policy

Health
Justice Health &
Forensic Mental Health Network

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End of Life Care, Resuscitation Plans and Advance Care Directives

Policy Number	1.174
Policy Function	Continuum of Care
Issue Date	6 July 2018
Summary	Justice Health & Forensic Mental Health patients nearing end of life due to disease progression should receieve the necessary level of support to plan for end of life decisions. End of Life Care and planning can include Resusitation Plans and Advance Care Directives.
Responsible Officer	ED Clinical Operations
Applicable Sites	☐ Administration Centres ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.) ☒ Health Centres (Adult Correctional Centres or Police Cells) ☐ Health Centres (Juvenile Justice Centres) ☒ Long Bay Hospital ☒ Forensic Hospital
Previous Issue(s)	Policy 1.174 (Dec 2013; Apr 2008)
Change Summary	• *Name Change to Resuscitation Plans to be in line with Ministry of Health Policy Directive PD2014_030* • *Change to MoH form from SMR020.050 to SMR020.056* • *Details of PAS Alerts added* • *JH&FMHN forms added for Advance Care Directives*
TRIM Reference	POLJH/1174
Authorised by	Chief Executive, Justice Health & Forensic Mental Health Network

1. Preface

An expectation exists that an individual's wishes for medical treatment be respected at the end of life. As a result, there is a recognised need for processes whereby a person's preferences for end of life care be known and considered at the time when critical treatment decisions need to be made.

This policy sets out the process for reaching end of life decisions, which is an important component of End of Life Care.

Advance Care Planning (ACP) is the process of preparing for likely scenarios near the end of life. It may allow for the use of life-sustaining treatments in ways that are more consistent with the person's choice and priorities at the end of life. This process usually includes assessment of, and dialogue about, a person's understanding of their medical history and condition, values, preferences and personal and family resources.

ACP is a broad and open process which may, or may not include the development of an Advance Care Directive (ACD) and/or a Resuscitation Plan.

An ACD is a document that describes future preferences for medical treatment in anticipation of a time when one is unable to express those preferences because of injury or illness. Completion of an ACD should be part of the broader ACP process.

A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures, including cardiopulmonary resuscitation (CPR), and to document other aspects of treatment at the end of life.

ACP, ACDs and Resuscitation Orders are optional and some individuals will prefer not to make decisions for the future, but rather make decisions about their medical treatment at the time the need arises.

This policy applies to all adult patients in ambulatory and inpatient settings.

2. Policy Content

2.1. Implementation – Roles and Responsibilities

ACP, including the development of ACDs and Resuscitation Plans, are not the responsibility of one particular group of healthcare staff. There are several levels of responsibility.

All healthcare staff with a direct caring role for patients, health records staff and patient related administrative staff should:

- Understand what ACP is
- Be able to explain ACP to patients in general terms
- Be able to locate and provide information about ACP to patients
- Be able to recognise and manage ACP forms within the health record system

Staff with a clinical role, such as Medical Officers (MO), nurses, social workers and allied health staff should comply with the above in addition to the following:

- Initiate and facilitate discussions with the patient and/or their 'person responsible'
- Fully document outcomes of ACP discussions in the health record, this includes the use of forms JUS060.091 *Advance Care Directive: Patient*; JUS060.090 *Advance Care Directive: Person Responsible* and form SMR020.056 *Resuscitation Plan – Adult.*

- Take responsibility for knowing if a patient has an ACD or Resuscitation Plan
- Make reference to ACDs or Resuscitation Plans during clinical handover to the multidisciplinary team
- Ensure reference to ACDs or Resuscitation Plans are made in all transfer and/or discharge documentation
- Ensure the Resuscitation Plans are completed by the treating, or delegated, MO responsible for the patient; and reviewed, updated and resigned on transfer to another centre or after a three month period from the date of the last medical update
- Enter PAS alert "Advance Care Directive" for every patient with an ACD or Resuscitation Plan
- Ensure the appropriate Clinical Director is aware of any patient with and ACD or Resuscitation Plan

3. Procedure Content

3.1. End of Life Care (EoLC) & Advance Care Planning (ACP)

Justice Health & Forensic Mental Health Network (JH&FMHN) patients nearing the end of their life should receive essential supportive care that can be provided within the Long Bay Hospital or, where necessary, at an external hospital.

EoLC is delivered through the collaboration of specialist and generalist palliative care providers with a focus on supportive and palliative care.

EoLC and ACP should be considered for patients nearing the end of their life due to life-limiting disease progression. This includes patients with incurable cancer; diseases with a prognosis of less than 12 months; early dementia; and terminal illness. Planning for EoLC should be considered on admission to the health centre or hospital to optimise the chance of meaningful end of life discussions for patients nearing end of life.

Effective ACP does not necessarily require the completion of a directive. The patient may choose to verbally communicate specific wishes to the healthcare team or family, or formally appoint a substitute decision maker to make treatment decisions on their behalf in the event of their loss of capacity due to physical disability and/or medical illness. Some patients may prefer a substitute decision maker due to issues such as illiteracy, education or personal beliefs. The ACP wishes should be clearly documented in the patient's medical history and communicated between treating health professionals.

NSW Health Guideline GL2005_057 *Guidelines for End-of-Life care and decision-making* provides further information on this matter.

For information relating to EoLC planning for patients with a mental illness, refer to *Dignity, Respect and Choice: Advance Care Planning for End of Life for People with Mental Illness - A Comprehensive Guide*

3.2. Advance Care Directives

All adults have the right to complete an ACD whilst remaining in the ambulatory or inpatient setting. All patients have the right to cancel or amend an ACD at any time.

ACDs should be developed by the multidisciplinary team, in collaboration with the patient, and signed off by the MO responsible for the patient using form JUS060.091 *Advance Care Directive: Patient*. It is not a legal

requirement for the multidisciplinary team or MO to be involved in the creation of an ACD if the patient does not accept their involvement, however it is encouraged.

If the patient does not have the capacity to engage with the multidisciplinary team to complete the ACD, a person responsible may complete the ACD. In this instance, a doctor should complete the form JUS060.090 *Advance Care Directive: Person Responsible* with the person responsible to verify that the patient does not have capacity to provide their own consent.

The Patient Administration System (PAS) alert "Advance Care Directive" must be added for every patient with an ACD. This alert will then appear on the patient's PAS and JHeHS profile

The following must be satisfied before an ACD is considered to have sufficient authority to act on:

- *Specificity*: It must be clear that an advance directive applies to the clinical circumstances arising. This can include treatment preferences in relation to both conditions existing at the time the ACD is made, as well as future anticipated conditions (including catastrophic injury). The advance care directive should be clear and specific enough to guide clinical care. The specificity of the ACD may be improved if the person discusses it with their doctor.

- *Currency:* An ACD prepared a long time before it is referred to may not reflect the current intentions of the patient. Nonetheless, if the person was competent at the time the ACD was made then it should still be treated as legally binding. People should be encouraged to review their directives periodically, for example once a year, after an illness, and/or with a change in health as treatment preferences may change accordingly.

- *Competence:* The person must have been competent to make their own health care decisions when the advance directive was drafted. A person should be considered competent to make a health care decision if they appear able to comprehend, retain, and weigh up the relevant information and then make a choice. Some situations may pose particular difficulties in assessing competence to make an ACD, such as early dementia or intermittent mental health problems. A second opinion from a suitably qualified health professional is advisable.

- *Witnessing:* It is not essential to have an ACD witnessed; however witnessing an ACD is best practice from a legal perspective.

At all times, the ACD remains the property of the patient and as such must be copied and placed in the patient's health record. The original document must be returned to the patient.

The appropriate Clinical Director(s) must be informed of the decision as soon as possible and provided with a copy of the document.

Development of an ACD involves significant consultation and communication with the patient and others, and may take some time to complete. NSW Health Guideline GL2005_056 *Advance Care Directives (NSW) – Using* provides further guidance on the completion of ACDs.

3.3. Resuscitation Plans

All adults have the right to complete a Resuscitation Plan whilst remaining in the ambulatory or inpatient setting. All patients have the right to cancel or amend a Resuscitation Plan at any time.

A Resuscitation Plan seeks to avoid clinical interventions where the likelihood for survival following the intervention is poor and/or unwanted by the patient. Decisions to withhold CPR seek to avoid the administration of unwanted and/or insufficiently beneficial interventions for patient at the end of life.

Following discussion with the multidisciplinary team, Resuscitation Plans must be completed by the treating, or delegated, MO responsible for the patient. The Resuscitation Plan must be filed where it is clearly visible in the front of the patient's health record. The multidisciplinary team must be advised of decisions made in relation to Resuscitation Plans and information provided during clinical handover and transfer of care. Reference to the Resuscitation Plan must be made in all transfer and/or discharge documentation.

NSW Ministry of Health form SMR020.056 *Resuscitation Plan – Adult* must be used. This form is to be ordered via ePOD.

PAS alert "Advance Care Directive" must be added for every patient with an ACD or Resuscitation Plan. This alert will then appear on the patient's PAS and JHeHS profile.

Resuscitation Plans must be reviewed, updated and re-signed on transfer to another centre or after a three month period from the date of the last update by the MO. The appropriate Clinical Directors must be informed of the decision and provided with a copy of the order. For patients under the *Mental Health (Forensic Provisions) Act 1990*, the Mental Health Review Tribunal must be informed.

Healthcare staff may initiate a clinical review of the patient for unrelieved symptoms associated with dying, even where activating an urgent clinical review has been deemed unnecessary in the resuscitation plan. In these instances, a plan for monitoring and managing symptoms associated with dying should be put in place.

NSW Health Policy Directive PD2014_030 *Using Resuscitation Plans in End of Life Decisions* provides further information on this topic.

3.3.1 Resuscitation Orders & Corrective Services NSW

In an event of a medical emergency, Corrective Services NSW (CSNSW) will commence CPR even if the patient has a current Resuscitation Plan in place indicating "No CPR". However, when the Network staff arrive at the point of care and assume management of the patient, all active treatments must follow the patient's wishes as documented in the Resuscitation Plan, including the cessation of CPR.

3.4 Consent, Persons Responsible & Patients without Capacity

Where there is time to plan for EoLC and to make decisions regarding Resuscitation Plans, discussions should be held with the patient, family or and/or person responsible before decisions are made. For patients under the *Mental Health (Forensic Provisions) Act 1990*, the Mental Health Review Tribunal must be informed.

If the patient is not capable of consenting to an ACD of Resuscitation Plan, the treating MO or delegate MO should seek consent from the patient's delegated 'person responsible' as required and detailed in the *Guardianship Act* 1987.

CSNSW Services and Programs Officers (SAPO) should be contacted to identify any person responsible, guardians or friends to assist with the development of ACDs or Resuscitation Plans.

Consent from a competent patient or their 'Person Responsible' should be obtained prior to release of ACD or Resuscitation plans to CSNSW.

3.5 Conflict Resolution

Where there is conflict between the multidisciplinary team, or between the team and patient's family or 'Person Responsible', the Ministry of Health publication *Conflict Resolution in End of Life Settings* provides useful guidance.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

5. Legislation and Related Documents

Legislation	*Guardianship Act 1987* *Mental Health (Forensic Provisions) Act 1990*
JH&FMHN Policies and Procedures	1.030 *Referrals for Admission - LBH Mental Health Unit (Adults)* 1.034 *Admission and Assessment – Medical Surgical Unit Long Bay Hospital* 1.035 *Admission and Assessment – Aged Care and Rehabilitation Unit Long Bay Hospital* 1.075 *Clinical Handover* 1.078 *Care Coordination, Risk Assessment, Planning and Review Forensic Hospital* 1.080 *Clinical Services Provided by JH&FMHN* 1.085 *Consent to Medical Treatment - Patient Information* 1.120 *Management of a Death* 1.141 *Release Planning and Transfer of Care Policy – Adult to External Providers* 1.142 *Discharge Planning - Medical Subacute and Aged Care Rehab Unit LBH* 1.170 *Early Release for Health Related Reasons* 1.175 *Management of Advanced Liver Disease and Hepatocellular Carcinoma* 1.252 *Access to Local Public Hospitals* 1.267 *Medical Responsibility LBH* 1.340 *Accommodation - Clinical Recommendations (Adults)* 1.395 *Transfer and Transport of Patients* 1.436 *Working With Families and Carers Long Bay Hospital and Custodial Mental Health* 1.435 *Working with Families and Carers - The Forensic Hospital* 4.014 *Clinical Application Systems – Alerts, Health Conditions, Allergies or Adverse Drug Reactions* 4.020 *Health Records*

JH&FMHN Forms	JUS060.091 *Advance Care Directive: Patient* JUS060.090 *Advance Care Directive: Person Responsible*
NSW MoH Policy Directives, and Guidelines	GL2005_057 *End-of-Life Care and Decision-Making – Guidelines* GL2005_056 *Advance Care Directives (NSW) – Using* PD2014_030 *Using Resuscitation Plans in End of Life Decisions* *Conflict Resolution in End of Life Settings* *Dignity, Respect and Choice: Advance Care Planning for End of Life for People with Mental Illness - A Comprehensive Guide*
NSW MoH Forms	SMR020.056 *Resuscitation Plan – Adult*