, if my heart stops and CPR is an option** (please initial one box only):

Please try to restart my heart or breathing (**Attempt CPR**) ☐

**OR**

Please allow me to die a natural death. Do not try to restart my heart or breathing (**No CPR**) ☐

**OTHER MEDICAL TREATMENTS**

If I am ill or injured and **not expected to get better**, or if my quality of life is unbearable as indicated in the table on page 3, **I DO NOT WANT TO HAVE** the following medical treatments (initial the box/boxes that are your choice):

Artificial ventilation (also called life support, breathing machine) ☐

Artificial feeding ☐

Renal dialysis ☐

**OTHER:** Please list below

**Even if I am expected to get better I would never want the following medical treatments:**

**I do not want to complete Section 3:**

_____

(Signature)

## SECTION 4 SPECIFIC REQUESTS FOR ORGAN AND TISSUE DONATION

**My wishes about organ and tissue donation for transplantation following my death are (initial your choice for each statement):**

| | Yes | No |
|---|---|---|
| I would like to donate my organs and tissues for transplantation following my death. | | |
| I have discussed my organ and tissue donation wishes with my family and friends and they are aware of my decision. | | |
| I have registered my wishes on the Australian Organ Donor Register. | | |

**Antemortem treatment for organ donation** (treatment/s immediately before my death only for the purpose of organ donation)

| | Yes | No |
|---|---|---|
| It is my wish to donate my organs for transplantation after my death. If I am dying, I consent to the doctors providing treatments before my death (including artificial ventilation, insertion of intravenous lines and administration of medications) intended only for the purpose of enabling me to donate my organs and tissue for transplantation. | | |

**I do not want to complete Section 4:**

_____

(Signature)

## SECTION 5 AUTHORISATION

### PERSONAL DETAILS

By signing this document, I confirm that:

- I have read the accompanying information booklet, or had the details explained to me
- I understand the facts and choices involved, and the consequences of my decisions
- I am aware that this Advance Care Directive will be used in the event that I cannot make or communicate my own health care decisions. If I am able to communicate, I will be included in decisions about my care.
- I have completed this Advance Care Directive of my own free will.

_____ ____/____/____

(Signature) (Date)

### DETAILS OF WITNESS*

I can confirm that _____ signed this document on ____/____/____

Signed: _____ Name (please print): _____

Address: _____ Phone: _____

### TREATING HEALTH PROFESSIONAL*

Name: _____ Phone: _____

Address: _____

Email: _____

I confirm that _____ had capacity and was aware of the implications of the information in this Advance Care Directive.

_____ ____/____/____

(Signature) (Date)

*While not legally required, it is strongly recommended that a health professional co-signs this Advance Care Directive and/or a person witnesses you sign this form.

SHPN (OCHO) 170184

Ambulance Service of New South Wales

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# Authorised Adult Palliative Care Plan

## Respecting patient wishes

## General Practitioner Information Kit

medicare local SOUTHERN NSW

Connecting health to meet local needs

# Authorised Adult Palliative Care

General Practitioners (GPs) involved in palliative care now have the option of closing the after hours gap for their palliative care patients. In consultation with the patient and their family, the GP may elect to complete a NSW Ambulance Authorised Adult Palliative Care Plan.

Once approved by NSW Ambulance, this plan specifically authorises NSW Ambulance paramedics to deliver individually tailored treatment based on the GP's orders as documented in the plan. In the event of Triple Zero (000) call-out by the patient, the NSW Ambulance Authorised Adult Palliative Care Plan is initiated, and may include administration of medications and other actions to relieve and manage symptoms in the home.

## What we know

Individuals with palliative care needs often access care through their local family GP and community palliative care nurse. Families and carers also have an important role in supporting individuals with palliative care needs in the home, particularly in the after hours period when health service providers may be more difficult to contact.

**This plan allows the paramedic responding to a Triple Zero (000) call to respect the palliative care wishes of the patient and follow the GP's orders.**

It is understood that families and carers are often well prepared with education and support, including medication regimes to help manage breakthrough pain and other symptoms in the after hours period. It is also understood that on occasion, things don't work and more help is needed.

According to a survey conducted in 2011, 76 per cent of Australians would prefer to die in their own homes. However, the most recent statistics on palliative care indicate that in 2009-10, 51 per cent of Australians who died that year did so within a hospital setting[1].

In the after hours period when sudden changes in health may lead to uncertainty, NSW Ambulance Triple Zero (000) service is commonly a first response. In the absence of detailed clinical knowledge about the patient, the paramedic's response is protocol based and transfer to the hospital emergency department is generally required. This transfer is often not the optimal outcome in these situations and may be avoidable. For a patient with palliative care needs, transfer may be avoidable if the paramedic has access to an authorised palliative care plan.

[1]Australian Healthcare and Hospitals Association

## What does an authorised adult palliative care plan include?

**Checklist and instruction sheet:**

### AUTHORISED ADULT PALLIATIVE CARE PLAN SUBMISSION OF AN AUTHORISED ADULT PALLIATIVE CARE PLAN

> The document can be completed electronically and saved utilising a PDF viewer e.g. ADOBE reader.
> All documentation must be completed using the attached form and may be submitted via email or fax. All applications are to be endorsed by the treating clinician.
> Email: protocolp1@ambulance.nsw.gov.au
> Fax: (02) 9320 7380.

### EXISTING AUTHORISED CARE PLANS

> Highlight/notify if the patient has a current Authorised Adult Palliative Care Plan and if this document version is an amendment or addition to the original plan.

### PATIENT DETAILS

> All fields are to be completed.
> Any handwritten details are to be clear and legible.
> The patient's full address (including street number) is complete (as the NSW Ambulance response alert is linked to the individual's address).

### CHOICES FOR CARE

> Ensure 'Yes' or 'Withhold' is selected (not both) for all response items.
> Select one of the four check box reasons for withholding resuscitation.
> All fields are to be completed, and if required, the medications to be authorised for administration by paramedics (pg.2).

### LOCATION OF CARE

> Provide the address of the designated alternative care facility.

### CONTACTS AND POST DEATH MANAGEMENT PLAN

> List the name and phone number for any relevant contacts.
> Complete relevant fields.

### UPDATING OF CARE PLANS

> Clinicians are to review and provide updated plans when required and provide an update of currency of the plan at the "Review Date".
> Clinicians where possible should complete the Plan in conjunction with the Palliative Care Service assisting with the care of this patient.
> In the event of death of the patient, the treating clinician is requested to notify NSW Ambulance.

**Please note:** The Authorised Adult Palliative Care Plans will remain valid for a 12 month period from date of endorsement by NSW Ambulance. Adult Palliative Care Plans will need to be reviewed and renewed prior to expiry by the treating clinician.

### APPROVAL OF AUTHORISED ADULT PALLIATIVE CARE PLANS

**Please note:** A NSW Ambulance Delegate will review each Authorised Adult Palliative Care application. Once the plan has been endorsed by NSW Ambulance, a letter will be sent to both the patient and the referring Treating Clinician.

# Authorised Adult Palliative Care

| Ambulance Service of New South Wales | **Authorised Adult Palliative Care Plan**<br>**AmbTRIM Ref**: ____ / _____<br>**Document: D**____ / _____ |
|---|---|

Where death is an expected outcome of underlying disease processes and providing palliative care, it does not indicate a withdrawal of care, but the provision of symptom management, psychosocial and spiritual support, and comfort during the end of life period.

Date of request: _____ Date to be reviewed: _____ (12 monthly)

| **Patient Details – please print clearly** | | |
|---|---|---|
| ☐ New patient (Select One) ☐ Existing patient | | |
| Name | | |
| Address | | Postcode: |
| Phone | | |
| DOB | | |
| Parent / carer | | |
| Language | | |

| **Clinical History** | | | |
|---|---|---|---|
| Diagnosis | | | |
| History | | | |
| Co-morbidities | | | |
| Symptoms | | | |
| Current Medications | | | |
| Allergies | | | |
| Weight of Patient | **Kgs** | Date of Weighing | |

**Choices for Care**

**Patient, Family and or Enduring Guardian Discussion**

This Adult Palliative Authorised Care Plan has been discussed and agreed in consultation with the family / enduring guardian and or carer, and have nominated the following care:

| | |
|---|---|
| Name of ☐ Family Member ☐ Enduring Guardian ☐ Carer | |
| Relationship to Patient | |
| Name of Clinician | |
| Provider Number of Clinician | |
| Signature of Clinician | |
| Signature of ☐ Family Member ☐ Enduring Guardian ☐ Carer | |
| Signature and Acknowledgment of Patient | |
| Date of meeting / discussion | |

## Location of Care

In the event that care at home becomes too difficult, the choice for end of life care is at:

_____

*The above location will be assessed and reviewed by the paramedics at the time of attending the patient. Distances and travelling times will be factored in transport destination decision.*

## Cardiac Arrest Treatment Decision

**IF THE PATIENT IS IN CARDIAC ARREST (select one)**

☐ **PERFORM CPR** **or** ☐ **WITHHOLD CPR**

☐ If withholding CPR, the patient, family, enduring guardian and/or carer and I, as treating clinician, have considered the care options and a decision to withhold resuscitation has been made based on the discussion between Patient, Family and or Enduring Guardian.

☐ The patient's current medical diagnosis of _____ and prognosis is such that, if CPR is successful it is likely to be followed by a length and quality of life, which is not in the wishes of the patient.

☐ Initiation of CPR is not in accordance with the orally expressed and/or documented, wishes of the patient who is/was mentally competent at the time of making the decision.

☐ Initiation of CPR is not in conjunction with an authorised Advance Care Directive (ACD).

Name of Clinician: _____Signature: _____ Ph.: _____

If concerns arise about validity or currency of the documents, or the safety of the environment, Ambulance protocols should be followed.

## Treatment Decision

**ADMINISTER THE FOLLOWING TREATMENT IF THE PATIENT IS NOT IN CARDIAC ARREST**

| Response | Yes | Withhold |
|---|---|---|
| Airway Management | ☐ | ☐ |
| Oxygen – bag and mask | ☐ | ☐ |
| Oxygen - passive | ☐ | ☐ |
| Nasopharyngeal suctioning | ☐ | ☐ |
| IV access | ☐ | ☐ |

## Medication Administration

Medications requested to be authorised for administration by ASNSW paramedics:

| Medication | Dose | Route | Time and Intervals |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# Authorised Adult Palliative Care

| Other relevant information |
|---|
| |

| Post Death Management Plan |
|---|

If the patient dies, the management of the patient is the responsibility of the Clinician / Palliative Care Team. Paramedics should:

1. Contact the Clinician/Palliative Care team

   Name of Clinician: _____ Ph.: _____

2. Provide appropriate support to the family

If the treating clinician is unable to be contacted, Paramedics must follow the Ambulance Policy on Transportation of Deceased Persons (SOP2006-062) and notify the dispatcher.

| For Consideration |
|---|

**Death during transport (No active treatment to commence)**

☐ Should the patient die during transport, transfer to: _____

Location Contact:_____

Location Contact Number:_____

| Contact Lists | | | |
|---|---|---|---|
| **Team** | **Name** | **Address** | **Contact Number/s** |
| Primary Team | | | |
| Palliative Care Team | | | |
| General Practitioner | | | |
| Community Nurse | | | |
| Other health services | | | |
| Spiritual / religious supports | | | |

| Endorsement | |
|---|---|
| Referred to ASNSW by (person / organisation): | |
| Name of Clinician completing the form: | |
| Designation: | Contact No: |
| Email address: | |
| Signature: | Date: |
| Authorised by ASNSW Executive Director Clinical Governance:<br>Office Use Only | |
| Signature: | Date: |

Please fax to 9320 7380 or scan and email to protocolp1@ambulance.nsw.gov.au

## Frequently Asked Questions

### IS THERE A RIGHT TIME TO INITIATE AN AUTHORISED PALLIATIVE CARE PLAN?

At some stage in the progression of an individual's illness, the decision may be made that further treatment is not indicated. At this point, ongoing medical care will aim to maintain comfort and function with an understanding that end of life is inevitable in the near future. An authorised palliative care plan is an appropriate response for individuals nearing end of life.

### WHO CAN INITIATE AN AUTHORISED PALLIATIVE CARE PLAN?

Caring for an individual with palliative care needs can be a complex undertaking and may involve a number of treating clinicians. The plan can be initiated by any members of the team, however final approval and signing prior to submission to NSW Ambulance is the responsibility of the treating GP.

### WHY DOES NSW AMBULANCE NEED TO AUTHORISE THE PLAN?

NSW Ambulance staff review the medical orders of each submitted plan to ensure the order is consistent with the capabilities and capacity of paramedics. It is possible a plan may be refused. If this were to occur, the requesting GP would be consulted.

### HOW DO I INITIATE AN AUTHORISED PALLIATIVE CARE PLAN?

An electronic version of the form is available at *www.snswml.com.au.* Discuss the plan with the treating team, patient, family, carers and/or enduring power of attorney and agree on what measures are appropriate for the situation.

Complete the form and email or fax the signed document as per instructions.

## For more information

For more information about the Authorised Adult Palliative Care Plan contact:

**The After Hours Coordinator**
Southern NSW Medicare Local
Email: afterhours@snswml.com.au
Phone: (02) 4475 0800