BALLARAT HOSPICE CARE INC.
Home Based Palliative Care

Comprehensive Palliative Care in Residential Aged Care Project[1]

Support and evidence map to Outcome 5.7 of the Strengthened Aged Care Quality and Safety Standards

The Comprehensive Palliative Care in Residential Aged Care Project supports residential aged care providers to strengthen the delivery of comprehensive palliative care to improve the quality of life and death for all residents. To achieve this, the project focusses on strengthening systems to support the provision of high quality palliative and end-of-life care. The priorities include:

1. Implementation of facility tailored recommendations to strengthen systems guiding and supporting the delivery of high quality comprehensive palliative care with a focus on implementing a systematic approach to identifying and responding to palliative care and end-of-life care needs
2. Strengthening workforce capability
3. Engaging the wider care team (GPs and specialist palliative care clinicians).

Our work is designed with awareness of the regulatory environment and standards. It provides evidence to

- National Safety and Quality Health Service (NSQHS) Standards 2nd Edition - Comprehensive Care Standard[2]
- National Palliative Care (NPC) Standards for All Health Professionals and Aged Care Services (2022)[3]
- Strengthened Aged Care Quality Standards (Outcome 5.7) coming into effect on November 1st, 2025[4].

The project specifically supports facilities in meeting the **Strengthened Aged Care Quality Standards – Outcome 5.7: Palliative Care and End-of-Life Care**. The following table outlines how this is achieved and provides examples of evidence that can demonstrate compliance.[5]

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[1] This project is a collaboration between Ballarat Hospice Care (funding recipient and project lead), Grampians Region Palliative Care Consortium and Grampians Regional Palliative Care Team (Grampians Health). It is funded by the Australian Department of Health and Aged Care, and Victorian Department of Health; Comprehensive Palliative Care in Aged Care Measure (2018). Project duration: 2023-25.

[2] Australian Commission on Safety and Quality in Health Care (2017). National Safety and Quality Health Service Standards. Second edition. Web: https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf. Accessed on 15/07/2024.

[3] Palliative Care Australia (2022). National Palliative Care Standards for All Health Professionals and Aged Care Services. First edition. Web: https://palliativecare.org.au/publication/national-palliative-care-standards-for-all-health-professionals-and-aged-care-services. Accessed on 25/08/2025.

[4] Australian Government Aged Care Quality and Safety Commission (n.y.): Strengthened Quality Standards. Web: https://www.agedcarequality.gov.au/sites/default/files/media/strengthened-quality-standards-provider-guidance.pdf. Accessed on 30/01/2025.

[5] ***Disclaimer: This program was developed independently and is provided as a resource only. While it has been designed to align with sector standards, it has not been reviewed, approved, or endorsed by the Aged Care Quality and Safety Commission. Responsibility for implementation and compliance with all applicable standards and regulatory requirements rests with the organisation.***

Actions	How our program supports these actions	Evidence (suggestions)
5.7.1 The provider has processes to recognise when the individual requires palliative care or is approaching the end of their life, supports them to prepare for the end-of-life and responds to their changing needs and preferences.	• Systematic approach to identifying deterioration and responding to palliative care needs; palliative care assessment is administered routinely at defined trigger points (on admission, integrated in Resident of the Day review or equivalent, upon return from hospital), as deterioration is noticed at any other time, and as requested by residents or families. • Tools: · PACOP (Palliative Aged Care Outcomes Program) Deteriorating Resident Tool (DRT) (Attachment 1) · Facility process map (flowchart guiding assessment and follow up actions) (Attachment 4)	• Project implementation audit tool *(Attachment 7)* • *ELDAC After Death audit tool and tracker (Attachments 8 and 9)* • *Consumer feedback, complements and complaints* • *Transfers out to hospital*
5.7.2 The provider supports the individual, supporters of the individual and other persons supporting the individuals and substitute decision maker, to: 1. Continue end-of-life planning conversations; 2. Discuss requesting or declining aspects of personal care, life-prolonging treatment and responding to reversible acute conditions; 3. Review advance care planning documents to align with their current needs, goals and preferences.	• Systematic approach supports early identification of palliative care needs with measurable information allowing · Timely conversations about preferences and wishes, goals of care and advance care planning; · Prediction of further deterioration. • Provision of resources to support staff to facilitate these conversations (Attachment 5; resources #2,3,4,5,6,7,8,9,10,11) • Provision of resources to support families and friends to have these conversations (Attachment 6, resources #1,2,3,5,6) • Support the nomination or assignment of a palliative care champion or portfolio within the facility. Champions are invited to attend education sessions (e.g. Aged Care Study Day) and receive regular updates on training, resources, and relevant information. • Ongoing education of staff through · Highlighting training opportunities; · Invitation to participate in Aged Care Palliative Care Community of Practice facilitated bi-monthly by Grampians Region Palliative Care Consortium.	• *ELDAC After Death audit tool and tracker (Attachments 7 and 8)* • *Transfers out to hospital number and trend data* • *% of completed advance care plans* • *Defined goals of care documented and current* • *Relevant resources included in admission pack* • *Relevant resources accessible for families in common areas* • *Staff education records*
5.7.3 The provider uses its processes from comprehensive care to plan and deliver palliative care that: a. Prioritises the comfort and dignity of the individual b. Supports the individual's spiritual, cultural and psychosocial needs c. Identifies and manages changes in pain and symptoms	• (a.), (b.), (c.) Process and tools: · PACOP Daily Symptom Assessment Scale (Daily SAS) (Attachment 2) · Problem Severity Score (included in Attachment 1) · Facility process map (flowchart guiding assessment and follow up actions) (Attachment 4) (d.) Prompted by the process map, anticipatory medications are charted and stock confirmed, and availability of required specialist equipment is confirmed	• Project implementation audit tool *(Attachment 7)* • *ELDAC After Death audit tool and tracker (Attachments 8 and 9)* • *Facility palliative care policy/procedure*

	d. Provides timely access to specialist equipment and medicines for pain and symptom management e. Communicates information about the individual's preferences for palliative care and the place where they wish to receive this care to aged care workers, supporters of individuals and other persons supporting individuals f. Facilitates access to specialist palliative care and end-of-life health professionals when required g. Provides a suitable environment for palliative care h. Provides information about the process when an individual is dying and about loss and bereavement to supporters of individuals and other persons supporting individuals.	• (e.) Prompted by the process map, the advance care plan remains relevant and current throughout the continuum of care and is communicated across the care team • (f.) Prompted by the process map, access to specialist palliative care is supported where appropriate • (e.) Use of PACOP DRT and Daily SAS provide a shared language within the in internal and external care team (General Practitioners and Specialist Palliative Care clinicians) ensure an evidence based approach to pain and other symptom management • (b.), (g.) Continuous advance care planning conversations result in identifying and facilitating where possible the resident's preferences regarding the palliative care environment • (h.) Provision of resources to support families and friends (Attachment 6) • (h.) Promotion of supports for staff (Attachment 5)	
5.7.4	The provider implements processes in the last days of life to: a. Recognise that the individual is in the last days of life and respond to rapidly changing needs b. Ensure medicines to manage pain and symptoms, including anticipatory medicines, are prescribed, administered, reviewed and available 24-hours a day c. Provide pressure care, oral care, eye care and bowel and bladder care d. Recognise and respond to delirium e. Minimise unnecessary transfer to hospital, where this is in line with the individual's preferences.	• (a.) The systematic approach supports recognition of the last days of life; Tool: *Early Warning Tool*, *Stop and Watch tool*, *SPCIT tool* or other acute assessment complimented by PACOP DRT (Attachment 1) • (b.) The systematic approach and process map in particular support charting of anticipatory medication where appropriate; *IMPREST system in place* • (d.), (e.) The systematic approach and process map in particular support unnecessary transfer to hospital through · Early identification of palliative care needs and symptoms (PACOP DRT), and symptom monitoring (Daily SAS) (Attachment 2) · Continuous advance care planning conversations and communication of preferences · Identification of available external supports	• Project implementation audit tool *(Attachment 7)* • *ELDAC After Death audit tool and tracker (Attachments 8 and 9)* • *End of life care plan audit (Attachments 9 and 10)*

Attachments:

Attachment 1 PACOP Deteriorating Resident Tool (DRT)
Attachment 2 PACOP Daily Symptom Assessment Scale (Daily SAS)
Attachment 3 CPCiAC tools training checklist
Attachment 4 Facility process map (flowchart guiding assessment and follow up actions)
Attachment 5 Resource order list – staff
Attachment 6 Resource order list – residents, families and carers
Attachment 7 Project implementation audit tool (CPCiAC systematic approach audit)
Attachment 8 ELDAC After Death audit tool
Attachment 9 ELDAC After Death audit tracker
Attachment 10 CPCiAC audit tool for QLD Health EoLCP
Attachment 11 CPCiAC audit tool for Safer Care Victoria EoLCP