Justice Health and
Forensic Mental Health Network

Justice Health NSW Policy

End of Life Care and Decision Making

Issue Date: 11 July 2023

Together for
Healthier Tomorrows

End of Life Care and Decision Making

Policy Number 1.174

Policy Function Continuum of Care

Issue Date 11 July 2023

Next Review Date 11 July 2026

Risk Rating High

Summary The implementation guide provides health staff with useful advice and process for negotiating end of life decisions.
It contains information on specific issues such as Making Resuscitation Plans and Advance Care Directives (ACDs) and recommends minimum standards for documentation of decisions about withholding, or withdrawal of, treatment, and dispute resolution for patients, families and staff.

Responsible Officer General Manager, Primary Care

Applies to
- ☐ Administration Centres
- ☐ Community Sites and programs
- ☒ Health Centres - Adult Correctional Centres or Police Cells
- ☐ Health Centres - Youth Justice Centres
- ☒ Long Bay Hospital
- ☒ Forensic Hospital

CM Reference POLJH/1174

Change summary
- Title change
- Reviewed for alignment with NSW Health Policy Guideline GL2021_004 End of Life Care and Decision-Making
- NSW Health Making an Advance Care Directive Information Booklet replacing JH&FMHN forms for Advance Care Directives

Authorised by Chair, Policy Steering Committee

Revision History

#	Issue Date	Number and Name	Change Summary
4	July 2023	1.174 End of Life Care and Decision Making	• Title change • Reviewed for alignment with NSW Health Policy Guideline

			GL2021_004 End of Life Care and Decision-Making • NSW Health Making an Advance Care Directive Information Booklet replacing JH&FMHN forms for Advance Care Directives
3	July 2018	1.174 End of Life Care, Resuscitation Plans and Advance Care Directives	• 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
2	December 2013	1.174 End of Life Care, Not for Cardio-Pulmonary Resuscitation Orders and Advance Care Directives – Adult Centres Only	• Name Change • Policy has been changed to include the correctional community. • No longer specific to Long Bay Hospital
1	April 2011	1.174 End of Life Care – Not for Resuscitation Orders and Advance Care Directives – Long Bay and Forensic Hospitals	• New policy

PRINT WARNING

Printed copies of this document, or parts thereof, must not be relied on as a current reference document.

Always refer to the electronic copy for the latest version.

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1. Preface

This implementation guide is to provide information for Justice Health NSW staff who are part of the treating team involved in end of life care. This may include Medicine, Allied Health Nurses including Aboriginal Health Workers.

Dying patients can be any age and are cared for in many settings including custodial settings. This guideline provides useful advice for Justice Health NSW staff about the process for navigating complex end of life decisions wherever that care is delivered. Refer to NSW Health Policy Guideline GL2021_004 *End of Life Care and Decision-Making* for further guidance. Additionally, Justice Health NSW Policy 1.170 *Mandatory Notification for Life Limiting Illness and Permanent Disability*, must be observed, outlining the requirement and obligation of Justice Health NSW staff to report to Corrective Services NSW (CSNSW) any opinion formed that because of illness a patient will not survive sentence or is totally and permanently unfit for correctional centre discipline.

Ideally, patients determine their own decisions for end of life care. Some aspects of this Guideline apply to these patients who have decision-making capacity or have documented their wishes. Often, however, patients lose decision-making capacity before their wishes are determined. In those situations, the treating team, person responsible, family and/or carer need to collaborate on a plan of care that considers the patient's best interests: reflecting the patient's wishes and values and avoiding both inappropriate over and under-treatment. This guideline is relevant to all situations where a consensus-building approach is recommended.

2. Policy Content

2.1 Roles and Responsibilities

Advance Care Planning (ACP) including the development of Advance Care Directives (ACDs) is not the responsibility of one particular group of healthcare staff. There are several levels of responsibility as detailed below.

All Justice Health NSW Clinical Staff (including NUMs, Nurses, NPs, MOs, Allied Health and Aboriginal Health Workforce):

- Understand what Advance Care Planning (ACP) is
- Be able to explain ACP to patients in general terms
- Be able to locate and provide information about ACP for staff and patients
- Be able to recognise and manage ACP forms within the health record system

Additionally,

Nursing Unit Managers (NUMs) and Health Centre and Long Bay Hospital Primary Health Nurses

- 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

Nurse Practitioners (NPs)

- Initiate and facilitate ACP discussions with the patient and/or their 'person responsible'
- Fully document outcomes of ACP discussions in the health record, this includes the use of the NSW Health Making an Advance Care Directive Form
- Enter PAS alert "Advance Care Directive" for every patient with an ACD
- 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

Medical Officer (MO)

- The development of Resuscitation Plans is the responsibility of treating or delegated Medical Officers (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
- Discussion with the patient/Person Responsible about resuscitation should generally be undertaken by the most experienced clinician.
- The 'delegated signatory Medical Officer' e.g., registrar who is not the treating Medical Officer may undertake the conversation with the patient/Person
- Responsible to complete and sign the Resuscitation Plan. However, this must be authorised by the responsible treating Medical Officer at the earliest opportunity.
- Delegation to a junior medical officer should only occur with adequate training, supervision and support. If a junior medical officer is required to discuss and document a Resuscitation Plan (e.g., out of hours) this must be discussed with the treating Medical Officer at the earliest opportunity.
- Enter PAS alert "Check Resuscitation Plan" for every patient with a Resuscitation Plan
- Ensure the appropriate Clinical Director is aware of any patient with and ACD or Resuscitation Plan
- 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

Palliative Care Allied Health Workforce (Physiotherapist, Occupational Therapist, Social Worker, Speech Pathologist, Podiatrist, Dietitian)

- Initiate and facilitate ACP discussions with the patient and/or their 'person responsible'
- Fully document outcomes of ACP discussions in the health record, this includes the use of the NSW Health Making an Advance Care Directive Form

- Fully document outcomes of ACP discussions in the health record, this includes the use of the NSW Health Making an Advance Care Directive Form
- Enter PAS alert “Advance Care Directive” for every patient with an ACD
- 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

Aboriginal Health Workforce

- Initiate, facilitate and support ACP discussions with Justice Health NSW staff and the patient and/or their ‘person responsible’
- Fully document outcomes of ACP discussions in the health record, this includes the use of the NSW Health Making an Advance Care Directive Form
- Enter PAS alert “Advance Care Directive” for every patient with an ACD

3. Definitions

3.1 Policy 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.

3.2 Key Definitions

Advance Care Directive

An Advance Care Directive (ACD) is a way a person can document what healthcare treatments they would like to have or refuse, should they find themselves in a position where they are unable to make or communicate decisions about their treatment and care.

In NSW, an ACD can be spoken or written. There is not a specific form that must be used. An ACD can only be made by an adult with decision-making capacity and if it is valid, it must be followed. Health practitioners and persons responsible have no authority to override a valid ACD. Further information about making an ACD can be found online at https://www.health.nsw.gov.au/patients/acp/Publications/acd-form-info-book.pdf

Advance Care Plan

An Advance Care Plan can be made by the individual or together with people that they trust and/or who are important to them. Where the individual is not able to make decisions, the Advance Care Plan can be made by their family/carer with a health practitioner. An Advance Care Plan is not a legal document.

Advance Care Planning

Advance Care Planning involves a person thinking about what care they would like should they find themselves in a position where they cannot make or communicate decisions about their treatment or care. It can include the person talking with family, carers and/or health practitioners, developing an Advance Care Plan, appointing an Enduring Guardian or making an Advance Care Directive.

Capacity

The ability for a person to make their own decisions is called 'capacity'. When a person has capacity, they can make their own decisions about things that happen in their life. Broadly speaking, a person has capacity to make a particular decision, when they are able to do all of the following:

- Understand the facts involved
- Understand the main choices
- Weigh up the consequences of the choices
- Understand how the consequences affect them
- Communicate their decision.

It is important to always presume that a person has the capacity to make all decisions for themselves. Capacity is decision specific, which means if there is doubt about a person's capacity then there will need to be an assessment of the person's capacity for each decision. If clinicians are concerned about a patient's capacity, consider referral to Custodial Mental Health. Within the Forensic Hospital, a patient's capacity needs to be clarified by the treating psychiatrist.

End of life

For the purposes of this Guideline, this refers to the timeframe when a patient is clearly approaching the end of their life and is living with/impaired by a life-limiting illness. This includes:

- the patient's last weeks or days of life, when deterioration is irreversible and
- when a patient is assessed as likely to die in the next 12 months

End of life care

End of life care is delivered to improve the quality of life for people who have a life-limiting illness, as well as their families and carers. It ensures the appropriate support and palliative needs are provided to the person, so they live as well as possible until their death.

Life-sustaining treatment

Life-sustaining treatment is any medical intervention, technology, procedure or medication that is administered to forestall the moment of death, whether or not the treatment is intended to affect life-threatening diseases or biological processes. These treatments may include, but are not limited to, mechanical ventilation, artificial hydration and nutrition, cardiopulmonary resuscitation, dialysis or certain medications (including antibiotics).

Palliative care

The World Health Organisation defines palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life- threatening illness, through the prevention and relief of suffering by means of early identification and assessment and treatment of pain and other problems, physical, psychosocial or spiritual.

Patient

For the purposes of this document, the patient describes the person receiving end-of-life care.

Person responsible (also referred to as Next of Kin [NOK])

If a person is not capable of consenting to their own treatment, the health practitioner should seek consent from their 'person responsible'. This is required by the Guardianship Act 1987.

Under section 33A(4) of the Guardianship Act 1987, there is a hierarchy of people who can be the person responsible. A person responsible is one of the following people in order of priority:

i. Guardian – an appointed guardian (or enduring guardian) who has been given the right to consent to medical and dental treatments, or

ii. Spouse or partner – if there is no guardian, a spouse, de-facto spouse or partner where there is a close continuing relationship, or

iii. Carer – if there is no spouse or partner, an unpaid carer who provides or arranges for domestic support on a regular basis, or

iv. Relative or friend – if there is no carer, a friend or relative who has a close personal relationship, frequent personal contact and a personal interest in the person's welfare, on an unpaid basis.

Resuscitation plan

A Resuscitation Plan is a medically authorised order to use or withhold resuscitation measures and document other time critical clinical decisions related to end of life. These were formerly called No CPR Orders. (Refer to NSW Health Form SMR020.056 Resuscitation Plan – Adult).

A Resuscitation Plan is made:

- With reference to pre-planning by patients (such as Advance Care Plans or directives)
- In consultation with patients/families
- Taking account of the current clinical status, as well as the wishes and goals of the patient.

Treating team

The treating team is the multidisciplinary team of health professionals involved in the patient's management and care. This may include medical specialists, general practitioners, nurses, Aboriginal Health Workers, Aboriginal Health Practitioners, Aboriginal Liaison Officers, allied health professionals such as social workers, physio therapists, dietitians and occupational therapists, lived experience professionals, patient advocates, chaplains or pastoral care workers.

Treatment limitation decisions

Treatment limitation decisions are those that involve the reduction, withdrawal or withholding of life-sustaining treatment.

For further key definitions refer to NSW Health Policy Guideline GL2021_004 *End of Life Care and Decision-Making*.

4. Principles

End of Life Care and Decision-Making is grounded in the nine principles of building consensus, respect for life and care in dying, the right to know and to choose, appropriate withholding and withdrawal of life-sustaining treatment, a collaborative approach to care, transparency and accountability, non-discriminatory care, rights and obligations of health practitioners, and continuous improvement.

For further information on these principles refer to NSW Health Policy Guideline GL2021_004 *End of Life Care and Decision-Making*.

5. Advance Care Planning

Health outcomes for patients, their families and carers improve when they can talk through their concerns, preferences, choices and decisions with health practitioners.

Ideally, these conversations start when the patient is well and should continue throughout their health care journey.

Currently in NSW, people can plan for end of life care by:

- discussing their preferences for life-sustaining treatment with their person responsible, family and/or carer while they are well
- writing an Advance Care Directive (ACD) if they are an adult with decision-making capacity, noting that an ACD can also be oral (which should be documented)
- formally appointing and/or informing an Enduring Guardian (where the person has decision-making capacity)
- developing an Advance Care Plan (ACP) in conjunction with their health practitioners, person responsible, family and/or carer

The critical element for effective advance care planning by any of the above approaches is discussion between the patient and where possible, their person responsible, family and/or carer, as well as their treating team.

An ACP may be developed by the individual (regardless of their capacity) and/or where possible, by their person responsible, family and/or carer on their behalf, in consultation with their treating team. An ACP is not a legal document.

However, an ACD in NSW can only be made by an adult with decision-making capacity. An ACD can be spoken or written in NSW. It does not need to be on a specific form to record their wishes. This means that all ACDs must be respected, including ACDs from other states and territories.

NSW Health has developed the *Making an Advance Care Directive* package which includes an ACD form and an information booklet to help complete the form.

Once completed, this should be scanned into JHeHS documents under Clinical Correspondence, Advance Care Directive and an 'Advance Care Directive' alert added to the patient's electronic health record.

6. Foundation for Sound Decision-Making

A number of factors support a sound process for end of life decision-making. These factors include:

- respecting the principles of this Guideline
- the changing context of treatment decisions at the end of life
- the relationship between the treating team/health care professional and the patient with decision-making capacity
- holistic assessment and the importance of multi-professional input including allied health reviews, interpreting services, disability supporter or advocate, and Aboriginal liaison
- the collaborative nature of the treating team/health practitioners and the patient and/or person responsible, family and/or carer
- supported decision-making tools as required, for example support to access and understand the information and resources needed to make a decision for themselves. This is particularly relevant for people with disability.
- the consensus building model where the patient has no decision-making capacity
- accountability
- the importance of palliative care.

For further information on foundations for sound decision-making refer to NSW Health Policy Guideline GL2021_004 *End of Life Care and Decision-Making*.

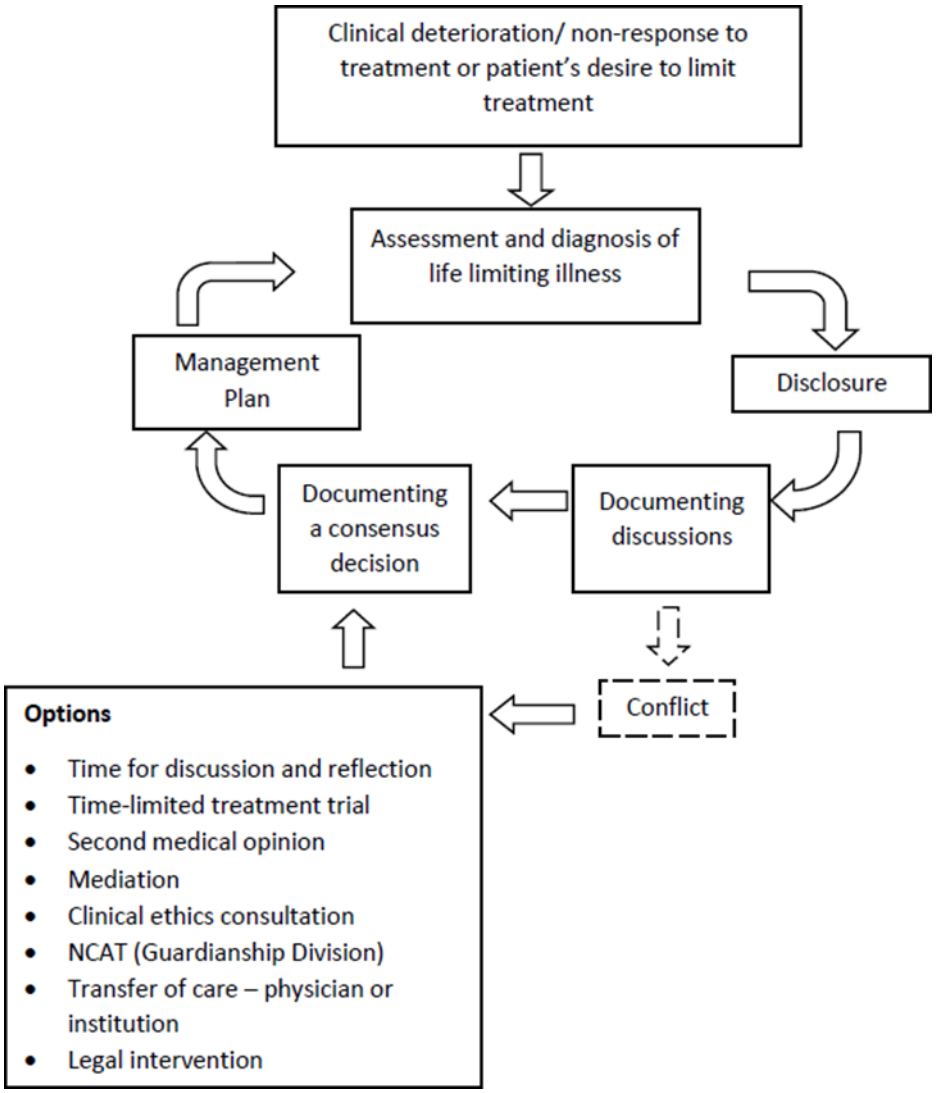
7. Developing a Management Plan

Planning end of life care is an iterative or cyclic process based on holistic, comprehensive assessment, disclosure, discussion and consensus building with the patient and/or their person responsible, family and/or carer and the treating team.

This process can take place over a short period, such as hours, where the patient suddenly or unexpectedly deteriorates, but it can also extend over weeks or months. End of life discussions may be included in JHeHS Progress Notes and clinical handover to facilitate follow up and discussion with the patient's treating team and GP/NP. This may be particularly relevant for aged and frail people, or those living with a chronic condition or receiving palliative care.

The key points in each step of this process (section 7.1) are discussed in the following sections.

7.1 Process of end of life decision-making



7.2 Assessment

A sudden or unexpected deterioration, or uncertainty about prognosis, usually requires efforts to stabilise the patient so that a complete assessment can be undertaken, and potential reversibility of the condition be established.

Development of an end of life management plan should be considered and discussed if:

- the patient's recovery is uncertain
- if the treating clinician asks him or herself, 'Would I be surprised if this patient were to die in 6 to 12 months?' and the answer is 'No'
- if the patient clinically deteriorates or is anticipated to do so
- or if the patient's condition is considered high risk.

The treating team should undertake this assessment at the earliest appropriate time. Life-sustaining treatment that has already commenced may be subsequently withdrawn if it is deemed no longer appropriate upon assessment of the patient's wishes or clinical condition. The treating team should document all of the information used to support their decision-making process.

If there is reasonable doubt within the treating team about the medical assessment, they should seek advice from other senior clinicians, if possible, with experience in the condition. Any second opinions should be documented.

Assessment should also include evidence of the patient's preferences and values where available from the patient, as documented in their ACD, or by their person responsible, family and/or carer if the patient has no capacity.

7.3 Disclosure

Accurate information in Plain English should be provided to patients, their person responsible, families and/or carers so they can participate meaningfully in decisions about end of life care. Where required, this information should be provided in a culturally appropriate way, for example engaging with Aboriginal Health Workers to create a culturally appropriate end of life pathway.

Uncertainty about prognosis or likely response to treatment should be communicated to patients, their person responsible, their families and carers. Prognostic information is ideally given by a health practitioner who is respected as an expert.

Ideally, Patients, their person responsible, families and/or carers should be engaged in open communication about possible outcomes early in treatment, especially where the patient is seriously or critically ill. This is to prevent unrealistic expectations about what can be achieved with treatment. In the custodial setting, engaging patient's person responsible, families and/or carers is a significant challenge. They cannot attend appointments. Justice Health NSW staff need to seek approval from the patient and CSNSW before they can speak to patient's families. Additionally, Justice Health NSW staff can encourage external treating teams to speak to patient's families.

7.4 Documenting discussions

Discussions with patients, their person responsible, families and/or carers about treatment limitation should ideally occur in stages over a period of time, preferably while the patient can determine the appropriateness of treatment or its withdrawal. It is recommended that nursing staff, or other key members of the treating team are present in these discussions to support and facilitate communication between the treating team, the person responsible, family and/or carer.

For further guidance on discussions and triggers for escalation to a Clinical Ethics Committee refer to NSW Health Policy Guideline GL2021_004 *End of Life Care and Decision-Making*.

7.5 Documenting a consensus decision

The agreed management plan for end of life care, and decisions about the use of life-sustaining treatment within that plan, should be documented and conveyed to all members of the treating team as well as the patient, their person responsible, family and/or carers.

These notes must clearly state:

- medical facts leading to the decision, including prognosis
- those involved in the discussion and if it was a family meeting
- the patient's wishes, where known and if documented in an ACP or ACD

- goals of treatment and care
- details about medical treatments to be provided, timeframe before review, or
- details about treatments to be withdrawn / withheld.

8. Resolving Disagreements

In most situations where a patient is dying, the patient, person responsible, family and/or carer and treating team readily come to an agreement on appropriate medical management.

However, disagreements can arise regarding treatment limitation decisions or other aspects of end of life care. Most disagreements between the treating team, the patient or the person responsible can be prevented by early, sensitive and proactive communication that clarifies goals of treatment, possible outcomes and the patient's values and wishes. That is where early engagement of the Palliative Care Team, culturally appropriate support services, and Aboriginal Health Workers may help.

For further information on resolving disagreements refer to NSW Health Policy Guideline GL2021_004 *End of Life Care and Decision-Making*.

9. Specific Issues

9.1 Voluntary Assisted Dying

The Parliament of New South Wales passed the *Voluntary Assisted Dying Act 2022* (VAD Act) on 19 May 2022. Historically, both euthanasia and assisted suicide were crimes under the Crimes Act 1900 (NSW). The VAD Act will allow eligible people the choice to access voluntary assisted dying from 28 November 2023. The legislation has many safeguards to ensure voluntary assisted dying is safe, accessible and appropriate. From now until November 2023, the NSW Ministry of Health (NSW Health) will plan for and implement voluntary assisted dying in NSW. Justice Health NSW Voluntary Assisted Dying Implementation Guidelines and Resources for custodial settings in NSW are currently under development.

Currently in NSW, the following is permitted:

- The refusal of any or all life sustaining treatments by a person with decision- making capacity
- Competent patients to prepare an advance refusal of treatment for a time of future incapacity
- Decisions by doctors, in consultation with the guardian/ person responsible for incapacitated patients, to withhold or withdraw treatments that will not benefit the patient, to permit a peaceful death.

Justice Health NSW strongly endorses patient autonomy and is committed to empowering patients in their choices, where the request is within the existing ethical and legal framework. In custodial settings empowering patient choices can be challenging for staff where wishes conflict with the secure environment and specific limitations and restrictions of incarceration.

9.2 Culturally appropriate and responsive care at end of life

Culturally appropriate care at end of life for people is supportive of personal, family and community needs. This can be particularly challenging in the custodial setting and requires collaboration between Justice Health NSW staff, the Palliative Care Team and Corrective Services NSW staff to best support and provide culturally appropriate care for patients at the end of their life.

Aboriginal Health Workers, Aboriginal Health Practitioners and Multicultural Health Workers can work with the patient, family and/or carers to inform the various service providers about their specific needs.

The Lesbian, Gay, Bisexual, Transgender or Intersex (LGBTI) community may face additional barriers when accessing appropriate and responsive care at end of life.

This may include experiences of discrimination in health care and other settings, and a lack of recognition of LGBTI families. As a result, it may be important for LGBTI patients to prepare clear advance care planning documents to protect their legal rights and end of life care preferences, particularly if their family and/or carer are not aware of or do not respect their sexual orientation, gender identity, intersex status or relationships.

People with disability may require additional supports to enable them to understand death, dying and end of life care, and to effectively make decisions about appropriate and responsive care. This may include the use of assistive technology, translated resources, or disability supporters/advocates. It is important not to underestimate the capacity of people with disability to understand and make decisions about their own health care.

9.3 Making Resuscitation Plans

Making a Resuscitation Plan is one step in the process of planning quality end of life care. It is a medically authorised order completed by the most senior medical officer to use or withhold resuscitation measures and document other aspects of treatment relevant at end of life.

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.

Decisions to withhold CPR and other resuscitation measures seek to avoid unwanted, excessively burdensome or insufficiently beneficial interventions for patients at the end of life. At some point in the course of life- limiting illness, a shift in the focus of care away from aggressive intervention and towards a palliative approach is often the agreed outcome.

The rationale for withholding resuscitation includes:

- Where there is a clearly stated, adequately informed and properly documented or verbally expressed refusal by a person with decision-making capacity. An ACD and ACP can inform decisions recorded in the Resuscitation Plan.
- Where the person has no capacity to make this decision, there is an adequately informed and properly documented decision to withhold resuscitation by the treating Medical Officer in consultation with the person responsible, family and/or carer.
- Where the treating Medical Officer judges that resuscitation offers no benefit or where the benefits are small and overwhelmed by the burden to the patient.

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 hard copy paper health record and scanned and uploaded to the relevant clinical folder in the patient's electronic health record in JHeHS. 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 "Check Resuscitation Plan" must be added for every patient with a 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 and Cognitive Impairment Forensic Provisions Act 2020*, the Mental Health Review Tribunal must be informed.

A medical officer's clinical judgement should be used where resuscitation is manifestly inappropriate or the patient is deceased, including situations where there is no documented plan.

NSW Health Resuscitation Plans are only valid for patients under the medical care of a doctor who is a NSW Health staff member.

For more information on Resuscitation Plans refer to NSW Health Policy Directive PD2014_030 *Using Resuscitation Plans in End of Life Decisions*.

9.4 Resuscitation Orders and Corrective Services NSW

In an event of a medical emergency (Code Blue) where a patient is unresponsive and not breathing normally, Corrective Services NSW (CSNSW) officers will follow CSNSW Medical Emergencies policy iwhich states officers must start CPR until Justice Health NSW health staff or paramedics arrive and take control. This does not apply if a patient is in a hospital ward. When the Justice Health NSW 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.

CSNSW policy states where a medical emergency occurs with a patient in a hospital ward (this includes the medical wards in Long Bay Hospital), correctional officers must immediately alert medical staff who will provide emergency medical care or treatment. Correctional officers must assist medical staff if requested. Medical staff will also be aware of any risks associated with providing CPR or the existence and application of an advanced care directive/not for resuscitation order which correctional officers may not be aware of.

9.5 Advance Care Directives (ACDs)

The NSW Supreme Court has said that valid ACDs must be followed as they are part of a person's right to make decisions about their health. Health professionals and persons responsible have no authority to override an ACD.

The following conditions should be met before ACD treatment decisions are followed. The ACD:

- is intended to apply to the clinical circumstances that have arisen
- must be sufficiently clear and specific to guide clinical care
- should be made by an adult patient and should reflect their wishes, rather than the wishes of another person, and
- there must not be any reasonable evidence to suggest that the ACD does not reflect the current intentions of the patient, or was made as a result of undue influence

It is best practice, but not legally necessary, that the ACD:

- is periodically reviewed by the patient, for example after an illness, or following a change in health status
- should be available at the time decisions need to be made, for example, by ensuring the likely person responsible and primary healthcare provider have a copy and any of its revisions
- be signed and witnessed, if it is written
- is developed by a patient with involvement or assistance from a medical practitioner.

If there is doubt about whether the ACD applies, or if there are concerns that the ACD is not valid, health treatment should be provided until clarification can be sought from the Supreme Court. The Justice Health NSW Legal Team and Ministry of Health's Legal and Regulatory Services Branch should be contacted in these circumstances. If after hours, the clinician should elevate the matter to the Justice Health NSW Chief Executive who can contact the Ministry of Health's General Counsel.

See section 5 of this Guideline for more detailed information about ACDs and advance care planning.

9.6 Organ and tissue donation

Incarceration / detention under the *Mental Health Act 2007* (MHA) does not preclude organ donation and each case is assessed individually. In order to become eligible for organ donation patients need to be at end of life and ventilated either in an Emergency Department (ED) or Intensive Care Unit (ICU). As Justice Health NSW do not have ED or ICU facilities in Long Bay Hospital, conversations regarding organ and tissue donation will occur in external hospitals, led by the Designated Officer of that institution, if a patient is at the end of their life and is ventilated in either ED or ICU.

9.7 Emergency treatment

In circumstances where treatment is necessary as a matter of urgency, a treating clinician or health may provide medical treatment without consent (from either the patient or the person responsible). This may occur when a patient's condition suddenly deteriorates and his or her wishes or likelihood of recovery are unknown. This treatment may be to:

- save the patient's life,
- prevent serious damage to the patient's health; or,

- to alleviate significant pain or distress, except in cases of special medical treatment.

Special medical treatment is treatment requiring additional consent or approval pursuant to legislation.

This treatment should be no more than is reasonably required in the best interests of the patient. This does not apply, however, if the patient, when competent, has unequivocally refused the provision of such treatment in the applicable circumstances and the clinician is satisfied on the available evidence that such a direction has been made.

This emergency principle also applies to children and young people if the treatment is required urgently to save the life or prevent serious damage to the health of the child or young person.

Any treatment provided without consent in an emergency must be documented in the patient's Health Record.

More information on consent is available from the NSW Health *Consent to Medical and Healthcare Treatment Manual* (Consent Manual)

For further information on diagnostics overshadowing, appropriate use of analgesia and sedation and artificial hydration and nutrition refer to NSW Health Policy Guideline GL2021_004 *End of Life Care and Decision-Making*.

10. Related Documents

Legislations	*Voluntary Assisted Dying Act 2022* *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* *Mental Health Act 2007*
Justice Health NSW Policies, Guidelines and Procedures	1.170 *Mandatory Notification for Life Limiting Illness and Permanent Disability*
Justice Health NSW Forms	
NSW Health Policy Directives and Guidelines	PD2014_030 *Using Resuscitation Plans in End of Life Decisions* GL2021_004 *End of Life Care and Decision-Making*
Other documents and resources	NSW Health *Making an Advance Care Directive* NSW Health *Consent to Medical and Healthcare Treatment Manual* NSW Health *End of Life and Palliative Care Framework 2019-2024*

NSW Health Resuscitation Plan – Adult (SMR020.056)

Corrective Services NSW *13.2 Medical Emergencies*

Appendix 1 – Resources and Contacts

NSW Ministry of Health

Information on access procedures to Advance Care Planning and/or Advance Care Directives on My Health Records www.health.nsw.gov.au/patients/acp/Pages/access-procedures-mhr.aspx

Information on Advance Care Planning for people with mental illness: a comprehensive guide www.health.nsw.gov.au/patients/acp/Pages/comprehensive-guide.aspx

Information on the Introduction to Advance Care Planning www.heti.nsw.gov.au/education-and-training/courses-and-programs

NSW End of Life and Palliative Care Framework 2019-2024 www.health.nsw.gov.au/palliativecare/Publications/eol-pc-framework.pdf

Information and resources on palliative care: www.health.nsw.gov.au/palliativecare/Pages/easy-read-resources.aspx

Information on Supporting Health Professionals in Advance Care Planning and End of Life (SHAPE) Conversations www.heti.nsw.gov.au/education-and-training/courses-and-programs

Information on informed consent requirements NSW Health Consent to Medical and Healthcare Treatment Manual www.health.nsw.gov.au/policies/manuals/Pages/consent-manual.aspx

NSW Health Care Interpreting Services www.health.nsw.gov.au/multicultural/Pages/health-care-interpreting-andtranslating-services.aspx

Further information can be downloaded through NSW Health website www.health.nsw.gov.au/pubs

Other websites

NSW Planning Ahead Tools https://planningaheadtools.com.au/

Clinical Excellence Commission's End of Life Program www.cec.health.nsw.gov.au/keep-patients-safe/end-of-life-care

The AMBER Care Bundle www.cec.health.nsw.gov.au/keep-patients-safe/end-of-life-care/amber-care

Last Days of Life www.cec.health.nsw.gov.au/keep-patients-safe/end-of-life-care/last-days-of-life

Agency for Clinical Innovation's Palliative Care Network https://aci.health.nsw.gov.au/networks/palliative-care

Information on Palliative Care Standards and Guidelines: www.pallcare.org.au/publications/index

Information on capacity and the Capacity Toolkit: www.justice.nsw.gov.au/diversityservices/Pages/divserv/ds_capacity_tool/ds_capacity_tool.aspx

Information about Guardianship and the NSW Trustee and Guardian www.tag.nsw.gov.au/guardianship

Information on guardianship and the role of the Guardianship Division of the NSW Civil and Administrative Tribunal www.ncat.nsw.gov.au/ncat/how-ncat-works/ncat-divisions-and-appealpanel/guardianship- division.html

Fact sheet on consent to medical treatment, and Fact sheet on person responsible https://ncat.nsw.gov.au/ncat/publications-and-resources/fact-sheets/guardianshipdivision- fact-sheets.html#Consent3