



TOOLKIT 16 · LONG-TERM CARE · TOOL 5 OF 6

End-of-Life Care Plan and Family Conversation Record

What matters to the person, what they want and do not want, who speaks for them, and the comfort plan — written while it can still be a conversation

How to begin. "Some people like to think ahead about the care they would want if they became very unwell. Would you like to talk about that, now or another time?" — The resident leads. Nothing is decided in one sitting. Family present if the resident wishes.

Resident · date · present at the conversation · capacity assessed ☐	
What matters most to me (in my words)	
Where I would prefer to be cared for at the end of life: here ☐ hospital ☐ home ☐ — and why	
If my heart or breathing stopped: attempt resuscitation ☐ / allow a natural death ☐ (doctor's order attached ☐)	
Transfer to hospital: yes, for treatable problems ☐ / only for comfort that cannot be given here ☐ / no ☐	
Treatments I do not want (e.g. feeding tube, ventilator, dialysis) · treatments I do want	
Who speaks for me if I cannot (name, relationship, phone) · legal document ☐	
Spiritual, religious and cultural wishes; who to call; rituals	
After death: who to contact first; any wishes	

Comfort plan for the last days

Need	Plan
Pain and breathlessness	Anticipatory medicines prescribed and available ☐ (opioid, anti-secretory, anti-emetic, sedative) · assessed 4-hourly
Mouth, skin, position	Mouth care 2-hourly; repositioning for comfort not schedule; pressure care
Food and fluids	Offered, never forced; family told this is normal
Company	Family may stay; a staff member checks hourly if alone; chaplain / faith leader as wished
Review	Doctor reviews daily; plan updated; family updated daily

Adapted from NHS "ReSPECT" and advance care planning guidance (OGL). Where national law provides a form for advance decisions, attach it.

ASF standards: LTC Standard 8 — end-of-life care (means of verification: plans in records, anticipatory prescribing); Standard 1