Coordinating Patient Care Toolkit

end-of-life ESSENTIALS®
education for acute hospitals

CHECKLIST

- [ ] When patients are being admitted, transferred, or discharged, it is important that you don't assume that someone else is managing important conversations or recognising dying. Who coordinates these aspects of care in your workplace?

- [ ] Next time you have a patient in your care who is approaching the end of life, check that they are still happy with their care plan. Ensure they have been able to express their wishes and goals and that these are clearly documented.

- [ ] Have you considered a family meeting to ensure that care is coordinated, and the patient's family are also involved? The Palliative Care Network of Wisconsin resources provide guidance on running a family meeting to discuss end-of-life care goals.

- [ ] Does the patient have an advance care plan in place? Check on admission and make sure this is transferred with the patient.

- [ ] If you have a patient who is to be discharged, have communication pathways been established with healthcare professionals who will take over the care (e.g., hospice or residential aged care facility)? Does the GP know they are being discharged? Are you aware of community services and resources to refer your patients and their families to, such as specialist palliative care services, or bereavement support?

HELPFUL LINKS

- End of Life Directions for Aged Care (ELDAC). 2025. ELDAC Toolkits
- palliAGED. 2025. Care Coordination
- Palliative Care Network of Wisconsin. 2019. Emergency Department Management of Hospice Patients

VIDEOS, BLOGS, PODCASTS

- End-of-Life Essentials Blog. 2025. End-of-Life Conversations: Lessons from Experts
- Palliative Care Australia. 2025. Discussing Choices – Indigenous Advance Care Plans
- Social Care Institute for Excellence (SCIE). 2014. Why it is essential to coordinate care

FURTHER READING

- Agerholm J, Jensen NK, Liljas A. Healthcare professionals' perception of barriers and facilitators for care coordination of older adults with complex care needs being discharged from hospital: A qualitative comparative study of two Nordic capitals. BMC Geriatr. 2023;23(1):32. doi:10.1186/s12877-023-03754-z
- Killackey T, Lovrics E, Saunders S, Isenberg SR. Palliative care transitions from acute care to community-based care: A qualitative systematic review of the experiences and perspectives of health care providers. Palliat Med. 2020 Dec;34(10):1316-1331. doi: 10.1177/0269216320947601
- Lennox A, Wright B, Bragge P. 2019. How can we improve the decision to transfer patients from regional or rural hospitals? Briefing Document. Jan 2019. Melbourne, Australia: BehaviourWorks Australia, Monash University. ISSN: 2208-5165

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