Recommended Citation

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An electronic copy of this resource can be downloaded at: www.caresearch.com.au/PA Toolkit

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About this Learning Guide

Context and Focus

Developed as part of the Residential Aged Care Palliative Approach (PA) Toolkit, this Learning Guide:

1. Is a companion resource for the training video: ‘Using the Residential Aged Care End of Life Care Pathway (RAC EoLCP).* This video uses a fictional residential aged care scenario to highlight the key steps in using the RAC EoLCP. In particular, it focuses on when and how to use the RAC EoLCP to support the high quality end of life [terminal] care of residents.

2. Is specifically designed for staff involved in the direct care of dying residents (e.g. registered nurses, enrolled nurses, careworkers).

3. Aims to increase knowledge, skills and confidence in using the RAC EoLCP.

4. Includes information and activities to reinforce and supplement material about the RAC EoLCP provided in the training video.

5. Should be worked through in conjunction with viewing the training video.

6. Is suitable for both individual and group-based learning situations.

Important

This Learning Guide is not intended as a stand-alone resource. It is designed to be used in conjunction with the training video: ‘Using the Residential Aged Care End of Life Care Pathway (RAC EoLCP).’

How to Use this Guide

The training video can be viewed:

• In a ‘play all’ format; or
• In segments corresponding to the major sections in the RAC EoLCP.

Both of these viewing options can be accessed from the training video’s main menu.

* The ‘Using the Residential Aged Care End of Life Care Pathway (RAC EoLCP)’ Training Video will be referred to as ‘training video’ in the remainder of this Learning Guide.
We recommend that:

1. You pause the training video after watching each segment in order to work through the corresponding section of this Learning Guide.

2. Take time to complete the activities in this Learning Guide. These can be completed either individually or in a group. Taking time to complete the learning activities will help to reinforce your understanding about how to correctly use each section of the RAC EoLCP document.

3. You refer to a copy of the RAC EoLCP document when watching the training video and working through this Learning Guide [Appendix A].

Key Point

The PA Toolkit includes a set of resources which, when used in combination, are designed to help residential aged care providers to implement a comprehensive, evidence-based palliative approach to caring for residents and their families.
Overview of a Palliative Approach in Residential Aged Care

Before focusing on when and how to use the RAC EoLCP, let’s briefly review:

• What is a palliative approach?
• Why implement a palliative approach in residential aged care?
• When should a palliative approach be implemented?

What is a Palliative Approach?

In determining a resident’s palliative care needs, it is important to distinguish between a palliative approach, specialised palliative service provision, and end of life (terminal) care. Understanding the differences between these three forms of palliative care is particularly important in care planning and in clarifying a resident’s treatment goals.¹

Key Point

Three Forms of Palliative Care¹

Palliative approach

A palliative approach aims to improve quality of life for residents with life-limiting illnesses and their families by reducing their suffering through early identification, assessment and treatment of pain, physical, cultural, psychological, social and spiritual needs. Importantly, this form of palliative care is not restricted to the last days or weeks of a resident’s life.

Specialised palliative service provision

This form of palliative care involves referral of a resident’s case to a specialist palliative care team. This, however, does not replace a palliative approach to care being provided by the residential aged care facility (RACF) but rather augments it with focused, intermittent, specific input when required. Specialist palliative care teams do not usually take over the care of a resident but instead provide advice on complex issues and support to aged care staff and general practitioners.

End of life (terminal) care

This form of palliative care is appropriate when a resident is in the final days or weeks of life and care decisions may need to be reviewed more frequently. Goals are more sharply focused on a resident’s physical, emotional and spiritual comfort and support for the resident’s family.
Important

The RAC EoLCP is specifically designed for use in the last week or days of a resident’s life.

Why Implement a Palliative Approach in Residential Aged Care?

The major benefit of using a palliative approach in residential aged care is that it improves residents’ quality of life by:

- Encouraging open and early discussions about advance care planning as well as death and dying which:
  - Assists the resident and their family to understand and accept the implications of disease progression.
  - Helps to involve the resident and their family in care planning and decision-making.
- Facilitating the early identification of changes in the resident’s condition and the prompt management of emerging symptoms which:
  - Provides opportunities for improved control of pain and other symptoms.
- Reducing unnecessary transfers to hospital because residential aged care staff develop knowledge and skills to successfully manage the palliative care needs of residents which:
  - Enables the resident to be cared for by familiar staff with whom they have a close relationship.
  - Enables the resident to die in their RACF home.2

Key Point

Use of a palliative approach enhances residents’ quality of life and the care provided by residential aged care facilities.2
When Should a Palliative Approach be Implemented?

There is no fixed ‘best time’ to commence a palliative approach. In general, a palliative approach is started when aggressive curative treatments are no longer appropriate for the resident and the focus of care is on symptom management, quality of life and comfort. The Palliative Approach Trajectories Framework [Figure 1] underpinning the PA Toolkit uses a resident’s estimated prognosis to trigger three key processes that are central to the successful implementation of a palliative approach: advance care planning, palliative care case conferences and use of an end of life care pathway.

Key Point

Estimated prognosis refers to a prediction made by a suitably qualified health professional about how long a resident has to live based on expert knowledge and clinical judgement about the resident’s condition and specific disease process(es).

Using the Palliative Approach Trajectories Framework [Figure 1], all new and existing residents requiring a palliative approach are assigned to one of three trajectories based on their estimated prognosis: Trajectory A, Trajectory B or Trajectory C. Each trajectory triggers specific processes and actions intended to meet the care and related needs of the resident.

Remember, prognostication is often imprecise. For this reason residents should be reviewed frequently by the general practitioner/nursing staff for changes in their clinical condition. Whenever a resident experiences an acute event or illness they must be re-reviewed. In the absence of any acute changes in the resident’s condition:

- Residents assigned to Trajectory A should be reviewed every six months.
- Residents assigned to Trajectory B should be reviewed monthly.
- Residents assigned to Trajectory C should be reviewed daily.

Important

In this Learning Guide we focus on residents assigned to Trajectory C in the Palliative Approach Trajectories Framework [Figure 1] - i.e. residents with an estimated prognosis of less than one week. The key process associated with Trajectory C is use of the RAC EoLCP.
Figure 1: Palliative Approach Trajectories Framework

ALL NEW AND EXISTING RESIDENTS

TRAJECTORY A
- Expected prognosis of greater than 6 months
  - Annual nurse led case conference including advance care planning
  - Review 6 monthly
  - Prognosis 6 months or less

TRAJECTORY B
- Expected prognosis of 6 months or less
  - Palliative care case conference including review of advance care planning
  - Assessment and management of palliative clinical symptoms
  - Review monthly
  - Prognosis less than 1 week

TRAJECTORY C
- Expected prognosis of less than 1 week
  - Commence Residential Aged Care End of Life Care Pathway
  - Review daily
  - If prognosis is greater than 1 week
Important

Consult the following PA Toolkit resources for detailed information about the components and use of the ‘Palliative Approach Trajectories Framework’:

- Module 1: Integrating a Palliative Approach
- Module 2: Key Processes
Overview of the RAC EoLCP

What is an End of Life Care Pathway?

An end of life care pathway is a structured multidisciplinary care plan which sets out essential steps in the care of a dying resident. There are currently a number of different end of life care pathways being used in acute care and residential aged care settings.3

Learning Activity 1

Take a few minutes to think about (or discuss in a group) the following questions:

- Have you used an end of life care pathway?
- If you have used an end of life care pathway, what benefits did you observe? (e.g. in caring for residents; in undertaking your day-to-day work)
- If you have used an end of life care pathway, what challenges did you encounter?

Purpose and Structure of the RAC EoLCP

The RAC EoLCP is an evidence-based clinical care plan specifically developed by the Brisbane South Palliative Care Collaborative for use by Australian RACFs in the delivery of end of life (terminal) care. It is a consensus-based, best practice guide for providing care during the last days of a resident’s life. When used within the framework of a palliative approach, the RAC EoLCP has been shown to improve outcomes for dying residents by enhancing the quality of end of life (terminal) care provided by RACFs.4,5

The RAC EoLCP is divided into five sections that facilitate the comprehensive planning, delivery, evaluation and documentation of end of life (terminal) care provided to dying residents. The five sections of the RAC EoLCP are:

- Section 1: Commencing a Resident on the Pathway
- Section 2: Medical Interventions and Advance Care Planning
- Section 3: Care Staff Interventions
- Section 4: Multidisciplinary Communication Sheet
- Section 5: After Death Care
Learning Activity 2

Take a few minutes to familiarise yourself with each section in the RAC EoLCP document. A copy of the RAC EoLCP is provided in Appendix A.

Benefits of Using the RAC EoLCP

The RAC EoLCP:

• Guides the provision of an evidence-based, best practice palliative approach to care in the last days of a resident’s life.
• Provides documented evidence of care as it is delivered.
• Supports high quality, standardised care for all residents.
• Supports internal quality assurance and audit processes within the RACF.\(^4\)
How to Use Each Section in the RAC EoLCP

Introducing the Pathway Document

Let’s now look at each section in the RAC EoLCP document in detail.

Learning Activity 3

The training video uses a fictional scenario about Mr Jack Smith to demonstrate how to use the RAC EoLCP. The following information introduces you to Mr Smith.

Fictional scenario: Jack Smith is an 87 year old gentleman who has been living at the aged care facility for three years. He has multiple advanced illnesses. In the last 12 months his health has declined and he has become very frail and debilitated. It is unlikely that Jack’s condition will improve and the GP and care team have agreed that a ‘palliative approach’ to caring for him and managing his symptoms is the appropriate treatment course.

1. Take a few minutes to think about [or discuss as a group] the actions that Jack’s care team should consider/undertake in providing him with a ‘palliative approach’ to care. Remember to jot down your ideas so that you can refer back to them later.

2. Now watch the first segment of the training video: ‘Introducing the Pathway Document’. Refer to page 1 of the RAC EoLCP document when watching this segment of the training video.

Remember:

When using the RAC EoLCP it is essential that all care practices remain resident and family centred. Considerations for practice include:

- Providing the resident and family with an opportunity to reflect upon, and tell you what brings meaning to their life, what they value, and how they wish care to be undertaken.
- Regularly reassessing goals and priorities to ensure that the resident, their family and care team are working together to maximise the resident’s comfort and dignity in the last days of life.
Section 1: Commencing a Resident on the Pathway

Learning Activity 4

This learning activity is divided into two parts for you to complete.

1. Take a few minutes to consider (or discuss as a group) the following questions:
   - Have you experienced the death of a resident?
   - Were you aware that the resident was in the last days/hours of life?
   - What signs of approaching death did you notice?

2. Watch ‘Section 1: Commencing a Resident on the Pathway’ of the training video. This segment of the training video relates to page 2 of the RAC EoLCP document.

Remember:

- It is essential that all members of the care team are familiar with and recognise the signs and symptoms indicating that a resident may be approaching the last days of life. This will ensure that the right information, care and support are provided to the resident and their family at the right time. You will find a list of the common signs and symptoms that occur as death approaches on page 2 of the RAC EoLCP document.

- The decision to commence the RAC EoLCP must be supported by the views of the general practitioner and the resident’s multidisciplinary care team in consultation with the resident (if possible) and the resident’s substitute decision maker. Refer to Appendix B for a flowchart related to the criteria for commencing a resident on the RAC EoLCP.

- The RAC EoLCP is designed to be used by all staff who are providing direct care and support to the resident and their family. Appendix C summarises the specific responsibilities of care team members when using the RAC EoLCP.

- If commenced on the Pathway and the resident’s condition stabilises it may be appropriate to take the resident off the Pathway.

Key Point

As noted in the training video, ‘Section 1: Commencing a Resident on the Pathway’ of the RAC EoLCP document highlights that:

- All parties must agree to commencement of the Pathway.
- Regular review of the resident’s condition is essential.
- The Pathway can be discontinued if the resident’s condition improves.
Section 2: Medical Interventions and Advance Care Planning

It’s important to remember that Section 2 of the RAC EoLCP document is divided into two parts:

• Part 1 – Medical Interventions
• Part 2 – Advance Care Planning

Learning Activity 5

This learning activity is divided into two tasks for you to complete.

1. Take a few minutes to consider (or discuss as a group) the following question related to Mr Jack Smith (who is featured in the training video).
   • What issues related to end of life care (e.g. treatment goals and preferences) need to be discussed and/or reviewed with Jack (if possible) and his substitute decision maker?

2. Watch ‘Section 2: Medical Interventions and Advance Care Planning’ of the training video. This segment of the training video relates to page 3 of the RAC EoLCP document.

Remember:

• The registered nurse/enrolled nurse needs to ensure that each item in Section 2 of the RAC EoLCP document is addressed and that appropriate follow up occurs and is documented.

• The first part of Section 2 covers medical interventions. In this section, the general practitioner or nurse practitioner is prompted to review medical management of the resident’s condition and cease unnecessary interventions and medications.

• Symptoms such as pain, breathlessness and restlessness occur commonly at end of life. It is essential that the general practitioner or nurse practitioner pre-emptively order medication(s) to manage these and any other end of life symptoms that the resident may experience.

• Residents and their families may be challenged or confronted by changes in medication and treatment. Clear communication explaining the reasons for the changes and revisiting the goals of care are very important at this time.

• The second part of Section 2 covers advance care planning. Important issues such as preference for place of care at end of life, cardiopulmonary resuscitation, administration of artificial hydration and intravenous or oral antibiotics are addressed with the resident (if possible) and their substitute decision maker. For detailed information about advance care planning, consult ‘Module 2: Key Processes’ in the PA Toolkit.
Key Point

As noted in the training video, ‘Section 2: Medical Interventions and Advance Care Planning’ of the RAC EoLCP document prompts members of the resident’s care team to:

• Review all current medications and interventions.
• Discontinue non-essential medications and interventions.
• Ensure medications to manage emerging terminal symptoms are ordered.
• Revisit and confirm goals of care.
Section 3: Care Staff Interventions

It’s very important to recognise that Section 3 of the RAC EoLCP document is divided into three separate parts:

- Part A - Care Management (page 4 of the RAC EoLCP document)
- Part B - Comfort Care Chart (pages 5 to 8 of the RAC EoLCP document)
- Part C - Further Care Action Sheet (pages 9 and 10 of the RAC EoLCP document)

Learning Activity 6

This learning activity is divided into two tasks for you to complete.

1. Take a few minutes to consider (or discuss as a group) the following question related to Mr Jack Smith (who is featured in the training video):

   - What are some of the psychological, spiritual and cultural needs that Jack may be experiencing, or that you may have been aware of, when caring for residents who were approaching the last days of life?

2. Watch ‘Section 3: Care Staff Interventions’ of the training video. This segment of the training video relates to pages 4 to 10 of the RAC EoLCP document.
**Section 3: Part A – Care Management**

‘Section 3: Part A – Care Management’ (see page 4 of the RAC EoLCP document) is completed by the registered nurse/enrolled nurse. In particular, this section addresses:

- Spiritual, religious and cultural needs of the resident.
- Communication with family regarding the resident’s condition.
- Ensuring family contact details are up-to-date.
- Providing supportive resources such as bereavement material to family members (e.g. the ‘What Now? Understanding Grief’ brochure from the PA Toolkit).
- Assessing the resident’s comfort needs and initiating strategies to enhance comfort.

**Key Point**

- If a ‘no’ or ‘pending’ response is recorded in any section of the RAC EoLCP document, reasons for this should be recorded on the ‘Multidisciplinary Communication Sheet’ (i.e. Section 4 on page 11 of the RAC EoLCP document) or in the RACF’s paper or electronic progress notes to facilitate follow-up actions.

- Brochures are available in the PA Toolkit to assist residents and their relatives/friends to gain a better understanding of the dying process, the RAC EoLCP, and issues associated with loss and grief.

**Section 3: Part B – Comfort Care Chart**

‘Section 3: Part B – Comfort Care Chart’ (see pages 5 to 8 of the RAC EoLCP document) requires all care staff to document symptom assessment and care provided to the resident. A new chart is commenced each day.

**Important**

Outcome scores for each care activity are recorded on the ‘Comfort Care Chart’ as:

- A = assessed and no action required
- F/A = further action required
- R/C = routine care
- N/A = not applicable
Learning Activity 7

Read page 5 of the RAC EoLCP document [the ‘Comfort Care Chart’] and then complete the following exercise based on your current work role.

**Registered Nurses and Enrolled Nurses:** At 0800 Jack is experiencing pain, restlessness and agitation. All other symptoms are controlled. How would you document the outcomes of your symptom assessment on the ‘Comfort Care Chart’? Use Extract 1 from the RAC EoLCP document below to record your answer.

**Careworkers:** At 0800 you attend to Jack’s physical care. When you repositioned Jack he grimaced and groaned. No concerns are noted with any other aspect of care given. How would you document the outcomes of the physical care you provided on the ‘Comfort Care Chart’? Use Extract 1 from the RAC EoLCP document below to record your answer.

Note: Pages 6 to 8 of the RAC EoLCP document are additional copies of the ‘Comfort Care Chart’.

---

**Extract 1: ‘Comfort Care Chart’ for Learning Activity 7**

```
<table>
<thead>
<tr>
<th>RAC EoLCP</th>
<th>Section 3: Part B – Comfort Care Chart</th>
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</thead>
<tbody>
<tr>
<td>Score each box:</td>
<td>A = assessed and no action required</td>
</tr>
<tr>
<td>Date:</td>
<td>1/1/13</td>
</tr>
</tbody>
</table>

**Symptom Management**
- Agitation: F/A
- Nausea / vomiting: A
- Respiratory difficulties: A
- Rattly respirations: F/A
- Pain: A
- Subcutaneous cannula check: A
- Subcutaneous infusion check: N/A

**Routine Comfort Measures**
- Comfortable positioning: F/A
- Mouth care – clean and moist: F/A
- Eye care – clean and moist: R/C
- Skin care: R/C
- Micturition – dry and comfortable: R/C
- Bowel care: A

**Psychosocial**
- Procedures explained: A
- Information regarding changes provided: A
- Any new concerns responded to: A
- Spiritual, religious, cultural needs / rituals identified and facilitated: A

**Completed by RN/EN every 2-4 hours**
- Completed by careworker, RN/EN every 2-4 hours
- Completed by RN/EN at least twice daily

**Initials**

<table>
<thead>
<tr>
<th>PH(EN/SM (CW)</th>
</tr>
</thead>
</table>

**Key:** RN Registered Nurse   CW Careworker
Note

See Appendix D to check that you have correctly entered the information related to Learning Activity 7 on the ‘Comfort Care Chart’.

Section 3: Part C - Further Care Action Sheet

‘Section 3: Part C - Further Care Action Sheet’ (see pages 9 and 10 of the RAC EoLCP document) records detailed information about issues/interventions related to the resident’s care that require follow up (‘Further Action’) as identified on the ‘Comfort Care Chart’ (Section 3: Part B of the RAC EoLCP document).

The effectiveness of all further actions should be monitored and documented. Some further actions such as repositioning a resident for comfort can be assessed and documented immediately while others, for example the administration of analgesic medications, need some time to monitor effectiveness.

Learning Activity 8

Read page 9 of the RAC EoLCP document (the ‘Further Care Action Sheet’) and then complete the following exercise based on your current work role.

Registered Nurses and Enrolled Nurses: How would you document on the ‘Further Care Action Sheet’ any further actions or interventions that you would carry out as a result of the problems you identified when completing the symptom assessment at 0800? Use Extract 2 from the RAC EoLCP document on the next page to record your answer.

Careworkers: How would you document on the ‘Further Care Action Sheet’ any further actions you would carry out as a result of the problem you identified when carrying out the physical care at 0800? Use Extract 2 from the RAC EoLCP document on the next page to record your answer.

Note: Page 10 of the RAC EoLCP document is an additional copy of the ‘Further Care Action Sheet’.
## Extract 2: ‘Further Care Action Sheet’ for Learning Activity 8

### RAC EoLCP Section 3: Part C Further Care Action Sheet

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>What occurred</th>
<th>Action taken</th>
<th>Initials</th>
<th>Time</th>
<th>Was action effective?</th>
<th>If ‘No’, what further action was taken?</th>
<th>Initials</th>
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<tr>
<td>1/1/13</td>
<td>0600</td>
<td>Mouth very dry and crusty.</td>
<td>Cleaned mouth and moisturiser</td>
<td>SM (CW)</td>
<td>0600</td>
<td>Yes</td>
<td>Partially effective. Reported to RN.</td>
<td>SM (CW)</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0600</td>
<td>Restless when turned</td>
<td>Gently repositioned</td>
<td>SM (CW)</td>
<td>0605</td>
<td>Yes</td>
<td>Reported to RN.</td>
<td>SM (CW)</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0605</td>
<td>Restless ++ S/C midazolam 2.5mg</td>
<td>PH (RN)</td>
<td>0630</td>
<td>√</td>
<td></td>
<td>PH (RN)</td>
<td></td>
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<tr>
<td>1/1/13</td>
<td>0605</td>
<td>Rattly Respirations + S/C buscopan 20mg</td>
<td>PH (RN)</td>
<td>0630</td>
<td>√</td>
<td></td>
<td>PH (RN)</td>
<td></td>
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<tr>
<td>1/1/13</td>
<td>0615</td>
<td>Assessed mouth. Dry and crusty Mucosa.</td>
<td>EoL mouth care protocol initiated</td>
<td>PH (RN)</td>
<td>0625</td>
<td>√</td>
<td></td>
<td>PH (RN)</td>
</tr>
</tbody>
</table>

**Key:** RN Registered Nurse  CW Careworker
**Note**

See Appendix D to check that you have correctly entered the information related to Learning Activity 8 on the ‘Further Care Action Sheet’.

**Remember:**

It is recommended that the RAC EoLCP document is kept in a discrete place near the resident’s bedside. This will enable staff to immediately document symptom assessment as well as any care interventions that they have carried out. This also facilitates easy access to up-to-date information about the care that has been provided to the resident and any issues that may be causing the resident discomfort or distress.

**Key Point**

As highlighted in ‘Section 3: Care Staff Interventions’ of the training video:

- **Section 3A** of the RAC EoLCP document relates to the resident’s spiritual, cultural, communication and comfort needs:
  - Ongoing communication with the resident and substitute decision maker/family is essential to ensure that they are aware of changes in the resident’s condition and that they understand and support care and treatment strategies.
  - Loss and grief issues need to be broached and bereavement information given to the resident [if appropriate] and to family members.

- **Section 3B** of the RAC EoLCP document relates to the assessment of symptoms and delivery of routine care:
  - Symptom assessment and delivery of physical care should be attended to at least four hourly.
  - Psychosocial care should be addressed at least twice daily.

- **Section 3C** of the RAC EoLCP document relates to the delivery and evaluation of further care actions:
  - All further care actions should be documented as they occur.
  - All further care actions should be actioned.
  - All interventions delivered should be evaluated in a timely manner to check their effectiveness.
Section 4: Multidisciplinary Communication Sheet

Learning Activity 9

This learning activity is divided into two tasks for you to complete.

1. Take a few minutes to think about (or discuss as a group) the following question:
   - In what ways could ‘Section 4: Multidisciplinary Communication Sheet’ in the RAC EoLCP enhance the care of a resident?

2. Watch ‘Section 4: Multidisciplinary Communication Sheet’ of the training video. This segment of the training video relates to page 11 of the RAC EoLCP document.

Remember:

The ‘Multidisciplinary Communication Sheet’ can be used by all members of the multidisciplinary care team to record additional information about changes in the resident’s condition, concerns expressed by family members and/or as a method of communication between care team members about any issues relating to the resident and their family.

Key Point

As noted in ‘Section 4: Multidisciplinary Communication Sheet’ of the training video:

- Record and share additional relevant information:
  - There is no need to duplicate any information recorded in other areas of the RAC EoLCP on the ‘Multidisciplinary Communication Sheet’ unless further information/explanation is required.
  - Any ‘no’ or ‘pending’ response recorded in any section of the Pathway document is explained in further detail on the ‘Multidisciplinary Communication Sheet’ to ensure that appropriate follow up occurs.

- Using your facility’s current paper or electronic progress notes is an alternative to documenting on the Multidisciplinary Communication Sheet.
Section 5: After Death Care

Learning Activity 10

This learning activity is divided into two tasks for you to complete.

1. Take a few minutes to think about (or discuss as a group) the following question:
   • What are some of the important tasks and activities carried out at your facility following the death of a resident?

2. Watch ‘Section 5: After Death Care’ of the training video. This segment of the training video relates to page 12 of the RAC EoLCP document.

Remember:

• Following the death of a resident, the registered nurse/enrolled nurse completes ‘Section 5: After Death Care’ of the RAC EoLCP document. This section of the RAC EoLCP document provides a checklist of tasks to be completed and ensures that all relevant people are informed of the resident’s death.

• Each residential aged care facility will have its own policies and procedures with respect to ‘final acts of care’. Ensure that you are aware of your facility’s specific policies and procedures in regards to after death care.

Key Point

As highlighted in the training video, ‘Section 5: After Death Care’ of the RAC EoLCP document:

• Provides a checklist of tasks to be completed after the resident’s death.
• Ensures all relevant people are informed of the resident’s death.
• Reminds staff to respond to the family’s bereavement needs:
  - Most families appreciate and benefit from bereavement support. It is important to ensure that the relatives and friends of dying residents are offered information about loss and grief (e.g. the ‘Now What? Understanding Grief’ brochure in the PA Toolkit).
Implementing the RAC EoLCP

It is recommended that implementation of the RAC EoLCP occurs within a ‘supportive framework’. Components of this framework include:

- Developing policies that guide the use of the RAC EoLCP.
- Ongoing education and training for staff about when and how to use the RAC EoLCP.
- Developing a strategy to ensure the immediate availability of medications to manage end of life (terminal) symptoms experienced by residents.6
- Having an audit process in place at your RACF to evaluate the use of the RAC EoLCP.

Important

The RAC EoLCP can be accessed and used at no cost. For further information and/or to download the RAC EoLCP visit:

Learning Activity 11

Take a few minutes to consider (or discuss as a group) how you could best contribute to the effective implementation of the RAC EoLCP within your facility.

Remember:

All nursing and care staff can contribute to the effective implementation of the RAC EoLCP. For example by:

- Being aware of their specific care and documentation responsibilities in relation to the RAC EoLCP. These are summarised in Appendix C.
- Continuing to build their knowledge and skills related to the delivery of high quality end of life (terminal) care. Refer to the Self-Directed Learning Packages Learning Packages in the PA Toolkit.
- Supporting and mentoring less experienced staff about how to use the RAC EoLCP in the delivery of high quality end of life (terminal) care.
- Reflecting on their end of life care practices and participating in audit processes as an ongoing quality improvement process within the facility.
Additional Resources

For further information about using an end of life care pathway within Australian residential aged care facilities see:

- End of Life Care Pathways:


- Residential Aged Care Palliative Approach Toolkit:

References


The RAC EoLCP Document

The Brisbane South Palliative Care Collaborative (BSPCC) RAC EoLCP™ was developed as part of a project funded by the Department of Health and Ageing.

This End of Life Care Pathway (EoLCP) document is a consensus based, best practice guide to providing care for residents in Residential Aged Care Facilities (RACFs) during the last days of their lives. The entire document forms part of the resident's medical record.

To commence the pathway, authorisation should be obtained from the resident’s General Practitioner (GP). If the GP cannot be contacted, interim authorisation can be obtained from one of the following: Palliative Care Medical Officer (PCMO), Palliative Care Nurse Specialist (PCNS) or Senior RACF Registered Nurse (RN). Authorisation can be verbal but needs to be confirmed in writing, by completing Section 1, within 48 hours.

Instructions for Completing the Pathway

Section 1: Commencing a Resident on the Pathway
Medical Officer to be consulted and documentation can be completed by any of the following: GP, PCMO, PCNS, RN

Section 2: Medical Interventions and Advance Care Planning
Medical Officer to be consulted and documentation can be completed by any of the following: GP, PCMO, PCNS, RN

Section 3: Care Staff Interventions

Part A - Care Management
To be completed by RN or Enrolled Nurse (EN)

Part B - Comfort Care Chart
To be completed by attending Nursing and Care Staff
A new chart is to be commenced daily

Part C - Further Care Action Sheet
Nursing and Care Staff are to document any further actions taken to improve comfort care

Section 4: Multidisciplinary Communication Sheet
All members of the multidisciplinary team can document here

Section 5: After Death Care
To be completed upon death of a resident by the attending nurse

Note: Dependent upon individual RACF practices, it may be preferred to use existing facility documentation tools to record Sections 4 and 5.
Section 1: Commencing a Resident on the Pathway

The signs and symptoms listed below are considered to indicate that the terminal phase of life is imminent. (‘Guidelines for a Palliative Approach in Residential Aged Care’ Australian Government Department of Health and Ageing [2006])

It is appropriate to start the pathway if three or more of these signs and symptoms are applicable to the resident. The final decision to commence the pathway is a clinical one, supported by the views of the GP, multidisciplinary team and, if possible, the resident and/or their representative.

Please note, in some cases residents may be commenced on the pathway and then taken off the pathway if their condition improves.

<table>
<thead>
<tr>
<th>Signs and symptoms associated with the terminal phase</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Experiencing rapid day to day deterioration that is not reversible</td>
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<tr>
<td>Requiring more frequent interventions</td>
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<td>Becoming semi-conscious, with lapses into unconsciousness</td>
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<td>Increasing loss of ability to swallow</td>
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<td>Refusing or unable to take food, fluids or oral medications</td>
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<td>Irreversible weight loss</td>
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<td>An acute event has occurred, requiring revision of treatment goals</td>
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<tr>
<td>Profound weakness</td>
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<td>Changes in breathing patterns</td>
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Agreement to commence on pathway

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### Section 2: Medical Interventions and Advance Care Planning

As a minimum, a reassessment of the commencement criteria should occur every three days.

<table>
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<tr>
<th>Intervention</th>
<th>Yes</th>
<th>No</th>
<th>Pending</th>
<th>N/A</th>
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<tr>
<td>Essential medications, via appropriate route, charted</td>
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<td>PRN medications ordered as per guidelines</td>
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<td>Nonessential medications discontinued</td>
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<tr>
<td>Subcutaneous infusion(s) commenced if appropriate</td>
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<td>Inappropriate interventions and observations discontinued (e.g., BSL, blood pressure monitoring)</td>
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### Advance Care Planning

Current condition and commencement of EoLCP discussed with resident / resident’s representative

Issues surrounding intravenous / parenteral and PEG feeding have been discussed with the resident / resident’s representative

Future care plan discussed with resident / resident’s representative (e.g., transfer to hospital, use of antibiotics)

‘Acute Resuscitation Plan’ / ‘Not for Resuscitation’ order discussed and agreed to by resident / resident’s representative

If recording a ‘no’ or ‘pending’ response, please document reasons for this on the multidisciplinary communication sheet to facilitate follow up action.

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<th>Verbal (✓)</th>
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*substitute decision maker
## Section 3: Part A - Care Management

The following information may already be documented in the resident’s chart. Please check that the information in the chart is current and document any changes as necessary.

<table>
<thead>
<tr>
<th>Spiritual / Religious / Cultural Needs</th>
<th>Yes</th>
<th>No</th>
<th>Pending</th>
<th>N/A</th>
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<tr>
<td>Have the spiritual / religious / cultural needs of the resident been addressed?</td>
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<td>Has the resident / resident’s representative* expressed a preferred Funeral Director?</td>
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<table>
<thead>
<tr>
<th>Communication with resident / resident’s representative*</th>
<th>Yes</th>
<th>No</th>
<th>Pending</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Have contact details of resident’s representative* been updated?</td>
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<td>Have attempts been made to inform the resident’s representative* that the resident is dying?</td>
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<td>Have issues around impending death been discussed with resident’s representative*?</td>
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<tr>
<td>Has resident’s representative* been approached regarding grief and loss issues?</td>
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<thead>
<tr>
<th>Comfort Planning</th>
<th>Yes</th>
<th>No</th>
<th>Pending</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Need for special mattress assessed?</td>
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<tr>
<td>Comfort Care Chart commenced?</td>
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<tr>
<td>Other (please state)</td>
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If recording a ‘no’ or ‘pending’ response, please document reasons for this on the multidisciplinary communication sheet to facilitate follow up action.

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### Section 3: Part B - Comfort Care Chart

- Record an entry against each item, as appropriate
- Minimum documentation is 4 hourly, though
- Psychosocial issues may only need assessment twice daily
- Further Actions (F/A) taken, other than routine care (R/C) to be recorded on the ‘Further Care Action Sheet’ (Sec 3 Part C)
- A new chart is to be commenced each day

<table>
<thead>
<tr>
<th>Score each box:</th>
<th>A = assessed and no action required</th>
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#### Symptom Management
- Agitation
- Nausea / vomiting
- Respiratory difficulties
- Rattly respirations

#### Pain
- Subcutaneous cannula check
- Subcutaneous infusion check

#### Routine Comfort Measures
- Comfortable positioning
- Mouth care - clean and moist
- Eye care - clean and moist
- Skin care
- Micturition - dry and comfortable
- Bowel care

#### Psychosocial
- Procedures explained
- Information regarding changes provided
- Any new concerns responded to
- Spiritual, religious, cultural needs / rituals identified and facilitated

**Initials**
# Section 3: Part B - Comfort Care Chart

- Record an entry against each item, as appropriate
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### Symptom Management
- Agitation
- Nausea / vomiting
- Respiratory difficulties
- Rattly respirations
- Pain
- Subcutaneous cannula check
- Subcutaneous infusion check

### Routine Comfort Measures
- Comfortable positioning
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<td>Bowel care</td>
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<td>Procedures explained</td>
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<td>Information regarding changes provided</td>
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<td>Any new concerns responded to</td>
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<td>Spiritual, religious, cultural needs / rituals identified and facilitated</td>
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Initials
### Section 3: Part B - Comfort Care Chart

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<th>Score each box:</th>
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#### Symptom Management
- Agitation
- Nausea / vomiting
- Respiratory difficulties
- Rattly respirations

#### Routine Comfort Measures
- Comfortable positioning
- Mouth care - clean and moist
- Eye care - clean and moist
- Skin care
- Micturition - dry and comfortable
- Bowel care

#### Psychosocial
- Procedures explained
- Information regarding changes provided
- Any new concerns responded to
- Spiritual, religious, cultural needs / rituals identified and facilitated

Initials
## Residential Aged Care End of Life Care Pathway (RAC EoLCP)

### Section 3: Part C - Further Care Action Sheet

- Please record Further Actions (F/A) taken on this sheet.
- If your facility uses medication stickers to record symptom management, they can be applied to this page.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>What occurred</th>
<th>Action taken</th>
<th>Initials</th>
<th>Time</th>
<th>Was action effective?</th>
<th>If ‘No’, what further action was taken?</th>
<th>Initials</th>
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### Section 3: Part C - Further Care Action Sheet

- Please record Further Actions (FA) taken on this sheet.
- If your facility uses medication stickers to record symptom management, they can be applied to this page.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>What occurred</th>
<th>Action taken</th>
<th>Initials</th>
<th>Time</th>
<th>Was action effective?</th>
<th>If ‘No’, what further action was taken?</th>
<th>Initials</th>
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</table>

**Affix identification label here**

- URN:
- Family name:
- Given name(s):
- Address:
- Date of birth:
- Sex: □ M □ F □ I
- Medicare No.:
## Section 4: Multidisciplinary Communication Sheet

- Please use this sheet for documenting additional information and interventions.

<table>
<thead>
<tr>
<th>URN:</th>
<th>Family name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given name(s):</td>
<td>Address:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Medicare No.:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Comments</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
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</table>
### Section 5: After Death Care

The following information may already be documented in the resident’s chart. Please check that the information in the chart is current and document any changes as necessary.

<table>
<thead>
<tr>
<th>Date of death:</th>
<th>/</th>
<th>/</th>
<th>Time of death:</th>
<th>:</th>
</tr>
</thead>
</table>

#### Informed of Death

<table>
<thead>
<tr>
<th>Resident’s representative* informed of death</th>
<th>Yes</th>
<th>No</th>
<th>Pending</th>
<th>N/A</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP informed of death</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedures for ‘final act of care’ according to RACF policy</td>
<td>Yes</td>
<td>No</td>
<td>Pending</td>
<td>N/A</td>
<td>Date</td>
</tr>
<tr>
<td>Infusion device removed and returned</td>
<td>Yes</td>
<td>No</td>
<td>Pending</td>
<td>N/A</td>
<td>Date</td>
</tr>
<tr>
<td>Resident inventory completed</td>
<td>Yes</td>
<td>No</td>
<td>Pending</td>
<td>N/A</td>
<td>Date</td>
</tr>
<tr>
<td>Removal of deceased resident from RACF according to policy</td>
<td>Yes</td>
<td>No</td>
<td>Pending</td>
<td>N/A</td>
<td>Date</td>
</tr>
<tr>
<td>Staff / residents informed of death as appropriate</td>
<td>Yes</td>
<td>No</td>
<td>Pending</td>
<td>N/A</td>
<td>Date</td>
</tr>
<tr>
<td>Bereavement leaflet / information given to NOK or other</td>
<td>Yes</td>
<td>No</td>
<td>Pending</td>
<td>N/A</td>
<td>Date</td>
</tr>
<tr>
<td>Pharmacy informed of death</td>
<td>Yes</td>
<td>No</td>
<td>Pending</td>
<td>N/A</td>
<td>Date</td>
</tr>
<tr>
<td>Allied Health Professionals informed of death</td>
<td>Yes</td>
<td>No</td>
<td>Pending</td>
<td>N/A</td>
<td>Date</td>
</tr>
</tbody>
</table>

*Substitute decision maker

If recording a ‘no’ or ‘pending’ response, please document reasons for this on the multidisciplinary communication sheet to facilitate follow up action.

<table>
<thead>
<tr>
<th>Print name</th>
<th>Title</th>
<th>Signature</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

---

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Appendix B:

Flow Chart - Criteria for Commencement of the RAC EoLCP

Assessment Criteria Completed

- Resident meets criteria (3+ signs/symptoms from Section 1)
  - Yes
  - No

- Can GP be contacted?
  - Yes
  - No

  - Does GP give verbal authorisation?
    - Yes
    - No

    - Does the substitute decision maker/family agree with commencement of RAC EoLCP?
      - Yes
      - No

      - Resident commences on RAC EoLCP
        GP to sign within 48 hours
      - Resident does not commence pathway: Establish an agreed upon care plan that best meets the resident’s care needs and preferences

    - No

- Are 2 RNs available to authorise commencing pathway?
  - Yes
  - No

  - Contact Specialist Palliative Service
  - No

- Is agreement reached?
  - Yes
  - No

  - Does Specialist Palliative Service give authorisation?
    - Yes
    - No

    - Resident commences on RAC EoLCP
      GP to be informed ASAP and signs documentation within 48 hours

    - No
### Appendix C: Specific Responsibilities of Care Team Members when Using the Residential Aged Care End of Life Care Pathway

<table>
<thead>
<tr>
<th>RAC EoLCP Section</th>
<th>General Practitioner (GP)</th>
<th>Registered Nurse (RN)/Enrolled Nurse (EN)</th>
<th>Careworker (CW)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1: Commencing a Resident on the Pathway</strong></td>
<td>Authorise the commencement of the Pathway. Verbal authorisation must be followed up by written authorisation within 48 hours.*</td>
<td>Identify signs and symptoms indicating that the resident is approaching the last days of life. Consult with the RACF care team, GP/medical officer and the resident’s substitute decision maker to gain consensus regarding resident’s prognosis of dying and agreement to commence the Pathway.</td>
<td>Report any changes that are occurring in the resident’s condition that may indicate that the resident is approaching the last days of life.</td>
</tr>
<tr>
<td><strong>Section 2: Medical Interventions and Advance Care Planning</strong></td>
<td>Assess the resident’s end of life care needs. Cease non-essential medications and interventions. Order medications to manage terminal symptoms. Review advance care plan and goals of care with the resident, if possible, and the resident’s substitute decision maker.</td>
<td>Contact GP/medical officer regarding: • Ceasing non-essential medications • Ceasing inappropriate interventions • Ordering medications to manage end of life (terminal) symptoms. Review advance care plan and goals of care with the resident, if possible, and the resident’s substitute decision maker.</td>
<td>Inform the RN/EN regarding knowledge of the resident’s expressed end of life care wishes.</td>
</tr>
<tr>
<td><strong>Section 3: Part A – Care Management</strong></td>
<td>Not applicable.</td>
<td>Address spiritual, religious and cultural needs of the resident and family. Ensure the resident’s substitute decision maker/family has up-to-date information about the resident’s condition and the care plan. Ensure all measures to enhance resident’s comfort are in place, e.g. pressure relieving mattress, syringe driver as needed.</td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Section 3: Part B – Comfort Care Chart</strong></td>
<td>Not applicable.</td>
<td>Assess the resident’s symptoms every two to four hours and document findings on the Comfort Care Chart. Assess psychosocial, spiritual and cultural needs twice daily and as required.</td>
<td>Carry out routine comfort measures such as positioning, skin, eye and mouth care every two to four hours. Inform the RN/EN of any distressing symptoms experienced by the resident.</td>
</tr>
<tr>
<td><strong>Section 3: Part C – Further Care Action Sheet</strong></td>
<td>Not applicable.</td>
<td>Document strategies initiated to manage symptoms. Evaluate efficacy of management strategies within an appropriate timeframe and document same.</td>
<td>Document concerns or symptoms identified as well as action taken. Evaluate the efficacy of the action within an appropriate timeframe and document same.</td>
</tr>
<tr>
<td><strong>Section 4: Multidisciplinary Communication Sheet</strong></td>
<td>Document information that is usually charted in progress notes.</td>
<td>Record additional information regarding the resident’s condition and any changes in treatment or care plan.</td>
<td>Document as per RACF policy.</td>
</tr>
<tr>
<td><strong>Section 5: After Death Care</strong></td>
<td>Not applicable.</td>
<td>Complete checklist of tasks and actions following the resident’s death.</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>

*Important: To commence the Pathway, authorisation should be obtained from the resident’s GP. If the GP cannot be contacted, interim authorisation can be obtained from one of the following: Palliative Care Medical Officer, Palliative Care Nurse Specialist or Senior RACF Registered Nurse.
Appendix D: Answers to Learning Activities 7 and 8

Learning Activity 7: ‘Comfort Care Chart’

<table>
<thead>
<tr>
<th>RAC EoLCP</th>
<th>Section 3: Part B – Comfort Care Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score each box: A = assessed and no action required</td>
<td>F/A = further action required</td>
</tr>
<tr>
<td>R/C = routine care</td>
<td>N/A = not applicable</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date: 1/1/13</th>
<th>0200</th>
<th>0400</th>
<th>0600</th>
<th>0800</th>
<th>1000</th>
<th>1200</th>
<th>1400</th>
<th>1600</th>
<th>1800</th>
</tr>
</thead>
</table>

**Symptom Management**
- Agitation: F/A
- Nausea / vomiting: A
- Respiratory difficulties: A
- Rattly respirations: F/A
- Pain: A
- Subcutaneous cannula check: A
- Subcutaneous infusion check: N/A

**Routine Comfort Measures**
- Comfortable positioning: F/A
- Mouth care – clean and moist: F/A
- Eye care – clean and moist: R/C
- Skin care: R/C
- Micturition – dry and comfortable: R/C
- Bowel care: A

**Psychosocial**
- Procedures explained: A
- Information regarding changes provided: A
- Any new concerns responded to: A
- Spiritual, religious, cultural needs / rituals identified and facilitated: A

**Initials:** PH(RN)/SM(CW) CW/RN

**Completed by RN/EN**
- every 2-4 hours
- by careworker, RN/EN
- at least twice daily

**Key:**
- RN Registered Nurse
- CW Careworker
# Learning Activity 8: ‘Further Care Action Sheet’

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>What occurred</th>
<th>Action taken</th>
<th>Initials</th>
<th>Time</th>
<th>Was action effective?</th>
<th>If ‘No’, what further action was taken?</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/13</td>
<td>0600</td>
<td>Mouth very dry and crusty.</td>
<td>Cleaned mouth Moisturiser applied</td>
<td>SM (CW)</td>
<td>0600</td>
<td>✓</td>
<td>Partially effective. Reported to RN.</td>
<td>SM (CW)</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0600</td>
<td>Restless when turned</td>
<td>Gently repositioned</td>
<td>SM (CW)</td>
<td>0605</td>
<td>✓</td>
<td>Reported to RN.</td>
<td>SM (CW)</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0605</td>
<td>Restless ++</td>
<td>S/C midazolam 2.5 mg</td>
<td>PH (RN)</td>
<td>0630</td>
<td>✓</td>
<td></td>
<td>PH (RN)</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0605</td>
<td>Rattly Respirations +</td>
<td>S/C buscopan 20 mg</td>
<td>PH (RN)</td>
<td>0630</td>
<td>✓</td>
<td></td>
<td>PH (RN)</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0615</td>
<td>Assessed mouth. Dry and crusty mucosa.</td>
<td>EoL mouth care protocol initiated</td>
<td>PH (RN)</td>
<td>0625</td>
<td>✓</td>
<td></td>
<td>PH (RN)</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0800</td>
<td>Jack grimacing and moaning</td>
<td>Delayed repositioning</td>
<td>CW</td>
<td>0805</td>
<td>✓</td>
<td>Reported to RN that Jack uncomfortable/distressed</td>
<td>CW</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0810</td>
<td>Jack restless/distressed. Appeared to be in pain</td>
<td>S/C morphine 2.5 mg S/C midazolam 2.5 mg</td>
<td>RN</td>
<td>0830</td>
<td>✓</td>
<td></td>
<td>RN</td>
</tr>
<tr>
<td>1/1/13</td>
<td>0835</td>
<td>Delayed repositioning at 0800 due to pain</td>
<td>Peaceful - repositioned</td>
<td>CW</td>
<td>0845</td>
<td>✓</td>
<td></td>
<td>CW</td>
</tr>
</tbody>
</table>

**Key:**

RN  Registered Nurse  
CW  Careworker
About the Residential Aged Care Palliative Approach Toolkit

The Residential Aged Care Palliative Approach Toolkit (PA Toolkit) includes a set of resources which, when used in combination, are designed to assist residential aged care providers to implement a comprehensive and evidence-based approach to care for residents.

The PA Toolkit includes the following resources:

• Module 1: Integrating a Palliative Approach
• Module 2: Key Processes
  - Advance Care Planning
  - Palliative Care Case Conferencing
  - End of Life Care Pathway
• Module 3: Clinical Care
  - Pain
  - Dyspnoea
  - Nutrition and Hydration
  - Oral Care
  - Delirium
• 3 Self-Directed Learning Packages (Nurse Introduction, Nurse Advance, Careworker)
• Workplace Implementation Guide: Support for Managers, Link Nurses and Palliative Approach Working Parties
• Training Support Guide: How to Develop a Staff Education and Training Strategy to Help Implement a Palliative Approach in Residential Aged Care
• Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents
• 3 Educational DVDs:
  - Suiting the Needs: A Palliative Approach in Residential Aged Care
  - All on the Same Page: Palliative Care Case Conferences in Residential Aged Care
  - How to Use the Residential Aged Care End of Life Care Pathway (RAC EoLCP)
• 2 Educational Flipchart Sets:
  - Introduction to a Palliative Approach
  - Clinical Care Domains
• Bereavement Support Booklet for Residential Aged Care Staff
• Therapeutic Guidelines: Palliative Care, Version 3, 2010
• Understanding the Dying Process brochure
• Now What? Understanding Grief Palliative Care Australia brochure
• Invitation and Family Questionnaire - Palliative Care Case Conferences
• Guidelines for a Palliative Approach in Residential Aged Care order form

For further information and to download PA Toolkit resources visit: www.caresearch.com.au/PAToolkit