



INSTRUCTION SHEET

NSW Ambulance Authorised Paediatric Palliative Care Plan

NSW Ambulance Authorised Paediatric Palliative Care Plans (PPCP) were developed to enable paramedics to provide individualised care to a patient, who has a life-limiting illness. The PPCP 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 PPCP it must be endorsed by NSW Ambulance. If the PPCP 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 PPCP can be emailed directly to the nominated email address in lieu of post. This will facilitate more timely access to the endorsed PPCP.
5. A copy of the endorsed PPCP will also be emailed or faxed to the medical practitioner.

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

PPCPs 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 – Paediatric Palliative Care Plan

NSW Ambulance Trim Number:		NSW Ambulance Document Number:
Patient's Details:		
New PPCP Patient <input type="checkbox"/>		Existing PPCP Patient <input type="checkbox"/>
Surname:	Given Name:	Date of Birth: Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>
Street No. & Name		Home Ph: Mobile:
Suburb:		Postcode:
Safety Issues at home: Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, please provide details)		
Language:	Interpreter required: Y <input type="checkbox"/> N <input type="checkbox"/>	Dialect:
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:

- Following consensus with the patient/parents/guardians, resuscitation is inappropriate
- 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 <input type="checkbox"/> No <input type="checkbox"/>
Pharyngeal Suction <input type="checkbox"/> Supplemental Oxygen <input type="checkbox"/> Bag & Mask Ventilation <input type="checkbox"/> Intubation <input type="checkbox"/>	If yes (please check the appropriate interventions): Vascular Access <input type="checkbox"/> IV Fluids <input type="checkbox"/> IV Antibiotics <input type="checkbox"/>

DEPARTMENT OF FAMILY AND COMMUNITY SERVICES

Is the patient known to the Department of Family and Community Services (Formally DOCS) Y N

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 Service should be notified

Patient Name:	Date of Birth:
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Email: AMBULANCE-clinicalprotocolp1@health.nsw.gov.au or fax (02) 9320 7380

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: Parent 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: (Please circle) Medical Practitioner _____ 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: _____