3.12.3 Understand the limits of medicine in prolonging life and recognise when efforts to prolong life may not benefit the patient.

3.12.4 Understand 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.
END OF LIFE CARE TOOLBOX

Advance Care Directive Form

By completing this Advance Care Directive you can choose:
1. Appoint one or more Substitute Decision-Makers and/or
2. Write down your values and wishes to guide decisions about your...

Version: 29.3.2015

South Australia
Consent to Medical Treatment and Palliative Care Act 1995

An Act to deal with consent to medical treatment; to regulate medical practice so far as it affects the care of people who are dying; and for other purposes.

Contents
Part 1—Preliminary
1 Short title
2 Objects
4A Repeal
4B References to provisions of related Acts
Part 2—Consent to medical treatment generally
Part 2A—Consent to medical treatment if person has impaired decision-making capacity
Part 3—Provisions governing medical practice

Version: 29.3.2015

South Australia
Advance Care Directives Act 2013

An Act to enable a person to make decisions and give directions in relation to their future health care, residential and accommodation arrangements and personal affairs; to provide for the appointment of substitute decision-makers to make such decisions on behalf of the person; to ensure that health care is delivered to the person in a manner consistent with their wishes and instructions; to facilitate the resolution of disputes relating to advance care directives; to provide protections for health practitioners and other persons giving effect to an advance care directive; and for other purposes.

Contents
Part 1—Preliminary
1 Short title
3 Interpretation
4 References to provision of health care to include withdrawal etc of medical treatment
5 Reference to particular forms of health care in advance care directives
6 Health practitioners cannot be compelled to provide particular health care
7 Required decision-making capacity
8 Application of Act
Part 2—Objects and principles
9 Objects
10 Principles
Part 3—Advance care directives
Division 1—Advance care directives
11 Giving advance care directives
12 Provisional power of attorney
13 Advance care directive not to give power of attorney
14 Giving advance care directives when English not first language
15 Requirements for witnessing advance care directives
16 Person must not give consent unless authorized to do so
17 Advance care directive revoke previous advance care directives
18 No revocation of advance care directive
19 Binding and non-binding provisions
20 Advance care directive has effect subject to its terms
Division 2—Substitute decision-makers
21 Requirements in relation to appointment of substitute decision-makers
22 Substitute decision-makers jointly and severally empowered

[393.2015] This version is gaz published under the Legislation Revision and Publication Act 2002
IF A PATIENT HAS LOST DECISION-MAKING CAPACITY:

Decide as if “in their shoes”

- 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?
- My job is to save lives isn’t it?
- What’s the legal situation if I don’t give treatment? Maybe I’d better keep trying to keep him alive.
- 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 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?
- My belief is that life is sacrosanct.
- What would this patient have wanted if they had been conscious?
- I don’t know how to tell them this bad news. I need to give them hope. Maybe I’ll give them one more round of treatment…
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.
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.
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

(b) must, if the patient or the patient's representative so directs, withdraw life sustaining measures from the 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")
WHAT IS THE DIFFERENCE BETWEEN EUTHANASIA AND PALLIATIVE CARE?

• Intention
• The “can you sleep at night?” rule
South Australia

Consent to Medical Treatment and Palliative Care Act 1995

An Act to deal with consent to medical treatment; to regulate medical practice so far as it affects the care of people who are dying; and for other purposes.

Contents
Part 1—Preliminary
1 Short title
2 Objects
3 Interpretation
4A References to provision of medical treatment etc to include withdrawal etc of medical treatment
4B Consent not required for withdrawal etc of medical treatment
Part 2—Consent to medical treatment generally
Division 1—Consent generally
6 Legal competence to consent to medical treatment
Division 4—Medical treatment of children
12 Administration of medical treatment to a child
Division 5—Emergency medical treatment
13 Emergency medical treatment
Part 2A—Consent to medical treatment if person has impaired decision-making capacity
14 Interpretation
14A Application of Part
14B Consent of person responsible for patient effective in certain circumstances
14C Person responsible for patient to make substituted decision
14D Person must not give consent unless authorized to do so
Part 3—Provisions governing medical practice
Division 1—Medical practice generally
15 Medical practitioners’ duty to explain
16 Protection for medical practitioners etc

South Australia

Advance Care Directives Act 2013

An Act to enable a person to make decisions and give directions in relation to their future health care, residential and accommodation arrangements and personal affairs; to provide for the appointment of substitute decision-makers to make such decisions on behalf of the person; to ensure that health care is delivered to the person in a manner consistent with their wishes and instructions; to facilitate the resolution of disputes relating to advance care directives; to provide protections for health practitioners and other persons giving effect to an advance care directive; and, for other purposes.

Contents
Part 1—Preliminary
1 Short title
3 Interpretation
4 References to provision of health care to include withdrawal etc of health care
5 References to particular forms of health care in advance care directives
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8 Application of Act
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11 Giving advance care directives
12 Provisions that cannot be included in advance care directives
13 Advance care directive not to give power of attorney
14 Giving advance care directives where English not first language
15 Requirements for witnessing advance care directives
16 Person responsible for patient to make substituted decision
17 Advance care directives revoke previous advance care directives
18 Revocation of advance care directives
19 Binding and non-binding provisions
20 Advance care directive has effect subject to its terms
Division 2—Substitute decision-makers
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22 Substitute decision-makers jointly and severally empowered

[29.3.2015] This version is in effect published under the Legislation Revision and Publication Act 2002

[14.7.2016] This version is in effect published under the Legislation Revision and Publication Act 2002
SIMPLIFIED DISPUTE RESOLUTION PROCESS

- If in doubt/dispute:

  - Office of the Public Advocate

  - Ph: 8342 8200
    Country SA Toll Free: 1800 066 969
For a dying patient, you now know:

- How to decide - i.e. “as if in the patient’s 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 you can focus on caring for your patient
END OF LIFE CARE TOOLBOX

RESUSCITATION ALERT
RESUSCITATION PLAN – 7 STEP PATHWAY
(COMMUNITY VERSION)

Home / Facility

Read accompanying instructions before completing.

This form should be used to identify medical practitioners responsible for reviewing the medical care of a patient in South Australia. The medical practitioner should complete in the Resuscitation Planning - 7 Step Pathway process in accordance with SA Health Resuscitation Planning - 7 Step Pathway (2021) and the SA Health Resuscitation Plan - Community Version - Revised 2023.

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 varies depending on the condition of the patient/resident. For urgent decisions, refer to the Resuscitation Plan - 7 Step Pathway instructions for the trigger criteria.

2. ASSESSMENT

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

3. CONSIDER

If possible, discuss the clinical situation (e.g., diagnosis, prognosis, treatment options and recommendations) with the patient/resident, Substitute Decision-Maker, and/or Patient/Resident and/ or where possible, individuals that the patient/resident has been involved in this planning.

IMPORTANT: Interpreter use is recommended for non-English speakers.

Does the patient/resident have decision-making capacity?

Yes  No

The critical situation must be discussed with the patient/resident.

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 priority order):

1. Person with an Advanced Care Directive (ACT) in place and approved by the District Director of Health (DHD).

2. Person with an Advanced Care Directive (ACT) in place and approved by the District Director of Health (DHD).

3. A Medical Guardian or an Enduring Guardian

If none of the above, a Person Responsible in the following legal order:

1. Guardianship appointed by the SA Civil and Administrative Tribunal (formerly Guardianship Board) in South Australia

2. Person with an Enduring Power of Attorney

3. Close adult friend who is available and willing to make a decision

If no one in the above categories then:

If no one in the above categories then:

4. If the patient/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: There is an Advanced Care Plan (e.g., Statement of Choices, Resuscitation Care Plans) that must be recorded in the medical record above.

SA Health

Date

Signature

END OF LIFE CARE TOOLBOX

RESUSCITATION ALERT
RESUSCITATION PLAN – 7 STEP PATHWAY
(COMMUNITY VERSION)

Home / Facility

4. RESUSCITATION PLAN

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

Indicate if the following decisions about resuscitation apply:

[ ] Patient/resident is not for any treatment aimed at prolonging life (excluding CPR)

[ ] 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) - PCOR 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

Name of doctor:

Date of admission

Designation

Signature

To insert the Resuscitation Plan into the MAR

Resuscitation Plan Code:

Date:

Signature

Drugs:

Name of Doctor ordering the plan:

Name of Doctor ordering the plan:

Resuscitation Plan Code:

Date:

Signature

Drugs:

Name of Doctor ordering the plan:

Name of Doctor ordering the plan:

Resuscitation Plan Code:

Date:

Signature

Drugs:

Name of Doctor ordering the plan:

Name of Doctor ordering the plan:

Resuscitation Plan Code:

Date:

Signature

Drugs:

Name of Doctor ordering the plan:

Name of Doctor ordering the plan:

Resuscitation Plan Code:

Date:

Signature

Drugs:
<table>
<thead>
<tr>
<th>ACD (or ACP)</th>
<th>Resuscitation Plan – 7 Step Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To tell us the patient’s wishes</strong></td>
<td><strong>For the responsible clinician to convert these wishes into usable clinical instructions about resuscitation and end of life care</strong></td>
</tr>
</tbody>
</table>
COMMUNITY VERSION: RESUSCITATION PLAN - 7 STEP PATHWAY

RESUSCITATION ALERT
RESUSCITATION PLAN - 7 STEP PATHWAY
(COMMUNITY VERSION)

Home / Facility:

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 2000 and relevant professional standards.
The SA Health version of this form should be used in SA Health services.

Assessments are not permitted to complete this form.

1. THOUGHT

Complete this form early if the clinical situation requires decisions about resuscitation or end of life care.

2. ASSESSMENT

Is there adequate clinical information to allow decisions to be made about resuscitation and/or end of life care? YES / NO

3. CONSULTATION

If possible, discuss the clinical situation (e.g. diagnosis, prognosis, treatment options and recommendations) with the patient/resident, Substitute Decision-Makers, and/or Person 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 / NO

If the patient/resident has decision-making capacity, this form should be completed with the patient/resident.

If the patient/resident does not have decision-making 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 Practice Guide.

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

4. RESUSCITATION PLAN

Note: A treatment option or procedure (e.g., ICU, surgical procedure, dialysis) must not be offered, recommended, or informed 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:

- Patient/resident is in need of any Treatment Aimed at Preserving Life (including CPR)
- Patient/resident is not in need of Treatment Aimed at Preserving Life (including CPR)
- Patient/resident is not to be resuscitated (including CPR)
- Patient/resident is not to be intubated
- Patient/resident is not to be ventilated
- Patient/resident is not to be given Prognostic Information
- Patient/resident is not to be given Medical Treatment

Medical Emergency Response (MERT) FOR HOSPITAL USE ONLY

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

Date:

Indicate treatment that will be provided:

- Patient/resident is to be resuscitated

5. TRANSPARENCY

Resuscitation plan explained to:

Name:

Tick if an interpreter is used:

Interpreter’s Name:

COMMUNITY VERSION

RESUSCITATION ALERT
RESUSCITATION PLAN - 7 STEP PATHWAY
(COMMUNITY VERSION)

Home / Facility:

Revise the Resuscitation Plan (make tick in box below)

Date:

Date required:

Date received:

Name of Doctor reviewing the plan:

Designation:

Signature:

Note: Original copy in the patient/resident's medical record. Duplicate copies provide to the patient/resident and the patient/resident’s family (if applicable).
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?”
• **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
## End of Life Care Toolbox

### Table 2

| Table 2: Clonazepam | Morphine | Haloperidol | Metoclopramide | Hyoscine

### Palliative Care Referral Form

An assessment by the palliative care team will aim to develop a management plan involving services that are appropriate to the patient’s circumstances. Incomplete forms or absence of additional documentation will delay the process.

If the matter is URGENT, please telephone your local palliative care service.

**Criteria for eligibility and a guide for referral to a palliative care service**

#### 1. TRIGGER

- Complete this form early if the clinical situation requires decisions about resuscitation or end of care.
- Complete the form to ensure that the clinical situation is documented in medical records.
- Complete the form to elicit and address any questions the patient/relative/resident may have.
- Complete the form to make sure that the patient/relative/resident and their next of kin understand the implications of the clinical situation.

#### 2. ASSESSMENT

- Is there adequate clinical information to allow decisions to be made about resuscitation and/or end of life care? [ ] Yes [ ] No
- [ ] Update on the existing plan
- [ ] End of life plan

#### 3. CONSULTATION

- Discuss with the patient/relative/resident and their next of kin
- Discuss with other medical specialties involved
- Discuss with other researchers involved

#### 4. RESUSCITATION PLAN

**Note:** A treatment option or procedure (e.g., ICU, surgical procedure, dialysis) must be offered, recommended, or both, if available, without prior discussion with, and agreement of, the relevant clinical team who provides the treatment or procedure.

- **Indicate if the following decisions about resuscitation apply:**
  - Is the patient/relative/resident not for CPR?
  - Is the patient/relative/resident not for intubation?
  - Is the patient/relative/resident not for intensive care treatment or admission?
  - Is the patient/relative/resident not for the following procedures or treatment (if relevant):

#### 5. TRANSPARENCY

- **Resuscitation plan explained to:**
  - **Resuscitation plan explained to:**
    - Patient/relative/resident
    - Next of kin
  - [ ] An educational package

#### 6. IMPLEMENT THE PLAN

- **Take practical steps to 6. IMPLEMENT the plan:**
  - **Date:**
  - **Time:**
  - **Resuscitation Plan:**
  - **This Resuscitation Plan will be reviewed:**
    - [ ] By the patient/relative/resident
    - [ ] By the medical team
    - [ ] By the Executive Team
  - **Resuscitation Plan:**
  - **Decision:**
  - **Signatory:**
  - **Date:**
  - **Time:**
END OF LIFE CARE TOOLKIT
Know Your Tools

Doojiggy
Hickeymabob
Redthingy
Jiggymadoo
Thingymajig
Doohickeys and Doodads
Squeezythingy
Gizmo
Whatchamacallit