NSW Ambulance

excellence in care

INSTRUCTION SHEET

NSW Ambulance Authorised Adult Palliative Care Plan

NSW Ambulance Authorised Palliative Care Plans (APCP) were developed to enable paramedics to provide individualised care to a patient, who has a life-limiting illness. The APCP will provide paramedics with the plan which has been developed by the medical practitioner in consultation with the patient and/or their person responsible. In order for the paramedic to follow the APCP it must be endorsed by NSW Ambulance. If the APCP is not endorsed, delay in the provision of the required treatment may result. Authorised Care Plans are only processed Mon - Fri (No Public Holidays)

Process for Endorsement

1. Form completed by the practitioner. If the form is being completed by both a medical and nurse practitioner, the medical practitioner must sign on page 2 and the nurse practitioner must complete the signature section on page 4. If the entire form is being completed by a medical practitioner one signature on page 4 will meet the medico-legal requirements. All fields must be completed and legible. Failure to complete the form legibly will result in the plans being returned to the author.
2. Completed form must be emailed to AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or faxed to (02) 9320 7380.
3. Completed form reviewed by NSW Ambulance and endorsed. If information is unclear or incomplete, clarification will be sought from the author and may result in processing delays.
4. Completed form with a covering letter will be mailed back to the address indicated on the form (this can take up to 10 days). If the patient/family agrees, the endorsed APCP can be emailed directly to the nominated email address in lieu of post. This will facilitate more timely access to the endorsed APCP.
5. A copy of the endorsed APCP will also be emailed or faxed to the medical practitioner.

N.B. please notify NSW Ambulance if the APCP is no longer required or if the patient dies.

APCPs remain valid for 12 months, after this time paramedics may not be able to follow the plan.

Paramedics carry a limited supply of routine medications (see list below). If the patient requires other medications to be administered to help manage symptoms, these medications must be available in the patient's residence.

Paramedics are not able to access medications that are in a locked medication safe in a RACF if the registered nurse is not available.

All Paramedics			
Adrenaline	Aspirin	Benzyl Penicillin	Clopidogrel
Compound sodium lactate	Droperidol	Enoxaparin Sodium	Fentanyl
Glucagon	Fexofenadine	Ibuprofen	Frusemide
Glucose Trinitrate	Ipratropium Bromide	Methoxyflurane	Metoclopramide
Midazolam	Morphine	Naloxone	Ondansetron
Oxygen	Paracetamol	Salbutamol	Tenecteplase
Intensive Care Paramedics Only			
Amiodarone	Atropine	Calcium Gluconate	Ketamine
Lignocaine	Sodium Bicarbonate		

NSW Ambulance Trim Number:	NSW Ambulance Document Number:

Patient's Details:	New APCP Patient ☐	Existing APCP Patient ☐
Surname:	Given Name:	Date of Birth: (DD/MM/YYYY) Sex: Male ☐ Female ☐ Other ☐
Street No. & Name		Home Ph: Mobile:
Suburb:		Postcode:
Safety Issues at home: Yes ☐ No ☐ (If yes, please provide details)		
Language:	Interpreter required: Yes ☐ No ☐	Dialect:
Is the patient Aboriginal or Torres Strait Islander? Yes ☐ No ☐ Prefer not to say ☐		
If patient is a hospital inpatient	Hospital Name:	MRN:

THIS SECTION MUST BE COMPLETED AND SIGNED BY A MEDICAL PRACTITIONER

RESUSCITATION STATUS

In the event of cardiopulmonary arrest: CPR ☐ NO CPR ☐

Rationale for withholding CPR:

- Withholding CPR complies with the competent patient's verbally expressed wishes. ☐
- Withholding CPR complies with the patient's applicable Advance Care Directive. ☐
- The patient's Enduring Guardian agrees that withholding CPR is consistent with the patient's wishes. ☐
- The patient's condition is such that CPR is likely to result in negligible clinical benefit. ☐

MEDICAL PRACTITIONER DETAILS

Name:	Contact Number:
Provider Number:	After-hours contact:
Organisation/Practice Name & Address:	
Email:	
As the medical practitioner, I support this care plan and by signing this form I request NSW Ambulance paramedics to implement the treatment options which have been discussed with the patient and is consistent with their treatment requirements	
Signature:	Date:

FOR COMPLETION BY A MEDICAL PRACTITIONER WHO ACCEPTS RESPONSIBILITY TO COMPLETE THE MCCD FOR EXPECTED HOME DEATH

Will you make yourself available at the time of the patient's death to view the body & complete the MCCD?

Yes ☐ No ☐ Comment:_____

Can you be contacted after hours? Yes ☐ No ☐

If No, are you prepared to provide a Medical Certificate of Cause of Death (MCCD) to the Funeral Director within 48 hours, if the death is not a reportable death under the Coroners Act 2009? Yes ☐ No ☐

Medical Practitioner Completing MCCD details:

A/H or Mobile (if available):_____Surgery Ph: _____

Print Full Name: _____ Signature:_____ Date:_____

NSW Ambulance Trim Number:	NSW Ambulance Document Number:
Patient Name:	Date of Birth:

This page can be completed by Medical or Nurse Practitioner

PATIENT'S CLINICAL HISTORY (Please print clearly – Attach additional pages if required)

Diagnosis:

History:

Goals of Care:

Is the patient known to a Palliative Care Service: Yes ☐ No ☐ (if yes, please specify)

Allergies:

PATIENT'S CURRENT MEDICATIONS

Drug Name	Strength	Frequency	Indication

As required medications to be administered to manage symptoms (if required please add extra list)

Medication	Strength	Frequency	Indication/s	Max 24 hour dose

Treatment Options

Aside from an intense focus on comfort, in the event of deterioration the following may be appropriate:

Respiratory Support: (Check box if appropriate)	Are other non-urgent interventions appropriate? Yes ☐ No ☐
Pharyngeal Suction ☐ Supplemental oxygen ☐ Bag & Mask Ventilation ☐ Intubation ☐	If yes (please check the appropriate interventions): Vascular access ☐ IV Fluids ☐ IV Antibiotics ☐

Patient Name:	Date of Birth:

This page can be completed by Medical or Nurse Practitioner

To facilitate more timely return of Authorised Care Plan please provide an email address. (If no email address is provided the endorsed plan will be mailed to the person indicated below):	
Email Address:	
Name of Recipient:	
Relationship of recipient to patient:	
PERSON RESPONSIBLE (PLEASE PRINT CLEARLY)	
Surname:	Given Name:
Relationship: Enduring Guardian ☐ Family Member ☐ Other ☐	
Address:	
Contact Number:	
Language:	Interpreter: Yes ☐ No ☐

Patient's & or Person Responsible's Acknowledgement of this Plan	
Patient's Signature:	Date:
Person Responsible's Signature:	Date:

LOCATION OF CARE

In the event that care at home becomes too difficult, the choice for future care is at:

_____

How to arrange admission to this location: _____

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

CONTACT LIST

Team	Name	Business Hours Contact	After hours contact
General Practitioner			
Palliative Care			
Primary Care Team			
Community Nurse			
Other Health Service			
Spiritual/Religious Supports			

MEDICAL OR NURSE PRACTITIONER DETAILS	
Name:	Contact Number:
Provider Number:	After-hours contact:
Designation: Medical Officer ☐ Nurse Practitioner ☐	
Organisation/Practice Name & Address:	
Email:	
As the medical/nurse practitioner, I support this care plan and by signing this form I request NSW Ambulance paramedics to implement the treatment options which have been discussed with the patient and is consistent with their treatment requirements	
Signature:	Date:

FOR OFFICE USE ONLY:	Date of Receipt: Renewal Date:	
Trim Number:	Document Number:	
Endorsed By Name:		Date:
Signature:		
Position:		