NSW Ambulance

excellence in care

INSTRUCTION SHEET

Authorised Paediatric Palliative Care Plan

SUBMISSION OF AN AUTHORISED 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

DATE OF APPLICATION & REVIEW DATE

The date of application is today's date. The review date may be any period of time up to 12 months from the date of applica-tion. It is the responsibility of the treating clinician to review the existing plan and submit changes to NSW Ambulance prior to the review date.

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).

Patients with existing NSW Ambulance Authorised Palliative Care Forms must have the 'Existing Patient' box checked.

CARDIAC ARREST TREATMENT DECISION

Ensure 'Perform CPR' or 'Withhold CPR' is selected (not both). All relevant statements must be checked in the box at the start of each statement.

All clinical treatment options must be checked as either 'administer' or 'withhold' (not both).

The treating clinician may authorised paramedics to administer medications outside their current scope of practice and/or as a variation to current pharmacology. Please note that medications outside of NSW Ambulance current clinical scope of practice must be with the patient at all times.

NSW Ambulance Clinical Pharmacology Scope of Practice as of July 2015: Adrenaline, Amiodarone*, Aspirin, Atropine*, Benzyl Penicillin, Calcium Gluconate*, Clopidogrel, Compound Sodium Lactate, Droperidol, Enoxaparin Sodium, Fentanyl, Fexofenadine, Frusemide, Glucagon, Glucose 10%, Glucose Gel, Glyceryl Trinitrate, Ibuprofen, Ipratropium Bromide, Ketamine*, Lignocaine*, Methoxyflurane, Metoclopramide, Midazolam, Morphine, Naloxone, Ondansetron, Oxygen, Paracetamol, Salbutamol, Sodium Bicarbonate*, Tenecteplase (* Intensive Care Paramedic only)

CLINICIAN DETAILS

All relevant details must be completed by the treating clinician. A completed plan with NSW Ambulance Authorisation will be sent to the treating clinician for their records. A valid email and/or facsimile number is required.

PATIENT CLINICAL HISTORY

All relevant fields must be completed.

FAMILY/ENDURING GUARDIAN DETAILS AND AUTHORISATION

The contact details for the appropriate family member/ enduring guardian must be entered. For adult palliative care plans you may opt for the completed plan to be sent to the patient or the family/enduring guardian in this section. (Note for paediatric patients the plans will be sent to the person nominated in this section only).

Where required the patient and/or family member/enduring guardian should sign the form on page 2.

LOCATION OF CARE, POST DEATH MANAGEMENT PLAN AND CONTACT LISTS

All relevant fields must be completed.

DEPARTMENT OF FAMILY AND COMMUNITY SERVICES (PAEDIATRIC PALLIATIVE CARE PLANS ONLY)

All relevant fields must be completed.

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

Date of Application: Review Date:

Trim number: Document number:

Patient Name:	New patient	Existing patient
Surname:	Date of Birth:	
Given Names:	Male	Female
Address:		
Interpreter Required: No Yes Language	Patient Weight	

CARDIAC ARREST TREATMENT DECISION

If the patient is in cardiac arrest (select one) PERFORM CPR WITHOLD CPR

Please check the statements which are applicable (may be more than one):

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

The patient's current medical diagnosis 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.

If initiation of CPR is not in conjunction with an Authorised Care Directive (ACD).

Note: If concerns arise about the validity of the documents or the safety of the environment, NSW Ambulance protocol will be followed.

TREATMENT AND MEDICATION OPTIONS

In cases where the patient is not in cardiac arrest, the following treatment and medication options have been considered appropriate through consultation with the patient and/or family and/or enduring guardian:

Airway Management	Administer	Withhold
Oxygen	Administer	Withhold
Nasopharyngeal suctioning	Administer	Withhold
IV access	Administer	Withhold

The following medications are to be administered by NSW Ambulance paramedics as directed. Please note: medications outside of the NSW Ambulance clinical scope of practice are required to be with the patient at all times.

Medication	**Dose/Route**	**Repeat times and intervals**

CLINICIAN DETAILS (PLEASE PRINT CLEARLY)

Name:	Contact number:
Provider number:	Fax:
Organisation/Practice Name and Address:	
Email:	

As the treating clinician, I authorise this Care Plan and by signing this form I authorise NSW Ambulance paramedics to implement the treatment options specified which have been discussed with the patient and consistent with their treatment requirements.

Signature:	Date:

Trim number: Document number:

Patient Name:	Date of Birth:

PATIENT CLINICAL HISTORY (PLEASE PRINT CLEARLY)
Diagnosis:
History:
Co-morbidities:
Current Medications:
Allergies:

PARENT/FAMILY/ENDURING GUARDIAN (PLEASE PRINT CLEARLY)			
Surname:			
Given Names:			
Relationship	Family Member	Enduring Guardian	Other:
Address:			
Contact Number:		Interpreter Required: Yes No (If yes, language):	
All correspondence will be sent to the person identified in this section			

PATIENT/FAMILY/ENDURING GUARDIAN AUTHORISATION	
Patient's Signature:	Date:
Family/Enduring Guardian Signature:	

Trim number: Document number:

Patient Name:	Date of Birth:

LOCATION OF CARE

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

While every effort will be made to accommodate the patient's wishes, NSW Ambulance will review the location of care at the time of attending the patient, distances and travelling times will be factored into the destination decision.

Should death occur during transport, treatment will be in accordance with the patient's wishes detailed on page 2 of this plan. In the event of death during transport the patient should be transported to:

POST DEATH MANAGEMENT PLAN:

If the patient dies, the management of the patient is the responsibility of the clinician/palliative care team. Paramedics should contact the patient's:

General Practitioner (GP): Name: Phone:

or Palliative Care Team: Name:

Phone (BH): (AH):

DEPARTMENT OF FAMILY AND COMMUNITY SERVICES

Is the patient known to the Department of Family and Community Services (Formally DOCS)? No Yes

If yes (tick as appropriate):

Family and Community Services are aware of the patient's condition and treatment decisions

In the event of the patient's death Family and Community Services should be notified

CONTACT LISTS

Team	Name	Contact Number (BH)	Contact Number (BH)
General Practitioner			
Palliative Care Team			
Primary Care Team			
Community Nurse			
Other Health Services			
Spiritual/Religious Supports			

NSW AMBULANCE USE ONLY

Endorsed by:	Date:
Signature:	