Recognising and Responding to Deterioration in Aged Care Residents – Resource for General Practitioners

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

BALLARAT HOSPICE CARE INC.
Home Based Palliative Care

Project partners: This 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: Victorian Department of Health and Australian Department of Health and Aged Care, Comprehensive Palliative Care in Aged Care (CPCiAC) Project Measure 2018

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* Specialist palliative care services that come under the Grampians Region Palliative Care Consortium include Ballarat Hospice Care, Wimmera Palliative Care Service, Western Health Bacchus Marsh Community Palliative Care, Central Grampians Palliative Care, as well as the region-wide consultancy service Grampians Regional Palliative Care Team.

To access the GP education session accompanying this resource, click on the link below:

https://ballarathospicecare.org.au/wp-content/uploads/2026/07/GP-Education-Session.mp4

Contents

1 Comprehensive Palliative Care in Residential Aged Care Project

1.1 Background

Over 60,000 people die in residential aged care every year. This represents about 30% of all deaths in Australia (1). Up to 50% of residents die within 6 months of admission (2). An estimated 90% of residents would benefit from a palliative approach to care due to expected deaths from a known life-limiting illness (3).

Residential aged care facilities play a vital role in providing generalist palliative care, particularly end-of-life care. For aged care staff to effectively meet the palliative care needs of residents, they must be equipped with the resources and frameworks that allow for early identification of those needs. Implementing these frameworks ensures that high-quality care is delivered not only to the residents but also to their families.

1.2 The Comprehensive Palliative Care in Residential Aged Care Project

Ballarat Hospice Care is leading a project aimed at enhancing generalist palliative care in residential aged care and improving access to specialist palliative care for residents with such needs. This is a Grampians region collaborative project between Ballarat Hospice Care, Grampians Region Palliative Care Consortium, and Grampians Regional Palliative Care Team. It is funded by the Australian Department of Health and Aged Care, as well as the Victorian Department of Health to strengthen comprehensive palliative care for aged care residents (4).

The top priority is to support residential aged care facilities in implementing a systematic approach to ***identifying*** and ***responding*** to palliative deterioration. Central to this is the introduction of an evidence-based, best practice palliative care needs assessment tool: the **Deteriorating Resident Tool (DRT)** (5) (see pages. 4 and 5). In addition, residential aged care facilities are provided with a flowchart (see page 9) outlining the trigger points for administering the DRT, as well as the responses to DRT assessment and symptom monitoring outcomes, reflecting the available supports and resources.

1.3 Why we are engaging with you

We are engaging with General Practitioners supporting aged care residents in order to

1. Assist General Practitioners and residential aged care facilities in the early identification of residents currently experiencing or at risk of deterioration.
2. Ensure that residents identified as deteriorating or at risk of deterioration have their needs and supports effectively met.

Using the above tools, combined with clinical judgement and/or concerns from the resident or family, will help identify those with current or impending palliative care needs. Aged care staff use this to make clinical decisions regarding commencing palliative care. Built into this process is a referral to the GP to initiate a range of strategies to anticipate and meet the palliative (including end of life) needs of the resident and their family.

These tools are used Australia-wide amongst palliative care services so ensure consistent communication between aged care staff, general practitioners, and specialist palliative care teams. This common language improves collaboration, enhances care coordination, and facilitates more effective decision-making.

1.4 Recommendations

1. Familiarise yourself with the Deteriorating Resident Tool; the Daily Symptom Assessment Scale and Problem Severity Score in particular.

   Short videos are available here (approximately five minutes each):

   - Symptom Assessment Scale (SAS): https://www.youtube.com/watch?v=XN55LYHJ1C8&list=PLWPX8BkJzVmqkKII8NsPA314ZRyFcEYjf&index=7
   - Problem Severity Score (PSS): https://www.youtube.com/watch?v=Gq6RRdyIqco&list=PLWPX8BkJzVmqkKII8NsPA314ZRyFcEYjf&index=8
   - Australia-modified Karnofsky Performance Status (AKPS): https://www.youtube.com/watch?v=OOzZqcx9oEE&list=PLWPX8BkJzVmqkKII8NsPA314ZRyFcEYjf&index=3
   - Rockwood Clinical Frailty Scale (RCFS): https://www.youtube.com/watch?v=NPE-bRG6rA0&list=PLWPX8BkJzVmqkKII8NsPA314ZRyFcEYjf&index=9

2. The DRT is completed routinely by residential aged care staff. When liaising with residential aged care staff, request the Deteriorating Resident Tool assessment outcomes - particularly the Symptom Assessment Scale and/or Problem Severity Score - as these will provide you with supporting evidence.

3. Based on DRT assessments, particularly changes in AKPS and RCFS, consider proactive palliative approaches to care such as advanced care planning, family discussions, medication rationalisation and/or anticipatory prescribing.

2 Deteriorating Resident Tool (DRT)

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

Website: ac-pc.com.au/wp-content/uploads/2024/10/Deteriorating-Resident-Tool_230120_FINAL.pdf - Accessed on 24/04/2025

The Deteriorating Resident Tool (DRT) is a standardised, evidence-based clinical assessment tool that provides residential aged care staff with the necessary framework to identify and evaluate the palliative care needs of residents.

By using this tool, staff can assess not only current symptoms but also predict the likelihood of future deterioration, allowing them to implement timely interventions.
The DRT is routinely administered at residential aged care facilities at the following trigger points:

- On admission
- As part of the standard resident review process
- Upon return from hospital (ED/Urgent Care Centre or hospital admission)
- When any staff member observes changes in the resident, e.g. after a fall, change of cognition, delirium, antibiotics, loss of appetite, loss of weight, behavioural change
- If requested by the resident, their family or friends

Completion of the DRT at resident admission to the residential aged care facility establishes a baseline for comparison of any future DRT assessments.

The DRT comprises of four evidence-based assessments, each of which plays a specific role in assessing either a resident's current palliative care symptom needs, or likelihood of deterioration.

Components of the DRT:

1. **Symptom Assessment Scale (SAS)**
   The SAS is used to assess the presence and severity of the most common palliative care symptoms. The SAS is resident-rated (where possible) to provide a **holistic view** of the resident's symptom burden. Each symptom is rated on a scale from 0 to 10, with 0 indicating no distress and 10 indicating severe distress.
2. **Problem Severity Score (PSS)**
   The PSS is **clinician-rated** and assesses the severity of issues across four key domains: Pain, "Other symptoms", "Psychological/Spiritual" & "Family/Carer". Each domain is rated on a scale from 0 (no problem) to 3 (severe problem).
3. **Australia-Modified Karnofsky Performance Status (AKPS)**
   The AKPS is a **clinician-rated tool** that measures the **functional status** of a resident from 100 (normal, no disease, no complaints) to 10 (comatose/barely rousable). **Most residents will have an AKPS of 70 – 40.** Changes in AKPS and lower scores of AKPS are associated with poorer prognosis, especially in residents with advanced cancer.

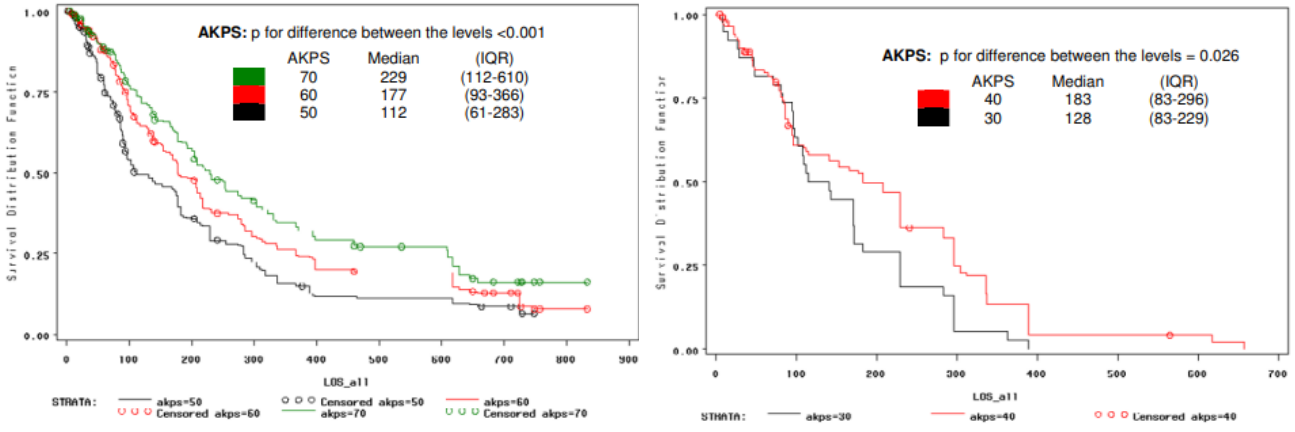


Figure 1. Survival percentages based on AKPS for patients admitted to a community palliative care service. (6)

4. Rockwood Clinical Frailty Scale (RCFS)

The RCFS is another **clinician-rated** tool that measures physical & cognitive frailty of the resident. It has nine levels, where level 1 = fittest for their age, nil issues, levels 2-8 describe increasing frailty (levels 7-8 are common for residents approaching end of life in ACHs), level 9 is for those who are terminally ill but not otherwise frail. Levels 5, 6 & 7 tend to correspond to mild, moderate & severe dementia respectively.

Frailty describes a state of reduced physiological reserves and inability to overcome stressors such as a fall, infection, or hospital admission. Higher severity of clinical frailty is associated with increased risk of adverse health outcomes including disability or death.

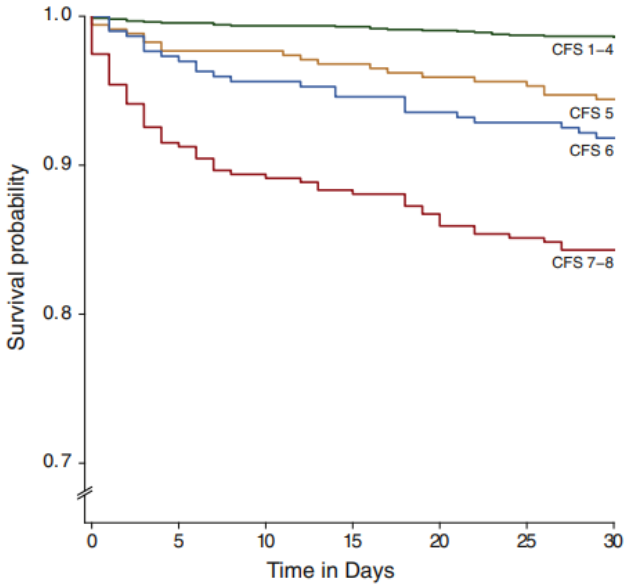


Figure 2: Survival Percentages based on Clinical Frailty Score (CFS) for patients aged 65 and older after presentation to the Emergency Department. To improve readability, the graph was cropped to 0.7 on the y axis. (7)

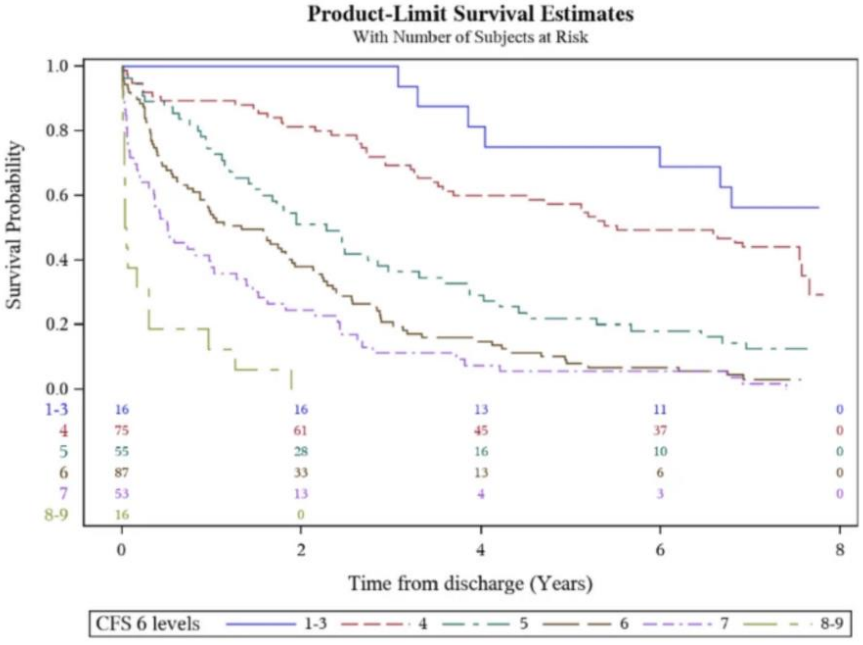
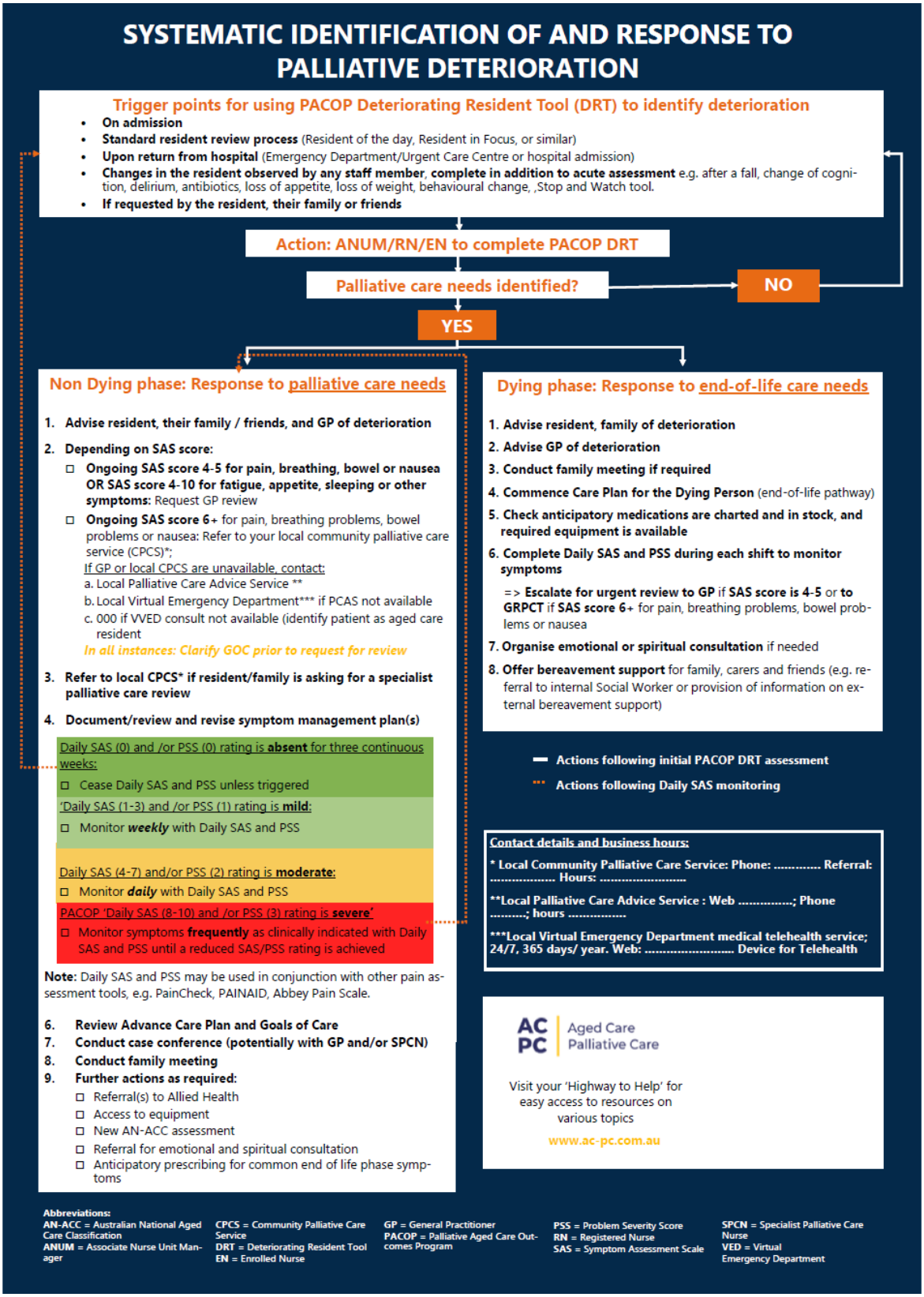


Figure 3: Surival after ED admission for age 70+ and critically unwell (defined as: Airway obstruction/stridor; oxygen saturation < 90%; respiratory rate < 8 or > 30 bpm; regular heart rhythm > 130 or irregular heart rhythm > 150bpm; systolic blood pressure < 90 mmHg; unconsciousness, defined as Reaction Level Scale (RLS) > 3 or Glasgow Coma Scale (GCS) < 8; ongoing seizure). (8)

3 Systematic Identification of and Response to Palliative Deterioration Flowchart

Generic example to be customised for each facility



4 Specialist Palliative Care

While many aged care residents have palliative care needs that can be managed by aged care staff in collaboration with the resident's GP, some residents have more complex palliative care needs, requiring review by a specialist palliative care clinician.

The PACOP Deteriorating Resident Tool helps aged care staff to identify when a resident has more complex palliative care needs. The process map residential aged care facilities have been provided with guides their response to those identified complex needs, including a score-based prompt to refer to their local specialist palliative care service for review by a Specialist Palliative Care Clinical Nurse Consultant. Further escalation to a Nurse Practitioner or Palliative Care Physician is possible.

Community palliative care services

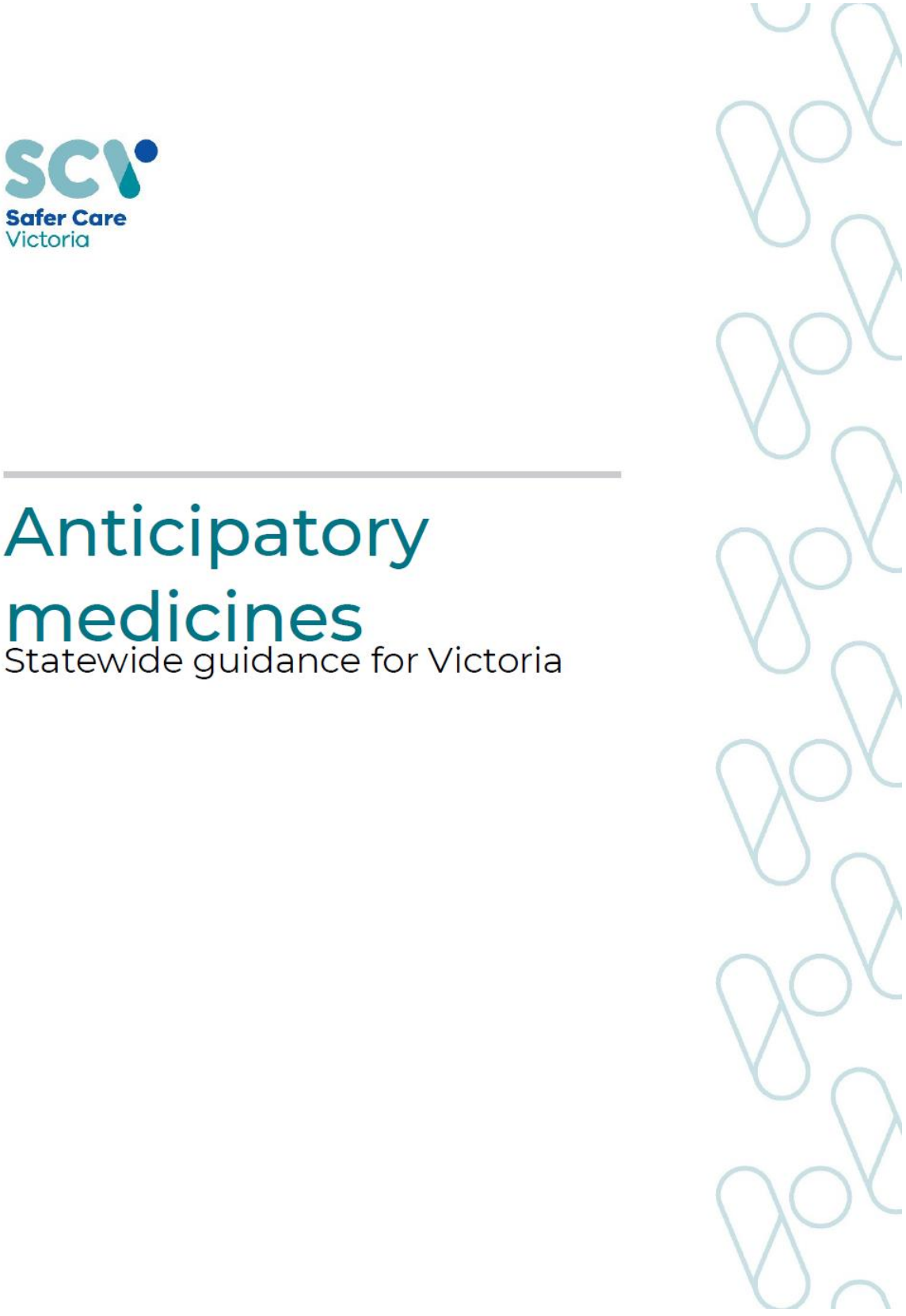
Community palliative care services provide in-home specialist palliative care nursing support to people with a diagnosed life-limiting illness, their families, and carers in their homes or other community settings. These services also provide specialist support to residential care facilities. They aim to improve the quality of life for those with serious illnesses by managing symptoms, providing emotional and social support, and addressing spiritual needs.

To find your local palliative care service in your state, visit:

- ACT: https://www.pallcareact.org.au/daisy
- Northern Territory: https://nt.gov.au/wellbeing/allied-health/palliative-care
- NSW: https://palliativecarensw.org.au/health-professionals/nsw-directory/
- South Australia: https://palliativecaresa.org.au/palliative-care-service-providers-2/
- Tasmania: https://pallcaretas.org.au/pct-directory/
- Victoria: https://www.pallcarevic.asn.au/directory/services
- Western Australia: https://palliativecarewa.asn.au/palliative-care/find-palliative-care-in-wa/

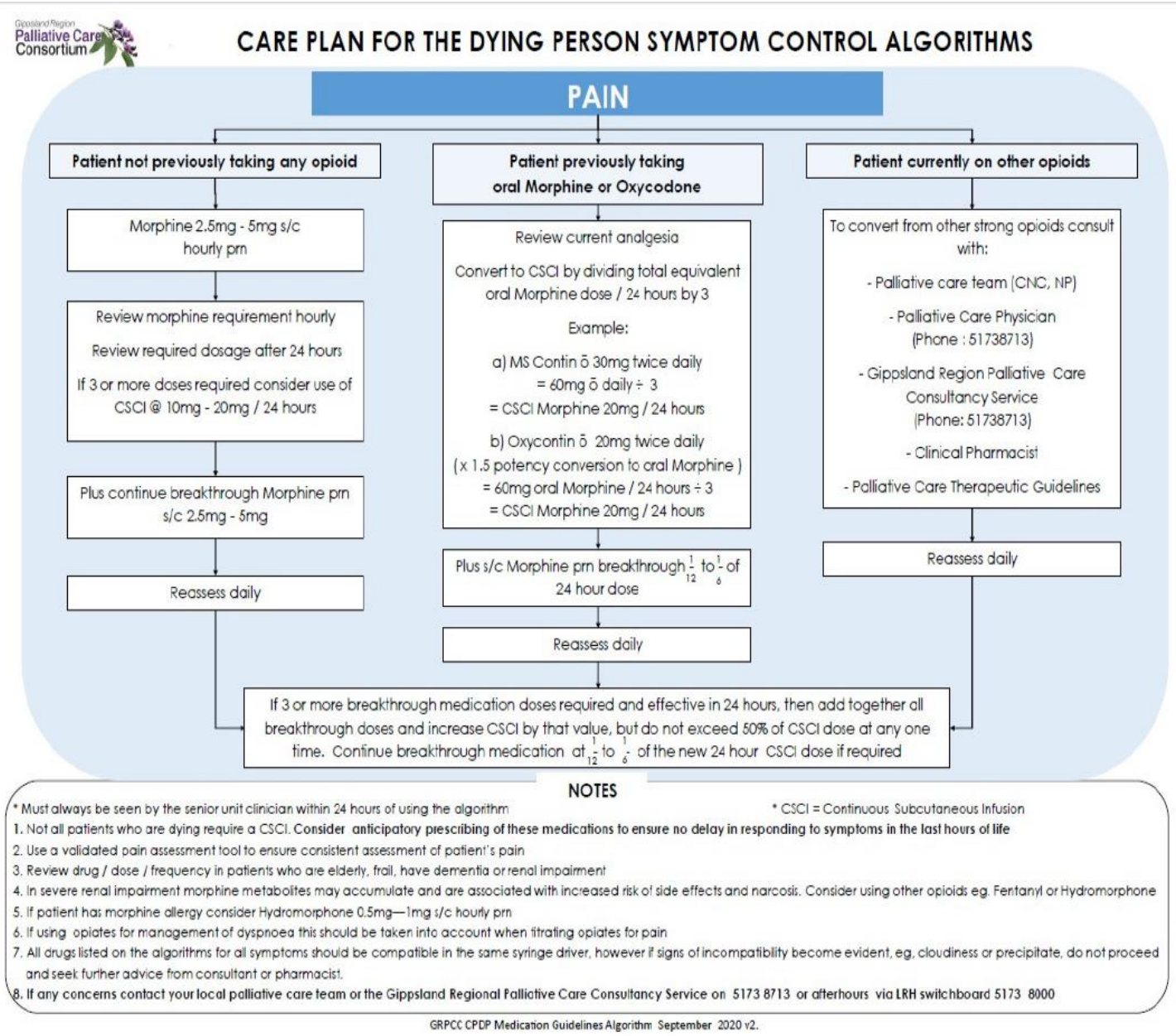
Or visit the Palliative Care Australia National Palliative Care Service Directory: https://nsd.palliativecare.org.au/s/search-service.

5 Anticipatory Medicines - Statewide Guidance for Victoria

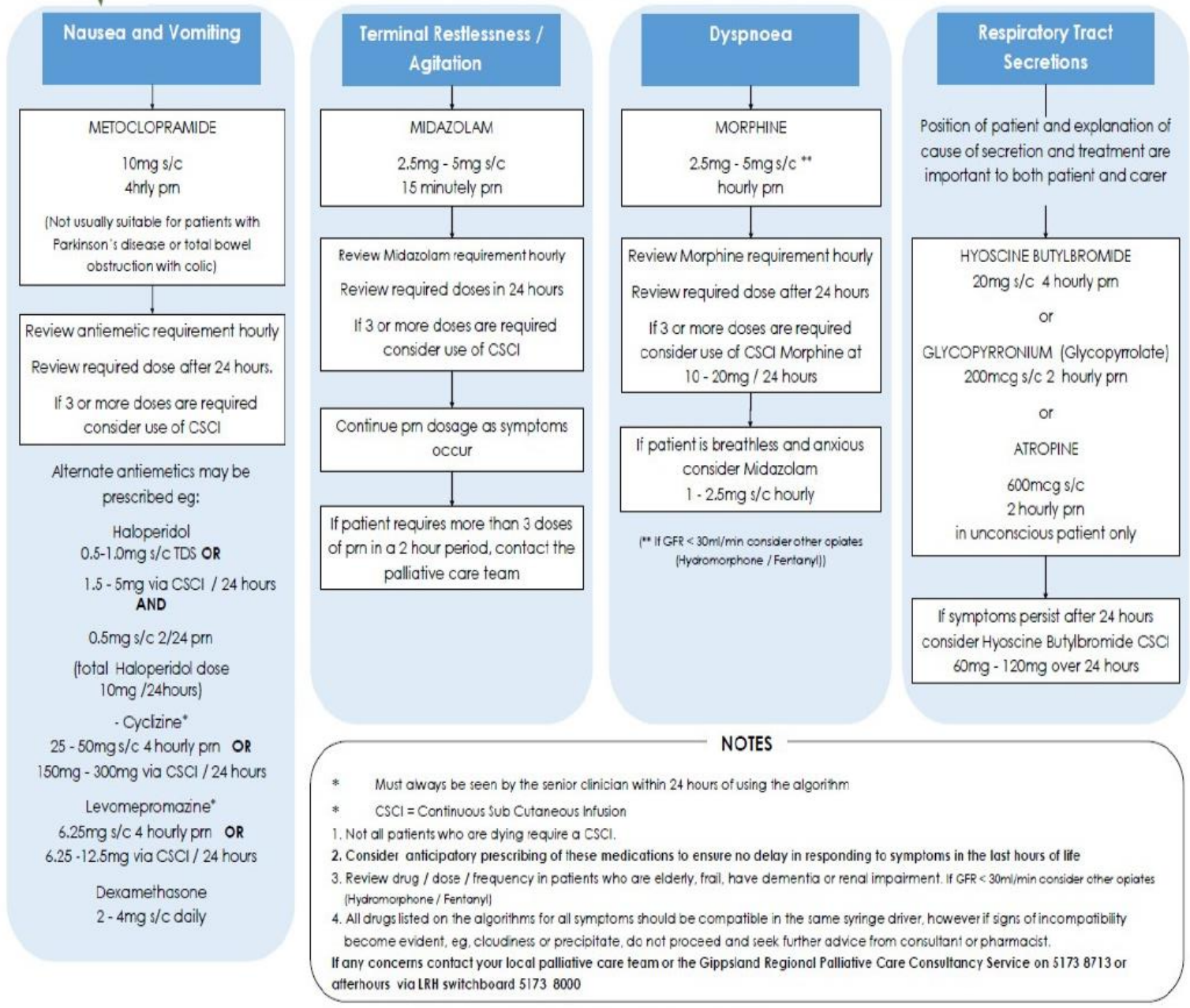


Appendix 1: Symptom control algorithms

Example of Symptom Control Algorithm, Gippsland Region Palliative Care Consortium19



CARE PLAN FOR THE DYING PERSON SYMPTOM CONTROL ALGORITHMS



GRPCC CPDP Medication Guidelines Algorithm September 2020 v2.

Website: safercare.vic.gov.au/sites/default/files/2020-03/GUIDANCE_Anticipatory%20medicines%20FINAL.pdf - Accessed on 24/04/2025

6 MBS Items Supporting a Planned General Practice Palliative Care Pathway in Residential Aged Care

This table provides a suggested timeframe and pathway for aged care residents with palliative care needs based on the current MBS items available to the general practitioner.

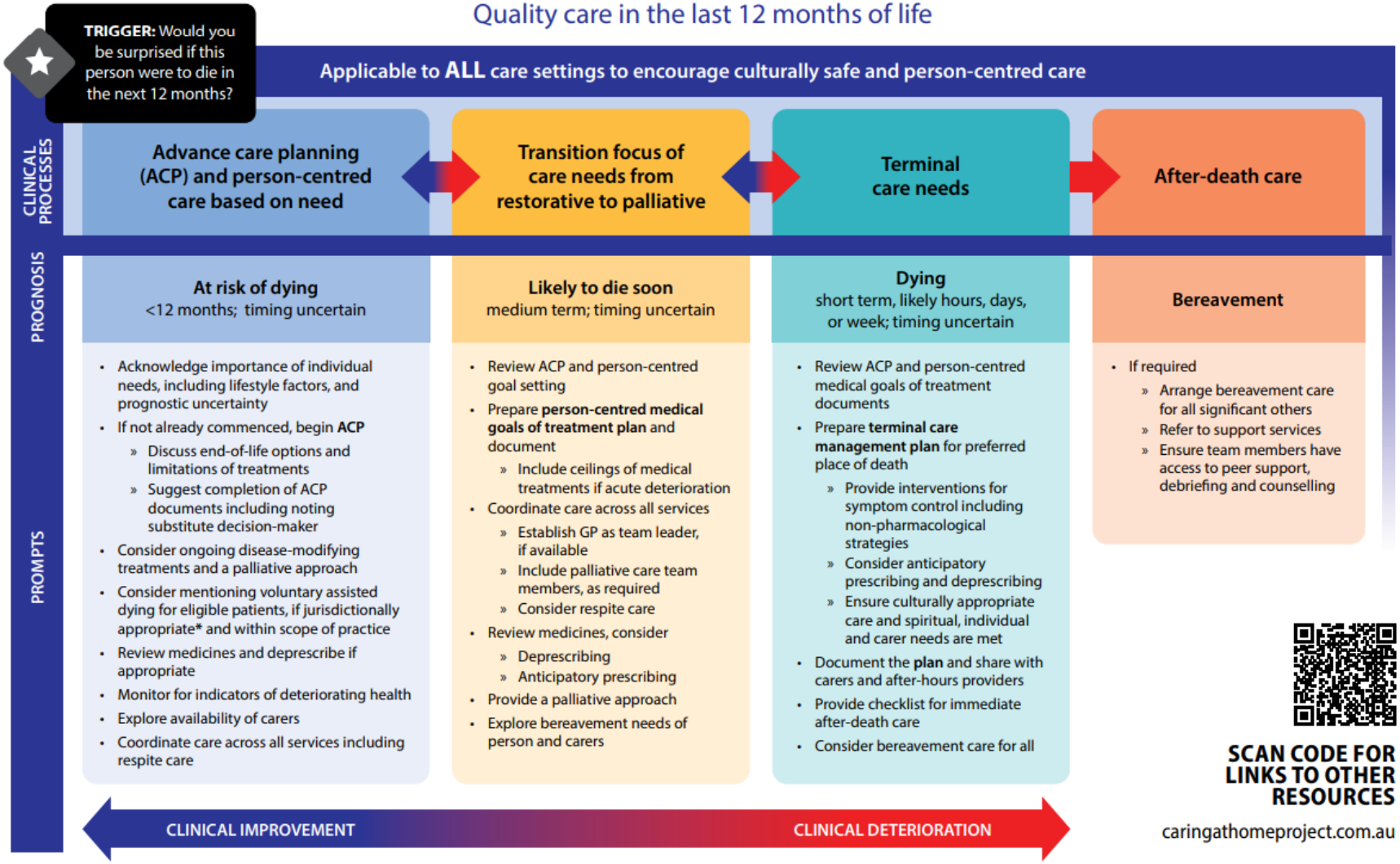
Suggested timeframe	Medicare initiative	Activities	MBS Item	MBS Benefit 100% (as of 01/08/24)
0 months	Comprehensive medical assessment	On admission, then annually. Identify who is appointed to assist with healthcare decisions for patients who do not have capacity for palliative care discussions. Select relevant item based on complexity and PN + GP time.	701 (<30 mins)	$67.60
			703 (30-45 mins)	$157.10
			705 (45-60 mins)	$216.80
			707 (>60 mins)	$306.25
	Residential Medication Management Review (RMMR)	GP participation in a medication management review for someone in a residential aged care facility. Candidates for this review include residents for whom quality use of medicines may be an issue, or those at risk of medication misadventure due to a significant change in their condition or medication regimen.	903	$120.80
1st month	Care plan contribution	GP contribution to a multidisciplinary care plan prepared by a residential aged care facility for managing terminal medical conditions.	731	$80.20
2nd month	GP-organised and coordinated multidisciplinary case conference	An opportunity for an holistic informed approach to ongoing care for the resident. Should involve the resident, the resident's significant others, the GP, and at least two other health and/or care providers.	735 (15-20 mins)	$80.55
			739 (20-40 mins)	$137.75
			743 (>40 mins)	$229.65

Suggested timeframe	Medicare initiative	Activities	MBS Item	MBS Benefit 100% (as of 01/08/24)
4th month	Long patient consultation (Level D or E)	Attendance and consultation at the residential aged care facility with the purpose of managing palliative care and end-of-life care needs, discussing goals of care, advance care planning, or for completing an Advance Care Directive based on earlier discussions.	90051 (Level D: 40-60 mins)	$122.15
			90054 (Level E: >60 mins)	$197.90
6th month	Care plan contribution	Review of the resident's multidisciplinary plan	731	$80.20
8th month	GP-organised and coordinated multidisciplinary case conference	An opportunity for a 'real time' discussion of the resident's ongoing care involving the multidisciplinary team (GP + 2 others) and, where possible, the resident and the resident's family or significant others.	739 (20-40 mins)	$137.75
After 12 months	Repeat comprehensive medication assessment, case conferences and care plan contributions where clinically required.		As above.	

Based on information from: PHN North Western Melbourne. MBS remuneration to support planned palliative care for patients: A guide for health professionals working in general practice and residential aged care. Melbourne: NWMPHN; 2017 [cited 2024 May 27]. Available from: https://nwmphn.org.au/wp-content/uploads/2020/12/NWMPHN-Palliative-Care-For-GP-and-RAC5.pdf

7 Prompts for End-of-Life Planning (PELP) Framework

Quality care in the last 12 months of life



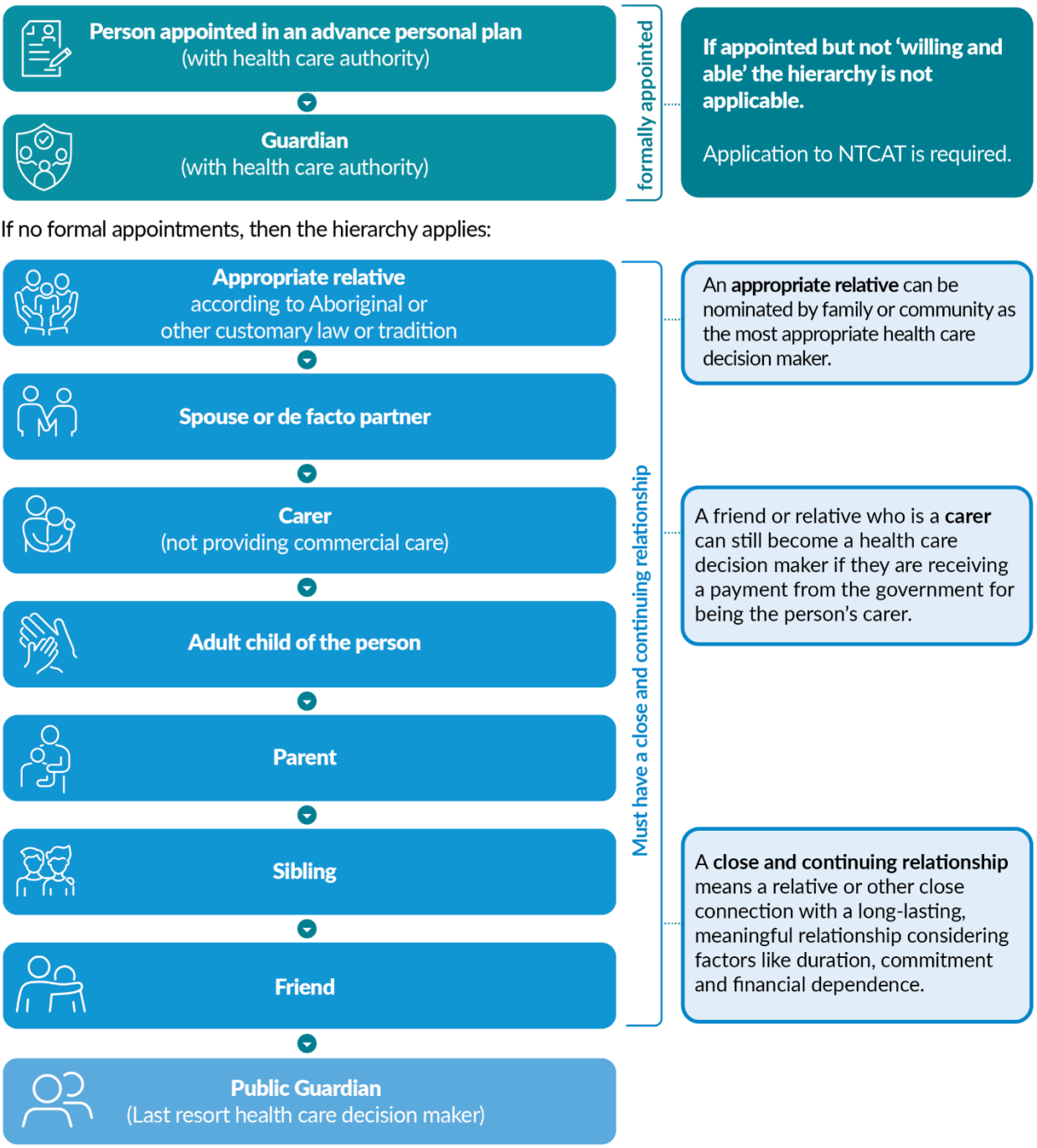
*Specific requirements for voluntary assisted dying vary between each state and territory. Healthcare services should familiarise themselves with the legislation in their jurisdiction and ensure patients and their families have access to appropriate information.

Adapted from: 1. Australian Commission on Safety and Quality in Health Care. National Consensus Statement: Essential elements for safe and high-quality end of life care. Sydney (AU) ACSQHC; 2023.
2. Alfred Health. End of Life Care Management Guideline. Melbourne (AU) Alfred Health; 2015. Prompt Doc No: AHG0068908 v10.1.
3. Reymond L, Cooper K, Parker D, Chapman M. End-of-life care: Proactive clinical management of older Australians in the community. AFP. 2016 Jan-Feb; 45(1): 76-8.

v2 07/2024

Website: caringathomeproject.com.au/for-health-professionals/pelp-framework - Accessed on 24/04/2025

8 Medical Treatment Decision Maker Hierarchy



Website:
pgt.nt.gov.au/sites/default/files/pgt_-_hierarchy_of_health_care_decision_makers.png - Accessed on 24/02/2025

9 Further Resources

9.1 Guidelines and Guidance Documents

Anticipatory medicines - Statewide guidance for Victoria (Safer Care Victoria)

Anticipatory medicines are injectable or sublingual medications prescribed to a person with a life limiting illness. These medications are prescribed and dispensed in preparation for a time when a person needs them. They are used to manage symptoms in the home with the goals of rapid relief and avoiding unplanned or unwarranted admission to a healthcare facility.

This document describes the use of anticipatory medicines for people with a life limiting or life threatening illness who are receiving palliative care or end of life care at their place of residence. It guides healthcare professionals in prescribing and obtaining supply of anticipatory medicines. It also supports healthcare professionals to assist carers to manage symptoms by using these medicines.

Website:
safercare.vic.gov.au/sites/default/files/202003/GUIDANCE_Anticipatory%20medicines%20FINAL.pdf - Accessed on 24/02/2025

Opioid conversion ratios (Safer Care Victoria)

Relative strength of opioids differs depending on the type of opioid and route of administration. Opioid conversion is a skill used by clinicians to ensure appropriate use of palliative medicines so that the patient receives optimal pain management. This document is used to guide clinicians to ensure that an effective and safe dose is used when an opioid rotation occurs such as when a patient on a pre-existing opioid loses the ability to swallow in the terminal phase.

Website:
safercare.vic.gov.au/sites/default/files/202102/GUIDANCE_Opioid%20Conversion%20FINAL_0.pdf

Syringe driver compatibility (Safer Care Victoria)

This guidance is intended for clinicians that deliver palliative care to people in specialist and non-specialist settings. It is intended to be used with the support of specialist palliative care clinicians.

Website:
safercare.vic.gov.au/sites/default/files/202102/GUIDANCE_Syringe%20driver%20compatability%20FINAL_0.pdf

9.2 Information

Advance Care Planning Australia

This is a national program that promotes advance care planning, including resources and national curriculum and learning. Advance care planning allows health professionals to understand and respect a person's future healthcare preferences, for a time when they become seriously ill and unable to communicate for themselves. All healthcare professionals and aged care workers have an important role to help with planning and ensuring people have choice in their care.

Website: advancecareplanning.org.au

ELDAC (End of Life Directions for Aged Care)

ELDAC provides information, guidance, and resources to support palliative care and advance care planning. There is a specific section for General Practitioners and Nurse practitioners.

Website: eldac.com.au

Aged Care Palliative Care

This website provides curated links to quality assessment, monitoring and communication tools, external support services, resources, bereavement support and more - primarily aimed at residential aged care staff, but also useful for General Practitioners.

Website: ac-pc.com.au

9.3 Supports

Palliative Care Advice Service

These specialist palliative care services offer free phone advice about palliative care and end-of-life care issues (for **non-emergency** health advice only). They can support you with issues such as:

- Symptom management
- Prescribing
- Converting medications from oral to injectable
- Continuous subcutaneous infusions (syringe drivers)
- Decision-making and advance care planning
- Navigating the palliative care system

They are unable to provide prescriptions, referrals, access medical records or replace the care of local healthcare providers.

Local services:

- Australian Capital Territory: Clinicians can contact the relevant hospital switchboard and ask for the palliative care specialist on call:
  - North Canberra Hospital – 02 6201 6111
  - The Canberra Hospital – 02 5124 0000

- Northern Territory: Clinicians can contact the relevant hospital switchboard and ask for the palliative care specialist on call:
  - Top End: Royal Darwin Hospital: 08 8922 8888
  - Central Australia: Alice Springs Hospital: 08 8951 7777
- New South Wales: Healthdirect Helpline. 24/7 statewide service. Phone: 1800 022 222
- Queensland:
  - 1300 PALLDR: 24/7 palliative care advice hotline for doctors, nurse practitioners, paramedics and pharmacists. Phone: 1300 725 537.
  - 1300 PALLCR: 24/7 hotline for nurses and allied health and Aboriginal and Torres Strait Islander health workers/practitioners in all care environments. Phone: 1300 725 527.
- South Australia: Statewide 24/7 Palliative Care Support Line. Phone:1300 673 122
- Tasmania: Clinicians can contact the after-hours telephone advice and support 4.30pm to 8.00am (Monday to Friday) and 24 hours (weekends and public holidays) via the Royal Hobart Hospital switchboard: 03 6166 8308.
- Victoria: Palliative Care Advice Service (PCAS). Available 7am to 10pm on 7 days a week. This service is for health professionals as well as patients and their families and carers. If you are a clinician and the PCAS nurse cannot resolve your query, the nurse will immediately transfer you to a palliative medicine specialist. Phone: 1800 360 000. Website: pcas.org.au
- Western Australia: Palliative Care Outreach Service: 1300 558 655 is a 24/7 telephone advisory service for advice on pain and symptom management, medication advice.

Palliative care service search directories

To find your local palliative care service in your state, visit:

- Australian Capital Territory: https://www.pallcareact.org.au/daisy
- Northern Territory: https://nt.gov.au/wellbeing/allied-health/palliative-care
- New South Wales: https://palliativecarensw.org.au/health-professionals/nsw-directory/
- Queensland: To find palliative care services in Queensland, call PalAssist at 1800 772 273 for free, 7-day-a-week (7am - 7pm) phone or online support PalAssist (https://www.palassist.org.au/contact/).
- South Australia: https://palliativecaresa.org.au/palliative-care-service-providers-2/
- Tasmania: https://pallcaretas.org.au/pct-directory/
- Victoria: https://www.pallcarevic.asn.au/directory/services
- Western Australia: https://palliativecarewa.asn.au/palliative-care/find-palliative-care-in-wa/

You can also visit the Palliative Care Australia National Palliative Care Service Directory: https://nsd.palliativecare.org.au/s/search-service.

Dementia Support Australia - GP Advice Service

If you are providing medical support for someone living with dementia who is experiencing behaviours and psychological symptoms of dementia (BPSD) you can contact one of Dementia Support Australia's medical specialists for clinical advice and support through their email service.

Website: dementia.com.au/who-we-help/health-care-professionals/services/gpas

Royal Flying Doctor Service - Memory Lane

Memory Lane is a no-cost service that will support patients in end of life care to visit a place that holds meaning for them. The service is entirely donor-funded and staffed by medically trained health care professionals who volunteer their time.

Website: flyingdoctor.org.au/vic/what-we-do/memory-lane/

9.4 Templates

Comprehensive medical assessment

Item 701/703/705/707 template

Website: swsphn.com.au/wp-content/uploads/2022/02/Comprehensive-Health-Assessment-Word-pdf.pdf

Care plan review/contribution template

Item 731 template

Website: health.gov.au/resources/publications/care-plan-contribution-template?language=en

9.5 Education (online)

End of Life Essentials

Free education modules designed to assist doctors, nurses and allied health professionals in delivering end-of-life care.

Website: endoflifeessentials.com.au

'The Advance Project - eLearning for GPs'

A two-hour online course covering: the role of GPs in advance care planning and palliative care provision; evidence-based tools for initiating advance care planning discussions; and assessing patients and carers palliative and supportive care needs.

Website: theadvanceproject.com.au/Education-Training/General-Practice-Training/General-Practitioners

'Healthcare Communication Collective'

In-person communication skills training to integrate evidence-based communication skills into clinical practice, especially for 'hard' conversations in patient care, to improve clinicians' confidence, effectiveness, and person-centeredness.

Website: healthcommcollective.com.au/

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