

## **What is the purpose of the Palliative Care Plan?**

The [NDIS LWB 5574 Palliative Care Plan](#), associated resources and processes are designed to meet LWB's responsibility to support a person as their life ends and ensure they are at the centre of planning their support for that process.

The Palliative Care Plan must be completed in consultation with the person's treating doctor, palliative care health professionals and other important people in their life. The Palliative Care Plan directs support to be provided to keep the person comfortable and supported as they die and includes information about health and medical support needs such as pain management and physical support.

## **What are the resources associated with the Palliative Care Plan?**

The Palliative Care Plan is also associated with the person's [NDIS LWB 5571 End of Life Care Plan](#) and Health and Wellbeing Plan. The Palliative Care Plan should be completed with an understanding of [LWB's Person Centred Practice Approach](#).

## **How do I complete the Palliative Care Plan?**

The Palliative Care Plan is to be completed by the person's treating doctor or health professionals responsible for directing the person's Palliative Care and with staff who know the person well. Certain areas of the plan are required to be completed by the treating health professional and require signoff and contact details of the health professional.

Remaining areas are to be completed by staff who know the person well in consultation with the person we support and family / carers / people who are important to them and also know them well.

## **What do I do with the completed Palliative Care Plan?**

Once the Palliative Care Plan has been completed, a copy is to be provided to the person we support (if they desire) and also saved in their CIRT record. Further, a copy of the Palliative Care Plan (and any other associated plans) is to be made available for support workers to ensure they understand the person's support requirements and how to provide them. A copy of the Palliative Care Plan can be provided to family members / key decision maker with the person's consent. All associated plans must be saved in the person's CIRT record.

LWB seeks to apply ethical principles and best practice standards for substitute decision making. Accordingly, no LWB staff member will act as an authorised decision-maker for any person they support. LWB staff will support decision making by focusing on resources and

support that enables a flexible approach to enhance the person's choice and control by strengthening opportunities for a person to be part of a collaborative network of relationships that influence how and what decisions will be made.

## Where are completed forms and documents saved in CIRTS?

The Palliative Care Plan must be saved in the person's CIRTS record as follows: <Plans and Assessments><Add New Plan><Service Type><Plan Name – Palliative Care Plan / DNR>

## When should the Palliative Care Plan be reviewed?

The treating doctor will provide the relevant review date for the Palliative Care Plan. Review of the person's palliative care needs will be overseen by the treating doctor and palliative care team involved.

## How to complete the Palliative Care Plan

Personal Details					
Name:			Date of Birth:		CIRTS ID
Address:					
Does the person identify as Aboriginal and/or Torres Strait Islander?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Palliative Planning Meeting:		Plan review date:
Key Decision Maker	Name:				
	Address:				Phone:
	email:				
Relationship:	<input type="checkbox"/> Person Responsible <input type="checkbox"/> Appointed Guardian <input type="checkbox"/> Other: (describe): _____				

### **Personal Details -**

**Purpose:** Identify the person's personal details and their Key Decision maker.

**Document:** Engagement Form

**Related Section:** Client Information

Diagnosis & medical information (to be completed by a Health Professional(s))			
Diagnosis:			
Co-morbidities:			
Date of diagnosis of current illness:		Prognosis / life expectancy:	
Current medical treatments:			
Proposed treatments and procedures:			
Name of treating Doctor(s):		Name of doctor:	
Address:		Address:	
Phone:		Phone:	
Has the person been informed of their illness? (this is the responsibility of the treating doctor)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:	
If yes, does the person understand their condition/prognosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:	
Does the person's Key Decision Maker understand the person is dying?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:	
Commencement Date of this Plan:		Comment:	
Other plans to be read in conjunction with this plan? E.g. Health Care Plan, Epilepsy Mgmt Plan, End of Life Care Plan			

Area of Support	Details / Action required	Comments (e.g. date required, priority, who responsible)
Pain Management		
Food and Fluids		
Skin Care		
Mouth Care		
Eye Care		
Bladder Care		

Bowel Care		
Positioning		
Oxygen Therapy		
Environment		
Emotional / psychological support		
Spiritual / Cultural needs		
Equipment and/or additional staff required		
Other Support:		

### Diagnosis & medical information

**Note:** this section is to be completed by the **Health Professional**.

**Purpose:** The Health Professional responsible for directing Palliative Care for the person documents their diagnosis, prognosis and what treatment will be given.

The Health Professional also documents the communication they have had with the person and their Key Decision Maker.

**Consultation:** The Health Professional will consult with the person and family/carers/people who are important to them and know them well when determining treatment options.

### Palliative Care Support

**Note:** this section is to be completed by a **Health Professional**

**Purpose:** Provides details of action required by staff to support the person with each area of care as their life ends.

**Consultation:** The Health Professional will consult with the person and family/carers/people in their support network when determining treatment options.

Resuscitation – (to be completed by Health Professional(s))					
Does the person wish to be resuscitated?	<input type="checkbox"/> No⇒ <input type="checkbox"/> Yes⇒	Details:			
What resuscitation interventions <b>should be</b> given to the person?					
What resuscitation interventions <b>should not be</b> given to the person?	<i>[Treating Medical Practitioner to confirm based on the person's circumstances that further medical treatment would be futile or unreasonably burdensome]</i>				
What to do in the event of unconsciousness, imminent or actual death (e.g. is CPR to be commenced? call palliative care nurse etc.)					
Commencement Date of Resuscitation Plan:		Note: from this date forward the person should not be resuscitated via CPR.			
To be completed by the person or their Authorised Decision Maker	Name:		Signature:		
Consent for the withdrawal of resuscitation interventions:	Relationship:		Contact No.		Date:

### Resuscitation

**Note:** this section is to be completed by a **Health Professional** and signed by the **person's Key Decision Maker**.

**Purpose:** Area where the Health Professional in consultation with the person and Key decision maker identifies what resuscitation measures should or shouldn't be provided to the person.

**Consultation:** The Health Professional(s) will consult with the person and their family/carers/ support network and when determining resuscitation options.

### Development of the Plan

All Health Professionals involved in the development of the Palliative Care Plan sign, date and provide their contact details in case the person, their family or staff need to make contact.

Palliative Care Health Professionals involved in the development of this plan				
Name	Profession	Signature	Date	Contact No.

Support Planning – to be completed with LWB Staff who know the person well		
Area of Support	Details / Action required	Comments (e.g. date required, priority, person responsible)
Family support		
Social support		
Preferred place of care in advanced stage of illness (e.g. home, hospice or hospital)		
Spiritual/ Religious/ Cultural		
Communication with the person about changes in their health		
Communication with others about the illness e.g. friends, day program		
Support for other people in our services		

Support Planning (continued) – to be completed with LWB Staff who know the person well		
Area of Support	Details / Action required	Comments (e.g. date required, priority, person responsible)
Facilitate request for legal assistance (e.g. request to complete a Will)		
Facilitate request for religious care (e.g. Last Rites)		
After death – (who to notify)		
Reportable Death <sup>2</sup>	Call LWB management & Police immediately to report the person's death.	See Reference at bottom of page for more information.
Funeral service (what are the persons' and family's wishes?) Also refer to End of Life Care Plan		

Response to the need for medical / health care assistance (complete where applicable)	
Call the doctor when:	Name of Doctor: Phone number:
Call the nurse when:	Name of Nurse: Phone number:
Call the hospital / ward when:	Name of hospital / ward: Phone number:
Call the ambulance when:	<b>CALL 000 for ambulance</b>
Call the family when:	Name of family member: Phone number:
Call the key decision maker when:	Name of key decision maker: Phone number:

### Support Planning

To be completed with the person by staff who know the person well.

**Purpose:** To identify support requirements including Religious / spiritual care, whether the person needs legal assistance, or religious care and who to notify when the person dies.

**Consult** with the person we support, their Key decision maker and Health Professional(s).

### Response to the need for medical / health care assistance

**Purpose:** To identify at what point to call the Doctor, nurse, hospital ward, ambulance, family and key decision maker and includes contact details for staff to use.

**Persons involved in planning meeting (Non- Health Professionals)**

Name:		Relationship to person		Signature		Date	
Name:		Relationship to person		Signature		Date	
Name:		Relationship to person		Signature		Date	
Name:		Relationship to person		Signature		Date	
Name:		Relationship to person		Signature		Date	
Name:		Relationship to person		Signature		Date	

**Persons involved in planning meeting -**

**Purpose:** to record all people involved in developing the Palliative Care Plan – Health Professional sign previous section.

**Approvals and consent**

I have reviewed this Palliative Care Plan and give approval for staff to implement the strategies detailed here in order to assist in the management of care.

Name	Relationship To Person	Signature	Date
	The person		
	Key Decision Maker		
	Line Manager		
	Operations Manager		

**Approvals and Consent**

**Purpose:** to record consent from the person (if they are able to sign), the person's Key Decision Maker and LWB Line Management.

**LWB Staff Declaration (All staff who work with this person to sign)**

I have read and understood this Palliative Care Plan and agree to implement it accordingly and as directed by my Line Manager.

Name		Signature & Date		Name		Signature & Date	
Name		Signature & Date		Name		Signature & Date	
Name		Signature & Date		Name		Signature & Date	
Name		Signature & Date		Name		Signature & Date	
Name		Signature & Date		Name		Signature & Date	
Name		Signature & Date		Name		Signature & Date	

**LWB Staff Declaration**

**Purpose:** All staff who work with the person must read the Palliative Care Plan and sign the LWB Staff Declaration to indicate they have read the plan, understand it and agree to implement it accordingly.

**CIRTS**

Once all staff have signed, the plan must be uploaded into the person's CIRTS Record.