Model of Care for the Recognition of and Response to Deterioration – Implementation Guide for Residential Aged Care

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

BALLARAT HOSPICE CARE INC.
Home Based Palliative Care

Project partners:	This implementation project is a collaboration between Ballarat Hospice Care (funding recipient and project lead), Grampians Region Palliative Care Consortium and its members, and Grampians Regional Palliative Care Team (Grampians Health).
Sponsors:	Australian Department of Health and Aged Care, and Victorian Department of Health, Comprehensive Palliative Care in Aged Care (CPCiAC) Project Measure 2018
Authors:	Donna Walter, CPCiAC Project Officer Diane Nimmo, Strategic Projects and Research Manager
Contact:	Diane Nimmo, Strategic Projects and Research Manager, Ballarat Hospice Care, email: dnimmo@ballarathospicecare.org.au
Project runtime:	07/2024 – 06/2026
Date:	June 2026

Contents

Acknowledgements

This project was conducted as a collaboration of Ballarat Hospice Care (funding recipient), Grampians Regional Palliative Care Team, Grampians Regional Palliative Care Consortium. It builds on the outcomes and learnings of the 2023/24 pilot project conducted between Ballarat Hospice Care (funding recipient), Grampians Regional Palliative Care Team, Grampians Regional Palliative Care Consortium, and Central Highlands Rural Health.

We thank the Australian Government Department of Health and Aged Care, and the Victorian State Government Department of Health for funding this Comprehensive Palliative Care in Aged Care (CPCiAC) Project. We are thankful to the funders for enabling the organisations in this collaboration to work on an approach to strengthening systems to improve the care aged care residents, their families and carers receive in the last phase of the residents' lives, and for enabling us to support residential aged care facilities across the Grampians region and beyond to implement this approach.

The Project Team acknowledges the generous support and thanks the Steering Committee members and Ballarat Hospice Care, Grampians Region Palliative Care Consortium, Grampians Regional Palliative Care Team, for their enthusiasm to design and carry out this project.

We thank all residential aged care managers and staff members across the Grampians region and beyond who have implemented this project at their facilities for their collaborative approach, and their passion and commitment to best-practice care and service delivery, and for striving to improve the lives of the residents, patients, families, carers, and healthcare and aged care workers.

We also thank the Palliative Aged Care Outcomes Program (PACOP) for their collaboration and support, permitting us to incorporate their Deteriorating Resident Tool and Daily Symptom Assessment Scale forms in our model of care for the recognition of and response to deterioration. This paves the path for participating facilities to build on the project work and take the next step by implementing the full PACOP program if they wish to do so.

Lastly, we extend our sincere thanks to Central Highlands Rural Health for their instrumental involvement in the 2023/24 pilot project, and to Ballarat Hospice Care specialist palliative care nurse, Valerie Armenante, CPCiAC Project Officer during the pilot project, for her outstanding work and for the passion and dedication she brought to this project and its purpose.

1 Introduction

1.1 Background

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.[1] 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 palliative care they require. A recent Australian study comes to the following conclusion:

> "Over 90% of individuals dying in residential aged care may have benefited from a palliative approach to care. This need is substantially underestimated by the funding-based care needs assessment, which utilises a narrow definition of palliative care when death is imminent. There is a clear imperative to distinguish between palliative and end-of-life care needs within residential aged care to ensure appropriate and equitable access to palliative care. (…) This estimate likely reflects the true need for palliative care in this population and importantly identified potential unmet need."[2]

It can be stated that acknowledging palliative care – not only end-of-life 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. Continuous assessment and prompt identification of palliative care needs are essential for providing appropriate care. With Outcome 5.7 of the Strengthened Aged Care Quality Standards (in effect from 01/11/2025) dedicated to palliative care and end of life care, providers must ensure systems are in place and staff is competent and confident in the delivery of both palliative care and end of life care.

1.2 About This CPCiAC Project

In January 2023, Ballarat Hospice Care received a non-recurrent grant from the AustraliaVictorian Department of Health to improve access to palliative care for residents in aged care. This funding formed part of a broader suite of initiatives under the Comprehensive Palliative Care in Aged Care (CPCiAC) national project agreement, jointly funded by the Australian Government Department of Health and Aged Care and the Victorian Department of Health.

To maximise the impact of this funding, extend its reach beyond the Ballarat Hospice Care service area, and ensure sustainability beyond the project's lifespan, the initiative was delivered in partnership with the Grampians Region Palliative Care Consortium (GRPCC) and the Grampians Region Palliative Care Team (GRPCT), auspiced by Grampians Health. Three Central Highlands Rural Health residential aged care facilities participated as pilot sites during the 2023/24 financial year.

A comprehensive literature review was undertaken to identify barriers and enablers to the provision of palliative care in residential aged care, as well as factors influencing the implementation of a sustainable model of palliative and end-of-life care. In parallel, an assessment of all three pilot facilities examined how both generalist and specialist palliative care services were being delivered at that time, identifying key gaps in care provision. A

[1] Palliative Care Australia (2017): Ensuring Palliative Care is Core Business for Aged Care. Web: https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2017/05/PCA018_Guiding-Principles-for-PC-Aged-Care_W03-002.pdf. Accessed on 11/05/2026.

[2] Humphrey, G. B., Inacio, M. C., Lang, C., Churches, O. F., Sluggett, J. K., Williams, H., Morgan, D. D., M To, T. H., Kellie, A., Wesselingh, S., & Caughey, G. E. (2024). Estimating potential palliative care needs for residential aged care: A population-based retrospective cohort study. *Australasian Journal on Ageing*, *43*(4), 782. Web: https://doi.org/10.1111/ajag.13345. Accessed on 11/05/2026.

thorough audit of existing tools and resources supporting the identification of, and response to, palliative care needs was also completed.

Based on the findings from these activities, a model of recognising and responding to deterioration was developed and trialled. This model enabled residential aged care staff to systematically identify palliative care needs early – well before the terminal phase – and to guide appropriate responses for delivering both palliative and end-of-life care.

Following positive evaluation outcomes from the pilot sites, and supported by additional non-recurrent funding in 2024/25, the CPCiAC Project expanded across the Grampians region. All 52 residential aged care facilities within the region, along with two additional services outside the region (totalling 54 facilities and 2,843 beds), were approached and invited to participate.

Over the course of the project, a gap analysis was conducted across the 54 residential aged care facilities to identify any gaps in the systems supporting the delivery of palliative care and end-of-life care. The gap analysis made evident that only one of the 54 facilities had a systematic approach to regularly conducting palliative care needs assessments in place (i.e. the full PACOP program). The remaining 98% lacked a structured process for the early identification and response to palliative care needs and symptoms, although all facilities had an end-of-life care plan in place.

This gap can be effectively addressed through the implementation of a systematic approach to early identification of palliative care and end-of-life care needs and symptoms, exemplified by the model of care developed, piloted, and implemented across the Grampians region and beyond as part of the Comprehensive Palliative Care in Aged Care (CPCiAC) Project between 07/2023 and 06/2026.[3]

This model of care was designed to strengthen equitable delivery of palliative care and end-of-life in residential aged care homes with the overarching aim of improving both quality of living and dying for all residents.

The model focusses on the *systematic identification of and response to* deterioration, including

- Timely and systematic identification of deterioration.
- Comprehensive symptom assessment and management.
- Ensuring access to specialist palliative care for residents with complex needs.
- Advance care planning, ensuring residents' preferences and wishes are documented and regularly reviewed as their condition changes.
- Addressing psychosocial and spiritual needs to support holistic, person-centred care.
- Delivery of coordinated, integrated, and person-centred care at end-of-life.
- Strengthening communication between internal and external clinicians, residential aged care staff, and residents, as well as their families and carers.

[3] Further project priorities included:

- Capacity building, including education for aged care staff, supporting the nomination of palliative care champions, an Aged Care Palliative Care Community of Practice, promotion of enabler resources through raising awareness for hardcopy resources for staff, and residents and their families, and enabling easy access to online resources.
- Engaging the wider care team, i.e. General Practitioners supporting aged care residents and Palliative Care Specialists

1.3 About This Implementation Guide

With this CPCiAC project concluding on 30 June 2026, this implementation guide is designed to support residential aged care facilities and providers both public and private to implement this model of care for the recognition of and response to deterioration independently, without the support of an external CPCiAC Project Officer.

It is relevant to facilities and providers across the Grampians region that were required to pause implementation during the project timeframe or were unable to commence implementation. It is also relevant for any facility, residential aged care provider or Project Officer who would like to replicate this project in different regions of Australia. All resources and learnings are presented in this guide to enable self-directed implementation or provide implementation support.

Intended audience: Clinical Innovation Leads, Quality and Education Managers, Directors of Nursing, Nurse Unit Managers, Associate Nurse Unit Managers, Registered Nurses, Enrolled Nurses, members of palliative care committees in residential aged care homes, Project Officers and Link Nurses supporting residential aged care facilities.

Implementation of this model of care for the recognition of and response to deterioration to ensure the delivery of comprehensive palliative care and end of life care meets resident's needs, is recommended, not mandated. It may need to be tailored to

- Suit individual settings, the needs of local 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.

1.4 Benefits of Implementing this Model of Care for the Recognition of and Response to Deterioration

Implementing this model of care for the recognition of and response to deterioration has numerous benefits:

For providers

- It can inform the development of procedures and policies related to palliative care and end-of-life care to ensure compliance with the Strengthened Aged Care Quality Standards effective from November 1st, 2025, with Outcome 5.7 specifically addressing palliative and end-of-life care.

For aged care managers

- Showcase continuous quality improvement and monitoring in high-quality, person-centred palliative care and end of life care.
- Increased staff confidence, skills and knowledge in advance care planning, decision-making, and palliative care.
- Improved palliative care and end-of-life care service delivery, and better experiences for staff, residents and families.
- Prevention of avoidable hospital admissions and emergency department visits.
- Support to meet the obligations and requirements under the Strengthened Aged Care Quality Standards.

For nurses

- Increased confidence, skills and knowledge in identifying deterioration towards end-of-life, palliative care needs and symptoms, decision-making, advance care planning, delivering palliative care and referral to specialist palliative care.
- Improved collaboration and communication with GPs and specialist palliative care clinicians.

For residents and their families

- Improved quality of life and end-of-life experiences for residents, and their families and friends.

1.5 Guiding Frameworks and Principles

Guiding frameworks

Our work aligns with and is conducted with and in commitment to the

- National Palliative Care Strategy[4].
- National Consensus Statement - Essential Elements for safe and high-quality end-of-life care[5].
- Victorian End of Life framework[6,7].

Guiding principles

- Improving the quality of life for residents in aged care towards the end of life is the key principle underlying our work.[8]
- Our approach adopts the Palliative Care Australia guiding principles for palliative and end-of-life care in residential aged care[9].[10]

---

[4] Department of Health (2018). Australian Government, Canberra: The National Palliative Care Strategy 2018 https://www.health.gov.au/resources/publications/the-national-palliative-care-strategy-2018. Accessed on 11/05/2026.

[5] Australian Commission on Safety and Quality in Health Care (2023). National Consensus Statement: essential elements for safe and high-quality end-of-life care. Web: https://www.safetyandquality.gov.au/sites/default/files/2023-12/national_consensus_statement_-_essential_elements_for_safe_and_high-quality_end-of-life_care.pdf. Accessed on 11/05/2026.

[6] Department of Health and Human Services (2016). Victoria's end of life and palliative care framework. State Government of Victoria, Melbourne. Web: https://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care/end-of-life-and-palliative-care-framework. Accessed on 11/05/2026.

[7] Department of Health and Human Services (2016). Victoria's end of life and palliative care framework. State Government of Victoria, Melbourne. Web: https://content.health.vic.gov.au/sites/default/files/2026-05/victorian-palliative-and-end-of-life-care-framework-2026%E2%80%9336.pdf. Accessed on 04/06/2026.

[8] World Health Organization (2020). Palliative Care. Web: https://www.who.int/news-room/fact-sheets/detail/palliative-care#:~:text=Palliative%20care%20is%20an%20approach,associated%20with%20life%2Dthreatening%20illness. Accessed on 11/05/2026.

[9] Palliative Care Australia (2018): Principles for Palliative and End-of-Life Care in Residential Aged Care. Web: https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2017/05/PCA018_Guiding-Principles-for-PC-Aged-Care_W03-002.pdf. Accessed on 11/05/2026.

[10] 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.

1.6 Quality Standards

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

- Strengthened Aged Care Quality Standards in effect from November 1st, 2025. Outcome 5.7 focuses on palliative and end-of-life care.[11]
- National Palliative Care (NPC) Standards for All Health Professionals and Aged Care Services (2022)[8]. The project also supports alignment to these standards, which guide the delivery of best practice palliative care and the palliative approach.
- National Safety and Quality Health Service (NSQHS) Standards 2nd Edition - Comprehensive Care Standard[12].

Evidence mapping

- The project specifically supports facilities in meeting the **Strengthened Aged Care Quality Standards – Outcome 5.7: Palliative Care and End-of-Life Care**. The CPCiAC project team has created an evidence mapping document (Appendix 12) showing how compliance can be achieved. The document includes examples of evidence aligned with the key CPCiAC recommendations, including the systematic identification and response to palliative care needs.

2 Model of Care for the Recognition of and Response to Deterioration: Systematic Approach to Identifying and Responding to Palliative Needs and Symptoms

The model of care for the recognition of and response to deterioration comprises of two palliative care assessment tools from the PACOP collection working alongside a customised facility process map to provide a systematic approach to identifying and responding to (emerging) palliative care needs.

2.1 About the Model of Care

This model of care for the recognition of and response to deterioration encompasses the following three elements:

1. Deteriorating Resident Tool (PACOP) (Appendix 1)
2. Facility Process Map (Appendix 3)
3. Daily Symptom Assessment Scale (PACOP) (Appendix 2)

Implementing this model of care into the everyday routines at your facility will ensure:

- Greater understanding and awareness that palliative care is an approach to care that focuses on improving quality of life for people living with life limiting illness, at any stage,

[11] Australian Government Aged Care Quality and Safety Commission (n.y.): Strengthened Quality Standards. Web: https://www.agedcarequality.gov.au/providers/quality-standards/strengthened-aged-care-quality-standards. Accessed on 11/05/2026.

[12] Australian Commission on Safety and Quality in Health Care (2017). National Safety and Quality Health Service Standards. Second edition. Web: https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf. Accessed on 11/05/2026.

by managing symptoms, supporting wellbeing, and aligning care with what matters most to the older person.

- Timely and systematic identification of palliative care needs (corresponds to Strengthened Aged Care Quality Standards Action 5.7.1).
- Symptom assessment, monitoring, and management, with a focus on pain and other symptoms. This includes anticipatory planning and responding to changing needs, prioritising the resident's comfort and dignity (corresponds to Strengthened Aged Care Quality Standards Actions 5.7.1, 5.7.3, and 5.7.4).
- Access to specialist palliative care for residents with complex needs (corresponds to Strengthened Aged Care Quality Standards Action 5.7.3).
- Prompts to review advance care planning documents to ensure they align with current needs, goals, and preferences (corresponds to Strengthened Aged Care Quality Standards Action 5.7.2);
- Support for the resident's ritual, cultural, and psychosocial needs (corresponds to Strengthened Aged Care Quality Standards Action 5.7.3).
- Utilisation of internal and external supports to avoid unnecessary transfers to hospital, in line with the resident's preferences (corresponds to Strengthened Aged Care Quality Standards Action 5.7.4).
- Well-coordinated, shared, and integrated person-centred care for patients at the end-of-life.
- Effective communication among internal and external clinicians (GPs and specialist palliative care clinicians), residential aged care staff, and with residents, their families and friends.

2.2 Model Tools: Overview and Guide to Use

2.2.1 Deteriorating Resident Tool (PACOP)

- The Deteriorating Tool (DRT) is the system's baseline assessment tool used to identify palliative care needs. It brings together four evidence-based assessment components to support symptom identification and anticipate future deterioration: the Symptom Assessment Scale (SAS), Problem Severity Score (PSS), Australia Modified Karnofsky Performance Status (AKPS), and Rockwood Clinical Frailty Scale (RCFS)
- The DRT includes resident-rated and clinician-rated assessments to support identification of symptoms and related care concerns.
- It also includes assessments of overall functional abilities and frailty to support prediction of future deterioration.
- The DRT supports staff to enhance resident wellbeing through early symptom management and timely, meaningful advanced care planning and goals of care conversations, guided by regular monitoring of changes.
- DRT assessments are aligned to the facility's routine processes and recommended at **4 specific trigger points - admission, resident of the day (or equivalent), return from hospital and** anytime there is a **change in condition**, concern, or stop and watch prompt- alongside the acute assessment.
- The summary section of the DRT form requires the assessor to review and reflect on the DRT assessment findings with a short set of YES/NO questions. Any YES answer leads to the utilization of the facility process map.

Deteriorating Resident Tool – Identifying the Palliative Care Needs and Symptoms

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

2.2.2 Facility Process Map

The facility process map is used when palliative care needs have been identified through a Deteriorating Resident Tool (DRT) assessment at one of the four trigger points. It guides staff in responding consistently and appropriately once palliative care needs are recognised.

What the process map provides

The process map is a visual guide that:

- Defines how deterioration and palliative care needs are managed in the residential aged care setting.
- Outlines how palliative and end of life care is delivered by residential aged care staff, in collaboration with:
  - The older person and their family and/or substitute decision maker
  - The resident's general practitioner (GP)
  - External services, including emergency services
  - Specialist palliative care clinicians, where required

Care phases and symptom monitoring

The process map:

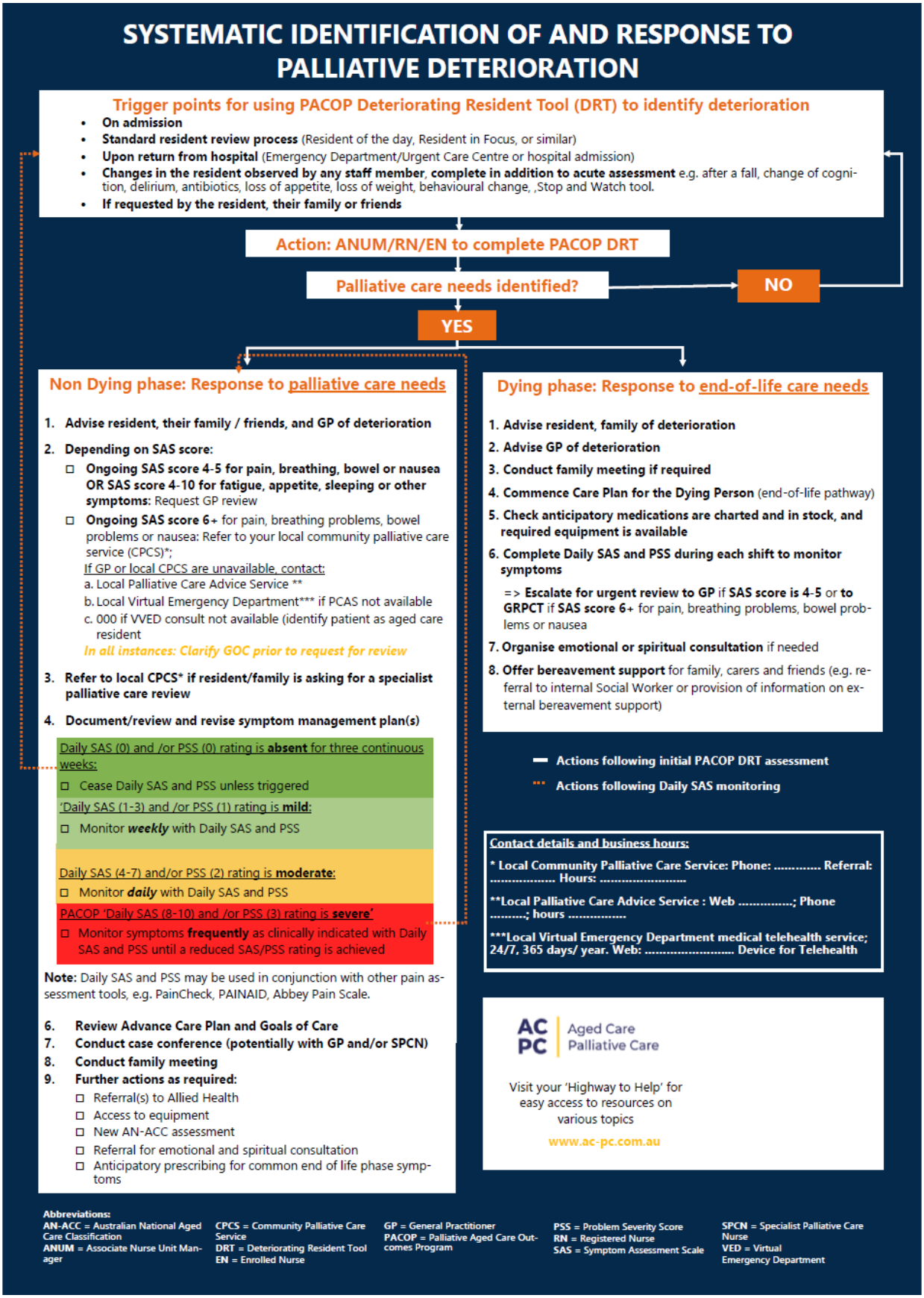
- Includes clear prompts for actions to support the older person's quality of life during the non-dying and quality of death during the dying phase.
- Provides guidance on symptom monitoring, including recommended frequency and duration of monitoring

Escalation and local adaptation

The process map also:

- Defines triggers for escalation to internal and external support services, including specialist palliative care.
- May be adapted to reflect the specific context of the facility, such as:
  - Locally available services
  - Established referral pathways
  - The involvement of local specialist palliative care teams.

Facility-specific Process Map – Guidance on Responding to Palliative Care Needs and Symptoms



2.2.3 Symptom Assessment Scale (PACOP)

The Daily Symptom Assessment Scale (SAS) is used for structured symptom monitoring when a change in a resident's condition indicates increased palliative care needs.

When to use the SAS

- Use SAS when a DRT assessment identifies a **moderate or severe** SAS symptom score.
- Use the **Daily SAS** for more frequent monitoring (it expands on the SAS table within the DRT).

What it includes

- One form with colour coding and symptom-rating descriptors (including guidance for proxy assessments where required).
- The SAS form allows multiple assessment scores to be recorded on a single form.
- A guide indicating when to report findings to a supervisor, aligned to SAS scores.

Frequency and duration

- The facility process map guides the frequency and duration of SAS monitoring based on the resident's response to symptom management interventions.
- Other pain assessment tools (for example, PAINAD or the Abbey Pain Scale) may be used alongside the SAS where appropriate.

Daily SAS – Monitoring symptoms

PACOP palliative aged care outcomes program

OUTCOMES COLLECTION

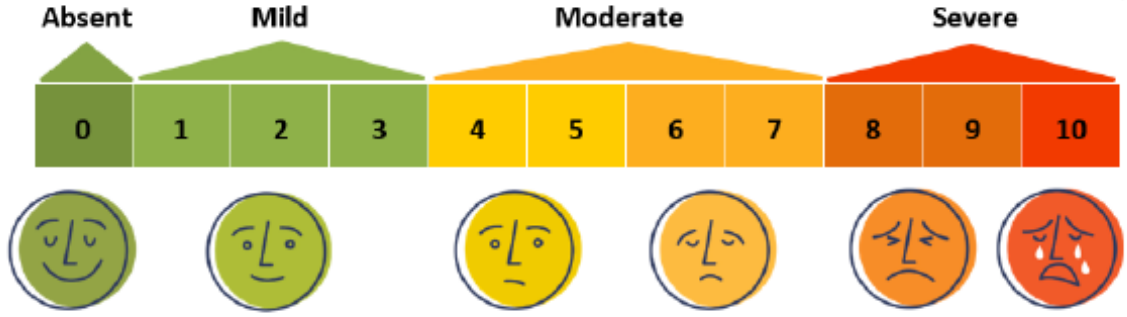
Daily symptom assessment

(Please complete or affix Label here)

UPI:
Surname
First name:
DOB:

Daily PCOC Symptom Assessment Scale (SAS)

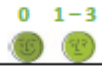
Please use this form to ask the Resident about the symptoms that bothered, worried or distressed them over the previous 24 hours. This information will help us to meet their needs.



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

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)

3 Implementation

Implementation focuses on embedding the model of care for the recognition of and response to deterioration into everyday practice through education, workflow integration, and supporting processes, with assistance from clinical champions. Implementation of this model of care should be staged and tailored to the specific needs of each facility.

While facilities may use their preferred implementation approach, experience from the CPCiAC project highlights the following critical success factors for each implementation stage.

3.1 Pre-implementation

3.1.1 Establishment of implementation working group

Establish an engaged, active working group to lead implementation of the model of care for the recognition of and response to deterioration. The group should be supported by an executive sponsor or leadership member and include members who are willing to take ownership of actions and follow-through. Experience shows that leadership support is a critical success factor in the implementation of this model care.

Objectives

- Support a coordinated, team-based approach to implementation.
- Define how the systematic approach applies in the local context (including workflows and responsibilities).
- Review palliative and end-of-life care processes, guidelines, policies, and procedures to incorporate the model.
- Identifying the desired timelines and required planning, communication and training tools and resources. Careful planning is another critical success factor in the implementation of this model of care.
- Identify, document, and address gaps and barriers to implementation.
- Clarify roles and responsibilities.
- Develop and deliver the implementation plan, monitor progress, and ensure milestones are achieved.

Membership (suggested selection criteria)

When establishing a working group, consider staff members who:

- Are motivated to improve palliative care outcomes for residents and interested in the model of care for the recognition of and response to deterioration.
- Can engage colleagues, influence practice, and advocate for the model.
- Are reliable and responsive, with strong communication and organisation skills.
- Demonstrate commitment and take ownership of agreed actions.

Planning resources

- CPCiAC project plan and action plan template (Appendix 4)
- NSW Agency for Clinical Innovation (2015). Implementation *Guide: Putting a model into practice*. Web: https://aci.health.nsw.gov.au/__data/assets/pdf_file/0007/291742/Clinical_Innovation_Program_Implementation_Guide.pdf (accessed on 11/05/2026).

3.1.2 Nomination of an implementation champion

Role

The implementation champion is a resourced clinical team member with a passion for quality improvement and palliative and end-of-life care. The implementation champion is supported by the executive sponsor / leadership member, coordinates implementation of the three elements of the systematic approach to identifying and responding to (emerging/existing) palliative care needs model. This includes applying quality improvement processes, engaging stakeholders, managing tasks and timelines, translating requirements into day-to-day practice, and resolving issues to achieve agreed outcomes.

Training responsibilities

The implementation champion facilitates face-to-face training for key staff (e.g., palliative care champions, managers, NUM/ANUMs, and clinical support nurses/educators) on:

- Assessment tools: PACOP Deteriorating Resident Tool (DRT) and Daily Symptom Assessment Scale (Daily SAS).
- Facility process map.

For external project officers

If external project officers are supporting residential aged care facilities to implement the systematic approach, use a *train-the-trainer* approach with the implementation champion so local staff can deliver and sustain training over time.
A recorded training session is available for the implementation lead and other key staff. Shorter, informal 'on-the-floor' training will also be needed for the broader workforce. To support this, brief "clinical bites" videos about the PACOP assessment tools are available via the *ACPC Highway to Help* website.

Resources

Training resources to train the implementation champion

- Train-the-trainer power point presentation with narration (Appendix 7)

Planning resources

- Staff and champions cheat sheet -concise summary of the internal process (Appendix 8)
- Staff-base set-up photo example (Appendix 5)

3.2 During implementation

Team engagement and ongoing communication

Strong team engagement underpins successful implementation of this model of care for the recognition of and response to deterioration. Staff are given opportunities for input to support shared ownership and consistent practice.
Clear, regular communication embeds the model of care for the recognition of and response to deterioration into daily practice. It allows to clarify processes and enable timely communication of issues and outcomes.

Monitoring and feedback

Monitoring uptake, compliance, and outcomes supports evaluation of implementation progress, identifies variation, and highlights barriers to implementation of the systematic approach. Data review supports continuous improvement. Providing feedback to staff is

reinforces expected practice, supports learning, and strengthens ongoing engagement with the model of care.

Resources

Clinical resources

- ACPC Highway to Help website: https://ac-pc.com.au/
- Deteriorating Resident Tool (PACOP)(Appendix 1)
- Daily Symptom Assessment Scale (PACOP) (Appendix 2)
- Facility process map template (editable copy) (Appendix 3)

Training resources

- PACOP clinical bites (link): https://ac-pc.com.au/assessment-tools/
- Staff and champions cheat sheet -concise summary of the internal process (Appendix 8)
- Training sign-off sheet -supports initial rollout and ongoing induction; includes QR links to the ACPC Highway to Help website and clinical bites (Appendix 9)

Communication resources

- Internal communication flyer -brief overview of what is changing and why the new tools are being introduced (Appendix 10)
- Screen saver -optional visual prompt to support rollout (Appendix11)

3.3 After implementation

Use monitoring and feedback to review and refine the systematic approach in your local context over time.

Monitoring questions

- Are the implementation objectives being achieved? If not, why not?
- What is working: Which solutions/processes are successful, and why?
- What needs improvement: Which solutions/processes could be revised or improved?
- Gaps and barriers: Are any gaps remaining? Have new gaps or barriers emerged?
- Has every clinical staff member been included in the training and roll out?
- Engagement: Do people need to feel more included in decisions about how changes occur?
- Capability: Do people need more education or training?

Actions

Use the findings to review and update processes that are not effective and to identify any staff members who may not yet have been included in training.

Communicate progress

Keep staff informed about implementation progress through channels such as:

- Newsletter articles
- Emails
- Meetings
- Brief presentations during clinical handovers
- Progress reports
- Information boards and the organisation’s intranet.

Celebrate successes and acknowledge the contributions of staff and stakeholders. Share outcomes broadly, particularly when monitoring shows meaningful improvement.

4 Beyond implementation - Quality monitoring and identifying quality improvement opportunities

The following audit tools support facility managers, nurse unit managers, palliative care champions, palliative care working groups, and relevant clinical governance committees to monitor practice and measure the impact of implementing the systematic approach. They can also help identify quality improvement opportunities in palliative care and advance care planning.

Post implementation audit

- CPCiAC project post implementation 'Systematic identification and response to palliative care needs' audit tool (Appendix13)

After death audits

- ELDAC after death audit tool V2 (Appendix 16)
- CPCiAC project after death audit tracker (Appendix 17)

End of life care plan audit

- CPCiAC project Safer Care Victoria Care Plan for the Dying Person Victoria audit tool (Appendix 14)
- CPCiAC project Queensland Government Residential Aged Care End of Life Care Pathway audit tool. (Appendix 15)

5 Strengthening staff palliative care capacity

Recommendation 1: Nominate two to three palliative care champions (or portfolio holders).

Establish a small team to foster a culture of compassionate, respectful, high-quality palliative and end-of-life care that is tailored to each resident's needs and preferences.

Support and development:

- Prioritise palliative care education and professional development opportunities for the appointed champions/portfolio holders.
- A draft palliative care champion position description is included in the resources zip folder accompanying this document. It can be adapted to suit the role or portfolio you wish to establish. (Appendix 6).

Recommendation 2: Linking in with the local/state palliative care community

Residential aged care facility managers, care coordinators, and palliative care champions/portfolio holders should connect with their local or state palliative care body/community to access education, training, and networking opportunities.

Example: The CPCiAC project team recommends participating in the Grampians Region Palliative Care Consortium–led Community of Practice (CoP) for Aged Care. Launched in March 2025, this CoP builds on established models in other regions and continues to grow.

What you can access through the CoP:

- Bi-monthly meetings featuring guest speakers on relevant aged care and palliative care topics
- A monthly aged care palliative care newsletter highlighting information and education opportunities (including local study days)

Recommendation 3: Palliative care education

The following options provide flexible approaches to building palliative care knowledge, skills, and confidence across the workforce. Services can select any of the recommended options based on their learning needs, capacity, and preferred mode of delivery.

- **Option 1: Reverse PEPA Aged Care (on-site education)**
  Engage Reverse PEPA Aged Care to deliver on-site palliative care education using a whole-workforce approach to capability and capacity building:
  - A PEPA Palliative Care Nurse Educator visits the facility to mentor staff and facilitate face-to-face learning.
  - Placements involve up to 4 days on site, with a minimum of 8–10 nominated participants.
  - The aim is to build staff knowledge, skills, and confidence to deliver a palliative approach.
  - Further information: https://pepaeducation.com/wp-content/uploads/2025/06/GDL_PEPA-AC_Placement-Information-Guide_V4_-2025_FINAL.pdf
- **Option 2: Standard PEPA/IPEPA placements (specialist service immersion)**
  - Undertake a 2–5-day placement in a specialist palliative care service, supported by a PEPA/IPEPA mentor, to build skills, knowledge, and confidence in caring for people with life-limiting illness in day-to-day practice.
  - Further information: https://pepaeducation.com/pepa-ipepa-placements/.
- **Option 3: Complete a palliative and end-of-life education needs assessment**
  - Undertake a staff education needs assessment to support a structured, tailored approach to ongoing learning and development. ELDAC tools and resources are available here: https://www.eldac.com.au/Our-Toolkits/Residential-Aged-Care/Assess-Your-Knowledge.

Recommendation 4: Progression to full PACOP implementation

As an extension on the implementation of the CPCiAC project model of care for the recognition of and response to deterioration, consider implementation of the complete PACOP program to monitor and guide palliative care with additional benefits of capturing de-identified data to inform quality improvement, benchmarking, and system-level enhancements across aged care services. An example of a facility process map incorporating the complete PACOP profile and outcomes collection is provided (Appendix 20). For further information about PACOP, please refer to the link provided in Section 6 below.

6 Useful contacts and resources

- **Aged Care Palliative Care (ACPC) 'Highway to Help'**
  - Information hub of tools and resources for staff and managers working in residential aged care facilities.
  - Web: https://ac-pc.com.au/
- **Palliative Aged Care Outcomes Program (PACOP)**
  - National palliative aged care program funded by the Australian Government Department of Health, Disability and Ageing.
  - Web: https://www.uow.edu.au/australasian-health-outcomes-consortium/pacop/
- **End of Life Directions (ELDAC)**
  - ELDAC (End of Life Directions for Aged Care) provides information, guidance, and resources for all aged care staff to support palliative care and advance care planning.
  - Web: https://www.eldac.com.au/

Appendices

- **Model tools**
  - Appendix 1: Deteriorating Resident Tool (PACOP)
  - Appendix 2: Daily SAS (PACOP)
  - Appendix 3: Editable version of Facility Process Map (example BHCI / Victoria)

- **Implementation planning**
  - Appendix 4: CPCiAC Project Plan and action plan template
  - Appendix 5: Example staff base set up photo
  - Appendix 6: Example palliative care champion role description

- **Education and training resources**
  - Appendix 7: Train the trainer narrated power point; accessible via https://ballarathospicecare.org.au/wp-content/uploads/2026/08/Train-the-trainer-narrated-powerpoint.pptx
  - Appendix 8: Cheat sheet for staff and champions - A concise summary of key points outlining the internal process
  - Appendix 9: Training sign off sheet – support for rollout of initial training and ongoing induction training-QR links to ACPC Highway to Help website and clinical bites
  - Appendix 10: Facility internal communication flyer
  - Appendix 11: Screen saver

- **Quality improvement resources**
  - Appendix 12: CPCiAC evidence map for the Strengthened Aged Care Quality Standards (Outcome 5.7: Palliative Care and End-of-Life Care)
  - Appendix 13: CPCiAC systematic approach audit tool: systematic identification of, and response to, palliative care needs; model of care audit tool
  - Appendix 14: CPCiAC project audit tool: Safer Care Victoria *Care Plan for the Dying Person* (Victoria)
  - Appendix 15: CPCiAC project audit tool: Queensland Government *Residential Aged Care End-of-Life Care Pathway*
  - Appendix 16: ELDAC after-death audit tool (V2)
  - Appendix 17: CPCiAC after-death audit tracker

- **Further resources**
  - Appendix 18: Resource order information list - family and resident resources
  - Appendix 19: Resource order information list - staff resources
  - Appendix 20: Editable version of Facility Process Map full PACOP (example BHCI / Victoria)
  - Appendix 21: Editable version of Generic Facility Process Map
  - Appendix 22: Editable version of Generic Facility Process Map full PACOP