Ambulance Service of New South Wales

excellence in care

Checklist and instruction sheet: Authorised Adult Palliative Care Plan

Submission of 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 electronically, via email or facsimile. All applications are to be endorsed by the treating clinician.
  Email contact: protocolp1@ambulance.nsw.gov.au
  Facsimile: (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 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 Ambulance.

Please note: The Authorised Adult Palliative Care Plans will remain valid for a 12 month period from date of endorsement by 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: An Ambulance Delegate will review each Authorised Adult Palliative Care application.

Once the plan has been endorsed by Ambulance, a letter will be sent to both the patient and the referring Treating Clinician.

Ambulance Service of New South Wales

Authorised Adult Palliative Care Plan

AmbTRIM Ref: ____ / _____
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

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: Office Use Only		
Signature:		Date:

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