

Prompts for End-of-Life Planning (PELP) Framework

Quality care in the last 12 months of life

TRIGGER: Would you be surprised if this person were to die in the next 12 months?

Applicable to **ALL** care settings to encourage culturally safe and person-centred care

CLINICAL PROCESSES

Advance care planning (ACP) and person-centred care based on need

Transition focus of care needs from restorative to palliative

Terminal care needs

After-death care

PROGNOSIS

At risk of dying
<12 months; timing uncertain

Likely to die soon
medium term; timing uncertain

Dying
short term, likely hours, days, or week; timing uncertain

Bereavement

PROMPTS

- Acknowledge importance of individual needs, including lifestyle factors, and prognostic uncertainty
- If not already commenced, begin **ACP**
 - » Discuss end-of-life options and limitations of treatments
 - » Suggest completion of ACP documents including noting substitute decision-maker
- Consider ongoing disease-modifying treatments and a palliative approach
- Consider mentioning voluntary assisted dying for eligible patients, if jurisdictionally appropriate* and within scope of practice
- Review medicines and deprescribe if appropriate
- Monitor for indicators of deteriorating health
- Explore availability of carers
- Coordinate care across all services including respite care

- Review ACP and person-centred goal setting
- Prepare **person-centred medical goals of treatment plan** and document
 - » Include ceilings of medical treatments if acute deterioration
- Coordinate care across all services
 - » Establish GP as team leader, if available
 - » Include palliative care team members, as required
 - » Consider respite care
- Review medicines, consider
 - » Deprescribing
 - » Anticipatory prescribing
- Provide a palliative approach
- Explore bereavement needs of person and carers

- Review ACP and person-centred medical goals of treatment documents
- Prepare **terminal care management plan** for preferred place of death
 - » Provide interventions for symptom control including non-pharmacological strategies
 - » Consider anticipatory prescribing and deprescribing
 - » Ensure culturally appropriate care and spiritual, individual and carer needs are met
- Document the **plan** and share with carers and after-hours providers
- Provide checklist for immediate after-death care
- Consider bereavement care for all

- If required
 - » Arrange bereavement care for all significant others
 - » Refer to support services
 - » Ensure team members have access to peer support, debriefing and counselling

CLINICAL IMPROVEMENT

CLINICAL DETERIORATION



SCAN CODE FOR
LINKS TO OTHER
RESOURCES

caringathomeproject.com.au

*Specific requirements for voluntary assisted dying vary between each state and territory. Healthcare services should familiarise themselves with the [legislation in their jurisdiction](#) and ensure patients and their families have access to appropriate information.

Adapted from: 1. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: Essential elements for safe and high-quality end of life care. Sydney (AU) ACSQHC; 2023.
2. Alfred Health. End of Life Care Management Guideline. Melbourne (AU) Alfred Health; 2015. Prompt Doc No: AHG0068908 v10.1.
3. Reymond L, Cooper K, Parker D, Chapman M. End-of-life care: Proactive clinical management of older Australians in the community. AFP. 2016 Jan-Feb; 45(1): 76-8.

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Definitions

Advance care planning	The process of preparing for likely scenarios near the end of life that usually includes assessment of, and discussion about, a person's understanding of their medical condition and prognosis, values, preferences and personal and family resources. Advance care planning supports a person in communicating their wishes about their end of life. ¹
Carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail and aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation or caring as part of a training or education program. ¹
Family	The family is defined as the people identified by the person as family. This may include people who are biologically related, however it may not. People who joined the family through marriage or other relationships, such as kinship, as well as the chosen family, street family for those experiencing homelessness, and friends (including pets) may be identified by the person as family. ¹
Goals of care	Goals of care are what a patient wants to achieve during an episode of care, within the context of their clinical situation. Goals may be clinical and personal and are determined in the context of a shared decision-making process. Identifying goals of care helps to organise and prioritise care activities and contributes to improved satisfaction, quality-of-life and self-efficacy for patients. ²
Palliative approach	An approach to treatment that improves the quality of life of patients and their families facing life-limiting illness, through the prevention and relief of suffering. It involves early identification, and impeccable assessment and treatment of pain and other problems (physical, psychosocial and spiritual). ³
Substitute decision-maker	Substitute decision-maker(s) are people appointed or identified by law to make substitute decisions on behalf of a person whose decision-making capacity is impaired. Substitute decision-maker(s) have legal authority to make decisions about health, medical, residential and other personal matters (but not financial or legal decisions); the relevant legislation varies between jurisdictions (states and territories). More than one substitute decision-maker may be appointed. ¹
Voluntary assisted dying	<p>Voluntary assisted dying (VAD) refers to the assistance provided to a person by a health practitioner to end their life. It includes:</p> <ul style="list-style-type: none"> • 'self-administration', where the person takes the VAD medication themselves and • 'practitioner administration', where the person is given the medication by a doctor (or in some Australian States, a nurse practitioner or registered nurse). <p>'Voluntary' indicates that the practice is a voluntary choice of the person, and that they are competent (have capacity) to decide to access VAD.⁴</p>

Sources: 1. Palliative Care Australia. National Palliative Care Standards for Specialist Palliative Care Providers. 5.1 ed. Canberra (AU) PCA; 2024.
 2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. 2nd ed. Sydney (AU) ACSQHC; 2021.
 3. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: Essential elements for safe and high-quality end of life care. Sydney (AU) ACSQHC; 2023.
 4. End of Life Law in Australia: Voluntary Assisted Dying (Internet). Queensland: QUT; 2023 (Cited 2024 June 7). Available from: <https://end-of-life.qut.edu.au/assisteddying>.