

Audit tool: End-of-Life Planning

Purpose

The purpose of this audit is to support quality improvement in caring for patients likely to be in their last year of life.

Background

Contents of the tool are based upon the clinical processes outlined in the [Prompts for End-of-Life Planning \(PELP\) Framework](#).

The PELP Framework was developed by caring@home, with funding from the Australian Government, in association with the Australian College of Nurse Practitioners (ACNP), Australia New Zealand Society of Palliative Medicine (ANZSPM), Blue Care – Queensland, Brisbane South Primary Health Network (BSPHN), Northern Territory Primary Health Network (NTPHN), Palliative Care Australia (PCA), Rural Doctors Association South Australia (RDASA) and The Royal Australian College of General Practitioners (RACGP).

Mapping of prompts to relevant standards

The questions in the tool have been mapped to:

- RACGP Standards for General Practice ⁽¹⁾
- Key Australian end-of-life care standards/guidelines for quality end-of-life care. ⁽²⁻⁵⁾

Continuing professional development (CPD) for general practitioners

This audit has an associated, free CPD Activity available from Medcast:

[The End-of-Life planning mini audit](#).

This practical, reflective learning CPD activity is designed to support general practitioners (GPs) in delivering best practice care to patients approaching the end of life. It prompts GPs to respond to structured questions about three patients, reflect on their findings and identify improvements to their current practice.

This course is formally accredited with RACGP and the Australian College of Rural and Remote Medicine (ACRRM).

If you belong to another CPD home, you can log the completed activity yourself.



¹The Royal Australian College of General Practitioners. Standards for General Practice. RACGP; 2023.

²Australian Commission of Safety and Quality in Health Care. National Consensus Statement: Essential elements for safe and high-quality end-of life care. Sydney: ACSQHC; 2015.

³Australian Government Department of Health and Aged Care. Aged Care Quality Standards. Canberra: DHAC; 2023.

⁴Australian Government Department of Health and Aged Care. National framework for advance care planning documents. Canberra: DHAC; 2023.

⁵Palliative Care Australia. National Palliative Care Standards for All Health Professionals and Aged Care Services. Canberra: PCA; 2022.

Considerations

Trigger

- 1 Documented triggers to introduce/continue end-of-life planning. (For example: SPICT/Surprise Question/ 75+ Health Assessment).
Yes / No
- 2 Primary condition/s.
Malignant / Non-malignant / Multi-morbidity

Clinical Process 1: Advance care planning (ACP) and person-centred care based on need

- 3 Documented evidence of advance care planning invitations/conversations about end-of-life care.
Yes / No
- 4 Documented evidence of discussion about / identification of substitute decision maker/s.
Yes / No
- 5 Documented evidence of a care plan considering:
- Possible end-of-life treatment options including:
 - Ongoing disease-modifying treatment options
 - A palliative approach
 - Mention of voluntary assisted dying for eligible patients, if jurisdictionally appropriate and within scope of practice.
 - Medicines review and deprescribing if appropriate
 - Monitoring for indicators of deteriorating health
 - Availability of carer/s
 - Coordination of care across all services including respite care.
- Yes / No

Clinical Process 2: Transition of focus of care needs from restorative to palliative

- 6 Documented evidence of medical goals of treatment plan aligned with the person's advance care planning goals including:
- Ceilings of medical treatment in case of acute deterioration
 - Discussion about person's preferred place of death (including undecided).
- Yes / No
- 7 If the person has/had complex needs, was a Specialist Palliative Care Service contacted?
Yes / No / Not needed in this case

Clinical Process 3: Terminal care needs

- 8 Documented evidence of a terminal care plan considering:
- Interventions for symptom control – pharmacological and non-pharmacological strategies
 - Anticipatory prescribing and deprescribing
 - Culturally appropriate care and spiritual, individual and carer needs.
- Yes / No
- 9 Is/was a Not For Resuscitation order completed and easily available?
Yes / No
- 10 Documented evidence of education to family and carer/s about processes after death.
Yes / No

Clinical Process 4: After-death care

- 11 Evidence that bereavement and emotional care is/was considered for all (person and their significant others).
Yes / No