NDIS LWB 5574 Palliative Care Plan

This Palliative Care Plan documents the medical and health support requirements for a person supported by Life Without Barriers (LWB) who is receiving palliative care. The plan must be written in partnership with a health professional and reviewed every 3 months or as relevant to the decline in the person's health. This plan should be read in conjunction with the person's End of Life Care Plan[1] (if they have developed one).

<table>
<tr><th colspan="6">Personal Details</th></tr>
<tr><td>Name:</td><td colspan="2"></td><td>Date of Birth:</td><td></td><td rowspan="5"></td></tr>
<tr><td>Address:</td><td colspan="2"></td><td>CIRTS ID:</td><td></td></tr>
<tr><td colspan="4">Does the person identify as Aboriginal and/or Torres Strait Islander?</td><td>☐Yes ☐ No</td></tr>
<tr><td colspan="4">Does the person have an Advance Care Directive in place?
*if yes, this must be referred to during the Palliative Care Planning process</td><td>☐Yes ☐ No</td></tr>
<tr><td colspan="2">Plan creation date:</td><td></td><td>Plan Review Date:</td><td></td></tr>
<tr><td rowspan="3">Authorised Decision Maker:
☐ Person Responsible
☐ Appointed Guardian
☐ Other:</td><td>Name:</td><td colspan="3"></td></tr>
<tr><td>Address:</td><td colspan="2"></td><td>Phone:</td><td></td></tr>
<tr><td>Email:</td><td colspan="4"></td></tr>
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[1] The End of Life Care Plan documents the person's preferences for how the person would like to be supported as their life ends and includes information such as who they would like with them, who to contact and funeral arrangements.

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)	☐Yes ☐ No	**Comment:**	
If yes, does the person understand their condition/prognosis?	☐Yes ☐ No	**Comment:**	

Does the person's Key Decision Maker understand the person is dying?	☐Yes ☐ 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			

Palliative Care Support – (to be completed by Health Professional(s))		
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:		

Resuscitation – (to be completed by Health Professional(s))							
Does the person wish to be resuscitated?	☐No⇨ ☐Yes⇨	**Details:**					
What resuscitation interventions **should be** given to the person?							
What resuscitation interventions **should not be** given to the person?	*[Treating Medical Practitioner to confirm based on the person's circumstances that further medical treatment would be futile or unreasonably burdensome]*						
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:**		

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 in consultation with person's Support Network.		
Area of Support	**Details / Action required**	**Comments (e.g. date required, priority, person responsible)**
Family support		
Social support		
Spiritual/ Religious/ Cultural		
Preferred place of care in advanced stage of illness (e.g.home, hospice, hospital)		

Support Planning – to be completed with LWB staff in consultation with person's Support Network.		
Area of Support	**Details / Action required**	**Comments (e.g. date required, priority, person responsible)**
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		
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[2]	***Call LWB management & Police immediately to report the person's death.***	*See Reference at bottom of page and refer to LWB Client Death Review Process LWB Intranet – Client Death*

– 2 **Reportable deaths:** The death of a person within LWB is a reportable death. Under the *Coroner's Act 2009,* the police must be notified. The deceased person should not be moved or changed until permission is given by the police. A police officer or doctor is responsible for reporting the death to the coroner. The coroner will determine if an autopsy or inquest is to be conducted. The funeral service and burial/cremation may be delayed. It is necessary for LWB staff to comply with these legal requirements and the person's family must be advised of these requirements when they are notified of the person's death.

Support Planning – to be completed with LWB staff in consultation with person's Support Network.		
Area of Support	**Details / Action required**	**Comments (e.g. date required, priority, person responsible)**
Funeral service (what are the persons' and family's wishes?) *Also refer to End of Life Care Plan*		

Response to need for medical / health care assistance (Health Professional to 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:	**CALL 000 for ambulance**
Call the family when:	Name of family member: Phone number:
Call the key decision maker when:	Name of key decision maker: Phone number:

Persons involved in planning meeting (Non- Health Professionals)			
Name:	**Relationship to person**	**Signature**	**Date**

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		

Upload to CIRTS as follows: Plans & Assessments> Add New Plan> Palliative Care Plan/DNR >Add Attachment> SURNAME FirstName YYYY.MM.DD.

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	
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