Framework for the Recognition of and Response to Deterioration in Residential Aged Care

2024

A collaboration between Ballarat Hospice Care, Grampians Region Palliative Care Consortium, Grampians Regional Palliative Care Team (Grampians Health), and Central Highlands Rural Health.

BALLARAT HOSPICE CARE INC.
Home Based Palliative Care

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[1] Full project title: Comprehensive Palliative Care in Aged Care

Abbreviations

ACD	Advance Care Directive
ACP	Advance Care Plan / Advance Care Planning
AN-ACC	Australian National Aged Care Classification
ANUM	Associate Nurse Unit Manager
AV	Ambulance Victoria
BHCI	Ballarat Hospice Care Inc.
CHRH	Central Highlands Rural Health
DRT	Deteriorating Resident Tool
ED	Emergency Department
EN	Enrolled Nurse
GH	Grampians Health
GP	General Practitioner
GRPCT	Grampians Regional Palliative Care Team
NFR	Not For Resuscitation
NP	Nurse Practitioner
NPC	National Palliative Care
NSQHS	National Safety and Quality Health Service
NUM	Nurse Unit Manager
PACOP	Palliative Aged Care Outcomes Program
PCA	Personal Care Assistant
PCAS	Palliative Care Advice Service
PPC	Preferred place of care
PPD	Preferred place of death
PSS	Problem Severity Score
RAC	Residential Aged Care
RACER	Residential Aged Care Enhanced Response
RN	Registered Nurse
SAS	Symptom Assessment Scale
UCC	Urgent Care Centre
VVED	Victorian Virtual Emergency Department

1 Introduction

As Australia's ageing population grows and the utilization of aged care services rises, there's a heightened demand for palliative care within this sector. Nearly one-third of individuals in residential aged care will die within their first year of admission, with death being the primary reason for discontinuing such care. Consequently, acknowledging palliative care as an integral aspect of residential aged care is crucial. Adequate systems, funding, and training must support aged care providers and their staff in delivering high-quality palliative care (16).

The Final Report of the Royal Commission into Aged Care Quality and Safety (2021) highlights that not all seniors in aged care access the evidence-based end of life care they require. To address this issue, comprehensive palliative care needs to be an inherent part of aged care services. Ensuring the provision of high-quality palliative care within aged care homes will enhance quality of life and end of life experiences for older Australians, offer better support to their families and unpaid caregivers, as well as residential aged care staff throughout the dying process and bereavement, and facilitate more effective allocation of limited health resources.

A foundational aspect of delivering palliative care involves the capacity and opportunity to engage in informed and compassionate conversations about death and dying with elderly individuals and their families. Recognizing cultural aspects related to death and dying is also essential in tailoring care to individuals and overcoming obstacles to accessing palliative care.

Palliative care is a universal human right; it is explicitly recognised under the human right to health. It should be provided through person-centred and integrated health services that pay special attention to the specific needs and preferences of individuals. It is imperative to ensure equitable access.

While many older people have predictable needs that can be met by aged care staff in conjunction with the person's usual primary health practitioners, some older people will develop more complex needs and will require support through specialist palliative care services. Aged care staff need to be able to identify when specialist palliative care is required and know how to access such specialist care. The ongoing assessment and timely identification of palliative care needs is critical to ensure the provision of appropriate palliative care. Optimal palliative care depends on a coordinated approach with frameworks for engagement between aged care and specialist palliative care services (17).

The provision of high-quality palliative care requires a person-centred and holistic approach that is not solely focused on dying and the last weeks of life in order to meet the needs of older Australians who are approaching the end of their lives.

The specific details in this framework apply to residential aged care services and residents in the Grampians region (for more information on the Grampians region please visit Grampians Region Palliative Care Consortium website www.grampianspalliativecare.com.au). Many of the principles and tools outlined in this framework still apply to those outside of this area, but specific contact details and service provision will vary. To identify the community palliative care service in your area please visit Palliative Care Victoria.

2 Purpose

This framework was developed to support the recognition of and response to deterioration. It aims to strengthen the equitable delivery of comprehensive palliative care in residential aged care homes in order to improve the quality of living and dying for all residents. It focusses on the *systematic recognition of and response to* deterioration, including

- Systematic timely identification of palliative care needs and symptoms
- Symptom assessment and management
- Ensure access to specialist palliative care for residents with complex palliative care needs
- Advance care planning including the resident's preferred place of death
- Addressing the resident's psychosocial and spiritual needs in order to achieve optimum quality of life and person-centred care for the individual.
- Provide well-coordinated shared and integrated person-centred care to patients who are at the end of life
- Support communication among internal and external clinicians, residential aged care staff, and with residents, their families and friends.

3 Scope

This framework applies to people who reside in an aged care facility (public or private).

4 Intended audience

Directors of Nursing, Nurse Unit Managers, Associate Nurse Unit Managers, Registered Nurses, Enrolled Nurses, members of palliative care committees in residential aged care homes.

5 Application

Implementation of this framework is recommended, not mandated. It may need to be tailored to

- Suit individual settings, the needs of particular populations, and available resources
- Align with relevant national and state legislation or other programs
- Work in synergy with local guidelines and processes, including for recognizing and responding to acute clinical deterioration.

6 Guiding frameworks and principles

6.1 Frameworks

This framework is written to align with and in commitment to the

- National Palliative Care Strategy (10)
- National Consensus Statement - Essential Elements for safe and high-quality end-of-life care (11)
- Victorian End of Life framework (2).

It realises and implements these frameworks on a local level.

6.2 Principles

6.2.1 Improving the quality of life for residents in aged care towards the end of life[2]

Improving the quality of life for residents in aged care towards the end of life is the key principle underlying this framework. Palliative care is defined as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated (5). Based on the above, seven elements are critical to translating the aim of improving the quality of life for residents in aged care towards the end of life into practice:

1. **Early identification of palliative care needs**
   a. In order to identify palliative care needs early, assessments need to be completed regularly. A systematic approach is required, where assessments are completed at defined trigger points.
   b. As deterioration can occur between regular assessments, all residential aged care staff who observe deterioration need to have the confidence to raise their concerns and request a palliative care assessment. This request needs to be followed up on by an appropriate clinical staff member.

[2] People are 'approaching the end of life', i.e. are appropriate for palliative care when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few days or hours) and those with:
   a. Advanced, progressive and incurable conditions
   b. General frailty and co-existing conditions that mean that they are expected to die within 12 months
   c. Existing conditions, if they are at risk of dying from a sudden acute crisis in their condition
   d. Life-threatening acute conditions caused by sudden catastrophic events. (1)

2. **Impeccable assessment**

   A comprehensive palliative care needs assessment requires specialist palliative care needs assessment tools, which clearly indicate whether a resident does or does not have palliative care needs.

3. **Taking a holistic approach**

   a. Physical symptoms as well as psychosocial and spiritual needs and problems are taken into consideration and are responded to.

   b. The needs of the family and carers are also taken into consideration.

4. **Relief of suffering through the treatment of symptoms and issues**

   a. Assessment outcomes need to be followed up with appropriate reviews and development of care plans which provide clear guidance to ensure symptoms are managed well.

   b. Relevant health professionals are involved in the care for a resident (GP, Allied Health, spiritual support, counselling).

   c. Residents with complex palliative care needs have access to specialist palliative care.

   d. Symptoms management is addressed timely depending on their severity.

5. **Prevention of suffering: As deterioration can be unpredictable, anticipatory planning is critical, particularly as the resident approaches the end of their life.**

6. **Team approach**

   a. Communication (verbal and written) within the residential aged care team, and between residential aged care staff and internal and external healthcare professionals needs to be effective and efficient.

   b. Relationships are strong and teamwork is promoted to ensure timely response to identified palliative care needs and the provision of safe, optimal resident care.

   c. Enable collaboration and shared decision making between the resident, family, residential aged care staff, and other clinicians (including the GP and specialist palliative care clinician)

   d. Minimisation of professional hierarchy to enable all care staff to contribute their specific knowledge to achieve person-centred, individualised and relationship focused comprehensive palliative and end of life care.

7. **Recognising and supporting resident, carer and family preferences where possible**

   a. For patients identified as approaching or at the end of life, discussions about wishes and preferences are important and need to be encouraged.

   b. These conversations need to involve a resident's family/carers/support person with the resident's consent.

c. Communication between residential aged care staff and the resident as well as their family and carers need to be open, honest, effective and efficient.

d. As preferences and choices can change, they need to be reviewed as the patient's condition or circumstances change.

e. Resident conversations and preferences need to be documented within a resident's record in order to communicate the resident's wishes and preferences and make them easily accessible to other health professionals.

These elements are represented throughout the framework elements.

6.2.2 Palliative Care Australia guiding principles for palliative and end of life care in residential aged care

This framework further adopts the Palliative Care Australia guiding principles for palliative and end of life care in residential aged care[3] (14):

1. **Consumers (aged care residents) physical and mental needs at end-of-life are assessed and recognised**
   a. End-of-life care should be recognised as part of the normal scope of practice of residential aged care, acknowledging that aged care facilities are home for many people at the end-of-life.
   b. All care is consumer and family centred and directed.
   c. The end-of-life needs of residents of aged care services are assessed, documented and regularly reviewed.
   d. The stages of life-limiting conditions are recognised, with end-of-life care needs acknowledged as requiring a palliative approach.
   e. Changes in consumer health status are recognised and changing needs documented and met.
   f. The mental health needs of consumers are assessed, documented and met including treatment for anxiety or depression if required.

2. **Consumers, families and carers are involved in end-of-life planning and decision making**
   a. Consumers, families and carers are kept regularly informed of the stages of the life-limiting condition and treatment options and supported through treatment decisions if circumstances change.
   b. Consumers, families and carers are supported to develop and regularly review advance care plans, particularly if circumstances change.
   c. Consumers are supported to regularly discuss and understand the implications of treatment options and different end-of-life care choices, with their needs and wishes documented.

[3] The Palliative Care Australia Guiding Principles for palliative and end of life care in residential aged care draw upon the 2015 National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care developed by the Australian Commission on Safety and Quality in Health Care (1).

d. Consumers, families and carers are supported to change advance care plans or treatment decisions if circumstances change. Consumers, families and carers understand their right to request or decline life-prolonging care.
e. Consumers understand that unless required by law, doctors are not obliged to initiate or continue treatments that will not offer a reasonable hope or benefit or improve the patient's quality of life.[4]
f. Where appropriate, substitute decision makers are identified and actively involved in discussing the consumer's needs and wishes.

3. **Consumers receive equitable and timely access to appropriate end-of-life care within aged care facilities**
   a. Consumers are able to access appropriate palliative care support, regardless of income, background, diagnosis, prognosis or geographic location.
   b. Consumers receive adequate and timely pain and symptom management.
   c. Consumers and staff have access to appropriate equipment to support end-of-life care and manage symptoms.

4. **End-of-life care is holistic, integrated and delivered by appropriately trained and skilled staff**
   a. End-of-life care is considered a core competency for aged care workers.
   b. End-of-life care is delivered by appropriately trained and skilled staff and teams.
   c. All staff with a caring role are trained and supported to recognise when end-of-life care is required and a consumer's needs have changed.
   d. Residential aged care services are adequately resourced to deliver and/or support the delivery of end-of-life care. This includes access to specialised equipment and materials.
   e. Staff actively develop and document care plans and a care leader is identified to ensure care is appropriate, in accordance with the consumer and family wishes, coordinated and holistic.
   f. All residential aged care services have access to specialist palliative care support when required. We recognise that this is a particular challenge for rural and remote locations.
   g. The roles of all those involved in end-of-life care are recognised, respected and supported, including specialist palliative care, general practitioners, primary health care, pharmacists, nurses, care staff, support and services staff, volunteers and those providing social and spiritual support.
   h. Staff in residential aged care services are appropriately supported in caring for consumers with life-limiting conditions.
   i. Transfers to other services are based on necessity or consumer/carer choice, with care plans shared.

5. **The end-of-life care needs of consumers with dementia or cognitive impairment are understood and met within residential aged care**

[4] National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care, Sydney, ACSQHC, 2015, p.5.

a. Dementia is recognised as a terminal illness.
b. Where possible, staff will encourage and support end-of-life care planning and decision-making with early involvement of the consumer, family and carers at the time of a dementia diagnosis.
c. Residential aged care services will provide appropriate care to consumers with behavioural and psychological symptoms of dementia or cognitive impairment, ensuring all appropriate services including end-of-life care are identified, documented and accessed.
d. Substitute decision makers are actively involved in discussing the consumer needs and wishes.

6. Consumers, families and carers are treated with dignity and respect

a. Consumers are treated with dignity and respect throughout end-of-life care, including after death.
b. Consumers, families and carers have their need for privacy respected, including after death.
c. Families, carers and friends are supported to spend as much time with a loved one as they wish, including after death.
d. Intimate care needs are attended to regularly and with respect to the consumer and their family and carers.
e. Consumer possessions are appropriately cared for and returned to family (or as directed by the consumer) in a timely manner after death.

7. Consumers have their spiritual, cultural and psychosocial needs respected and fulfilled

a. Residential aged care services respect diversity and provide end-of-life care that meet the needs of consumers, including those from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander peoples and people who identify as lesbian, gay, bisexual, transsexual or intersex.
b. Spirituality, defined as 'the way we seek and express meaning and purpose; the way we experience our connection to the moment, self, others, our world and the significant or sacred'6 is discussed with consumers and families, and consumers and families are supported in having those needs met.
c. Cultural needs are discussed with consumers and families, and consumers and families are supported in having their needs met.
d. In alignment with the values of the Compassionate Communities movement, consumers, families and carers are supported in identifying and maintaining caring networks.
e. Consumers are offered support to document key aspects of their lives, to reflect their contributions and chart a 'life story'.
f. As far as is practical, consumers are encouraged to identify and fulfil last wishes and goals.

8. Families, carers, staff and residents are supported in bereavement

a. Families and carers are supported to care for and/or stay with, a loved one after death.

b. Spiritual and cultural needs following death are understood and respected and families and carers supported in undertaking death and grief related practices and rituals.
c. Families and carers are offered support in grief and grieving, or referred to appropriate support services.
d. Staff and other residents of aged care services are appropriately supported in loss and grief.

Palliative and end-of-life care delivered in accordance with these principles will help older Australians in residential aged care to live the remainder of their lives to the fullest with dignity and in comfort and to have the best death possible. It will also support families and carers in caring for their loved one and during the bereavement period and support staff to deliver the best care possible (14).

7 Standards

This framework is designed with awareness of the regulatory environment and standards. The primary standards were cross matched as presented in the appendix.

This framework provides evidence to

- Strengthened Aged Care Quality Standards (2025)
- National Palliative Care (NPC) Standards for All Health Professionals and Aged Care Services (2022).

8 About this Framework

8.1 Vision

Deterioration in aged care residents is recognised in a timely manner. Symptoms are assessed regularly and well managed. Residents with complex needs have access to specialist palliative care clinicians for consultation. Communication among the care team (residential aged care internal and with external health professionals) and with the resident, their family and unpaid carers is effective and efficient. Advance Care Planning takes place, resulting in person-centred care including care preferences being known and met.

8.2 Mission

To support residential aged care services and their staff to deliver comprehensive palliative care to their residents to ensure optimum quality of life by systematically assessing their residents for deterioration and responding timely and appropriately to any identified needs. This framework offers a model, tools, and processes to achieve this.

8.3 Value statement

The efforts are focused on achieving the best quality of life for all aged care residents, ensuring equitable, appropriate, holistic, well-coordinated and integrated shared person-centred care.

8.4 Objectives

For residents, their families and carers

Residents to live their best life possible through early identification of, and timely and adequate response to deterioration. This includes:

- Identification and appropriate response to any symptom management needs and in a timely manner and at an early stage in order to enable the provision of comprehensive palliative care focussing on the enhancement of quality of life
- Supporting residents with complex needs to access specialist palliative care
- Avoiding ED presentation and hospital admission where possible and appropriate
- Advance Care Planning to identify and meet the resident's wishes and preferences, (including preferred place of care and preferred place of death), thus ensuring the delivery of person-centred care
- Ensuring identification of end of life
- Ensuring the coordination of care with other health care professionals (GP, specialist palliative care consultant, pharmacist, allied health, social workers that may be involved in the care for a resident and their family and (unpaid) carers
- Facilitating timely, efficient and effective communication with the resident, their family and friends
- Supporting anticipatory planning (including medications)
- Making the resident, their families and friends feel safe and supported.

For residential aged care staff

Support residential aged care staff to deliver comprehensive palliative care as opposed to end of life care only under the consideration of resource limitations. This includes support to ensure the following:

- Identification of deterioration, including the need for (urgent) review by the GP or specialist palliative care clinician
- Structured, comprehensive process that guides and standardises the identification of and response to deterioration, providing assessment and communication tools, and clearly outlining escalation criteria and options
- Facilitate continuous monitoring of palliative care needs, symptoms and residents' response to care plans put in place
- Facilitate continuous collaboration and timely, effective and efficient communication between the care team (residential aged care staff, GP, specialist palliative care service, pharmacist, allied health, social worker), resulting in the delivery of well-coordinated shared care
- Facilitating timely, efficient and effective communication with the resident, their family, carers and friends
- Facilitate specialist palliative care support where symptom management is complex to achieve best outcome for the resident
- Facilitate anticipatory planning, including anticipatory prescribing of end of life medications
- Facilitate the optimal provision of resident-centred palliative care during the dying phase
- Facilitate continuous education for residential aged care staff, particularly with regard to symptom management
- Provide support for staff to support residents, their families and carers to achieve their preferences, including preferred place of care and/or death by prompting Advance Care Planning reviews and facilitating Advance Care Planning conversations
- Empower all RAC staff in direct and non-direct care roles to support the (early) identification of deterioration
- Ensure efficient use of resources.

For GPs

- Facilitate systematic identification of deteriorating residents and need for review, enabling timely response to symptom burden, thereby avoiding a potential crisis
- Facilitate collaboration and communication between the care team (residential aged care staff, specialist palliative care service, pharmacist, allied health, social worker, resulting in the delivery of well-coordinated shared care
- Build confidence in the local care team to support anticipatory planning
- Facilitate palliative care education.
- Ensure efficient use of resources.

For community health care professionals

For Specialist Palliative Care Services

- Support identification of residents with complex needs for escalation to specialist palliative care clinician
- Facilitate support to residential aged care facilities with regard to care delivery to residents with complex needs
- Facilitate sustainable mode of delivering education and training to residential aged care staff
- Ensure efficient use of resources.

8.5 Strategy

Implementation of this framework for comprehensive palliative care in residential aged care will achieve the above stated objectives. This framework was developed in response to barriers, solutions and enablers identified in the BHCI, GRPCT (GH) and CHRH CPCiAC Pilot Project. However, this framework can be applied to all residential aged care homes in the Grampians region. If adopted beyond this region, referral pathways and potentially the end of life pathway will need to be adapted to reflect local circumstances.

This framework includes the following elements:

1. A model of systematic identification of and response to palliative care needs
2. Clinical, administration and communication tools and processes to operationalise this model:
    - An assessment tool for the identification of palliative needs (PACOP Deteriorating Resident Tool), also facilitating communication with specialist palliative care services and GPs
    - An assessment tool for monitoring symptoms (PACOP Daily SAS), also facilitating communication with specialist palliative care services and GPs
    - A tool for reviewing residents with identified palliative care needs with input from a specialist palliative care consultant (Needs Rounds)
    - A recording sheet for Needs Rounds
    - A referral pathway for specialist palliative care review with complex symptom burden
    - A communication tool to facilitate open and effective advance care planning conversations with deteriorating residents
    - A communication tool to facilitate effective and efficient handover to internal and external clinicians involved in the care for a resident
    - A comprehensive end of life care plan (Safer Care Victoria Care Plan for The Dying Person) to assist with the planning and delivery of end of life and after death care.
3. Definitions of roles and responsibilities within this model.

9 Model of care for the identification of and response to deterioration

9.1 Model for the identification of and response to deterioration

The model for recognising and responding to deterioration defines the way deterioration is identified and care is delivered by residential aged care staff, supported by the resident's GP, specialist palliative care clinicians where required, and external emergency services, aiming to collaboratively deliver optimal patient care in situ where possible. It outlines best practice care for these residents as their health declines in the last 12 months of their lives.

SYSTEMATIC IDENTIFICATION OF AND RESPONSE TO PALLIATIVE DETERIORATION

Trigger points for using PACOP Deteriorating Resident Tool (DRT) to identify deterioration

- **On admission**
- **Standard resident review process** (Resident of the day, Resident in Focus, or similar)
- **Upon return from hospital** (Emergency Department/Urgent Care Centre or hospital admission)
- **Changes in the resident observed by any staff member, complete in addition to acute assessment** e.g. after a fall, change of cognition, delirium, antibiotics, loss of appetite, loss of weight, behavioural change, ,Stop and Watch tool.
- **If requested by the resident, their family or friends**

Action: ANUM/RN/EN to complete PACOP DRT

Palliative care needs identified? → **NO**

YES

Non Dying phase: Response to palliative care needs

1. **Advise resident, their family / friends, and GP of deterioration**
2. **Depending on SAS score:**
   - ☐ **Ongoing SAS score 4-5 for pain, breathing, bowel or nausea OR SAS score 4-10 for fatigue, appetite, sleeping or other symptoms:** Request GP review
   - ☐ **Ongoing SAS score 6+** for pain, breathing problems, bowel problems or nausea: Refer to your local community palliative care service (CPCS)*;
     If GP or local CPCS are unavailable, contact:
     a. Local Palliative Care Advice Service **
     b. Local Virtual Emergency Department*** if PCAS not available
     c. 000 if VVED consult not available (identify patient as aged care resident
     In all instances: Clarify GOC prior to request for review
3. **Refer to local CPCS* if resident/family is asking for a specialist palliative care review**
4. **Document/review and revise symptom management plan(s)**

Daily SAS (0) and /or PSS (0) rating is **absent** for three continuous weeks:
- ☐ Cease Daily SAS and PSS unless triggered

'Daily SAS (1-3) and /or PSS (1) rating is **mild**:
- ☐ Monitor ***weekly*** with Daily SAS and PSS

Daily SAS (4-7) and/or PSS (2) rating is **moderate**:
- ☐ Monitor ***daily*** with Daily SAS and PSS

PACOP 'Daily SAS (8-10) and /or PSS (3) rating is **severe'**
- ☐ Monitor symptoms **frequently** as clinically indicated with Daily SAS and PSS until a reduced SAS/PSS rating is achieved

Note: Daily SAS and PSS may be used in conjunction with other pain assessment tools, e.g. PainCheck, PAINAID, Abbey Pain Scale.

6. **Review Advance Care Plan and Goals of Care**
7. **Conduct case conference (potentially with GP and/or SPCN)**
8. **Conduct family meeting**
9. **Further actions as required:**
   - ☐ Referral(s) to Allied Health
   - ☐ Access to equipment
   - ☐ New AN-ACC assessment
   - ☐ Referral for emotional and spiritual consultation
   - ☐ Anticipatory prescribing for common end of life phase symptoms

Dying phase: Response to end-of-life care needs

1. **Advise resident, family of deterioration**
2. **Advise GP of deterioration**
3. **Conduct family meeting if required**
4. **Commence Care Plan for the Dying Person** (end-of-life pathway)
5. **Check anticipatory medications are charted and in stock, and required equipment is available**
6. **Complete Daily SAS and PSS during each shift to monitor symptoms**

   => **Escalate for urgent review to GP** if **SAS score is 4-5** or **to GRPCT** if **SAS score 6+** for pain, breathing problems, bowel problems or nausea
7. **Organise emotional or spiritual consultation** if needed
8. **Offer bereavement support** for family, carers and friends (e.g. referral to internal Social Worker or provision of information on external bereavement support)

— **Actions following initial PACOP DRT assessment**

··· **Actions following Daily SAS monitoring**

Contact details and business hours:

*** Local Community Palliative Care Service: Phone: ..... Referral: ..... Hours: .....**

****Local Palliative Care Advice Service : Web .....; Phone .....; hours .....**

*****Local Virtual Emergency Department medical telehealth service; 24/7, 365 days/ year. Web: ..... Device for Telehealth**

AC PC Aged Care Palliative Care

Visit your 'Highway to Help' for easy access to resources on various topics

www.ac-pc.com.au

Abbreviations:
AN-ACC = Australian National Aged Care Classification
ANUM = Associate Nurse Unit Manager
CPCS = Community Palliative Care Service
DRT = Deteriorating Resident Tool
EN = Enrolled Nurse
GP = General Practitioner
PACOP = Palliative Aged Care Outcomes Program
PSS = Problem Severity Score
RN = Registered Nurse
SAS = Symptom Assessment Scale
SPCN = Specialist Palliative Care Nurse
VED = Virtual Emergency Department

9.2 Tools and processes to operationalise the model of care

9.2.1 Clinical Tools

9.2.1.1 Stop and Watch Tool

Stop and Watch
Early Warning Tool

INTERACT
Assisted Living
V 1.0 Tool

If you have identified an important change while caring for or visiting a resident, please **circle** the change and notify a nurse or supervisor.

S
- Seems different than usual

T
- Talks or communicates less

O
- Overall needs more help

P
- Pain – new or worsening; Moans or grimaces *(for residents with severe dementia)*, participated less in activities

a
- Ate less

n
- No bowel movement in 3 days; or diarrhea

d
- Drank less

W
- Weight change

A
- Agitated or nervous more than usual

T
- Tired, weak, confused, or drowsy

C
- Change in skin color or condition

H
- Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk resident

Name of Resident

Your Name

Observation Reported to: *Date and Time (am/pm)*

Nurse/Supervisor Response *Date and Time (am/pm)*

Nurse/Supervisor Name

This form is also intended for other residential health care facilities including those listed by the National Center for Assisted Living *(www.ahcancal.org/ncal/).*

9.2.1.2 PACOP Deteriorating Resident Tool – Identifying the need for palliative care

PACOP P

DETERIORATING RESIDENT TOOL

(affix addressograph label here)

UPI:
Surname:
First name:
DOB:
Sex:

A Health professional (RN or EN) to complete if the resident has deteriorated clinically and is not due for their routine 3 monthly Profile Assessment.

Date of assessment: __ __ / __ __ / __ __ __ __ **Time:** _____hrs

PCOC SYMPTOM ASSESSMENT SCALE (SAS) Where possible, ***ask the resident*** *to rate their symptom distress over the last 24-hours or nominate who rated the assessment. Can be completed by a registered/enrolled nurse or care worker with the resident and family wherever possible.*

Who *rated* the level of symptom distress (SAS)?
☐ Resident ☐ Family/unpaid carer ☐ Care worker ☐ Healthcare professional

LEVEL OF DISTRESS
(Select one for each symptom)

	Absent		Mild			Moderate				Severe	
	0	1	2	3	4	5	6	7	8	9	10
Distress from Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Fatigue	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Breathing Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Bowel problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Nausea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Appetite problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Difficulty Sleeping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from other Symptom *(Specify)*_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PROBLEM SEVERITY SCORE (PSS) Problems over the past 24 hours *(Select one box for each criteria)*

	Absent (0)	Mild (1)	Moderate (2)	Severe (3)
Pain	☐	☐	☐	☐
Other symptoms	☐	☐	☐	☐
Psychosocial/spiritual wellbeing	☐	☐	☐	☐
Family/Carer	☐	☐	☐	☐

AUSTRALIA MODIFIED KARNOFSKY PERFORMANCE STATUS (AKPS) *(Select one box only)*

Normal, no complaints or evidence of disease	**100**	☐
Able to carry on normal activity, minor signs of symptoms/disease	**90**	☐
Normal activity with effort, some signs or symptoms of disease	**80**	☐
Care for self, unable to carry on normal activity or to do active work	**70**	☐
Occasional assistance but is able to care for most needs	**60**	☐
Requires considerable assistance and frequent medical care	**50**	☐
In bed (chair) more than 50% of the time	**40**	☐
Almost completely bedfast (chairfast)	**30**	☐
Totally bedfast & requiring nursing care by professionals &/or family	**20**	☐
Comatose or barely rousable	**10**	☐

ROCKWOOD CLINICAL FRAILTY SCALE (RCFS) *(Select one only)*		
	☐ **1. Very Fit**	People who are **robust, active, energetic** and **motivated**. These people commonly exercise regularly. They are among the fittest for their age.
	☐ **2. Well**	People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
	☐ **3. Managing Well**	People whose **medical problems are well controlled** but are not regularly active beyond routine walking.
	☐ **4. Vulnerable**	While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.
	☐ **5. Mildly frail**	These people often have **more evident slowing**, and need **help in high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework. ***(Mild dementia usually corresponds here)***
	☐ **6. Moderately frail**	People need **help with all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cueing, standby) with dressing. ***(Moderate dementia usually corresponds here)***
	☐ **7. Severely frail**	**Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months). ***(Severe dementia usually corresponds here)***
	☐ **8. Very severely frail**	**Completely dependent**, approaching end of life. Typically, they could not recover from even a minor illness.
	☐ **9. Terminally ill**	Approaching end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Identifying the need for palliative care

YES to ANY of these statements/questions/assessments below:

☐ Yes	☐ No	Based on clinical judgement, the current assessment and all the information available to you, do you believe the resident would benefit from palliative care?
☐ Yes	☐ No	The resident and/or family is requesting palliative care
☐ Yes	☐ No	Based on clinical judgement, the current assessment and all the information available to you do you believe the resident has a prognosis of <3 months?
☐ Yes	☐ No	One or more moderate/severe symptom distress (SAS) or problem severity (PSS) score
☐ Yes	☐ No	An AKPS of 40 or less
☐ Yes	☐ No	A Rockwood Clinical Frailty Scale (RCFS) score of 8 or 9

YES to *ANY* – Resident would benefit from Palliative Care (e.g. PACOP Outcomes Collection)

NO to *ALL* – Review care plan to address deterioration & continue to monitor using PACOP Profile Collection

*Clinical assessment completed by (Name)*_____

Designation: ☐ACH Manager ☐Clinical Manager ☐ RN/EN ☐Palliative care CNC/CNS ☐Other

PROFILE COLLECTION - Deteriorating Resident Tool 230120_FINAL

9.2.1.3 PACOP Daily SAS – Monitoring symptoms

PACOP palliative aged care outcomes program

OUTCOMES COLLECTION

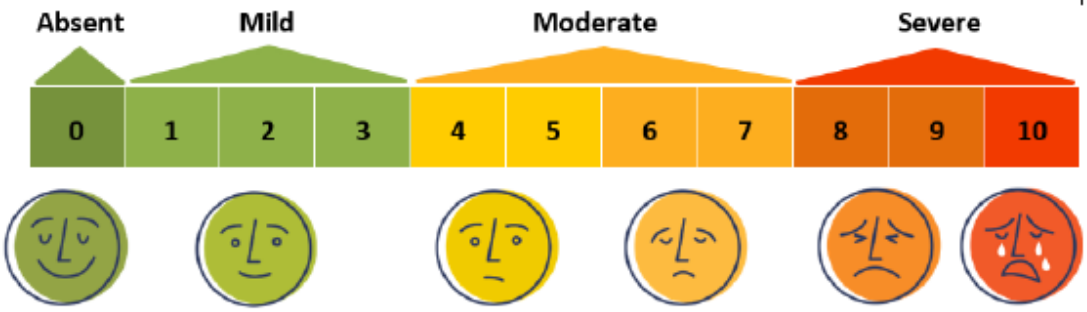
Daily symptom assessment

(Please complete or affix Label here)

UPI:
Surname
First name:
DOB:

Daily PCOC Symptom Assessment Scale (SAS)

Please use this form to ask the Resident about the symptoms that bothered, worried or distressed them over the previous 24 hours. This information will help us to meet their needs.



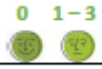
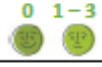
1. Use the scale above to choose a number between 0 and 10 that shows how bothered, worried or distressed the resident is.
2. You can add and rate other symptoms in the blank space at the bottom of the list.

Date									
Time									
Distress from Pain									
Distress from Fatigue									
Distress from Breathing problems									
Distress from Bowel problems									
Distress from Nausea									
Distress from Appetite problems									
Difficulty Sleeping									
Distress from Other Symptom									
Specify 'Other Symptom'									
Rated **by:** R=Resident F=Family/unpaid carer C=care worker H=Health Care Professional									
Staff initials									

CARE WORKER ACTIONS BASED ON SAS SCORES

Absent (0)	Mild (1-3)	Moderate (4-7)	Severe (8-10)
No action required	Report to RN/Supervisor WITHIN SHIFT	Report to RN/Supervisor WITHIN 30 MINUTES	Report to RN/Supervisor IMMEDIATELY

Daily SAS Draft V1.7 220225

SYMPTOM	SAS SCORE GUIDE
PAIN	Any discomfort, ache, soreness, stabbing, sharp or dull pain
0 1–3 	Score 0 resident states no distress from pain OR does not show signs of distress from pain
	Scores 1-3 OR may appear slightly uncomfortable or unsettled
4 - 7 	Scores 4 to 7 OR shows signs such as groaning, moaning, grimacing, being agitated or restless
8 - 10 	Scores 8-10 OR shows signs such as crying, groaning, grimacing, holding/guarding parts of the body, signs appear to worsen on movement, being very restless or agitated or aggressive
FATIGUE	Loss of strength, low energy, very tired, weakness
0 1–3 	Score 0 resident states no distress from fatigue OR does not show signs of distress from fatigue
	Scores 1-3 OR appears mildly frustrated when trying to complete usual activities
4 - 7 	Scores 4 -7 OR appears moderately frustrated/annoyed when trying to complete usual activities. Disinterested in usual activities.
8 - 10 	Scores 8-10 OR appears very irritated and/or frustrated when attempting to complete usual activities. Resident may not attempt activities or gives up easily, or is sleepy at inappropriate times (e.g., meals).
BREATHING	Rapid breathing, noisy breathing, shallow breathing, irregular breathing
0 1–3 	Score 0 Resident states there is no distress from breathing OR does not show signs of distress from breathing
	Scores 1-3 OR seems a bit breathless and worried. Gets breathless when moving around.
4 - 7 	Scores 4- 7 OR seems quite short of breath, and is taking big breaths in and out, and appears to be concentrating/fixating on their breathing. Gets breathless when talking uninterrupted for a time.
8 - 10 	Scores 8-10 OR seems short of breath and signs of panic such as grabbing onto staff, refusing to eat or drink, avoiding talking more than a couple of words at a time, is restless or agitated
BOWELS	Constipation, diarrhoea, abdominal discomfort
0 1–3 	Score 0 Resident states no distress from bowels OR does not show signs of distress from bowels
	Scores 1-3 OR appears concerned with opening their bowels, or mild lower stomach discomfort shown by holding or touching lower stomach
4 - 7 	Scores 4-7 OR appears quite concerned with opening their bowels, appears have pain or discomfort in their lower stomach, may request to go to the toilet constantly and sits for long periods on the toilet. Straining to open bowels OR may be upset by diarrhoea or faecal incontinence
8 - 10 	Scores 8-10 OR very fixated with opening their bowels, appears to have severe pain/discomfort in lower stomach, may be restless/agitated, may not have opened bowels for a few days but has a small amount of runny faeces, may refuse food OR may be highly distressed by diarrhoea/faecal incontinence.
NAUSEA	Feeling sick, wanting to vomit, dislike of food odours
0 1–3 	Score 0 Resident states no distress from nausea OR does not show signs of distress from nausea
	Scores 1-3 OR shows dislike of food & drink, may dry retch, may vomit
4 - 7 	Scores 4-7 OR may actively push away or turn away from food, may dry retch, may vomit, and appears upset when this happens
8 - 10 	Scores 8-10 OR is refusing food and drink, gags, dry retches or vomits often, and appears very upset and/or exhausted when this happens
APPETITE	Not wanting to eat, decrease in food intake
0 1–3 	Score 0 Resident states no distress relating to appetite OR are eating and drinking normally
	Scores 1-3 OR may only eat part of their meal and appears mildly frustrated
4 - 7 	Scores 4-7 OR attempts to eat and drink, may sigh, and stop eating or attempts to eat/drink but gives up partway through meal/snack and appears frustrated or annoyed
8 - 10 	Scores 8-10 OR may refuse food/drink and appears very irritated/frustrated/annoyed. May push food away or is upset by sight of food. Refuses to attend dining room OR upset when food is placed near them.
SLEEPING	Awake during the night-sleeping during the day, restless and/or irritable during the night
0 1–3 	Score 0 Resident states no distress from sleeping OR shows no signs of distress from sleeping
	Scores 1-3 OR may be tossing and turning throughout the night or when trying to sleep
4 - 7 	Scores 4-7 OR may be tossing/turning when trying to sleep, sighing, or calling out for staff, unable to sleep for more than short periods. Upset about being tired and sleepy during the day.
8 -10 	Scores 8-10 OR unable to fall asleep/stay asleep, very restless, very agitated, repeatedly calling for staff, constantly tired, low mood, irritable. Falls asleep during normal activities (e.g., shower, meals)

Daily SAS Draft V1.7 220225

9.2.1.4 Palliative Care Needs Rounds[5]

Palliative Care Needs Rounds, also called Needs Rounds offer a forum for the review of residents who were identified as having palliative care needs. Residents for review at Needs Rounds are identified with the PACOP Deteriorating Resident Tool.

Needs Rounds are monthly meetings run by a specialist palliative care clinician, where up to 8 residents with palliative care needs are discussed. They are attended by care facility staff including personal care assistants, registered and enrolled nurses, ANUMs, NUMs, Clinical Coordinators, Allied health practitioners activities coordinators and ancillary staff.

Needs Rounds can take place face to face at the residential aged care facility or via Telehealth video linkup between the participating residential aged care staff and specialist palliative care clinician.

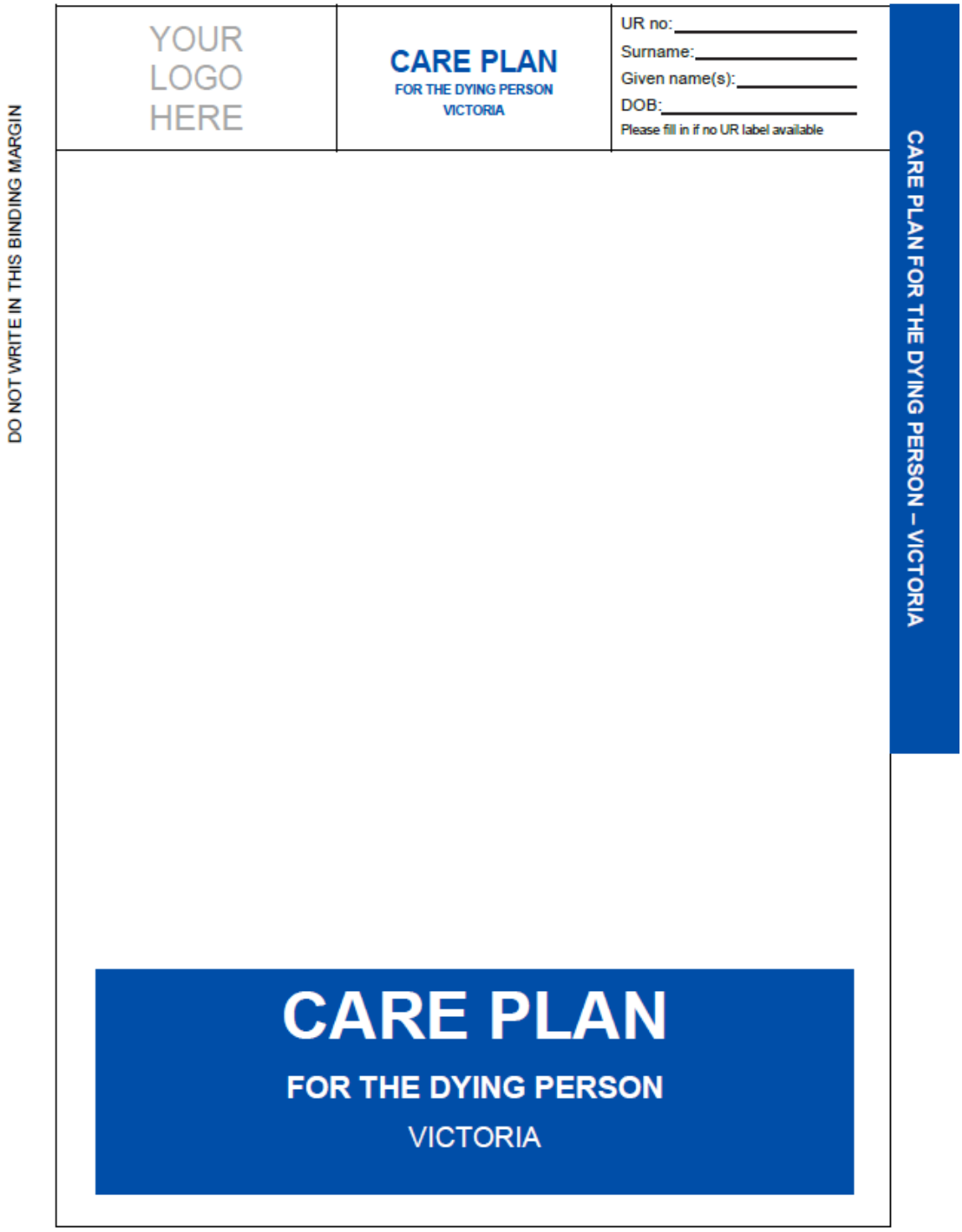
Needs Rounds integrate case-based responsive education, with a discussion of each referred resident's bio-psycho-social status to promote symptom management and identify opportunities to reinforce and extend staff knowledge.

Discussion of residents at Needs Rounds frequently leads to conducting advance care planning with resident input and identifying legally appointed alternate decision makers. Care plans are formulated for symptom control, the management of current and anticipatory medicines is also covered. Additional referrals (including to specialist palliative care for review) and case conferences can also be initiated if required.

[5] Based on Calvary Health / University of Stirling (2020): Palliative Care Needs Rounds: The Implementation Guide. Web: https://www.calvarycare.org.au/wp-content/uploads/2020/08/Calvary-Palliative-Care-Needs-Rounds-Implementation-Manual.pdf, last accessed on 04/12/2023.

9.2.1.5 End of life pathway – Safer Care Victoria Care for the Dying person

Please note: This is recommended for facilities located in Victoria. Please adapt for facilities outside Viuctoria.



CARE PLAN FOR THE DYING PERSON – VICTORIA Guidance

YOUR LOGO HERE

CARE PLAN
FOR THE DYING PERSON
VICTORIA

UR no: _____
Surname: _____
Given name(s): _____
DOB: _____
Please fill in if no UR label available

Health professional guidance

RECOGNISING DYING

The possibility that a person may die within the next few days or hours is recognised and communicated clearly; all decisions made and actions taken are in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

Each multidisciplinary team (MDT)* assessment should always consider:

1. Is there a potentially reversible cause for the person's condition? E.g. exclude opioid toxicity, renal failure, hypercalcaemia, infection.
2. Is a specialist referral required? Seek a second opinion or specialist palliative care support as needed.

COMMUNICATE, INVOLVE AND SUPPORT

Sensitive communication takes place between staff, the dying person and those identified as important to them.

Staff must check if there is an existing advance care directive and if so, ensure it is reviewed.

Shared decisions are made about treatment and care to the extent the dying person wants or is able to participate. The possibility that the person may be dying is discussed. This communication must be conducted in a way that maximises dignity and privacy.

The needs of relative/friend(s)/support person/medical decision maker are explored, respected and met as far as possible. Staff must check understanding of the information being communicated and document this.

CREATE AN INDIVIDUALISED PLAN WITH ONGOING MEDICAL REVIEW

A care plan tailored to the individual needs of the dying person and those identified as important to them is developed and continually reviewed.

The agreed plan of care is co-ordinated and delivered with dignity, care and compassion. It is inclusive of, but not limited to, needs related to food and drink, symptom management and emotional, spiritual, religious and cultural support.

REVIEW

This care plan should be a continuum. The dying person's condition, needs and wishes should be reviewed at least daily by the senior treating doctor* and a registered nurse (Div 1).

A full MDT reassessment and review should be triggered when:

1. There is a significantly improved conscious level, functional ability, mobility, ability to perform self-care and/or
2. There are concerns expressed regarding the plan of care from the dying person, relative, friend, support person, medical treatment decision maker or treating team member.

This care plan will be discontinued in the event that the person's condition improves and a new goal of care must be developed and initiated.

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

The aim of the **Care Plan for the Dying Person – Victoria** is to guide and enable health professionals to focus on individualised care during the last days and hours of life. It facilitates the delivery of high-quality care tailored to the individual needs of the dying person and those identified as important to them, when death is expected.

As with all care plans, the information in this document aims to support but does not replace clinical judgement.

GUIDING PRINCIPLES

- Recognising clinical deterioration and probable death is fundamental to quality care provision.
- Comprehensive and clear communication must occur especially when it is thought that a person is imminently dying.
- Everyone – the healthcare team, the dying person and those identified as important to them – must understand and accept the person is thought to be imminently dying prior to any discussions related to commencing the Care Plan for the Dying Person – Victoria.
- The Care Plan for the Dying Person – Victoria should not be commenced if there is not full acceptance by the MDT or relative/friend(s) that death is imminent.
- All clinical decisions must be made in the dying person's best interest and be inclusive of medical, physical, emotional, religious, spiritual and cultural factors.
- The care plan does not preclude the use of clinically assisted nutrition, hydration or antibiotics.
- Continuing care decisions should always be made in consultation with the senior treating doctor*, the MDT* the person who is dying (when possible and appropriate) and those identified as important to them.
- Uncertainty is an integral part of dying and there are occasions when a person who is thought to be dying lives longer, or dies sooner than expected. Daily review of care needs and wishes must be undertaken and a second opinion or specialist palliative care support sought as needed.

Responsibility for the use of the **Care Plan for the Dying Person – Victoria** as part of a continuous quality improvement program sits within the governance of an organisation and must be underpinned by an education and training program.

The care plan should be implemented in conjunction with the **Care Plan for the Dying Person – Victoria, Health professional user guide**.

This is a legal document and should be used in conjunction with other relevant clinical documentation as per individual health service policies and procedures.

*__DEFINITIONS__ (for the purposes of this document)

Senior treating doctor
The most senior doctor responsible and familiar with clinical care decisions related to this dying person.

Multidisciplinary team (MDT)
At a minimum a MDT consists of a senior treating doctor and a registered nurse (Div 1) who is responsible for the care of this dying person.

MDT delegate
Doctor or registered nurse (Div 1) with delegated responsibility from a senior treating doctor to make decisions related to commencing this dying person on the **Care Plan for the Dying Person – Victoria.**

CARE PLAN FOR THE DYING PERSON – VICTORIA Medical

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

1. Recognising dying (must be completed by a doctor)

1.1 Commencement

Must be completed by a senior treating doctor and co-signed by a registered nurse (Div 1)

The MDT has assessed the person as imminently dying and they support the commencement of the **Care Plan for the Dying Person – Victoria.** ☐ Yes ☐ No (If 'No', do not commence)

A resuscitation plan is documented:	☐ Yes	☐ No	Further action:	Initial:
Will the dying person have CODE BLUE/MET calls in response to deterioration?	☐ Yes	☐ No	State reason for call:	Initial:

MDT authorisation

Senior treating doctor (Print name)	Signature:	Date: / /20 Time: : hours	
Registered nurse (Print name)	Signature:	Date: / /20 Time: : hours	

Verbal authorisation

If the senior treating doctor is not immediately available, the nominated MDT delegates can sign authority to commence the Care Plan for the Dying Person – Victoria.

SENIOR TREATING DOCTOR SIGNATURE MUST BE OBTAINED WITHIN 24 HOURS OF COMMENCEMENT

Name of the senior treating doctor verbal authorisation was obtained from:

MDT delegate (Print name)	Signature:	Date: / /20 Time: : hours	
MDT delegate (Print name)	Signature:	Date: / /20 Time: : hours	

1.2 Legal and relevant decision assisting information

Does the person have capacity to make medical decisions at this time?	☐ Yes	☐ No		Further action:	Initial:
Is there an instructional and/or a values directive in a patient's record/ MyHealthRecord/ or available elsewhere?	☐ Yes	☐ No		Further action:	Initial:
Is there a medical treatment decision maker identified for if/when this person does not have capacity?	☐ Yes Name:		☐ No		Initial:
Registered organ/tissue/ corneal donor?	☐ Yes	☐ No	☐ Follow up	Further action:	Initial:
Will this be a reportable Coronial death? (Refer to health service policy/procedures)	☐ Yes	☐ No	☐ Follow up	Further action:	Initial:
Other e.g. autopsy, donating to medical science	☐ Yes	☐ No	☐ Follow up	Further action:	Initial:

Record more detailed responses/instructions in Section 4.2 or 4.3

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

1.3 Communication – Information exchange		
Is an interpreter required? Language(s):	☐ Yes	☐ No
Is the dying person able to take a full and active role in communication?	☐ Yes	☐ No
Does the dying person understand that they are now dying?	☐ Yes	☐ No
Are the relative/friend(s) able to take a full and active role in communication?	☐ Yes	☐ No
Are the relative/friend(s) aware that their relative / friend is now dying?	☐ Yes	☐ No
Are the relative/friend(s) aware that the Coroner is likely to be involved?	☐ Yes	☐ No
Have relevant staff been informed that this person is imminently dying?	☐ Yes	☐ No

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

2. Medical review of care needs (must be completed by a doctor)

2.1 Initial assessment

☐ Conscious	☐ Semi-conscious	☐ Unconscious
☐ Able to swallow	☐ Experiencing delirium	

2.2 Medication management

Medications must be prescribed and available in anticipation of symptoms which may develop. Anticipatory prescribing is recommended in end-of-life care

Medication prescribed for:		**The person is currently:**		
Pain	☐ Yes	In pain	☐ Yes	☐ No
Agitation	☐ Yes	Agitated	☐ Yes	☐ No
Nausea and vomiting	☐ Yes	Nauseous and/or vomiting	☐ Yes	☐ No
Dyspnoea	☐ Yes	Dyspnoeic	☐ Yes	☐ No
Respiratory tract secretions	☐ Yes	Experiencing secretions	☐ Yes	☐ No

2.3 Current interventions

Have current interventions been assessed and non-essentials discontinued?

	Not required	**Discontinued**	**Continued**	**Commenced**
Essential medications via appropriate route	☐	☐	☐	☐
Continuous subcutaneous infusion (CSCI) (Refer to health service policy/ procedures)	☐	☐	☐	☐
Intravenous antibiotics	☐	☐	☐	☐
Clinically assisted hydration ☐ PEG/PEJ ☐ NG/NJ ☐ IV ☐ SC	☐	☐	☐	☐
Clinically assisted nutrition ☐ PEG/PEJ ☐ NG/NJ ☐ TPN	☐	☐	☐	☐
Oxygen therapy	☐	☐	☐	☐
Anticoagulation therapy	☐	☐	☐	☐
Routine blood tests	☐	☐	☐	☐
Blood glucose monitoring	☐	☐	☐	☐
Recording of vital signs	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
Implantable Cardioverter Defibrillator (ICD) is deactivated	☐ Yes	☐ Further action	☐ Not appropriate	

Record more detailed responses/instructions in Section 4.2 or 4.3

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

2.4 Referral to specialist palliative care service		
Does the dying person require a specialist palliative care referral?	☐ Yes	☐ No
	☐ Palliative care team already involved	
Describe reason for referral:		

Doctor completing medical review	
Print name:	Signature:
Date: / /20	Time: : hours

CARE PLAN FOR THE DYING PERSON – VICTORIA Psychosocial

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

3. Planning individualised care (to be completed by any member of the MDT)

3.1 Brochures

Those identified as important to the dying person have had a full explanation of the facilities and services available to them including relevant information brochures	☐ Yes	☐ No

☐ **Care Plan for the Dying Person – Victoria** 'Family member/friend information brochure'	☐ Other specific brochures List:	☐ Facility orientation brochure

3.2 Contact information

1st contact person

Name:	Relationship:	
Have contact numbers been checked and updated?	☐ Yes	☐ No
Interpreter required?	☐ Yes	☐ No

When to contact:

☐ Anytime ☐ Not at night ☐ Deterioration ☐ Death only

Other relevant information:

2nd contact person

Name:	Relationship:	
Have contact numbers been checked and updated?	☐ Yes	☐ No
Interpreter required?	☐ Yes	☐ No

When to contact:

☐ Anytime ☐ Not at night ☐ Deterioration ☐ Death only

Other relevant information:

3.3 Funeral arrangements (please check clinical record first for this information)

Funeral arrangements discussed	☐ Yes	☐ No	☐ Not appropriate
Name of funeral director (if known)			

3.4 Person-centred communication

Is the dying person able to fully participate in this discussion?	☐ Yes	☐ No – please go to Section 3.6 and refer to instructional/values directive.

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

3.5 Communication with the dying person (If appropriate, ask the dying person the following questions)		
Does the dying person understand that they are now dying?	☐ Yes	☐ No
Do you have any emotional, spiritual, religious/cultural needs or wishes we need to be aware of now, at the time of and/or after death?	☐ Yes	☐ No
If yes, what are they?		
What is important to you now?		
What would bring comfort at this time? E.g. music, own pillow/bed linen, etc.		
In the absence of relative/friend(s), who else do you want us to share this information with? Name: *Record in Section 3.2*		
Is there anything else you would like to tell us, ask us or we can support you with?	☐ Yes	☐ No
If yes, please describe:		

3.6 Communication with relative/friend(s) **Ask the relative/friend(s) the following questions**		
What is important to you now?		
What is important at the time of death?		
What is important for your relative/friend at the time of and/or after death?		
Is there anything else you would like to tell us, ask us or we can support you with?	☐ Yes	☐ No
If yes, please describe:		

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

3.7 Bereavement risk

Potential risk is identified	☐ Yes	☐ No
Referral made to:		

High risk factors: limited social support, emotional distress, family conflict, cumulative losses, sudden or unexpected deterioration

3.8 Allied health/support services required

	Person		Relative		Contacted (date/initial)	Additional information
Social work	☐ Yes	☐ No	☐ Yes	☐ No		
Spiritual/religious advisor/pastoral care	☐ Yes	☐ No	☐ Yes	☐ No		
Cultural advisor/ healer/elder	☐ Yes	☐ No	☐ Yes	☐ No		
Aboriginal hospital liaison officer	☐ Yes	☐ No	☐ Yes	☐ No		

Record more detailed responses / instructions in Section 4.2 or 4.3

Further comments

CARE PLAN FOR THE DYING PERSON – VICTORIA Initial assessment

YOUR LOGO HERE

CARE PLAN
FOR THE DYING PERSON
VICTORIA

UR no: _____
Surname: _____
Given name(s): _____
DOB: _____
Please fill in if no UR label available

4. Delivery of care (to be completed by any member of the MDT)

4.1 Initial assessment

This care plan should be reviewed at least daily by the MDT

Minimum documentation is four hourly however certain psychosocial issues may only need assessment once per shift

Care plan day: Date: / /20

SYMPTOM MANAGEMENT

A = Assessment and no action required
R/C = Routine care
F/A = Further action required
N/A = Not applicable

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Free of pain												
Free of agitation/ restlessness												
Free of nausea/ vomiting												
Free of dyspnoea/ breathlessness												
Free of respiratory tract secretions												
Free of urinary problems												
Free of bowel problems												
Subcutaneous cannula care												
Subcutaneous infusion check												

PERSONAL COMFORT CARE

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Receives food and fluids to support needs												
Is comfortably positioned												
Skin care needs are met												
Personal hygiene needs are met												
Mouth is clean and moist												
Eyes are clean and moist												
Environment supports needs												

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA		UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

PSYCHOSOCIAL CARE												
	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Emotional, spiritual, religious, cultural needs/rituals are met												
Procedures/care plan explained												
Information regarding changes provided												
Relative/friend(s) supported												
Record all F/A in Section 4.2: Further care action report												
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial
Print name of person doing assessment												
N:												
AM:												
PM:												
N: RESPONSIBLE REGISTERED NURSE: (If different from above)												
N:												
AM:												
PM:												

CARE PLAN FOR THE DYING PERSON – VICTORIA Ongoing assessment

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

4. Delivery of care (to be completed by any member of the MDT)

4.1 Ongoing assessment

This care plan should be reviewed at least daily by the MDT

Minimum documentation is four hourly however certain psychosocial issues may only need assessment once per shift

MDT review. Is the person imminently dying?		☐ Yes	☐..No
If 'No', has the MDT agreed that this care plan should be discontinued?		☐ Yes	☐..No
Care plan discontinued:	Date: / /20	Time: :	hours
Please complete 'Section 6 - Care plan discontinued' and attach to the **front** page of this care plan and file			
Care plan day:		Date: / /20	

SYMPTOM MANAGEMENT

A = Assessment and no action required

F/A = Further action required

R/C = Routine care

N/A = Not applicable

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Free of pain												
Free of agitation/ restlessness												
Free of nausea/ vomiting												
Free of dyspnoea/ breathlessness												
Free of respiratory tract secretions												
Free of urinary problems												
Free of bowel problems												
Subcutaneous cannula care												
Subcutaneous infusion check												

PERSONAL COMFORT CARE

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Receives food and fluids to support needs												
Is comfortably positioned												
Skin care needs are met												
Personal hygiene needs are met												
Mouth is clean and moist												
Eyes are clean and moist												
Environment supports needs												

PSYCHOSOCIAL CARE												
	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Emotional, spiritual, religious, cultural needs/rituals are met												
Procedures/care plan explained												
Information regarding changes provided												
Relative/ friend(s) supported												
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial
Print name of person doing assessment												
N:												
AM:												
PM:												
N: RESPONSIBLE REGISTERED NURSE: (If different from above)												
N:												
AM:												
PM:												

CARE PLAN FOR THE DYING PERSON – VICTORIA Ongoing assessment

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

4. Delivery of care (to be completed by any member of the MDT)

4.1 Ongoing assessment

This care plan should be reviewed at least daily by the MDT

Minimum documentation is four hourly however certain psychosocial issues may only need assessment once per shift

MDT review. Is the person imminently dying?	☐ Yes	☐..No
If 'No', has the MDT agreed that this care plan should be discontinued?	☐ Yes	☐..No
Care plan discontinued: Date: / /20	Time: : hours	
Please complete 'Section 6 - Care plan discontinued' and attach to the **front** page of this care plan and file		
Care plan day:	Date: / /20	

SYMPTOM MANAGEMENT

A = Assessment and no action required F/A = Further action required

R/C = Routine care N/A = Not applicable

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Free of pain												
Free of agitation/ restlessness												
Free of nausea/ vomiting												
Free of dyspnoea/ breathlessness												
Free of respiratory tract secretions												
Free of urinary problems												
Free of bowel problems												
Subcutaneous cannula care												
Subcutaneous infusion check												

PERSONAL COMFORT CARE

	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Receives food and fluids to support needs												
Is comfortably positioned												
Skin care needs are met												
Personal hygiene needs are met												
Mouth is clean and moist												
Eyes are clean and moist												
Environment supports needs												

PSYCHOSOCIAL CARE												
	0200	0400	0600	0800	1000	1200	1400	1600	1800	2000	2200	2400
Emotional, spiritual, religious, cultural needs/rituals are met												
Procedures/care plan explained												
Information regarding changes provided												
Relative/ friend(s) supported												
	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial	Initial
Print name of person doing assessment												
N:												
AM:												
PM:												
N: RESPONSIBLE REGISTERED NURSE: (If different from above)												
N:												
AM:												
PM:												

CARE PLAN FOR THE DYING PERSON – VICTORIA Action report

YOUR LOGO HERE

CARE PLAN
FOR THE DYING PERSON
VICTORIA

UR no:_____
Surname:_____
Given name(s):_____
DOB:_____
Please fill in if no UR label available

4. Delivery of care

4.2 Further care action report

Date	Time	Issue/item	Action	Outcome of action			
				Was the action effective?		Time	Initial
				Yes	No		

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

Progress notes CARE PLAN FOR THE DYING PERSON – VICTORIA

4. Delivery of care

4.3 Integrated progress notes

IMPORTANT: Record any of the following: MDT reviews, changes in condition, appropriateness of the care plan (by MDT daily), significant events/conversations/visits or other

Time	Date	Notes	Designation

CARE PLAN FOR THE DYING PERSON – VICTORIA Care after death

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

5. Care after death (this section MUST be completed)

5.1 Verification of death

A doctor and/or registered nurse(s) can verify death. (*Refer to health service policy/procedures)*
Where a doctor is unavailable immediately to sign a Medical Certificate of Cause of Death (death certificate) or to document that a person has died, other health professionals (registered nurses and midwives) can **verify the fact of death.**
There is a minimum guideline for the clinical assessment necessary to establish that death has occurred.
Please refer to the **'Care Plan for the Dying Person – Victoria, Health professional user guide'** for further guidance.

Verification of death by:

Doctor/registered nurse	Signature
Registered nurse	Signature
Location of the clinical assessment	
Date of death: / /20	Time of death: : hours

☐	No palpable carotid pulse **and**
☐	No heart sounds heard for 2 minutes **and**
☐	No breath sounds heard for 2 minutes **and**
☐	Fixed (non-responsive to light) and dilated pupils **and**
☐	No response to centralised stimulus (e.g. trapezius muscle squeeze, supraorbital pressure, mandibular pressure or the common sternal rub) **and**
☐	No motor (withdrawal) response or facial grimace in response to painful stimulus (e.g. pinching inner aspect of the elbow)
☐	**Optional** ECG strip shows no rhythm

5.2 Notifying relative/friend(s)

Person(s) present at time of death				
If relative/friend(s) not present, have they been notified?			☐ Yes	☐ No
Name of person informed		Relationship		
The relative/friend(s) have been provided with information regarding the next steps, including bereavement information.			☐ Yes	☐ No

5.3 Care of the deceased

Care of the deceased has been undertaken according to the dying person's/relative/friend(s) wishes and health service policy/procedures	☐ Yes	☐ No

5.4 Communication by health service

Other documentation has been completed according to health service policy/procedures

• Death certificate or eMedical Disposition Form	☐ Yes	☐ No
• Discharge letter	☐ Yes	☐ No
• Other:	☐ Yes	☐ No

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no:_____ Surname:_____ Given name(s):_____ DOB:_____ Please fill in if no UR label available

The death is communicated according to health service policy/procedures.		
• Healthcare team/GP	☐ Yes	☐ No
• Health service IT system	☐ Yes	☐ No
If a 'No' is recorded, a further action **must** be recorded in Section 4.2: Further care action report		

5.5 Coroner		
Is this a reportable Coronial death? If 'yes', refer to health service policy/procedures	☐ Yes	☐ No

5.6 ONLY complete this section in the context of possible organ donation	
Brain death may have occurred. The formal determination of brain death is usually in the context of organ donation and requires specific requirements and preconditions to its clinical determination.	
☐ **Person declared brain dead**	
Date of death: / /20	Time of death: : hours
Please attach a copy of the ANZICS documentation 'Determination of Brain Death'.	

Consider any staff support needs following this death. Refer to health service policy/ procedures.

CARE PLAN FOR THE DYING PERSON – VICTORIA Discontinued

YOUR LOGO HERE	**CARE PLAN** FOR THE DYING PERSON VICTORIA	UR no: _____ Surname: _____ Given name(s): _____ DOB: _____ Please fill in if no UR label available

6. Care plan discontinued

6.1 Multidisciplinary team (MDT) decision making

Complete when the MDT has made the decision the person is no longer imminently dying and attach to the **front** page of this care plan and file.

Senior treating doctor Print name:	Signature:
Date: / /20	Time: : hours

☐ **Verbal authorisation**

☐ **Senior treating doctor** Print name: Pager/contact number:	Signature:
☐ **Registered nurse** Print name:	Signature:

Date: / /20	Time: : hours	Ward

Has the resuscitation plan been reviewed and updated?

☐ Yes, reviewed and updated ☐ Yes, reviewed and unchanged ☐ No

Has the CODE BLUE/MET call criteria been reviewed and updated (if needed)?	☐ Yes	☐ No

Other MDT decision makers (where applicable)

Name:		Designation:	
Name:		Designation:	

6.2 Reason(s) why the Care Plan for the Dying Person – Victoria was discontinued

6.3 Outline discussion with person/relative/friend(s)

Person involved in discussion and aware of discontinuation of **Care Plan for the Dying Person – Victoria**: ☐ Yes ☐ No

☐ **Verbal**

☐ Name:		Relationship:	
☐ Name:		Relationship:	

6.4 Referral to specialist palliative care service

Does the person require specialist palliative care referral?	☐ Yes	☐ No
Already referred, name of service:		
Describe reason for referral:		

Contact made by:		
Designation:		Date: / /20

9.2.2 Communication tools

9.2.2.1 REDMAP framework[6]

REDMAP is a structured roadmap consisting of six steps designed for conducting future care planning discussions with individuals facing serious illnesses, health challenges, progressive disabilities, or older individuals experiencing increased frailty. This planning process actively involves the individual and their close circle of supporters. It uses evidence-based communication approaches.

[6] Source: https://www.spict.org.uk/wp-content/uploads/2023/10/REDMAP-Framework-Sept-2023.pdf. Accessed on 12/12/2023.

Future Care Planning in Care Homes – talking with residents

Future care planning is about thinking and planning ahead so that we can give each resident the best possible care. If your health changes, it is better if we have a good plan for you.

READY	**Can we talk about why planning ahead helps people get better care?**
Making a plan helps people who live in a care home, like you, think about their care and what is important to them. You may have talked with your family or a close friend about this before. It is a good idea to talk about what might happen if you get unwell. This could be from a health problem or illness you have already. It might be a new illness. Sometimes a resident gets ill with an infection or a fall. We can make plans and talk with your family or friends if you wish.	
EXPECT	**It would help to hear what you know already, and think might happen.**
People have different things they want to talk about. Please ask us about anything you want to know or are worried about. We can make a plan with you now, if you are ready.	
DIAGNOSIS	**There are things we know, and things we're not sure about.**
People who live in care homes are often in poorer health and need help with day to day living. We are doing our best to help you to stay well, but it is possible you may get unwell at some point. Some treatments may not work for you, or you might not want them. That's why it is important for us to talk about making a future care plan with you.	
MATTERS	**We'd like to know what's important to you, and how best to care for you.**
We put what you tell us into your care plan so we know about how you'd like to be cared for.	
ACTION	**Let's talk about what we can do to care for you, and things that will not help.**
Let's start with your health problems and make plans for what might happen. There are also some situations it is good to plan ahead for like a sudden illness or an infection. Many people feel that staying in their familiar care home to be looked after is the best place when they are very ill and may be dying. Being comfortable is what matters to them. We have medicines in the care home to help us manage any symptoms or discomfort, if we need them. Hospital treatment may be better in a few conditions, like a hip fracture. Going to hospital has risks and benefits. Can we talk about where would be the best place of care for you? Antibiotic tablets or syrup, other medicines, and oxygen can be given in the home, if needed. Cardiopulmonary resuscitation (CPR) is a medical treatment that does not work when a person is in poor health or dying. Any other treatments that can help are still given. ***Either*** You already have a decision recorded about CPR not working for you, or CPR being a treatment that you'd not want. ***Or*** There is no CPR decision recorded so the GP practice team will review this and discuss it with you.	
PLAN	**Let's make a care plan with you.**
We have your care plan in the home in case we need it. Your plan also goes into your GP record and a secure record used by professionals if people need urgent care called a Key Information Summary (KIS). Some care homes use a ReSPECT care plan. Your plan can be changed at any time. There are some situations we can think about and discuss together. If you have any questions please ask. You can talk to care home staff, and the staff from the GP practice too.	

9.2.2.2 ISBAR

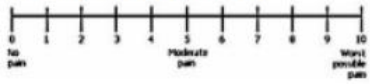
For efficient and effective handovers to internal and external clinicians (e.g. at Needs Rounds), the ISBAR format is recommended:

Resident's Name
Date of Birth **Age**

ISBAR Handover Information

NOTE: Please complete prior to contacting the GP/NSW Ambulance. If TRANSFER to ED send:
ISBAR Form, Observations Chart, Medication Chart and Advance Care Plan

Go Back

I Introduction/ Identify	**Your name and role** **RACF** **Phone** **Fax** **Name and position of person you are speaking to**
S Situation	**Resident's main problem /symptom at present?** **How long has this been an issue?**
B Background	**Is there any relevant medical history?** *(have chart available)* **Medications** *(have chart available)* **Known Allergies:** **Initial treatment and the Initial treatment and the effect on the resident?** **Resident's family notified Yes / No** **Name of the Resident's usual GP:** **Is there an Advance Care Plan in place? If so, what is it?**
A Assessment	***Observations:*** *(have chart available)* ***Baseline:*** ***Date: Time:*** ***Temp:*** ***Blood pressure*** ***Pulse rate: (regular/irregular)*** ***Respirations:*** ***Oxygen saturation:*** ***BGL:*** ***Weight: Current Observations:*** ***Temp:*** ***Blood pressure:*** ***Pulse rate: (regular/irregular)*** ***Respirations:*** ***Oxygen saturation:*** ***BGL:*** ***Weight:*** ***Urinalysis:*** ***Injuries or abnormal Injuries or abnormal findings (See Symptom Reference Guide over page):*** ***Is resident more confused than usual?*** ***Yes /No*** ***How much pain is the patient in?***  ***0 – No hurt*** ***2- Hurts a Bit*** ***4 – Hurts a little*** ***more 6 – Hurts even more 8 – Hurts a whole lot 10 – Hurts worst*** ***Circle the type of pain: Chronic / Acute/Acute on chronic***
R Recommendation	**I am requesting assistance with / advice for:** *Symptom management; Medication review; GP assessment of patient; Sending patient to ED; Other* _____ **Goals of Care** *(consider Advance Care Plans)*: **Doctor's Orders/ Ambulance Triage / Other Comment**
	Name ..... **Signature** ..... **Date** .....

Adapted from Hunter New England LHD & Hunter Primary Care, BAR4AC/Nurse Clinical Handover Information

9.3 Roles and responsibilities

9.3.1 Residential Aged Care staff

9.3.1.1 (Associate) Nurse Unit Manager ((A/)NUM)

- Provide strong team leadership in the delivery of comprehensive palliative care
- Complete Deteriorating Resident Tool
  - When the resident moves into the aged care home
  - As part of the resident of the day review process
  - Upon return from hospital (ED/UCC or hospital admission)
  - As indicated if any residential aged care staff member in direct or indirect care roles observes a change in the resident (e.g. after a fall, administration of antibiotics, change of cognition, delirium, loss of appetite, loss of weight, behavioural change)
- If indicated through Deteriorating Resident Tool outcome (completed at trigger points or monitoring), take appropriate action:
  - Referral to Needs Rounds
  - Referral to GP for review
  - Referral to GRPCT if indicated, or involvement of Palliative Care Advice Service, Victorian Virtual Emergency Department or Ambulance Victoria Residential Aged Care Enhanced Response Pathway
  - Review resident Advance Care Plan (including goals of care) and take appropriate action if required:
    - Conversations with the resident and/or their family
    - Revise in collaboration with GP
- Develop person-centred palliative care plans, taking into account resident specific care needs, goals and preferences
- Take responsibility for any follow up actions:
  - Document/review symptom management plans
  - Ongoing monitoring: Weekly completion of PACOP DRT and taking action depending on the outcome as per model of systematic identification and response to deterioration
  - Referral to GRPCT
  - Referrals to Allied Health
  - Access to equipment
- Communicate with family
- Organise family meeting
- Referral for emotional and spiritual consultation
- Check anticipatory medications are charted and in stock , and required equipment is available
- Commence Care plan for the Dying Person when appropriate
- Organise and facilitate case conferences
- Participate and present residents (ISBAR communication tool) at Needs Rounds
- Work collaboratively with the multidisciplinary care team to ensure resident needs are met
- Have knowledge and an understanding of advanced care planning principles and promote these values; initiate advance care planning (including Goals of Care) conversations with residents, their families and GPs
- Develop process for staff to share their learnings in the palliative care field, and provide guidance and support

- Assist with identifying staff training needs with regard to palliative care (Relevant tools: ELDAC Individual Training Needs Assessment)
- Ensure ELDAC Death Audit learnings lead to quality improvement

9.3.1.2 Registered Nurse (RN)

- Complete Deteriorating Resident Tool as indicated if any residential aged care staff member in direct or indirect care roles observes a change in the resident (e.g. after a fall, administration of antibiotics, change of cognition, delirium, loss of appetite, loss of weight, behavioural change)
- If indicated through Deteriorating Resident Tool outcome (completed at trigger points or monitoring), take appropriate action:
  - Referral to Needs Rounds
  - Review resident Advance Care Plan (including goals of care) and take appropriate action if required:
    - Conversations with the resident and/or their family
    - Revise in collaboration with GP
- Develop person-centred palliative care plans, taking into account resident specific care needs, goals and preferences
- Take responsibility for any follow up actions:
  - Document/review symptom management plan
  - Ongoing monitoring: Weekly completion of PACOP DRT and taking action depending on the outcome as per model of systematic identification and response to deterioration
  - Referral to GRPCT
  - Referrals to Allied Health
  - Access to equipment
- Communicate with family
- Referral for emotional and spiritual consultation
- Commence Care plan for the Dying Person when appropriate
- Complete Daily SAS to monitor symptoms
- Participate and present residents (ISBAR communication tool) at Needs Rounds
- Work collaboratively with the multidisciplinary care team to ensure resident needs are met
- Have knowledge and an understanding of advanced care planning principles and promote these values; initiate advance care planning (including Goals of Care) conversations with residents, their families and GPs

9.3.1.3 Enrolled Nurse (EN)

- Complete Deteriorating Resident Tool as indicated if any residential aged care staff member in direct or indirect care roles observes a change in the resident (e.g. after a fall, administration of antibiotics, change of cognition, delirium, loss of appetite, loss of weight, behavioural change)
- If indicated through Deteriorating Resident Tool outcome (completed at trigger points or monitoring), take appropriate action:
  - Referral to Needs Rounds
  - Review resident Advance Care Plan (including goals of care) and take appropriate action if required:

        - Conversations with the resident and/or their family
        - Revise in collaboration with GP
- Develop person-centred palliative care plan, taking into account resident specific care needs, goals and preferences
- Take responsibility for any follow up actions:
    - Document/review symptom management plan
    - Ongoing monitoring: Weekly completion of PACOP DRT and taking action depending on the outcome as per model of systematic identification and response to deterioration
    - Referral to GRPCT
    - Referrals to Allied Health
    - Access to equipment
- Communicate with family
- Referral for emotional and spiritual consultation
- Complete Daily SAS to monitor symptoms
- Participate and present residents (ISBAR communication tool) at Needs Rounds
- Work collaboratively with the multidisciplinary care team to ensure resident needs are met
- Have knowledge and an understanding of advanced care planning principles and promote these values; initiate advance care planning (including Goals of Care) conversations with residents, their families and GPs

9.3.1.4 Personal Care Assistant (PCA)

- Have knowledge and an understanding of advanced care planning principles and promote these values; relay relevant information obtained in conversations with the resident to EN, RN, ANUM or NUM.
- Recognise changes in the patient's condition and alert ANUM/RN, triggering an assessment with the Deteriorating Resident Tool (e.g. after a fall, administration of antibiotics, change of cognition, delirium, loss of appetite, loss of weight, behavioural change; Stop and Watch tool)
- If indicated through Deteriorating Resident Tool outcome (completed at trigger points or monitoring), take appropriate action: Review resident Advance Care Plan (including goals of care) and initiate conversations with the resident and/or their family if required. Relay relevant information obtained in conversations with the resident to EN, RN, ANUM or NUM.
- Take responsibility for any follow up actions:
    - Document any action taken in symptom management plans
    - Access to equipment
- Communicate with family
- Complete Daily SAS to monitor symptoms
- Participate and present residents (ISBAR communication tool) at Needs Rounds
- Work collaboratively with the multidisciplinary care team to ensure resident needs are met

9.3.1.5 Non-direct care staff

- Recognise changes in the patient's condition and alert ANUM, triggering an assessment with the Deteriorating Resident Tool (e.g. after a fall, administration of antibiotics, change

of cognition, delirium, loss of appetite, loss of weight, behavioural change; Stop and Watch tool)
- Participate in Needs Rounds

9.3.1.6 Palliative Care champion / portfolio holder

- Support implementation and facilitation of this Framework for the Provision of Comprehensive Palliative Care in Residential Aged Care, its various tools and Needs Rounds through
  - regular communication about the implementation plan to keep others up to date and gather feedback on the process
  - being a responsive "go to" person to provide support to the team, and to identify and help solve any difficulties arising throughout the implementation
  - Help communicate to GPs, families, or other parties how using this framework and Needs Rounds is improving care.
  - Contribute to role modelling the Needs Rounds process.
- Provide strong team leadership in the delivery of comprehensive palliative care
- Ensure implementation and sustainability of death audits (Tool: ELDAC Death Audits)

9.3.2 External health professionals

9.3.2.1 Community specialist palliative care nurse or nurse practitioner

- Link in with the senior person from the care facility and palliative care champion/portfolio holder
- Facilitate Needs Rounds (face to face or online)
- Provide specialist palliative care advice to residential aged care staff during Needs Rounds on residents with relevant needs identified through PACOP Deteriorating Resident Tool or Daily SAS
- Provide education through Needs Rounds and (advisory) leadership around change
- Encourage sharing of learnings with other residential aged care staff
- Have knowledge and understanding of advanced care planning principles and promote these values
- No review or direct provision of care to residents

9.3.2.2 GP

- Respond to requests of review of residents with relevant needs identified through the PACOP Deteriorating resident Tool
- Contribute to care plans / symptom management plans
- Attend family meetings and case conferences
- Medication management including anticipatory prescribing
- Collaborate with pharmacists on medication management
- Have a knowledge and understanding of advance care planning principles and promote these values; initiate advance care planning (including Goals of Care) conversations with residents, their families and GPs
- Attend to Advance Care Planning (including Goals of Care) documentation Commence Care plan for the Dying Person

9.3.2.3 Specialist palliative care clinician

- Timely response to referrals from residential aged care homes
- Review of residents requiring specialist palliative care intervention with GP consent
- Consultation and advice to other services and healthcare teams/professionals (including residential aged care staff and GPs) providing end-of-life care
- Have knowledge and understanding of advanced care planning principles and promote these values; initiate advance care planning (including Goals of Care) conversations with residents, their families and GPs

9.3.3 Referral processes

9.3.3.1 Needs Rounds recording sheet and referral process

Needs Rounds - Recording sheet[1]

Instructions:

1. Pin up this sheet in a clinical office.
2. Clinical staff to record residents identified with PACOP Deteriorating Resident Tool (DRT) as having palliative care needs for review at Needs Rounds.
3. Bring this sheet to the Needs Rounds to record actions triggered by the meeting.
4. Record actions required after the Needs Rounds and the staff member who will be responsible for organising these actions

Needs Rounds details:

Date of Needs Rounds: _____

Needs Rounds Facilitator (Palliative Care Nurse):_____

Facility staff participant names and roles: _____

[1] Adapted from Calvary Palliative Care Needs Rounds: The Implementation Guide. Web: https://www.calvarycare.org.au/wp-content/uploads/2020/08/Calvary-Palliative-Care-Needs-Rounds-Implementation-Manual.pdf. Accessed on 14/12/2023.

Residents for review:

Resident name	Recent GP or GRPCT review Y/N	Review/ document symptom assessment plan (including monitoring with PACOP DRT or Daily SAS)	Case conference required? Y/N	Family meeting required? Y/N	Other referrals? (please specify)	Access equipment? (please specify)	Action by (insert name)
1.							
2.							
3.							
4.							
5.							

Resident name	Recent GP or GRPCT review Y/N	Review/ document symptom assessment plan (including monitoring with PACOP DRT or Daily SAS)	Case conference required? Y/N	Family meeting required? Y/N	Other referrals? (please specify)	Access equipment? (please specify)	Action by (insert name)
6.							
7.							
8.							
9.							
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9.3.3.2 Community Palliative Care referral process

- Office hours: Please check with you local community palliative care service
- Referral process*: Please check with you local community palliative care service

**Please note: Referral must be discussed with GP*.

9.4 Additional supports

9.4.1 Local Palliative Care Advice Service – Example Vicotria: Palliative Care Advice Service (PCAS)

The Palliative Care Advice Service offers free, confidential advice for all Victorians seeking information about life-limiting illness, palliative care or end-of-life care. The service is for non-emergency health advice only. PCAS can assist doctors, nurses, healthcare workers or provider with symptom management, prescribing and decision-making. They can also be there just to listen.

When contacting the Palliative Care Advice Service, the caller will speak to a specialist palliative care nurse who will collect some basic information about the caller and the reason for the call. The nurse will provide specialist evidence-based information to help the caller or the person they care for.

If the caller is a clinician and the PCAS nurse cannot resolve the query, the nurse will immediately transfer the caller to a palliative medicine specialist. Please be advised that the Physician will advise on prescriptions but cannot prescribe.

All conversations, and any information that is provided, remain private, confidential and secure.

How to access the Palliative Care Advice Service:

- Service hours: 7:00am - 10:00pm, 365 days a year.
- Phone (free call): 1800 360 000
- Web: pcas.org.au

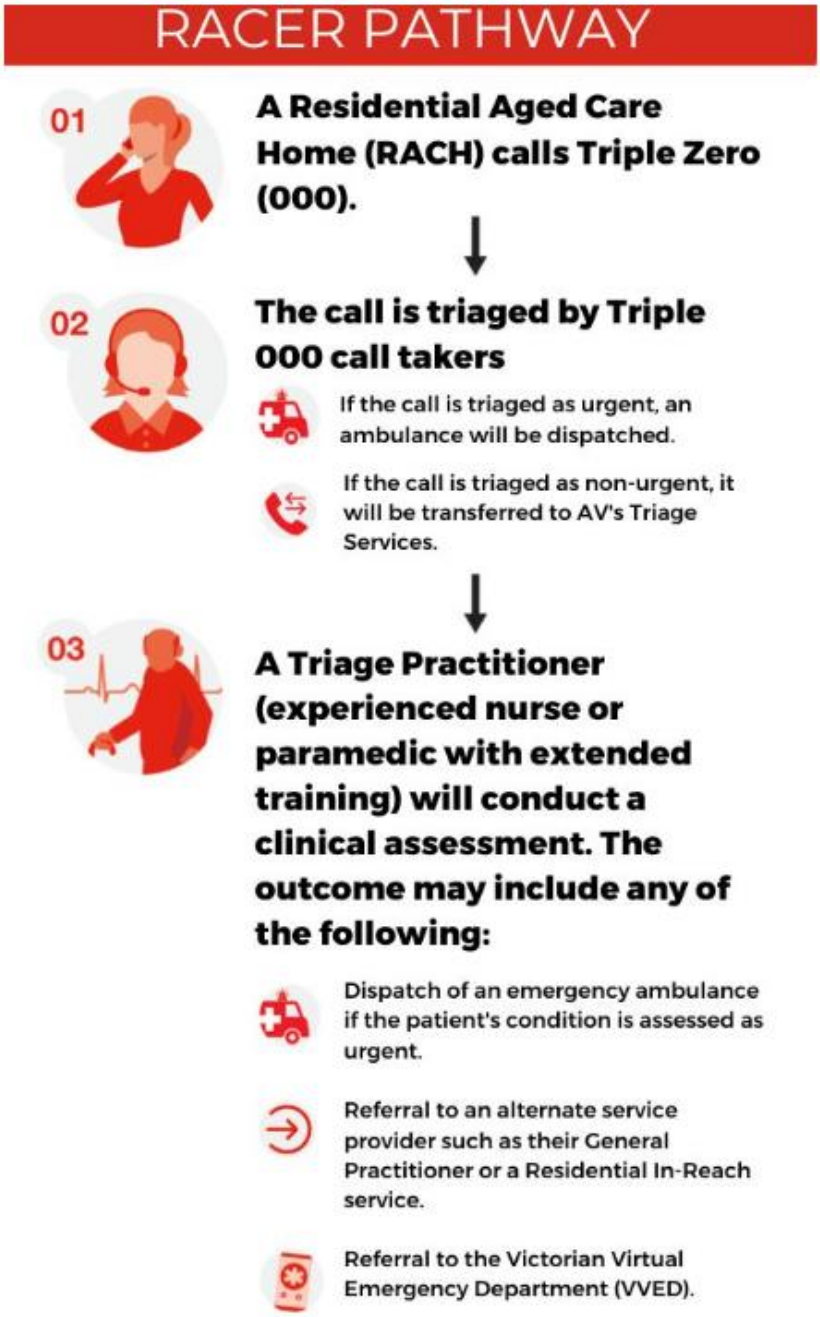
9.4.2 Local Ambulance Service – Example Victoria: Ambulance Victoria - Residential Aged Care Enhanced Response (RACER) Pathway

The RACER pathway connects and coordinates Triple Zero (000) calls from residential aged care homes to best meet patients' individual care needs. For many patients, the best care option is a medical or nursing assessment within their home environment (either in person or via telehealth) rather than transport to a hospital Emergency Department. This approach reduces the risk of complications that are often associated with hospitalisation of older persons, such as delirium, hospital-acquired trauma (such as falls) and infections.

Through the RACER pathway, Triple Zero (000) calls for aged care residents who are experiencing non-urgent medical issues, are transferred to AV's Triage Services. Triage Practitioners (experienced nurses and paramedics with advanced training) conduct a thorough patient assessment and refer eligible patients directly to the service that best meets the individual's needs. This process is illustrated below.

RACER was developed with the addition of the Victorian Virtual Emergency Department (VVED) to an existing suite of referral options for AV's Triage Practitioners to consider for

appropriate RACH patients. The VVED is a telehealth service that connects patients to highly skilled emergency doctors and nurses, virtually. Other service options under RACER include but are not limited to the patient's general practitioner (GP); Residential In-Reach (in-person assessment conducted by doctors and/or nurses from a hospital local to the patient's RACH); and locum doctors. These services can also be organised directly by RACH staff, saving Triple Zero (000) calls for emergencies.



Patients will continue to receive an ambulance response, and transport to a hospital emergency department, when required.[7]

[7] Source: https://www.ambulance.vic.gov.au/community/racer. Accessed on 12/12/2023.

9.4.3 Local Virtual Emergency department – Example Victoria: Victorian Virtual Emergency Department (VVED)

VVED is a public health service for non-life-threatening emergencies.
To help aged care providers across Victoria, VVED offer a Virtual ED specialist medical telehealth service. The VVED is open 24 hours a day, seven days a week, with senior physician coverage from 8 am to 2 am, and emergency nurse coverage from 11.30 pm to 8 am. VVED offers on-demand consultations, enabling Residential Aged Care Facilities to call VVED while the patient still at their facility or residence, and have a direct consultation with an emergency physician. We provide a pathway for referral back to primary health care providers for patients who have had an emergency telehealth consult and require follow-up.

How to access VVED:

- Service hours: 24/7, 365 days a year
- Web: vved.org.au/aged-care

9.5 Compilation of curated links to resources for palliative care in aged care: Aged Care Palliative Care (ACPC) resource hub

The Aged Care Palliative Care website (www.ac-pc.com.au) provides a compilation of selected resources, easily accessible by all aged care staff seeking support to provide timely and high quality palliative care to all residents. It covers the following topics:

- Key education resources for all staff working in residential aged care
  - Palliative care
  - Advance Care Directives and Goals of Care
  - Needs Rounds
  - Case Conferences
  - Symptom management
  - Dying phase and end-of-life care
  - Voluntary Assisted Dying
  - Grief and bereavement
  - Self-care
  - Dementia
  - Communication with clinicians
  - Culturally and linguistically diverse residents (CALD)
  - Aboriginal and Torres Strait Islanders residents
  - LGBTIQ+ aged care residents
  - Residents with intellectual disability
  - Resources to support residents, and their families and cares
  - Further resources and support for more comprehensive palliative care knowledge and skills
- Information about and links to external organisations providing support in-hours and after-hours
- Organisational support

This website is accessible via www.ac-pc.com.au or the QR code:

10 Definitions

Advance care planning
Advance care planning is the process of planning for future health and personal care. A person makes their values, beliefs and preferences known so they can guide clinical decision making when and if they are unable to make or communicate their decisions themselves. Advance care planning can be verbal or written. Both verbal and written advance care plans can result in the appointment of a substitute decision-maker (3)

Advance Care Directive
An advance care directive, is a legal document which allows an adult to document their preferences for future medical treatment, should they lose decision-making capacity and are unable to give medical instructions. A person can record general statements about their values and preferences to guide future medical treatment decisions, or record instructions consenting to or refusing specific types of treatment. (9) An Advance Care Directive is witnessed and signed by two people, of which one must be a registered medical practitioner. Neither witness can be an appointed medical treatment decision maker for the person.

Carer
A carer is someone who provides support and care to a person formally or informally (2). In this context, a carer is referred to as an informal carer as opposed to residential aged care staff.

Case Conference
A palliative care case conference is a meeting held between the resident (if able to participate), their family and their legal substitute decision-maker (SDM), and members of the care team including the GP to assess care plans and clinical care needs.
They can be a useful way to:

- help the person and family members to understand the goals of care
- discuss options for future care
- share information
- help families to deal with distress
- assess relevant options and choices in the case of an emergency
- check if there is an Advance Care Directive (ACD)
- check if the ACD needs to be updated.

Case conferences can be a comfortable way to:

- ask questions
- discuss issues
- make decisions.

Talking through issues in a case conference may stop them from becoming major issues. This way, emergencies or crises can be avoided. (12)

End of life
Essential Elements for Safe and High-Quality End-of-Life Care[9] states that people are ‘approaching the end of life’, i.e. are appropriate for palliative care when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few days or hours) and those with:

- advanced, progressive and incurable conditions

- general 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. (1)

End of life care
This describes the care delivered to people with progressive, incurable illness to live as well as possible until they die. It allows the supportive and palliative care needs of both the patient and their family to be identified and met using the palliative approach to care for approximately the last 12 months of life. (2)

Family meeting
A family meeting involves residential aged care staff, if possible the resident, their family members and or unpaid carers, and possibly the resident GP. A family meeting provides the opportunity to empower and support the resident and their family and friends, to raise their questions and concerns with representatives from the care team share, and clarify goals of care and other information about the care provided to the resident.

Goals of care
Goals of Care planning is a structured process used to provide clarity to the reason for admission to hospital and the expected treatment steps towards discharge. The treating team works with the resident and family to identify Goals of Care. Goals of Care inform medical decision-making and limitations of medical treatment. Medical management aligns with the patient's values and preferences from the point of admission. (1) This is an ongoing conversation and consultation with the patient, family, carer and health professions during the admission. The Goals of Care Summary categorises provide a guide based on four levels of care intent:

A: Curative or restorative phase with no limitation of medical treatment

B: Curative or restorative with some limitations of medical treatment

C: Supportive and Palliative Care Phase

D: Terminal Phase.

When category D applies and death is imminent and expected, the Care Plan for the Dying Person is activated.

Integrated care
Integrated care is the provision of well-connected, effective and efficient care that takes account of and is organised around a person's health and social needs. (6)

Life-limiting illness
A person with life-limiting illness may die prematurely. This term is often used for people living with a chronic condition that may seem life threatening but can continue for many years or even decades. (2)

Medical treatment decision maker
Who has legal authority to make medical treatment decisions on behalf of another person if this person is unable to make their own decisions is specified in Victoria's Medical Treatment Planning and Decisions Act 2016. This person is called a medical treatment decision maker. A medical treatment decision maker is chosen by appointing someone to this role, providing the person has decision-making capacity to do so. (7)

A medical treatment decision maker's role is to make all necessary decisions about a person's medical treatment when they are unable to do so. In those circumstances it is the decision maker's responsibility to make the same decisions that the person would make if they were able to. This decision must be informed by the medical treatment decision maker's understanding of the person's preferences and values. (8)

Model of Care
A Model of Care broadly defines the way health services are organised and delivered. It outlines best-practice care and services through core components (the components describe who delivers which particular intervention, when, where, how, to whom, and for what purpose) and principles that sit within a framework that provides the structure for the implementation and subsequent evaluation of care. (4)

Needs Rounds
Needs Rounds offer a forum for the review of residents who were identified as having palliative care needs. Needs Rounds are monthly meetings run by a specialist palliative care clinician, where numerous residents with palliative care needs are discussed. They are attended by care facility staff including personal care assistants, registered and enrolled nurses, ANUMs, managers, activities coordinators and ancillary staff. Needs Rounds can take place face to face at the residential aged care facility or via Telehealth video linkup between the participating residential aged care staff and specialist palliative care clinician. (15)

Palliative care
Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten or postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patients illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- Will enhance quality of life, and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications. (8)

Person-centred care
Person-centred care means that the client is involved in all planning and decision-making and care is aligned with their priorities. (2)

Preferred place of care
The location where a person wishes to be cared for. The location where a person's family and/or carer(s) wish to care for a person.

Preferred place of death
The location where a person wishes to die. The location where a person's family and/or carer(s) wish for a person to die.

APPENDIX

Standards cross matched

Strengthened Aged Care Quality Standard actions to corresponding National Palliative Care (NPC) Standards for All Health Professionals and Aged Care Services elements[8]

The following table is based on a mapping document developed by Palliative Care Australia that aligns the *National Palliative Care Standards for Specialist Palliative Care Providers* (Version 5.1, 2024) with the strengthened *Aged Care Quality Standards* (2025). To access this document, click here.

	Outcome	Corresponding NPC for All Health Professionals and Aged care Services Standard(s) (See table below)
Standard 1	**The individual**	
Outcome 1.1	The provider demonstrates that the provider understands that the safety, health, wellbeing and quality of life of individuals is the primary consideration in the delivery of funded aged care services. The provider demonstrates that the provider understands and values individuals, including their identity, culture, ability, diversity, beliefs and life experiences. The provider demonstrates that the provider develops funded aged care service with, and tailored to, individuals, taking into account their needs, goals and preferences.	1.6, 1.6, 2.6
Outcome 1.2	The provider must deliver funded aged care services to individuals in a way that is free from all forms of discrimination, abuse and neglect, treats individuals with dignity and respect, and respects the personal privacy of individuals. The provider demonstrates that the provider understands the rights of individuals under the Statement of Rights. The provider must have practices in place to ensure that the provider acts compatibly with the Statement of Rights, in accordance with subsection 24(2) of the Act (acting compatibly with the Statement of Rights).	

[8] The National Palliative Care Standards for All Health Professional and Aged Care Services has been developed to complement the National Palliative Care Standards (NCPS) 5th edition 2018, with the aim of supporting better experiences and outcomes for people receiving generalist palliative care.

Outcome 1.3	The provider must support individuals to exercise choice and make decisions about their funded aged care services and provide them with support to exercise choice and make decisions when they want or need it. The provider must provide individuals with timely, accurate, tailored and sufficient information about their funded aged care services, in a way they understand. The provider must support individuals to exercise dignity of risk to achieve their goals and maintain independence and quality of life.	1.5, 1.6, 2.2, 3.3
Outcome 1.4	Before entering into any agreements with individuals about the delivery of funded aged care services, the provider must provide individuals with the opportunity to exercise autonomy, the time they need to consider the agreement and an opportunity to seek advice. The provider must support individuals to understand and make informed decisions about their agreements, fees and invoices.	1.5, 2.2
Standard 2	**The organisation**	
Outcome 2.1	The provider must engage in meaningful and active partnerships with individuals to inform organisational priorities and continuous improvement.	1.5, 2.2, 7.2, 8.6
Outcome 2.2a	The governing body must lead a culture of quality, safety and inclusion that supports aged care workers to provide quality funded aged care services by focussing on continuous improvement, embracing diversity and prioritising the safety, health and wellbeing of aged care workers.	2.6, 5.7, 6.1, 9.1
Outcome 2.2b	The governing body must lead a culture of quality, safety and inclusion that supports individuals accessing quality funded aged care services by focussing on continuous improvement, embracing diversity and prioritising the safety, health and wellbeing of individuals.	9.1
Outcome 2.3	The governing body is accountable for the delivery of quality funded aged care services and must maintain oversight of all aspects of the provider's operations. The provider must use a quality system to enable and drive continuous improvement of the provider's delivery of funded aged care services. The provider must maintain current policies and procedures that guide the way aged care workers undertake their roles and require aged care workers to follow the policies and procedures.	1.3, 4.3, 4.7, 7.2, 8.2, 8.3, 8.4, 8.9, 9.1
Outcome 2.4	The provider must use a risk management system to identify, manage and continuously review risks to individuals, aged care workers and the provider's operations.	4.6, 8.2
Outcome 2.5	The provider must use an incident management system to safeguard individuals and acknowledge, respond to, effectively manage and learn from incidents.	8.3
Outcome 2.6a	The provider must encourage and support aged care workers to make complaints and give feedback about the provider's delivery of funded aged care services without reprisal. The provider must acknowledge and transparently manage all complaints and feedback and use complaints and feedback to contribute to the continuous improvement of funded aged care services.	4.7, 8.9

Outcome 2.6b	The provider must encourage and support individuals and others to make complaints and give feedback about the provider's delivery of funded aged care services without reprisal. The provider must acknowledge and transparently manage all complaints and feedback and use complaints and feedback to contribute to the continuous improvement of funded aged care services.	
Outcome 2.7	The provider must ensure that information recorded about an individual is accurate and current, is able to be accessed and understood by the individual, supporters of the individual, aged care workers, registered health practitioners, allied health professionals, allied health assistants and others involved in the individual's care. The provider must ensure that the information of individuals is kept confidential and is managed appropriately, in line with their informed consent.	2.5, 5.3
Outcome 2.8	The provider must demonstrate that the provider understands and manages their workforce needs and plans for the future.	1.1, 9.1, 9.2, 9.4, 9.5, 9.6
Outcome 2.9	The provider must deliver funded aged care services to individuals by aged care workers who are skilled and competent in their roles, hold relevant qualifications for their roles and have expertise and experience relevant to delivering quality funded aged care services. The provider must provide aged care workers with training and supervision to enable them to effectively perform their roles.	1.1, 4.7, 6.2, 9.3, 9.4, 9.5, 9.6
Outcome 2.10	The provider must demonstrate that emergency and disaster management planning considers and manages the risks to the health, safety and wellbeing of individuals and aged care workers.	
Standard 3	**The care and services**	
Outcome 3.1	The provider must actively engage with individuals to whom the provider delivers funded aged care services, supporters of individuals (if any) and any other persons involved in the care of individuals in developing and reviewing the individual's care and services plans through ongoing communication. Care and services plans must describe the current care needs, goals and preferences of individuals and include strategies for risk management and preventative care. The provider must ensure that care and services plans are regularly reviewed and are used by aged care workers to guide the delivery of funded aged care services.	1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.9, 3.2, 3.3, 4.1
Outcome 3.2	The provider must ensure that individuals receive quality funded aged care services that meet their needs, goals and preferences and optimise their quality of life, reablement and maintenance of function. The provider must ensure that funded aged care services are delivered in a way that is culturally safe and culturally appropriate for individuals with specific needs and diverse backgrounds.	1.3, 1.4, 2.6, 2.9, 3.1, 3.2, 3.3, 4.5, 4.6, 5.4

Outcome 3.3	The provider must ensure that critical information relevant to the delivery of funded aged care services to individuals is communicated effectively to the individuals, between aged care workers delivering the services, with supporters of the individuals and other persons supporting the individuals and with registered health practitioners, allied health professionals, allied health assistants and others involved in the individual's care. The provider must ensure that risks to individuals, and changes and deterioration in the condition of individuals, are escalated and communicated as appropriate.	1.3, 1.5, 3.3, 3.4, 5.2
Outcome 3.4	The provider must ensure that individuals receive funded aged care services that are planned and coordinated, including where multiple health providers and registered providers, supporters of individuals and other persons supporting individuals are involved.	1.2, 2.3, 2.9, 3.1, 3.2, 3.4, 4.4, 5.1, 5.3
Standard 4	**The environment**	
Outcome 4.1a	When delivering funded aged care services to individuals in their homes, the provider must support the individuals to mitigate environmental risks relevant to the services. Where the provider uses equipment in the delivery of any funded aged care services to individuals, or provides equipment to individuals, the equipment must be safe and must meet the needs of the individuals.	7.3
Outcome 4.1b	Where the provider delivers funded aged care services to individuals other than in their homes, the provider must ensure that individuals are able to access funded aged care services in a clean, safe and comfortable environment that optimises their sense of belonging, interaction and function. Where the provider uses equipment in the delivery of any funded aged care services to individuals, or provides equipment to individuals, the equipment must be safe and must meet the needs of the individuals.	2.6, 3.6, 7.3
Outcome 4.2	The provider must have an appropriate infection prevention and control system. The provider must ensure that aged care workers use hygienic practices and take appropriate infection prevention and control precautions when delivering funded aged care services.	
Standard 5	**Clinical care**	
Outcome 5.1	The governing body must ensure that the governing body continuously improves the safety and quality of clinical care services to individuals and that the provider delivers safe and quality clinical care services to individuals. The provider must integrate clinical governance into corporate governance to actively manage and improve the safety and quality of clinical care services delivered to individuals.	1.1, 2.5, 3.4, 4.3, 5.3
Outcome 5.2	The provider must ensure that individuals, aged care workers, registered health practitioners and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance. The provider must ensure that infection risks are minimised and, if they occur, are controlled effectively.	

Outcome 5.3	The provider must encourage and support individuals, aged care workers, registered health practitioners and allied health professionals to use medicines in a way that maximises benefits and minimises the risks of harm. The provider must ensure that before administering medicine to an individual, the medicine has been prescribed for the individual and medicines are appropriately and safely administered, monitored and reviewed by registered health practitioners, considering the clinical needs and informed decisions of the individual. The provider must ensure that medicines-related adverse events are monitored and reported and are used to inform safety and quality improvement.	3.4, 3.6
Outcome 5.4	The provider must ensure that individuals receive comprehensive, safe and quality clinical care services that are evidence-based, person-centred and delivered by registered health practitioners, allied health professionals, allied health assistants or nursing assistants. Clinical care delivered by the provider must encompass clinical assessment, prevention, planning, treatment, management and review to minimise harm and optimise quality of life, reablement and maintenance of function. The provider must have systems and processes that support coordinated, multidisciplinary clinical care services that are delivered to individuals, in partnership with individuals, supporters of individuals and other persons supporting individuals, and that are aligned with the individual's needs, goals and preferences. The provider must support early identification of, and response to, changing clinical needs.	1.2, 1.3, 1.4, 1.5, 1.7, 2.6, 2.8, 2.9, 2.10, 3.3, 3.5, 4.1, 4.6
Outcome 5.5	The provider must identify, monitor and manage high impact and high prevalence risks in the delivery of clinical care services to ensure the delivery of safe, quality clinical care services and to reduce the risk of harm to individuals.	1.4, 2.6, 4.6, 6.5
Outcome 5.6	The provider must ensure that individuals who experience cognitive impairment (whether acute, chronic or transitory) receive comprehensive funded aged care services that optimise clinical outcomes and are aligned with their needs, goals and preferences. The provider identifies situations and events that may lead to changes in behaviours.	3.3, 4.6
Outcome 5.7	The provider must recognise and address the needs, goals and preferences of individuals for palliative care and end-of-life care, and must preserve the dignity of individuals in those circumstances. The provider ensures that the pain and symptoms of individuals are actively managed, with access to specialist palliative and end-of-life care when required. The provider must ensure that supporters of individuals and other persons supporting individuals are informed and supported, including during the last days of life.	1.3, 1.5, 2.4, 2.8, 3.3, 3.7, 4.1, 4.2, 4.4, 5.3, 5.5, 6.3, 6.6, 7.1, 8.8
Standard 6	**Food and nutrition**	
Outcome 6.1	The provider must partner with individuals to deliver a quality food and drinks service that includes appetising and varied food and drinks and an enjoyable dining experience.	

Outcome 6.2	The provider must demonstrate that the provider understands the specific nutritional needs of individuals and assesses the current needs, abilities and preferences of individuals in relation to what and how they eat and drink.	1.4
Outcome 6.3	The provider must provide individuals with food and drinks that meet their nutritional needs and are appetising and flavoursome; variation and choice about what they eat and drink; and choice about how much they eat and drink.	
Outcome 6.4	The provider must support individuals to eat and drink. The provider must ensure that the dining experience meets the needs and preferences of individuals to support social engagement, function and quality of life.	
Standard 7	**The residential community**	
Outcome 7.1	The provider must ensure that individuals receive funded aged care services that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do. The provider must ensure that individuals feel safe in their residential care home.	2.6, 7.4
Outcome 7.2	The provider must ensure that individuals experience a well-coordinated transition, whether planned or unplanned, to or from a provider. The provider must set out clear responsibility and accountability for the delivery of funded aged care services to individuals between aged care workers, registered health practitioners, allied health professionals, allied health assistants and across organisations.	3.3, 3.4, 4.4, 5.1, 5.2, 5.6, 8.8

NPC for All Health Professionals and Aged care Services Standard	Description
Standard 1	**Comprehensive assessment of needs** Initial and ongoing assessment comprehensively incorporates the person's physical, psychological, cultural, social, and spiritual experiences and needs. 1.1 The initial and ongoing assessments are carried out by qualified interdisciplinary personnel. 1.2 The assessment is coordinated to reduce the burden of duplication on the person, family* and carers. 1.3 Clinical assessment tools are informed by the best available evidence and identify those approaching the end of life as well as those that are imminently dying. 1.4 The person's needs are reassessed on a regular basis 1.5 The person, their family* and carers are provided with clear information on how, and whom, to contact when there is a change in their illness or circumstances, including after hours. 1.6 Initial and ongoing assessments are documented in the person's clinical record. d ongoing assessments are documented in the person's clinical record. 1.7 Ongoing assessments are used to inform the care plan and any subsequent changes to it.
Standard 2	**Developing the comprehensive care plan** The person, their family and carers and substitute decision-maker(s) work in partnership with multidisciplinary teams to communicate, plan, set goals of care and support informed decisions about the comprehensive care plan. 2.1 Care planning is informed by the assessment process and reflects a person-centred, holistic approach that incorporates cultural, spiritual, physical, psychological and social needs. 2.2 The person, their family* and carers are provided with up to date information appropriate to meet their needs and support informed participation in care planning and decision-making. 2.3 Systems are in place to identify a substitute decision maker if a person does not have the capacity to make decisions for themselves. 2.4 The person is supported to consider, document and update their future care goals, including in an advance care plan. 2.5 A system is in place for receiving, storing, accessing and sharing existing advance

care plans and goals of care.

2.6 Specific attention is paid to the needs of people who may be vulnerable or at risk, to support communication, goal setting and care planning. This includes, but is not limited to Aboriginal and Torres Strait Islander peoples, people seeking asylum, people who have experienced torture and trauma, people who are experiencing homelessness; people living with mental illness, intellectual disabilities or dementia; paediatric populations or people from ethnically and culturally diverse backgrounds.

2.7 Initial and ongoing discussions informing the care plan are documented and readily available to guide care delivery.

2.8 The expectations and preferences of the person, their family* and carers for the type and place of care are discussed, negotiated and an agreed plan is documented.

2.9 The care plan is reviewed and updated regularly, on the basis of re-assessments of the person's condition, needs, and preferences, and in consultation with the person, their family* and carers. Changes to the care plan are documented.

2.10 Care plans incorporate management for emergency and out-of-hours support, including certification of death and plans for the care and collection of the body where this is required after hours.

Standard 3 Caring for carers

The needs and preferences of the person's family and carers and substitute decision-maker(s) are assessed, and directly inform provision of appropriate support and guidance about their role.

3.1 At least one carer is identified for each person as far as possible and their specific needs, including their need for information, are assessed and documented.

3.2 The service works with the family* and carers to understand their needs and desired level of involvement in care. The potential benefits and risks around assisting with care are discussed with the person, their family* and carers and there is ongoing assessment of their willingness and ability to participate in the provision of care.

3.3 There are systems in place to ensure that the person's nominated family* and carers are supported to participate in the provision of health care in accordance with the preferences of the person, their family* and carers (taking into account privacy requirements).

3.4 The family* and carers are provided with up-to-date information and resources that are adapted to meet their needs and that inform their participation in care planning and delivery. This may include information about accessing respite services, equipment, financial support and other services, as well as encouraging the involvement of personal support networks and self-care.

3.5 The family* and carers are provided with a clear plan for emergency and out of hours events.

3.6 Depending on the location of care and the person's needs and preferences, the family* and carers are educated on how to safely assist with care, including managing risk, manual handling and activities of daily living.

3.7 The family and carers are provided with information about the signs and symptoms of approaching death and the steps to take following death, in a way that is appropriate for their age, culture and social situation.

Standard 4 Providing care

The provision of care is based on the assessed needs of the person, informed by evidence, and is consistent with the values, goals and preferences of the person as documented in their care plan.

4.1 Care is delivered promptly, in accordance with the changing needs of the person, their family* and carers, their documented care plan and their goals and preferences.

4.2 The care plan and person's preferred place of care and death, is discussed, documented and the associated care is planned for.

4.3 Clinical Practice is informed by new and emerging evidence.

4.4 Where care cannot be delivered in accordance with the goals and preferences of the person, this is discussed with the person, their family*, and carers, and an agreed alternative plan is documented and communicated.

4.5 There are protocols and procedures in place for the escalation of care where required, based on assessed needs.

4.6 The service aims to actively pre-empt distress to the best of their ability but when it occurs, the response to it is timely, appropriate, effective, acceptable, and actions are documented.

4.7 The effectiveness of care is measured according to established indicators and outcomes.

Standard 5 Transitions within and between services

Care is integrated across the person's experience to ensure seamless transitions within and between services.

5.1 There are systems and processes (policies and guidelines) in place that support and promote continuity of care, and timely access, across settings and throughout the course of the person's illness. This includes, but is not limited to, referrals, admissions, discharge and handover between services, and referral to other specialties (e.g., mental health) to ensure needs are met without delay.

5.2 The service has in place effective communication systems to support integrated care, including processes for communicating information about the care plan, goals of care, prognosis and death of the person within and between services.

5.3 Care plans demonstrate appropriate actions to support seamless transition between care settings.

5.4 Specialist palliative care services' have in place clear referral and admission criteria, and these are communicated to the local health and wider community, resulting in equitable access to services based on clinical need.

5.5 Referrals from the specialist palliative care service are made to appropriate specialists or services that are able to meet the identified physical, psychosocial and spiritual needs of the person, their family* and carers (for example acute pain services, mental health services, bereavement counsellors).

5.6 Services assist local community-based service providers to build their capability to help people to be cared for in their home, where this aligns with the person's preferences.

5.7 The organisation has mechanisms in place to assess needs of the local and wider health community and uses this information to develop plans for future improvement of the service.

Standard 6 Grief support

Families and carers have access to grief support services and are provided with information about loss and grief.

6.1 Culturally appropriate information and resources about loss and grief and bereavement support services is routinely provided to families* and carers before and after the death.

6.2 The service provides education about loss, grief and bereavement to staff, volunteers and other community providers.

6.3 The service employs a structured assessment of bereavement that addresses emotional, behavioural, social, spiritual and physical domains.

6.4 The risk assessment process begins on intake to the palliative care service and continues throughout the service's involvement with the person and beyond.

6.5 The service uses validated tools to assess for signs and symptoms of persistent and intense distress in bereaved persons.

6.6 The service develops strategies and referral pathways, in partnerships with other providers in the community, to assist families* and carers in feeling more prepared for the death and to accommodate grief into their lives after bereavement.

6.7 Referrals to bereavement, specialist mental health and/or counselling professionals are made when clinically indicated.

6.8 The organisation has mechanisms in place for the specialist palliative care team to access education, training and supervision to meet the loss, grief and bereavement needs of the family* and carers.

Standard 7 Service culture

The service has a philosophy, strategy, values, culture, structure, and environment that supports the delivery of person and family-centred palliative care.

7.1 The values and culture of the service explicitly support the provision of person-centred palliative care.

7.2 The philosophy and objectives of the service are documented and incorporated into clinical practice guidelines, policies and procedures.

7.3 The care setting provides an appropriate environment to support people reaching the end of their lives, their family* and carers, including as appropriate the technological innovations to support their preferences and cultural needs.

7.4 Services understand the community they serve, and use this information to both provide optimal specialist palliative care services and influence wider health, aged and social care systems that meet the needs of that community.

Standard 8 Quality improvement

Services are engaged in quality improvement and research, based on best practice and evidence, to improve service provision and development.

8.1 An ongoing quality improvement process is implemented to review clinical performance and outcomes, and to identify, implement and evaluate improvement activities.

8.2 Data about the effectiveness of palliative care delivery is collected, reviewed and reported locally.

8.3 System failures are systematically identified and investigated, and there are opportunities to learn from error.

8.4 The service engages in robust and rigorous clinical audit review.

8.5 The service is accredited to ensure achievement of governance and safety requirements.

8.6 The service participates in benchmarking processes to compare its service delivery over time and/or with external organisations.

8.7 The service supports staff to lead or participate in palliative care research wherever possible.

8.8 Specialist palliative care services support other services providing care to people at the end-of-life to improve the quality of that care.

8.9 The person, their family* and carers and the community are provided with opportunities to provide input into the evaluation of the service via formal and informal feedback mechanisms.

Standard 9 Staff qualifications and training

Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles.

9.1 The service employs a multidisciplinary team of health professionals with recognised qualifications, credentialing and experience to meet the physical, psychological, social, cultural and spiritual needs of the person, their family and carers.

9.2 Staff in clinical leadership and management positions have recognised qualifications and experience in relevant fields.

9.3 A formal assessment of palliative care education and training is undertaken for all members of the health service to identify professional development requirements.

9.4 Staff and volunteers receive appropriate supervision and support in accordance with an established professional development framework, inclusive of evidence-based digital health and innovations training.

9.5 Staff undergo training to ensure delivery of culturally safe and responsive care.

9.6 A culture of self-care opportunities, with staff trained in self-care strategies and advised on how to access personal support.

9.7 Volunteer programs are recognised, supported, and managed in accordance with the relevant volunteer standards.

LINKS

- Ambulance Victoria Residential Aged care Enhanced Response (RACER) Pathway: www.ambulance.vic.gov.au/community/racer
- ISBAR tool: www.wnswphn.org.au/uploads/documents/corporate%20documents/WHAL%20RACF%20ISBAR%20Framework_FINAL.pdf#:~:text=RACF%20ISBAR%20Framework%20is%20being%20developed%20as%20a,protocols%20within%20the%20residential%20aged%20care%20facility%20%28RACF%29
- Palliative Aged Care Outcomes Collaboration (PACOP): www.uow.edu.au/ahsri/pacop
- Palliative Care Advice Service (PCAS): www.pcas.org.au
- Aged Care Palliative Care (ACPC): www.ac-pc.com.au
- REDMAP: www.spict.org.uk/wp-content/uploads/2023/12/Care-Planning-Questions-for-Residents-Dec-2023.pdf
- Safer Care Victoria Care for the Dying person: www.safercare.vic.gov.au/best-practice-improvement/clinical-guidance/palliative/care-plan-for-the-dying-victoria
- Stop and Watch Tool: www.ohsu.edu/sites/default/files/2019-03/INTERACT-Stop-and-Watch.pdf
- Victorian Virtual Emergency Department: www.vved.org.au/aged-care

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