



Australasian College
for Emergency Medicine

End of life and palliative care in the emergency department

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Document Review

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Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	July-2016	Approved by Council
V2	May-2020	Definitions expanded. Changes made to content under the Policy heading – Screening Tools. Overall streamlining of content and clearer Policy, and Procedure and Actions statements. Two new references and links to related documents and resources added.
V3	July 2025	Minor updates and revision of headings

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1. Purpose

This policy aims to promote discussion and awareness of end-of-life care (EoLC), ensuring emergency department (ED) staff have the skills and confidence to deliver high-quality care. It also outlines ED systems and processes for recognising and providing appropriate care to patients nearing the end of life (EoL).

2. Scope

This policy applies to all Australian and New Zealand EDs. It pertains to the treatment of adults at the EoL, recognising the important role emergency medicine and EDs have in the continuum of EoLC within the diverse communities that they serve.

3. Definitions

Advance Care Directive (Aust) and Advance Directive (NZ)

A legal document that states a person's preferences for treatment and care when they are unable to express their wishes. An Advance Care Directive (ACD) or Advance Directive (AD) also enables a person to appoint a substitute decision-maker. More than one substitute decision maker may be appointed under an ACD (depending on the jurisdiction). ACD and AD documentation differs between jurisdictions – information on jurisdictional requirements is found [here](#) for Australia and [here](#) for New Zealand.^{1,2}

Advance care planning

Involves planning for future health decisions in the event that a person may not be able to express or have capacity to determine their goals and wishes regarding their treatment and care. Advance care planning can involve preparing an Advance Care Directive, an Advance Care Plan or Statement of Choices and appointing a substitute decision maker.²

End of life (EoL)

End of life (EOL) refers to the stage when a patient is living with and significantly impaired by a terminal illness or a progressive chronic condition. This stage includes people where any of the following apply:^{3,4}

- Death is imminent (expected within hours or days).
- Advanced, progressive, incurable conditions.
- Advanced frailty and co-existing conditions that mean that they are expected to die within 12 months.
- Existing conditions, if they are at risk of dying from a sudden acute crisis in their condition.
- Life-threatening acute conditions caused by sudden catastrophic events.

End of life care (EoLC)

End of life care (EoLC) includes physical, emotional, spiritual and psychosocial assessment, care and treatment delivered by health professionals and ancillary staff. It also includes support of families/whānau and carers, and care of the patient's body after their death.^{3,4}

Existential distress

A form of suffering that may be experienced at any stage of life but is often experienced by those approaching end of life. This may be characterised by feelings of hopelessness, loss of purpose or dignity, being a burden, or a desire for death. It relates to deeper questions about meaning, identity, and one's place in the world, significantly affecting emotional and psychological wellbeing during serious illness or impending death.⁵

¹ Health New Zealand Te Whatu Ora. *Advance care planning – A guide for the New Zealand health care workforce*. Wellington, New Zealand. 2021.

² Australian Government Department of Health. *National Framework for advance care planning document*. May 2021.

³ General Medical Council. *Treatment and care towards the end of life: good practice in decision making*. London (UK): GMC. 2010.

⁴ Australian Commission on Safety and Quality in Health Care. *National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care*. Sydney: ACSQHC; 2015.

⁵ Caresearch. *Clinical evidence summaries – Suffering*. 2024.

Frailty

A 'condition or syndrome that results from a multisystem reduction in reserve capacity to the extent that a number of physiological systems are close to, or past, the threshold of symptomatic clinical failure. As a consequence, the person with frailty is at increased risk of disability and death from minor external stresses.'

Non-beneficial treatment

Non-beneficial treatments are interventions that will not be effective in treating a patient's medical condition or improving their quality of life (QoL). Non-beneficial treatment may, in individuals approaching end of life and their unique contexts, include interventions such as diagnostic tests, medications, artificial hydration and nutrition, intensive care, and medical or surgical procedures. Non-beneficial treatment has sometimes been referred to as futile treatment, but this is not a preferred term.^{4,6}

Palliative care

Palliative care is an approach that improves the quality of life of patients and their families/whānau at end of life. It seeks to relieve suffering through the early identification, correct assessment and treatment of distressing symptoms and other issues, whether physical, psychosocial or spiritual.⁷

Substitute decision maker

A substitute decision maker is a person appointed or identified by law (in some but not all jurisdictions) to make decisions on behalf of a person whose decision-making capacity is impaired. Substitute decision makers have legal authority to make these decisions; however the relevant legislation varies between jurisdictions (states and territories and countries). An Advance Care Directive or an Advance Directive can appoint a substitute decision maker, and more than one substitute decision maker may be appointed.

Supported decision making

An approach where individuals are assisted and empowered to contribute to their own healthcare decisions. It recognises each person's right to express their preferences, exercise autonomy, and actively contribute to decisions affecting their medical care, ensuring that appropriate support is provided to help them understand options and outcomes relevant to their emergency care.

Total pain

A holistic concept in palliative care encompassing physical, emotional, psychological, social, and spiritual suffering. In emergency medicine, recognising total pain involves assessing not only physical symptoms but also distress arising from emotional anguish, social isolation, or existential concerns, ensuring comprehensive care that addresses all dimensions of patient suffering during critical episodes or at end-of-life.^{7,8}

4. Introduction

Palliative care grew out of oncology and the care of patients with incurable cancer. However, in both Australia and Aotearoa New Zealand, there are rising rates of chronic medical conditions, multimorbidity, chronic diseases and cognitive impairment. The changing demographic, and the increase in prevalence of chronic diseases, have resulted in growth in the demand for EoL and palliative care services, as well as increasing palliative-care related hospitalisations.⁸

The number of EoLC associated ED presentations has increased, despite evidence that EoLC or palliative interventions are more beneficial for the patient if they are begun earlier in the primary health care sector.^{2,6} The ED has therefore become a location where discussions about selecting medical treatment that aligns to goals of care, EoLC plans are discussed and initiated, or where EoLC plans are implemented.^{9,10}

⁶ Health New Zealand Te Whatu Ora. *The New Zealand Palliative care strategy*. 2001.

⁷ World Health Organization (WHO). *Palliative Care*. 2018.

⁸ Australian Institute of Health and Welfare. *Palliative care services in Australia, Summary*. 2024.

⁹ Sweeney AL, Alsaba N, Grealish L, May K, Huang YL, Ranse J, Denny KJ, Lukin B, Broadbent A, Burrows E, Ranse K, Sunny L, Khatri M, Crilly J. End-of-life care: A retrospective cohort study of older people who died within 48 hours of presenting to the emergency department. *Emergency Medicine Australasia*. 2023 Nov 1;36(1):1-11

¹⁰ Arendts G, Carpenter C R, Hullick C, Burkett E, Nagaraj G, Rogers IR. Approach to death in the older emergency department patient. *Emergency Medicine Australasia*. 2016; 28: 730-734.

5. Policy

5.1 Identification of Patients Progressing to EoL

ACEM supports actions that rapidly identify patients at EoL and act on patients' wishes about their EoLC. This may help avoid non-beneficial treatment.^{11,12}

The following recommendations are made:

- Senior clinical input is advisable in identifying the patient who is progressing to EoL. Identifying such patients is complex but essential. Tools to assist in identifying patients at EoL and initiatives to improve quality of life (QoL) are covered in the next section.
- Emergency clinicians should engage in dialogue with patients identified as being on an EoL trajectory to establish the goals of care. This conversation should include carers, families/whānau, substitute decision makers, and other involved health care professionals.
- Emergency clinicians should liaise closely with the patient's primary care providers and usual specialists to ensure appropriate transition of care and transfer of information.
- Emergency physicians and ED staff should be given training and resources to provide each patient with individual goal-focussed EoLC. This includes referral to specialist palliative care services and personnel as and when required.
- Health facilities should prioritise providing appropriate space to accommodate dying patients.

5.2 Tools to Identify a Patient at EoL and Enhance Quality of Life

Emergency physicians will have experience in identifying the patient who is imminently dying (hours to days). Identification of patients who are at high risk of dying during their hospital stay or within 3-12-month period is more complex, and available tools perform modestly in an ED setting.

5.2.1 Screening Tools

The following screening tools may assist in identifying a patient progressing to or at EoL, noting that these tools are not designed specifically for the ED context:

- **Criteria for Screening and Triaging to Appropriate Alternative Care (CrisTAL)**

The CrisTAL tool is designed to predict short-term mortality risk in older people presenting to EDs, guiding decisions about appropriate care pathways.¹³ The complexity of data collection could limit quick bedside utility.

- **Supportive and Palliative Care Indicators (SPICT)**

The SPICT can assist in identifying patients at risk of deteriorating and dying in all care settings.¹⁴ This tool also provides indicators which clinicians can use to identify when it may be appropriate to initiate EoLC discussions with patients and their families/whānau or carers, or substitute decision maker. However, there is limited validation study data of the use of SPICT in the ED.

- **Clinical Frailty Scale (CFS)**

The Clinical Frailty Scale (CFS) may assist in identifying patients who would benefit from advance care planning discussions.¹⁵ Assessment of patient's pre-morbid functional state (typically defined as baseline health status two weeks prior to ED presentation) using the CFS (or other validated frailty tool) is useful in identifying those who are most frail and at risk of deterioration. Frailty is dynamic and people may transition across levels of frailty. The CFS is a tool that assesses frailty on a scale of 1 (very fit) to 9 (terminally ill) and more significant degrees of frailty are associated with

¹¹ O'Connor A, Winch S, Lukin W, Parker M. Emergency medicine and futile care: Taking the road less travelled. *Emergency Medicine Australasia*. 2011; 23: 640-643.

¹² End of life direction for aged care. *Futile or non-beneficial treatment*. 2024.

¹³ Cardona M, et al. Predictive validity of the CrisTAL tool for short-term mortality in older people presenting at Emergency Departments: a prospective study. *European Geriatric Medicine*. 2018;9:891-901.

¹⁴ Bourmorck D, de Saint-Hubert M, Desmedt M, Piers R, Flament J, De Brauwier I. SPICT as a predictive tool for risk of 1-year degradation and death in older people admitted to the emergency department: a bicentric study in Belgium. *BMC Palliative Care*. 2023 Dec 1;22(1)

¹⁵ Elliott A, Taub N, Banerjee J, Arjaz F, Jones W, Teece L et al. Does the Clinical Frailty Scale at Triage predict outcomes from emergency care in older people? *Annals of Emergency Medicine*. 2021 June 1;77(6):620-7

a CFS of 6-9. This can give the emergency physician some confidence in initiating goals of care discussions with the patient their families/whānau or carers or substitute decision maker.¹⁴

- **‘The Surprise Question’**

If the emergency physician asks themselves “Would I be surprised if the patient died in the next 6-12 months?” and the answer is “no”, they may need to reassess the patient’s situation and needs. This may lead to the start of conversations about goals of care and limitations of intervention that can be continued by the patient’s primary care provider or hospital inpatient services. Unfortunately, using this tool alone has performed poorly to modestly especially in on-cancer patients.¹⁶ Used alone as a screening tool cannot currently be recommended.¹⁷ However, it may be useful when used in conjunction with an assessment of frailty and physician gestalt.

5.2.2 Standards

ACEM supports high-level standards and processes that can improve patient outcomes through enhanced QoL at the EoL within the community and the ED. ACEM endorses the following standards and processes:

- **Australian National Safety and Quality Health Service (NSQHS) Standards**

The Australian Commission on Safety and Quality in Health Care (ACSQHC) states that delivering high-quality EoLC is part of the Comprehensive Care Standard.¹⁸ There are key actions (Action 5.15-5.20) relating to: identifying a patient at EoL; clinician access to specialist palliative care advice; access to Advance Care Plans and documenting them in patient records; supervision and support for the workforce in delivering EoL care; regularly reviewing EoL care provided; and ensuring that patients, carers and families are involved in shared decision making at EoL. These standards are underpinned and guided by the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.⁴

- **Australian National Consensus Statement: Essential elements for safe and high-quality EoL care**

This document was developed by the ACSQHC and intends to inform physicians and other healthcare professionals of recommended practices in the provision of EoLC.⁴ ACEM considers that all hospitals or health organisations involved in the provision of EoL or palliative services should utilise the National Consensus Statement as a guiding document in the development of their own standards or practices. This Consensus Statement should also be used alongside the National Consensus Statement: essential elements for recognising and responding to clinical deterioration.¹⁹

- **Te Ara Whakapiri: principles and guidance for the last days of life**

This document, developed by the New Zealand Ministry of Health (MoH), is intended to offer guiding principles and components for the care of adults at the EoL.²⁰ The principles offer guidance on EoLC in all settings, including the home, residential aged care facilities, hospitals and hospices. ACEM considers that Te Ara Whakapiri should be viewed as a crucial document in guiding a holistic approach to EoLC that respectfully involves patients, carers, whānau, and medical practitioners in the EoLC planning process. Te Tahu Hauru: Health Quality & Safety Commission of New Zealand outlines culturally sensitive approaches to EoLC.¹⁹

- **Indigenous Programme of Experience in Palliative Care (IPEPA)**

IPEPA have published a guideline for clinicians on cultural considerations for Aboriginal and Torres Strait Islander peoples at EoL.²¹ It is important to consider the diversity of cultural and spiritual beliefs regarding EoL amongst Aboriginal and Torres Strait Islander peoples and asking questions in a culturally appropriate manner to understand the wishes of a patient and their family. This resource offers practical advice regarding language use and communication styles to provide culturally safe EoLC. It also details questions to ask the patient and family to understand their EoL wishes and the importance of engaging an Aboriginal Health Worker or Aboriginal Liaison Officer

¹⁶ Gupta A, Burgess R, Drozd M, Gierula J, Witte K, Straw S. The Surprise Question and clinician-predicted prognosis: a systematic review and meta-analysis. *BMJ Support Palliative Care*. 2024 June 26;0:1-14

¹⁷ Glick J, Gallo MB, Chelluri J, Courtright J. Utility of the “Surprise Question” in Critically Ill Emergency Department Patients. *Annals of Emergency Medicine*. 2018 Oct; 72(4): Suppl S68

¹⁸ Australian Commission on Safety and Quality in Health Care. *Comprehensive Care Standard*. 2019.

¹⁹ Australian Commission on Safety and Quality in Healthcare. *National consensus statement: Essential elements for recognising and responding to acute physiological deterioration*.

²⁰ Ministry of Health (NZ). *Te Ara Whakapiri: Principles and Guidance for the Last Days of Life*. 2017.

²¹ Indigenous Program of Experience in the Palliative Approach. *Cultural considerations: providing end of life care for Aboriginal peoples and Torres Strait Islander peoples*. 2017.

(if available) in their EoLC.

5.3 Advance Care Planning

Advance care planning, as well as a well-documented Advance Care Directive (ACD) or Advance Directive (AD), can reduce rates of non-beneficial treatment and associated hospitalisations. Advance care planning can also allow patients to remain and be cared for in their home, residential aged care facility, or other preferred location.^{1,2}

ACEM recognises that EDs are part of a patient's continuum of care. ACEM advocates that General Practitioners (GPs) or treating specialist have, and are adequately remunerated for, discussions with their patients about advance care planning and their preferences for treatment of a terminal or chronic condition and EoLC. Emergency physicians can assist this process by ensuring relevant EoLC information is conveyed to the patient's GP and usual specialists after an ED attendance. ACEM will work with other relevant stakeholders to enhance community perceptions of advance care planning as a beneficial health-seeking behaviour that facilitates the delivery of person-centred and goal-concordant care.

5.4 Availability of Advance Care Directive or Advance Directives in EDs

ACEM advocates for existing Advance Care Directives (ACD) or Advance Directives (AD) to be made easily available to ED staff, as well as other health service providers, through a centralised electronic system.^{1,2} The centralisation of such information could ensure that physicians and patients can work together for a common understanding of the goals of care.

ACEM considers that standardised formatting and language of ACDs and ADs across all jurisdictions should be considered to assist health services in the provision of quality EoLC according to the wishes of the patient. Standardised approaches using online platforms can assist in the easy access of ACD and AD documents in EDs. ACDs and ADs should also be underpinned by best practice standards and in accordance with relevant legislation^{1,2,4}

5.5 Shift in Terminology for EoLC

ACEM supports a shift in commonly used terminology to promote a holistic and compassionate understanding of EoLC processes. For example, in place of the terms 'do not resuscitate' (DNR) or 'not-for-resuscitation' (NFR), ACEM endorses the use of the term 'allow natural death' or 'allow natural processes'. Other terms such as 'goals of care' and 'limitations of medical treatment' are also recommended to facilitate discussions.

ACEM encourages physicians to improve their skill in using terminology that promotes sharing of prognostic information, eliciting decision-making preferences, understanding fears and goals, and patients' wishes for family involvement.²²

5.6 Emergency Physician Training Role

ACEM recognises that emergency physicians have an important role in training and coaching of emergency medicine trainees in EoL decision making and discussions.

5.7 People Living with Dementia

ACEM recognises the specific EoLC needs of people living with dementia. Additional communication support for people living with dementia and their families/whānau is a key priority in the National Consensus Statement.⁴ This includes recognising responsive behaviours in dementia that may represent EoL.

5.8 Location of Death

ACEM recognises that the location of death is a key indicator of quality EoLC. It is ACEM's view that EDs are not the optimal place for EoLC to occur in many situations. ACEM advocates for improved community palliative care services. Patients presenting to ED at EoL should be provided with all opportunities to proceed with their EoLC in the location of their expressed preference.⁴ This could include hospital, hospice, home or residential aged care facility. This must be done in a manner that ensures that all aspects of quality EoLC can be achieved, and pathways of care and referral are prioritised. This also recognises that preferences for location of EoLC may change throughout a person's end of life journey.

²² ACP Decisions. *The goals-of-care conversations: a best practice, step-by-step approach*. 2021.

Close liaison with primary care or specialist palliative care clinicians if already involved with care, is a necessary component of quality EoLC.

6. Procedures and Actions

6.1 Health Service Support

ACEM advocates for health services to provide emergency physicians and EDs with the necessary resources and training to facilitate provision of quality EoLC.

6.2 ED Staff Competencies

ED staff should be competent in the following aspects of EoLC:

- Sensitive initiation of conversations with patients and their families regarding palliation and EoLC in the context of existing advance care plans and/or goals of care using appropriate terminology promoting a holistic and compassionate understanding of EoLC processes.
- Routinely enquiring about and locating existing advance care plans when caring for a patient at risk of being EoL.
- In the absence of existing advance care plans to sensitively assist patients, and/or their substitute decision makers, to explore the persons' goals, preferences and values in order to guide appropriate treatments in the ED.
- To have an understanding of the organisations that can assist patients to formally document their advance care plans. This includes understanding the legal and ethical implications of advance care planning.
- Recognising and respecting cultural, spiritual, and religious differences among individuals in advance care planning and EoLC, and engaging relevant specialist support services (e.g., cultural liaison officers, or spiritual care providers) when required.
- Adjusting treatment plans based on the expressed goals of care, including sharing information and uncertainty around future care with the patient and their family/whānau.²¹
- Recognising patients approaching end-of-life, including where there are repeated presentations with signs of progressive decline, such as reduced oral intake, functional deterioration, or increasing frailty.⁹
- Providing best possible symptom management in EoL and palliative crises that meet the patient's needs.⁸ Having a comprehensive understanding of the term 'total pain' as a more integrated view of suffering at EoL and how this can be addressed.^{7,8} Actively engaging the continuity care provider for palliative care to avoid future crisis presentations.
- Understanding the local law (relevant state and/or country legislation) and guiding principles of substitute decision making and obtaining information and direction from substitute decision makers when required.^{23,24,24}
- Navigating and managing conflict around goals of care and advance care planning, and knowledge of the relevant mediation services and strategies.
- Providing psychosocial and bereavement support, and knowledge of relevant referral services for patients or their family/whānau or carers.

7. Related documents

- *P51 Care of Older Persons in the Emergency Department*
- *P34 Policy on Organ and Tissue Donation*

²³ Tō tatou reo. *Advance care planning*. 2024.

²⁴ Advance care Planning Australia. *Create your plan*. 2024.

²⁴ End of Life Law for Clinicians. *Palliative Care Education*. 2025.

8. Related links

- [Advance Care Planning Australia](#)
- [Advance Care Planning New Zealand](#)
- [End of Life Directions for Aged Care](#)
- [End of Life Law in Australia](#)

9. References

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