The Key Elements of Providing Good End of Life Care in the Community

A Quick Tour for GPs

Dr Chris Moy

Government of South Australia

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Case: Dorothy

Profile:

- 78 yo married woman who lives at home with her husband and has a supportive family
- Rapidly progressive lung cancer – no curative treatment available

To be discussed today:

1) **Understanding your obligations and the law**

2) **Converting a patient's wishes into clinical instructions**

3) **If your patient is not for resuscitation or curative treatment, what are you going to do to ensure their comfort and dignity?**

4) **Putting things in place to ensure that everything goes to plan**

1) Understanding your Obligations and the Law

What are my professional obligations in providing end of life care to Dorothy?

A Doctor's Professional Standards:

AHPRA Medical Board of Australia
Good Medical Practice: A Code of Conduct for Doctors in Australia (October 2020)

3.12.3 Understanding the limits of medicine in prolonging life and recognising when efforts to prolong life may not benefit the patient

3.12.4 Understanding that you do not have a duty to try to prolong life at all cost. However, you do have a duty to know when not to initiate and when to cease attempts at prolonging life, while ensuring that your patients receive appropriate relief from distress.

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1) Understanding your Obligations and the Law

What is the legal document on which Dorothy can write her wishes if she were to lose decision-making capacity?

One Advance Care Directive Form

Consent Act
- ~~Medical Power of Attorney~~
- ~~Anticipatory Direction~~

Guardianship Act
- ~~Enduring Power of Guardian~~

Advance Care Directives Act

1 Advance Care Directive

(Financial) Powers Act
Dealt with separately

One Advance Care Directive Form

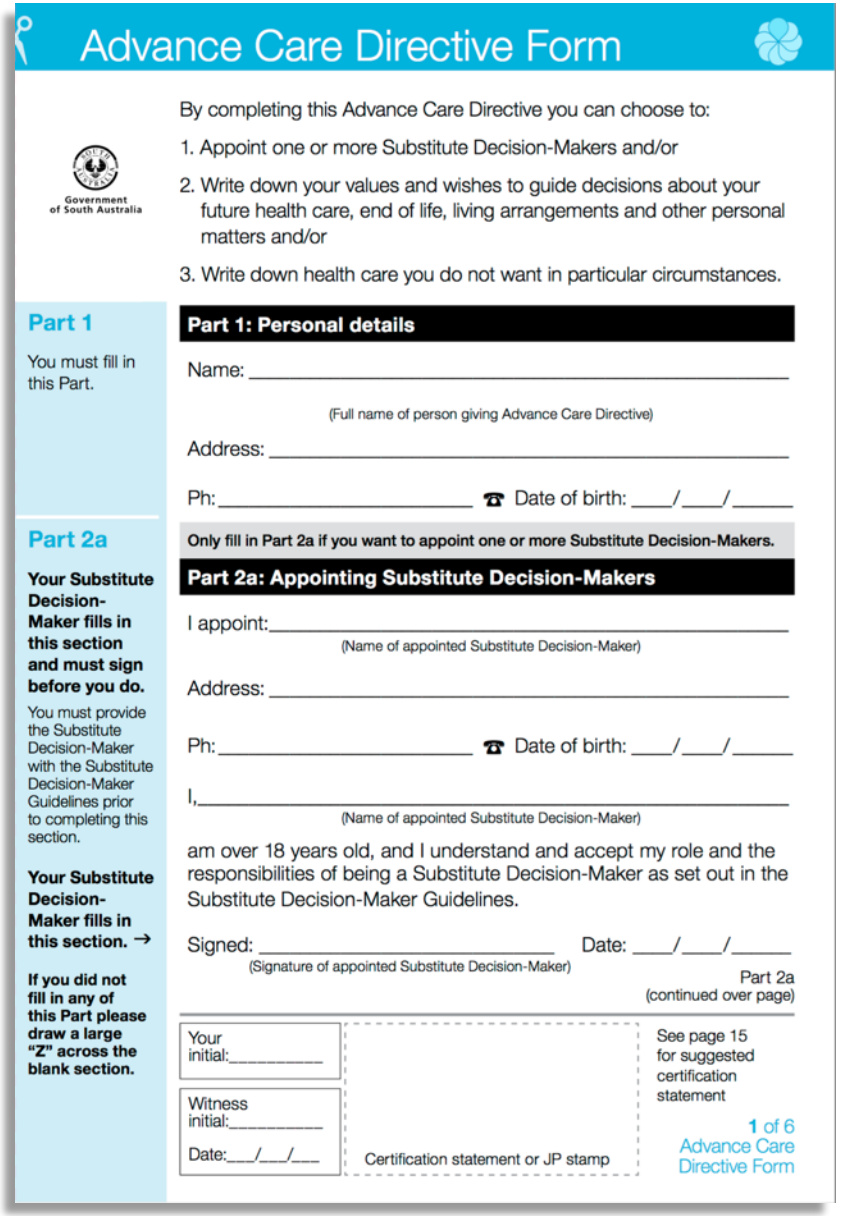
On the Advance Care Directive (ACD) Form
Competent adults (18 years and over) can:

- Appoint:
  - one or more Substitute Decision Makers (SDMs)

AND/OR

- Document:
  - Wishes, instructions and personal values

Applies at any period when a patient loses decision-making capacity



Advance Care Directive Form

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By completing this Advance Care Directive you can choose to:

1. Appoint one or more Substitute Decision-Makers and/or
2. Write down your values and wishes to guide decisions about your future health care, end of life, living arrangements and other personal matters and/or
3. Write down health care you do not want in particular circumstances.

Part 1

You must fill in this Part.

Part 1: Personal details

Name: _____

(Full name of person giving Advance Care Directive)

Address: _____

Ph: _____ ☎ Date of birth: ___/___/_____

Part 2a

Only fill in Part 2a if you want to appoint one or more Substitute Decision-Makers.

Your Substitute Decision-Maker fills in this section and must sign before you do.

You must provide the Substitute Decision-Maker with the Substitute Decision-Maker Guidelines prior to completing this section.

Your Substitute Decision-Maker fills in this section. →

If you did not fill in any of this Part please draw a large "Z" across the blank section.

Part 2a: Appointing Substitute Decision-Makers

I appoint: _____

(Name of appointed Substitute Decision-Maker)

Address: _____

Ph: _____ ☎ Date of birth: ___/___/_____

I, _____

(Name of appointed Substitute Decision-Maker)

am over 18 years old, and I understand and accept my role and the responsibilities of being a Substitute Decision-Maker as set out in the Substitute Decision-Maker Guidelines.

Signed: _____ Date: ___/___/_____

(Signature of appointed Substitute Decision-Maker)

Part 2a (continued over page)

Your initial:_____

Witness initial:_____

Date:___/___/___

Certification statement or JP stamp

See page 15 for suggested certification statement

1 of 6 Advance Care Directive Form

One Advance Care Directive Form

- If an SDM is appointed, they can make lawful decisions as if they are the person – they legally "become the person"
- SDMs can be appointed to act individually or together- BUT- health practitioners only have to contact the first SDM that can be reached- it is then up to that SDM to contact any other SDMs
- Non binding requests- advisory
- Binding refusals- must be complied with if relevant to the situation

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1) Understanding your Obligations and the Law

If Dorothy deteriorates, how do I determine whether she has decision-making capacity?

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One Advance Care Directive Form

Only applies if there is Impaired Decision-Making Capacity

Under the Act, decision-making capacity:

- is presumed
- should be supported
- residual capacity respected – can understand some things but not others
- fluctuating capacity respected

Impaired decision-making capacity- only relates to a particular decision when consent is required

In respect of a particular decision, impaired decision-making capacity means they cannot:

- understand relevant information
- retain such information
- use information to make the decision- i.e. risks vs benefits
- communicate the decision (in any manner)

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1) Understanding your Obligations and the Law

What should be the main thing to consider in making decisions for Dorothy if she has lost decision making-capacity?

If a patient has lost decision-making capacity:

Decide as if “in their shoes”

My job is to save lives isn't it?

What are the clinical parameters that will tell me that this patient is at the end of their life?

What’s best for this patient?

What’s the legal situation if I don’t give treatment? Maybe I’d better keep trying to keep him alive.

What’s this bit of paper – an Advance Care Directive? And what’s this plan? And who is this person calling themselves a medical power of attorney? Who do I listen to?

What is the protocol in this situation? What did the textbook say? What did the consultant do the last time this happened?

His children are saying that we should let him go. But his wife is saying that we must keep him alive. What do I do?

I don’t know how to tell them the news. I need to be. Maybe I’ll be more round treatment…

My belief is that life is sacrosanct.

What would this patient have wanted if they had been conscious?

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1) Understanding your Obligations and the Law

Which person should I speak to, or which document should I rely on, to obtain consent for treatment?

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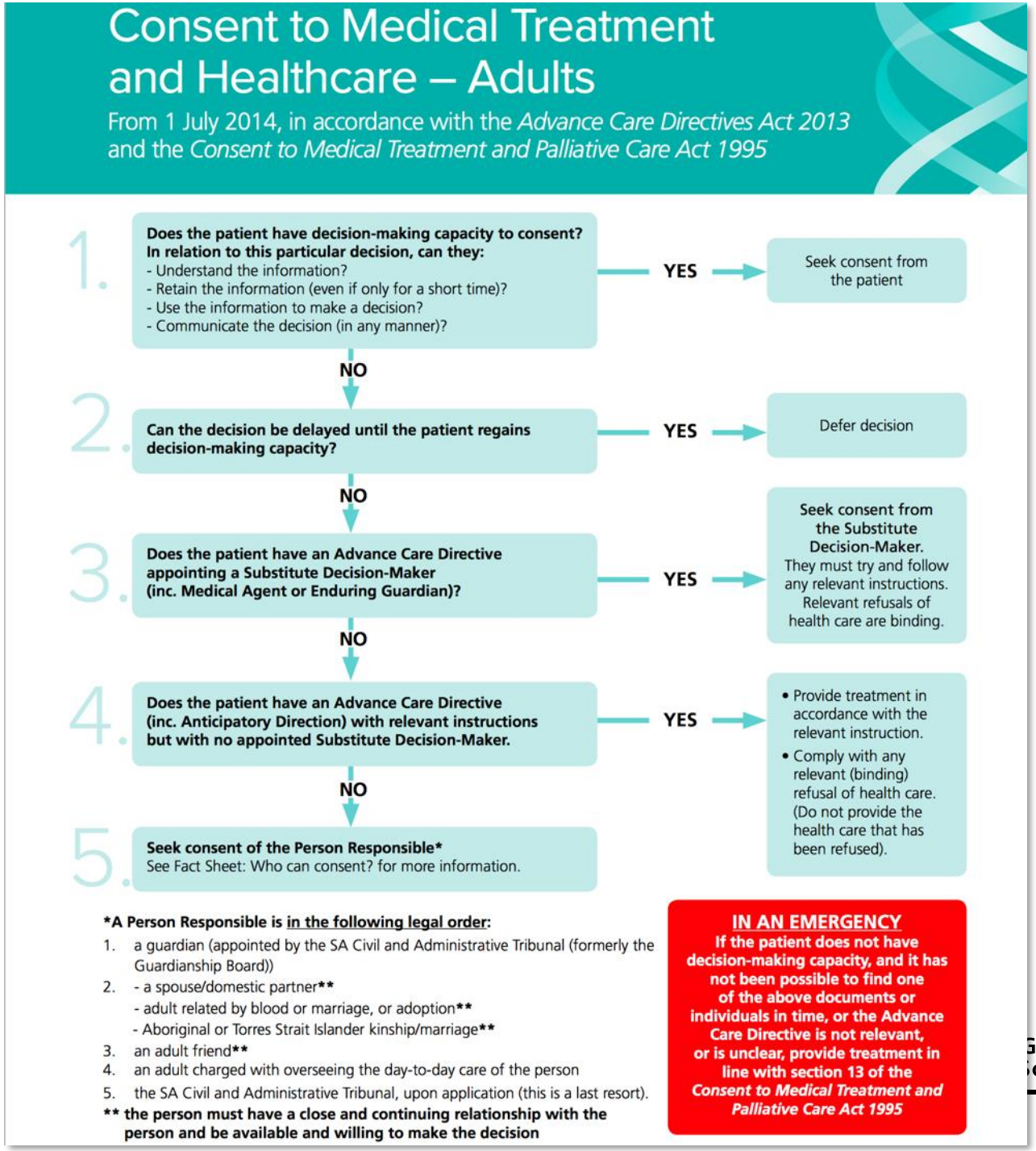
Clear consenting hierarchy



Consent to Medical Treatment and Healthcare – Adults

From 1 July 2014, in accordance with the *Advance Care Directives Act 2013* and the *Consent to Medical Treatment and Palliative Care Act 1995*

1. **Does the patient have decision-making capacity to consent? In relation to this particular decision, can they:**
   - Understand the information?
   - Retain the information (even if only for a short time)?
   - Use the information to make a decision?
   - Communicate the decision (in any manner)?

   YES → Seek consent from the patient

   NO

2. **Can the decision be delayed until the patient regains decision-making capacity?**

   YES → Defer decision

   NO

3. **Does the patient have an Advance Care Directive appointing a Substitute Decision-Maker (inc. Medical Agent or Enduring Guardian)?**

   YES → **Seek consent from the Substitute Decision-Maker.** They must try and follow any relevant instructions. Relevant refusals of health care are binding.

   NO

4. **Does the patient have an Advance Care Directive (inc. Anticipatory Direction) with relevant instructions but with no appointed Substitute Decision-Maker.**

   YES →
   - Provide treatment in accordance with the relevant instruction.
   - Comply with any relevant (binding) refusal of health care. (Do not provide the health care that has been refused).

   NO

5. **Seek consent of the Person Responsible***
   See Fact Sheet: Who can consent? for more information.

***A Person Responsible is <u>in the following legal order</u>:**

1. a guardian (appointed by the SA Civil and Administrative Tribunal (formerly the Guardianship Board))
2. - a spouse/domestic partner**
   - adult related by blood or marriage, or adoption**
   - Aboriginal or Torres Strait Islander kinship/marriage**
3. an adult friend**
4. an adult charged with overseeing the day-to-day care of the person
5. the SA Civil and Administrative Tribunal, upon application (this is a last resort).

**** the person must have a close and continuing relationship with the person and be available and willing to make the decision**

<u>IN AN EMERGENCY</u>
If the patient does not have decision-making capacity, and it has not been possible to find one of the above documents or individuals in time, or the Advance Care Directive is not relevant, or is unclear, provide treatment in line with section 13 of the *Consent to Medical Treatment and Palliative Care Act 1995*

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1) Understanding your Obligations and the Law

What should I do if there is a dispute about what treatment to provide for Dorothy?

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Simplified dispute resolution process

If in doubt/dispute:

Office of the Public Advocate

Ph: 8342 8200
Country SA Toll Free:
1800 066 969

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1) Understanding your Obligations and the Law

Can Dorothy's family force me to provide her with "futile" treatment?

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No requirement to provide treatment which is of no medical benefit to a dying patient

1) A change in 2014 to S17(2) of the Consent Act which clarifies that there is:
   - no longer a requirement to provide, and the ability to withdraw, treatment
   - which a doctor does not think is of benefit to a patient
   - in the terminal phase of a terminal illness, persistent vegetative state or minimally responsive state

➢ Can make decisions based on what is good practice rather than on medico-legally defensive grounds

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The previous problem

s17 (2) of the Consent to Medical Treatment and Palliative Care Act 1995

17(2) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, is, in the absence of an express direction by the patient or the patient's representative to the contrary, under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state.

Amendment of section 17 (2)

The care of people who are dying:

A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision:

(a) is under no duty to use, or to continue to use, life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state without any real prospect of recovery or in a persistent vegetative state (whether or not the patient or the patient's representative has requested that such measures be used or continued); and

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1) Understanding your Obligations and the Law

Will the law protect me in giving Dorothy enough medication to make her comfortable?

Protection in giving adequate treatment to maintain the comfort and dignity of a dying patient

The Consent Act:

17—The care of people who are dying

(1) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress—

(a) with the consent of the patient or the patient's representative; and

(b) in good faith and without negligence; and

(c) in accordance with proper professional standards of palliative care,

even though an incidental effect of the treatment is to hasten the death of the patient.

Equals protection in giving adequate treatment to maintain the comfort and dignity of the patient, even though a secondary effect of treatment might be to hasten the death of the patient (“double effect”)

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What is the difference between Euthanasia and Palliative Care?.....

- Intention
- The “can you sleep at night?” rule

1) Understanding your Obligations and the Law: A Summary

For a dying patient, you now know:

- How to decide - i.e. “as if in the patients shoes”
- Who to ask - i.e. follow the “Consent Hierarchy”
- What to do in a dispute - i.e. call the Public Advocate
- That there is no requirement to provide treatment that is of no medical benefit
- That you are protected in giving enough medication to maintain the comfort and dignity of a dying patient

So focus on caring for her!

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2) Converting a patient's wishes into clinical instructions

How can I document clinical instructions for Dorothy's care that will be understood and respected by other health practitioners (e.g. nurses, locums, ambulance officers) in an emergency?

The 2010 End of Life Working Group

ACD (or ACP)

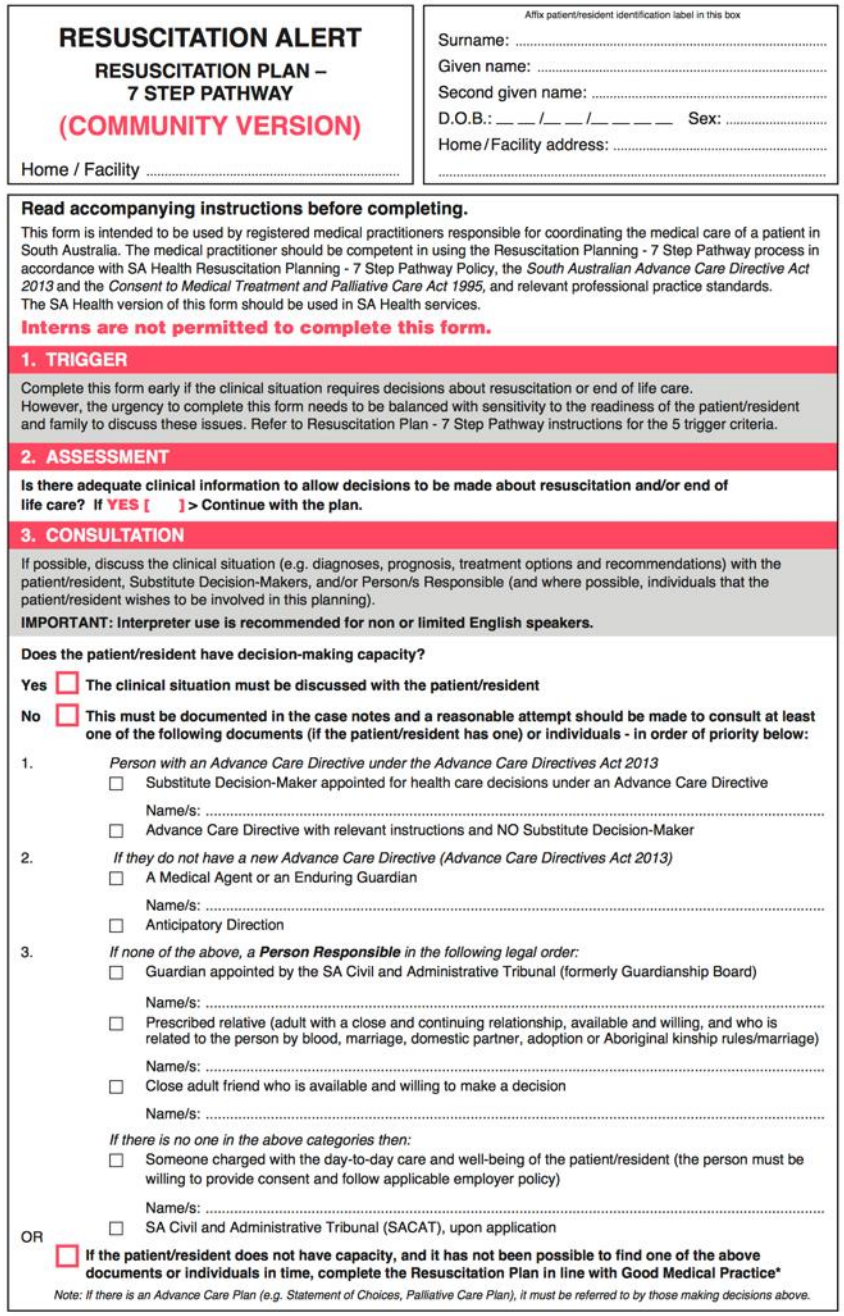
To tell us the patient's wishes

Resuscitation Plan –

7 Step Pathway

For the responsible clinician to convert these wishes into usable clinical instructions about resuscitation and end of life care

Community Version: Resuscitation Plan-7 Step Pathway



RESUSCITATION ALERT

RESUSCITATION PLAN – 7 STEP PATHWAY

(COMMUNITY VERSION)

Home / Facility .....

Affix patient/resident identification label in this box

Surname: .....

Given name: .....

Second given name: .....

D.O.B.: __ __ /__ __ /__ __ __ __ Sex: .....

Home / Facility address: .....

.....

Read accompanying instructions before completing.

This form is intended to be used by registered medical practitioners responsible for coordinating the medical care of a patient in South Australia. The medical practitioner should be competent in using the Resuscitation Planning - 7 Step Pathway process in accordance with SA Health Resuscitation Planning - 7 Step Pathway Policy, the *South Australian Advance Care Directive Act 2013* and the *Consent to Medical Treatment and Palliative Care Act 1995*, and relevant professional practice standards.
The SA Health version of this form should be used in SA Health services.

Interns are not permitted to complete this form.

1. TRIGGER

Complete this form early if the clinical situation requires decisions about resuscitation or end of life care.
However, the urgency to complete this form needs to be balanced with sensitivity to the readiness of the patient/resident and family to discuss these issues. Refer to Resuscitation Plan - 7 Step Pathway instructions for the 5 trigger criteria.

2. ASSESSMENT

Is there adequate clinical information to allow decisions to be made about resuscitation and/or end of life care? If YES [ ] > Continue with the plan.

3. CONSULTATION

If possible, discuss the clinical situation (e.g. diagnoses, prognosis, treatment options and recommendations) with the patient/resident, Substitute Decision-Makers, and/or Person/s Responsible (and where possible, individuals that the patient/resident wishes to be involved in this planning).

IMPORTANT: Interpreter use is recommended for non or limited English speakers.

Does the patient/resident have decision-making capacity?

Yes ☐ **The clinical situation must be discussed with the patient/resident**

No ☐ **This must be documented in the case notes and a reasonable attempt should be made to consult at least one of the following documents (if the patient/resident has one) or individuals - in order of priority below:**

1. *Person with an Advance Care Directive under the Advance Care Directives Act 2013*
   - ☐ Substitute Decision-Maker appointed for health care decisions under an Advance Care Directive
     Name/s: .....
   - ☐ Advance Care Directive with relevant instructions and NO Substitute Decision-Maker
2. *If they do not have a new Advance Care Directive (Advance Care Directives Act 2013)*
   - ☐ A Medical Agent or an Enduring Guardian
     Name/s: .....
   - ☐ Anticipatory Direction
3. *If none of the above, a **Person Responsible** in the following legal order:*
   - ☐ Guardian appointed by the SA Civil and Administrative Tribunal (formerly Guardianship Board)
     Name/s: .....
   - ☐ Prescribed relative (adult with a close and continuing relationship, available and willing, and who is related to the person by blood, marriage, domestic partner, adoption or Aboriginal kinship rules/marriage)
     Name/s: .....
   - ☐ Close adult friend who is available and willing to make a decision
     Name/s: .....

   If there is no one in the above categories then:
   - ☐ Someone charged with the day-to-day care and well-being of the patient/resident (the person must be willing to provide consent and follow applicable employer policy)
     Name/s: .....
   - ☐ SA Civil and Administrative Tribunal (SACAT), upon application

OR ☐ **If the patient/resident does not have capacity, and it has not been possible to find one of the above documents or individuals in time, complete the Resuscitation Plan in line with Good Medical Practice***

Note: If there is an Advance Care Plan (e.g. Statement of Choices, Palliative Care Plan), it must be referred to by those making decisions above.

RESUSCITATION ALERT

RESUSCITATION PLAN – 7 STEP PATHWAY

(COMMUNITY VERSION)

Home / Facility .....

Affix patient/resident identification label in this box

Surname: .....

Given name: .....

Second given name: .....

D.O.B.: __ __ /__ __ /__ __ __ __ Sex: .....

Home / Facility address: .....

.....

4. RESUSCITATION PLAN

Note: A treatment option or procedure (e.g. ICU, surgical procedure, dialysis) must not be offered, recommended, or inferred to be available, without prior discussion with, and the agreement of, the relevant clinical team which provides this treatment or procedure.

Indicate if the following decisions about resuscitation apply:

Tick here if this single option applies:

[ ] Patient/resident is Not for any Treatment Aimed at Prolonging Life (including CPR)

Or you may specify individually each or all of the following that apply:

[ ] Patient/resident is Not for CPR

[ ] Patient/resident is Not for invasive ventilation (i.e. intubation)

[ ] Patient/resident is Not for intensive care treatment or admission

[ ] Patient/resident is Not for the following procedures or treatment (specify): .....

.....

Medical Emergency Response (MER) **FOR HOSPITAL USE ONLY**

To be completed by the admitting doctor upon admission if patient/resident is hospitalised.

Please circle which applies: **MER Call Yes** **MER Call No**

Hospital: ..... Name of doctor: .....

Date: ..... Designation: ..... Signature: .....

Indicate treatment that will be provided:

Note:

- *A decision not to provide CPR does not rule out other treatment or medical care (e.g. IV fluids, antibiotics) being provided.*
- *Treatment **must** include a plan (or a contingency plan) to maintain patient/resident comfort and dignity. This could include the prescription of medications to control symptoms such as pain and dyspnoea, or referral to Palliative Care.*

.....

.....

.....

.....

☐ **NOT FOR TRANSFER TO HOSPITAL** unless palliative care measures fail to maintain the comfort and dignity of the patient/resident in their place of residence.

5. TRANSPARENCY

Resuscitation plan explained to: ☐ Patient/resident (mandatory if he/she has capacity) ***or***

☐ Substitute Decision-Makers/Person Responsible Name: .....

☐ *Tick if an interpreter is used:* *Interpreter's Name:* .....

Take practical steps to 6. IMPLEMENT the plan and to 7. SUPPORT the patient/resident and family through the process

Resuscitation Plan Date	/ /	**This Resuscitation Plan is valid until:**	To revoke this Resuscitation Plan (strike through and write VOID):
Practice/ mobile number		**Date:** or [ ] Indefinitely or until revoked	**Date revoked:** / /
Name of Doctor			**Name of Doctor revoking the plan:**
Designation			Designation:
Signature			**Signature:**

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Created January 2016

Original copy – file in the patient's/resident's medical record **Duplicate copies – provide to the patient/resident and the patients/resident's facility/carer (if applicable)**

RESUSCITATION ALERT **COMMUNITY VERSION**

The Resuscitation Plan-7 Step Pathway

- Will replace the practice of writing informal “NFR”, “Not for CPR” or “Not for Cardiopulmonary Resuscitation” orders in notes
- Supports a clinician in working through the correct:
  - clinical
  - legal
  - ethical steps in the correct order
- **And, if the patient is not for resuscitation, MUST ask:**

“What are you going to do to maintain the patient’s comfort and dignity?”

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Why do we need another form?

Actually, we don’t. The heart of this is a process, not a form

- **NFR order with process around it**
- Helps doctors make the right decision
- Protects both the patient and the doctor
- **Standardised document** that everyone recognises and respects- doctors, nurses, ambulance officers, aged care staff
- Can be **used- and is transferable across- all hospital, aged care and community sectors**
- Includes **"Not for Transfer to Hospital" order** for patients who do not wish to be transferred to hospital

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3) If your patient is not for resuscitation or curative treatment, what are you going to do to ensure their comfort and dignity?

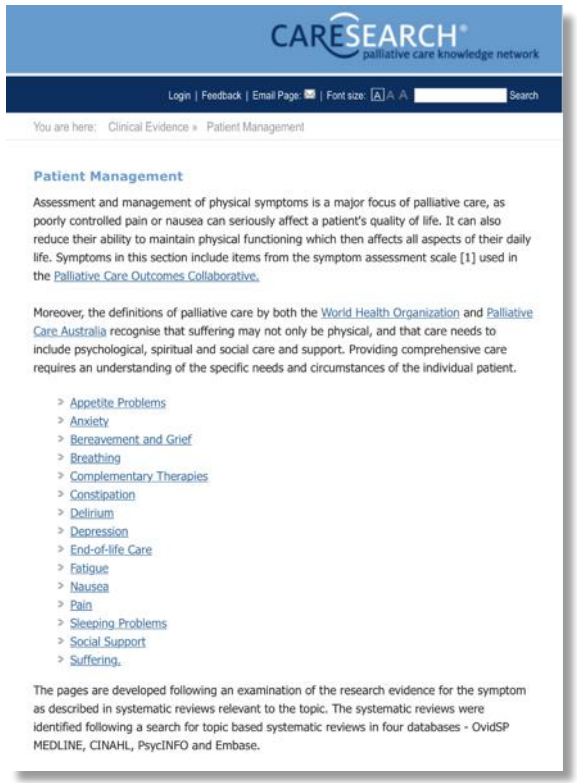
What should I do to make sure that Dorothy doesn't suffer as she dies?

Options:

1. Prescribe medications for the patient: **”Do it yourself”**

2. Call or refer to Specialist Palliative Care Service: **“Shared Care”**

Some resources



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Prescribing opiates: Basics

- Starting oral opiates:
  - 2.5-5mg Morphine syrup 1 hourly prn

- Conversion to long acting:
  - Add up prn doses over 24 hours and convert to long acting oral preparation e.g. if she has required 4-5 x 5mg doses of Morphine per day= 20-25mg total/24hrs = 10mg MS Contin bd

- Breakthrough doses:
  - 1/6 of total daily dose 1 hourly prn

- Changing opiates:
  - Reduce calculated dose by 30% because of cross tolerance

- Converting to subcutaneous morphine:
  - Divide oral dose by 3

A Tool to Assist in Anticipatory Prescribing

Prescribing Guidelines for the Pharmacological Management of Symptoms for Adults in the Last Days of Life

All patients at the end of life are entitled to **treatment aimed at optimising their comfort and dignity**. The treating team – doctors, nurses and other clinicians - responsible for the care of a dying patient must work together with the patient and/or their decision makers to ensure that the patient receives appropriate, timely and adequate treatment to relieve distress. This often requires prescribing medications for symptom management.

Anticipatory prescribing

There are several common symptoms that may cause distress in dying patients. Ordering medications ahead of time, *'anticipatory prescribing'*, ensures prompt management of these symptoms when they occur.

When to use these guidelines:

These guidelines outline recommended initial medications, doses and administration regimens for the management of common symptoms in the last days of life. The guidelines can be used in:

- anticipation of distressing symptoms developing, and/or
- response to a patient suffering from distressing symptoms.

These guidelines have primarily been developed for use in SA Health inpatient settings.

BEFORE WRITING UP MEDICATION ORDERS

- Discuss the need for medications to support symptom management with the patient and/or the patient's decision-maker(s).
- Review the patient's **current medications** and consider:
  - ceasing any non-beneficial or burdensome medications
  - continuing essential medications via the subcutaneous route where possible
  - potential for development of distressing withdrawal symptoms if specific medications are abruptly ceased(refer to *Medication Cessation for Adults in the Last Days of Life fact sheet*).
- Be aware that the doses of medications outlined in these guidelines may need to be **increased** if the patient is already prescribed analgesics (particularly moderate to high dose opioids), anxiolytics, anti-emetics or anticonvulsants.
- Check for **allergies** and for potential **contraindications, interactions or side effects**.

WHILE WRITING UP THE MEDICATION ORDERS

- Ensure that the **reason** for administering the medication is documented in the **'indication'** box of each medication, using terms consistent with those used in the table overleaf.

AFTER MEDICATION ORDERS ARE WRITTEN UP

- Ensure the patient is reviewed regularly and commence medications in anticipation of, or as soon as symptoms are identified.
- Review treatment outcome for **effectiveness** and **side effects.**
- Regularly review the management plan with the patient and/or the patient's decision maker(s).
- Ensure **handover** to all medical and nursing staff involved in the care of the patient; for example, at shift changes, on transfer of the patient to another ward or facility, or on discharge of the patient.

URGENT CLINICAL REVIEW is required if there is:

- **inadequate relief** of a symptom despite three maximum doses administered in succession at the shortest specified time interval, **or**
- any clinical concern.

Further information about symptom management, prescribing or administering medications, or other related issues may be obtained from:

- Relevant SA Health fact sheets
- Therapeutic Guidelines: Palliative Care

Urgent phone advice can be obtained from Specialist Palliative Care Services: contact via the relevant hospital switchboard.

INDICATION	MEDICATION	DOSE	ROUTE	FREQUENCY	PRACTICE POINTS *Dosing should begin with the lower dose in any given range.*
Pain or Dyspnoea	*Morphine – pain* *Morphine - dyspnoea*	2.5mg to 5mg 1mg to 2.5mg	Subcut	every hour as required	> Doses listed are for opioid naïve patients. > Where opioids are already prescribed, convert regular oral opioid dose to the appropriate 24hour subcutaneous dose and administer by a continuous subcutaneous infusion. > HYDROmorphone is approximately **FIVE** times more potent than morphine.
	If the patient has a contraindication to morphine, for example: > ***known or suspected renal impairment, or*** > ***an allergy to morphine*** ***then give either:***				
	Fentanyl	25microgram to 50 microgram	Subcut	every hour as required	
	OR				
	HYDROmorphone	0.5mg to 1mg	Subcut	every hour as required	
Anxiety or Terminal Restlessness	*Clonazepam*	0.25mg to 0.5mg	Subcut	every 12 hours as required	> Clonazepam has a long duration of action and is prone to accumulate and lead to over sedation. > Midazolam has a very rapid onset and short duration of action. It is preferred if amnesia and sedation are required. A subcutaneous infusion is required to achieve sustained effect.
	OR				
	Midazolam	2.5mg	Subcut	every hour as required	
Delirium or Agitation	*Clonazepam*	0.25mg to 0.5mg	Subcut	every 12 hours as required	> An antipsychotic may be used as an alternative to or in addition to a benzodiazepine. > Reserve antipsychotics for patients with distressing refractory symptoms using the lowest dose possible. Refer to Clinical Guideline for advice. > Avoid haloperidol in Parkinson's Disease or if extrapyramidal side effects are distressing; olanzapine is preferred. *Seek specialist palliative care clinician advice.*
	OR				
	Midazolam	2.5mg	Subcut	every hour as required	
	AND / OR				
	Haloperidol	0.5mg to 1mg	Subcut	every 2 hours prn; suggested maximum 5mg in 24 hours	
Nausea	*Metoclopramide*	10mg	Subcut	every 4 hours prn, to a maximum of 30mg in 24 hours	> Metoclopramide is contraindicated in suspected bowel obstruction > Avoid using metoclopramide and haloperidol in Parkinson's Disease or if extrapyramidal side effects are distressing; ondansetron is preferred. *Seek specialist advice.*
	OR				
	Haloperidol	0.5mg to 1mg	Subcut	every 4 hours prn; suggested maximum 5mg in 24 hours	
Gurgly / Noisy Breathing	*Hyoscine butylbromide*	20mg	Subcut	every 2-4 hours as required; maximum 120mg in 24 hours	> Start early and evaluate response. Cease therapy if ineffective after 3 consecutive doses

Required ward imprest list

Clonazepam 1mg/mL injection	Midazolam 5mg/mL injection
Haloperidol 5mg/mL injection	Metoclopramide 10mg/2mL injection
Hyoscine butylbromide 20mg/mL injection	Morphine 10mg/mL injection
Fentanyl 100microgram/2mL injection OR HYDROmorphone 2mg/mL injection	

For further information: www.sahealth.sa.gov.au/lastdaysoflife

Medicines and Technology Programs
SA Health
L8 Citi Centre Building, 11 Hindmarsh Square
ADELAIDE SA 5000
Telephone: 08 8204 1944
www.sahealth.sa.gov.au
Public- I3 – A1

Approved SA Health Safety and Quality Strategic Governance Committee February 2019. Next review: August 2023
[2018-05404 A948795]

Specialist Palliative Care Services

Refer to

Metropolitan Services

- Northern Adelaide Palliative Care
  Phone: 8161 2499
  Fax: 8161 2169

- Central Adelaide Palliative Care
  Phone: 8222 6825
  Fax: 8222 6055

- Southern Adelaide Palliative Care
  Phone: 8404 2058
  Fax: 8404 2119

Statewide Services

- Paediatric Palliative Care
  Phone: 8161 7994
  Fax: 8161 6631

Country Services

For metropolitan referrals to country, please direct to the **Country Referral Unit**.

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4) Putting things in place to ensure that everything goes to plan

What can be done to increase the likelihood that Dorothy's treatment will align with her wishes?

Some suggestions:

- Case/family conference - getting everyone on “same page”

- Collation of important documents in Patient Handheld Record
  - Contact List – list of ‘who to call’ for assistance at any time
  - ACD and Resuscitation Plan - 7 Step Pathway (if completed)
  - Medical History or Care Plan
  - Medication List

- My Health Record

- Work together with Specialist Palliative Care: GP Shared Care

- Understand role of Extended Care Paramedics

- Try Anticipate what you patient or their family will need

Government of South Australia

SA Health

Case 1: Esther

Profile:

88 year old woman

- Full mobility, lives alone and mainly independent except for a weekly cleaning service.
- She has as reasonable quality of life but has been deteriorating after several recent admissions with falls and pneumonia

Presentation at Emergency Department :

- Develops pneumonia with dehydration and acute delirium
- Assessed that she would require IV fluids and antibiotics to recover
- Does not have decision-making capacity

Situation:

- She has an ACD with one SDM appointed and who is present and vague documented wishes about not wanting to live if she had brain damage

……What should you do at this point?

Case 1: Esther

Answer:

Seek the consent of the SDM before administering treatment

Case 1: Esther……continued

Subsequent events:

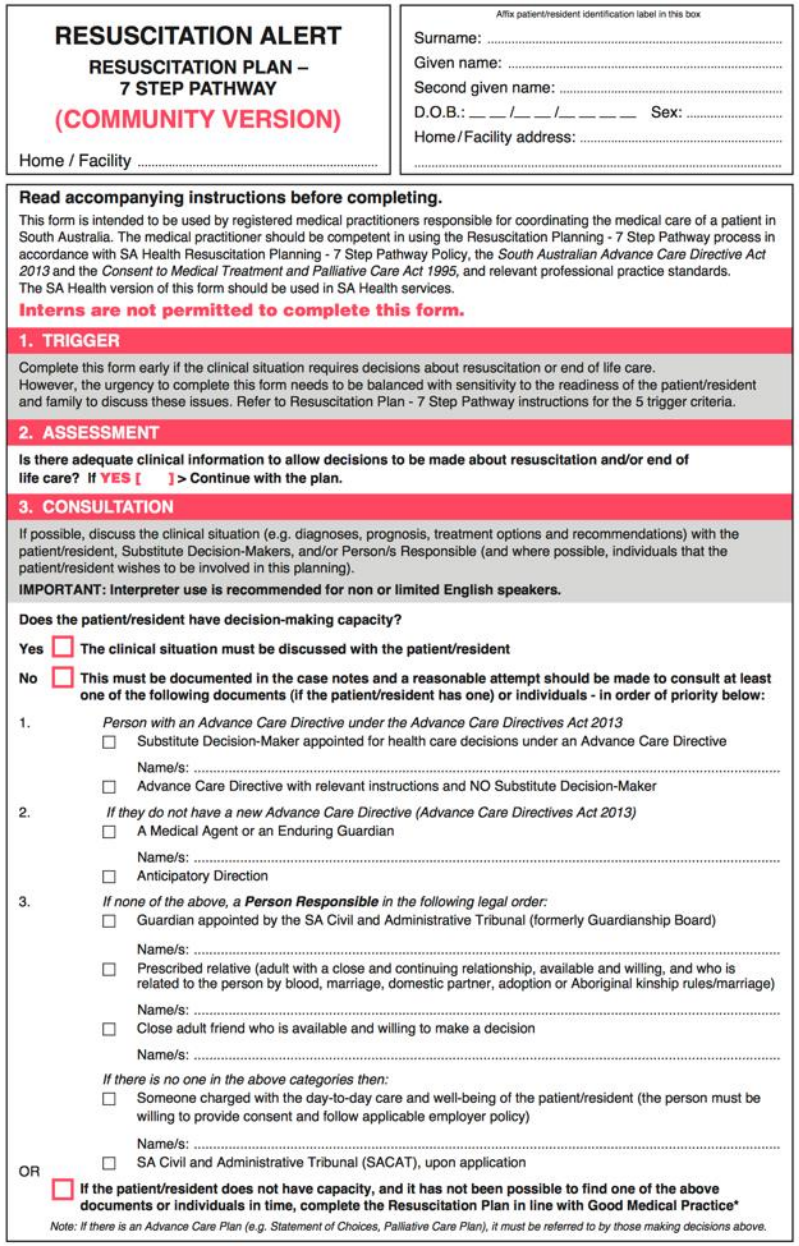
- She survives the pneumonia but has a CVA while in hospital leaving her with a dense R hemiplegia
- She has a permanent IDC
- She is bed/chair bound and fully dependent for care

Situation:

- She is transferred to a nursing home due to care needs
- A family conference is held- and resuscitation and end of life care is discussed
- She alert, aware of what has happened, understands what she is told, and can speak to express her wishes- which have not changed

……How would you fill out a Resuscitation Plan-7 Step Pathway form?

Community Version: Resuscitation Plan-7 Step Pathway



RESUSCITATION ALERT

RESUSCITATION PLAN – 7 STEP PATHWAY

(COMMUNITY VERSION)

Home / Facility .....

Affix patient/resident identification label in this box

Surname: .....

Given name: .....

Second given name: .....

D.O.B.: __ __ /__ __ /__ __ __ __ Sex: .....

Home / Facility address: .....

.....

Read accompanying instructions before completing.

This form is intended to be used by registered medical practitioners responsible for coordinating the medical care of a patient in South Australia. The medical practitioner should be competent in using the Resuscitation Planning - 7 Step Pathway process in accordance with SA Health Resuscitation Planning - 7 Step Pathway Policy, the *South Australian Advance Care Directive Act 2013* and the *Consent to Medical Treatment and Palliative Care Act 1995*, and relevant professional practice standards. The SA Health version of this form should be used in SA Health services.

Interns are not permitted to complete this form.

1. TRIGGER

Complete this form early if the clinical situation requires decisions about resuscitation or end of life care. However, the urgency to complete this form needs to be balanced with sensitivity to the readiness of the patient/resident and family to discuss these issues. Refer to Resuscitation Plan - 7 Step Pathway instructions for the 5 trigger criteria.

2. ASSESSMENT

Is there adequate clinical information to allow decisions to be made about resuscitation and/or end of life care? If YES [ ] > Continue with the plan.

3. CONSULTATION

If possible, discuss the clinical situation (e.g. diagnoses, prognosis, treatment options and recommendations) with the patient/resident, Substitute Decision-Makers, and/or Person/s Responsible (and where possible, individuals that the patient/resident wishes to be involved in this planning).

IMPORTANT: Interpreter use is recommended for non or limited English speakers.

Does the patient/resident have decision-making capacity?

Yes ☐ **The clinical situation must be discussed with the patient/resident**

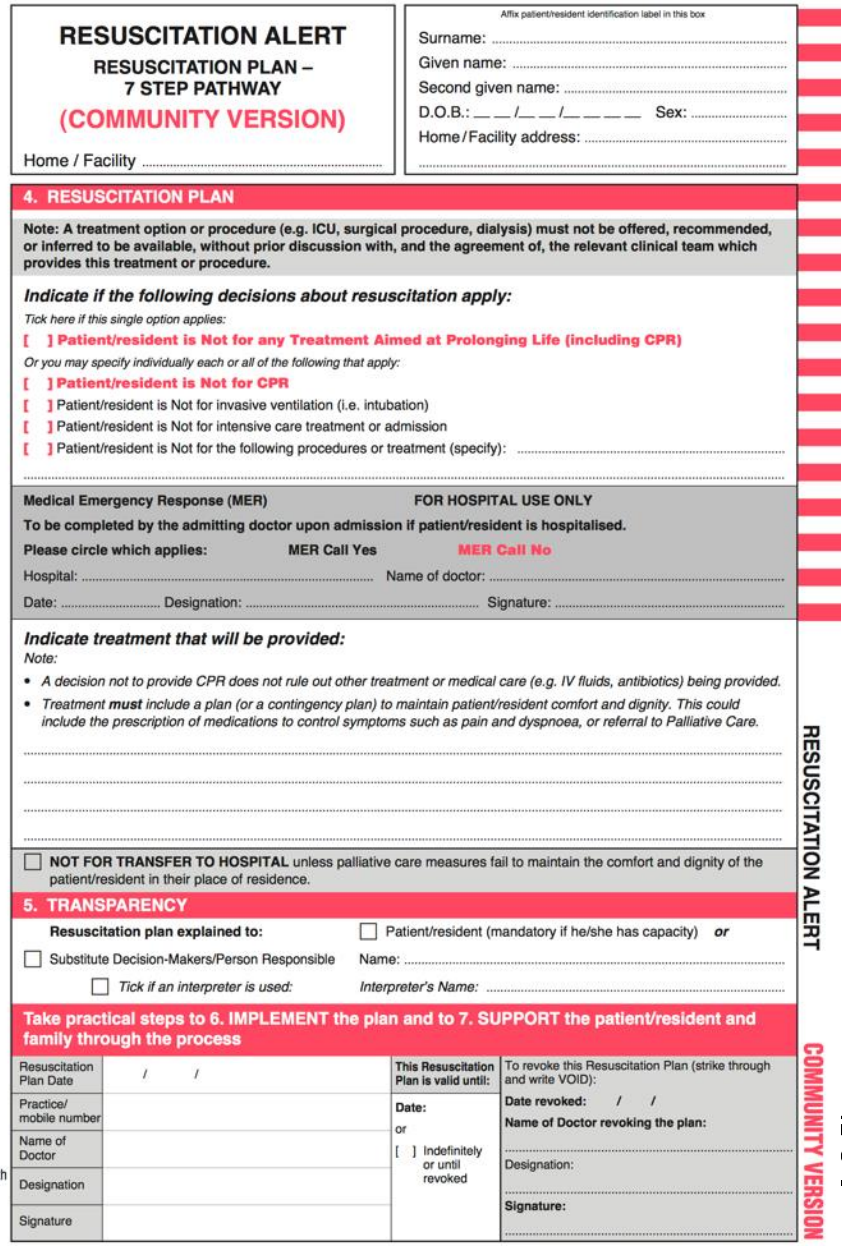
No ☐ **This must be documented in the case notes and a reasonable attempt should be made to consult at least one of the following documents (if the patient/resident has one) or individuals - in order of priority below:**

1. *Person with an Advance Care Directive under the Advance Care Directives Act 2013*
   - ☐ Substitute Decision-Maker appointed for health care decisions under an Advance Care Directive
     Name/s: .....
   - ☐ Advance Care Directive with relevant instructions and NO Substitute Decision-Maker
2. *If they do not have a new Advance Care Directive (Advance Care Directives Act 2013)*
   - ☐ A Medical Agent or an Enduring Guardian
     Name/s: .....
   - ☐ Anticipatory Direction
3. *If none of the above, a **Person Responsible** in the following legal order:*
   - ☐ Guardian appointed by the SA Civil and Administrative Tribunal (formerly Guardianship Board)
     Name/s: .....
   - ☐ Prescribed relative (adult with a close and continuing relationship, available and willing, and who is related to the person by blood, marriage, domestic partner, adoption or Aboriginal kinship rules/marriage)
     Name/s: .....
   - ☐ Close adult friend who is available and willing to make a decision
     Name/s: .....

   If there is no one in the above categories then:
   - ☐ Someone charged with the day-to-day care and well-being of the patient/resident (the person must be willing to provide consent and follow applicable employer policy)
     Name/s: .....
   - ☐ SA Civil and Administrative Tribunal (SACAT), upon application

OR ☐ **If the patient/resident does not have capacity, and it has not been possible to find one of the above documents or individuals in time, complete the Resuscitation Plan in line with Good Medical Practice***

Note: If there is an Advance Care Plan (e.g. Statement of Choices, Palliative Care Plan), it must be referred to by those making decisions above.



RESUSCITATION ALERT

RESUSCITATION PLAN – 7 STEP PATHWAY

(COMMUNITY VERSION)

Home / Facility .....

Affix patient/resident identification label in this box

Surname: .....

Given name: .....

Second given name: .....

D.O.B.: __ __ /__ __ /__ __ __ __ Sex: .....

Home / Facility address: .....

.....

4. RESUSCITATION PLAN

Note: A treatment option or procedure (e.g. ICU, surgical procedure, dialysis) must not be offered, recommended, or inferred to be available, without prior discussion with, and the agreement of, the relevant clinical team which provides this treatment or procedure.

Indicate if the following decisions about resuscitation apply:

Tick here if this single option applies:

[ ] Patient/resident is Not for any Treatment Aimed at Prolonging Life (including CPR)

Or you may specify individually each or all of the following that apply:

[ ] Patient/resident is Not for CPR

[ ] Patient/resident is Not for invasive ventilation (i.e. intubation)

[ ] Patient/resident is Not for intensive care treatment or admission

[ ] Patient/resident is Not for the following procedures or treatment (specify): .....

.....

Medical Emergency Response (MER) **FOR HOSPITAL USE ONLY**

To be completed by the admitting doctor upon admission if patient/resident is hospitalised.

Please circle which applies: **MER Call Yes** **MER Call No**

Hospital: ..... Name of doctor: .....

Date: ..... Designation: ..... Signature: .....

Indicate treatment that will be provided:

Note:

- *A decision not to provide CPR does not rule out other treatment or medical care (e.g. IV fluids, antibiotics) being provided.*
- *Treatment **must** include a plan (or a contingency plan) to maintain patient/resident comfort and dignity. This could include the prescription of medications to control symptoms such as pain and dyspnoea, or referral to Palliative Care.*

.....

.....

.....

.....

☐ **NOT FOR TRANSFER TO HOSPITAL** unless palliative care measures fail to maintain the comfort and dignity of the patient/resident in their place of residence.

5. TRANSPARENCY

Resuscitation plan explained to: ☐ Patient/resident (mandatory if he/she has capacity) ***or***

☐ Substitute Decision-Makers/Person Responsible Name: .....

☐ *Tick if an interpreter is used:* *Interpreter's Name:* .....

Take practical steps to 6. IMPLEMENT the plan and to 7. SUPPORT the patient/resident and family through the process

Resuscitation Plan Date	/ /	**This Resuscitation Plan is valid until:**	To revoke this Resuscitation Plan (strike through and write VOID):
Practice/ mobile number		**Date:** or [ ] Indefinitely or until revoked	**Date revoked:** / /
Name of Doctor			**Name of Doctor revoking the plan:**
Designation			Designation:
Signature			**Signature:**

SA Health

Created January 2016

Original copy – file in the patient's/resident's medical record **Duplicate copies – provide to the patient/resident and the patients/resident's facility/carer (if applicable)**

RESUSCITATION ALERT **COMMUNITY VERSION**

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The End

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