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

PROGNOSIS

PROMPTS

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

At risk of dying <12 months; timing uncertain

- · 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

Likely to die soon medium term; timing uncertain

- 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

Dying

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

- · 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

Bereavement

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



SCAN CODE FOR LINKS TO OTHER RESOURCES

caringathomeproject.com.au

CLINICAL IMPROVEMENT

CLINICAL DETERIORATION

*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.

