



Residential Aged Care  
Palliative Approach Toolkit

**Workplace Implementation Guide**  
Support for Managers, Link Nurses and  
Palliative Approach Working Parties



This document is licensed under a **Creative Commons Attribution-NonCommercial 3.0 Australia licence**. To view a copy of this licence visit:

<http://creativecommons.org/licenses/by-nc/3.0/>

© State of Queensland (Queensland Health) 2013

In essence you are free to copy, distribute and transmit the work, and to adapt the work. You must attribute the work in the manner specified by the author or licensor (but not in any way that suggests that they endorse you or your use of the work). You may not use this work for commercial purposes. Any of the above conditions can be waived with permission from the copyright holder.

## Recommended Citation

Brisbane South Palliative Care Collaborative (2013) Workplace Implementation Guide: Support for Managers, Link Nurses and Palliative Approach Working Parties, Brisbane: State of Queensland (Queensland Health)

## Enquiries

All enquiries about this document should be directed to:



Brisbane South Palliative Care Collaborative (Queensland Health)  
Email: [bspcc@health.qld.gov.au](mailto:bspcc@health.qld.gov.au)

An electronic copy of this resource can be downloaded at: [www.caresearch.com.au/PAToolkit](http://www.caresearch.com.au/PAToolkit)

## Acknowledgements

This resource was developed as part of the National Rollout of the Palliative Approach Toolkit for Residential Aged Care Facilities Project. The Project was funded by the Australian Government Department of Social Services under the Encouraging Better Practice in Aged Care (EBPAC) Initiative.

Brisbane South Palliative Care Collaborative would like to thank the following for assistance in developing this resource:

- The University of Queensland/Blue Care Research and Practice Development Centre
- Steering Committee for the National Rollout of the Palliative Approach Toolkit for Residential Aged Care Facilities
- Clinical Education Reference Group for the National Rollout of the Palliative Approach Toolkit for Residential Aged Care Facilities
- Clinical staff from Metro South Palliative Care Services (Queensland Health)

## Disclaimer

Information in this resource is provided as a general guide only. Although the Brisbane South Palliative Care Collaborative has attempted to make the information in this resource as accurate as possible, the information is for educational use only and is provided in good faith without any express or implied warranty.

Brisbane South Palliative Care Collaborative has exercised due care in ensuring that the information in this resource is based on the available best practice literature or, in the absence of this literature, expert opinion. There is no guarantee given as to the accuracy or currency of any information in the resource. The information in this resource does not constitute professional advice and should not be relied on as such.

Clinical material presented in this resource does not replace clinical judgement. No information in this resource is intended as medical advice. It should not be used to diagnose, treat, cure or prevent any disease, nor should it be used for therapeutic purposes or as a substitute for an appropriate health professional's advice.

Neither Brisbane South Palliative Care Collaborative nor any person associated with the preparation of this resource accepts liability for any injury, loss or damage (including without limitation direct, indirect, punitive, special or consequential) incurred by use of or reliance upon the information provided in this resource.

## Contents

About this Guide	2
Context and Focus	2
A Palliative Approach in Residential Aged Care	3
Overview of the Ten Steps for Implementing a Palliative Approach in Your RACF	6
Step 1: Identify Key Staff in Your Facility	8
Step 2: Identify and Engage Stakeholders	13
Step 3: Develop or Review Palliative Approach Policy and Procedures	21
Step 4: Develop or Review Policies and Procedures for Medications to Manage End of Life (Terminal) Symptoms	24
Step 5: Review Clinical Assessment Tools and Procedural Forms	27
Step 6: Review Palliative Approach Key Processes	29
Step 7: Use the Palliative Approach Trajectories Framework to Assist Key Process Selection	33
Step 8: Review Each Resident's Clinical Care	35
Step 9: Review Staff Education and Training in a Palliative Approach	36
Step 10: Conduct Audits as Part of Continuous Improvement and Quality Control	40
References	47
Appendix A: Ten Implementation Steps Worksheet	49

## List of Figures

Figure 1: Palliative Approach Trajectories Framework	5
--	---

## List of Tables

Table 1: Ten Steps for Implementing a Palliative Approach in Residential Aged Care Facilities	7
Table 2: Guidance for Using a Specialist Palliative Care Service (SPCS)	20
Table 3: Staff Education and Training Resources in the PA Toolkit	38

## List of Templates

Template 1: Example Role Description – Palliative Approach Link Nurse	9
Template 2: Example Stakeholder Engagement Strategies	14
Template 3: Example Letter – Invitation to General Practitioner	17
Template 4: Example Policy – Palliative Approach in Residential Aged Care	22
Template 5: Example Review Form - Clinical Tools	28
Template 6: Example Review Form - Key Process Documents	28
Template 7: After Death Audit Tool	41
Template 8: Organisational Policies and Structures Audit Tool	43

## ABOUT THIS GUIDE

### Context and Focus

In Australia, the proportion of people dying in residential aged care facilities (RACFs) has steadily increased over the last two decades. In addition, those entering residential aged care are increasingly frail, often highly dependent and have multiple co-morbidities.<sup>1</sup> The complex needs of residents and their families have prompted recognition of the importance of using a palliative approach in residential aged care settings.

Implementing a palliative approach in your RACF is best supported by considering evidence-based care and how it can be supported through organisational structures and processes.

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

1. Sets out ten steps for implementing a facility-wide palliative approach in your RACF, identifies key considerations when planning and undertaking each step, and provides templates/tools to assist you (where relevant) in completing each step.
2. Is designed to be used by residential aged care managers, palliative approach link nurses and palliative approach working parties.
3. Supplements information contained in the following PA Toolkit resources:
  - Module 1: Integrating a Palliative Approach
  - Module 2: Key Processes
  - Module 3: Clinical Care
  - Self-Directed Learning Packages:
    - Nurse Introduction
    - Nurse Advanced
    - Careworker
  - 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
  - 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)
  - Educational Flipcharts:
    - Introduction to a Palliative Approach
    - Clinical Care Domains

It's important for you to review the information in these resources in conjunction with using this Workplace Implementation Guide.

4. Is designed to support the delivery of high quality and evidence-based palliative care in residential aged care.

**The 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.**

## A Palliative Approach in Residential Aged Care

Before working through the ten implementation steps in detail, let's briefly review:

- What is a palliative approach?
- Why implement a palliative approach?
- When should a palliative approach be implemented?

### What is a palliative approach?

A palliative approach:

- Aims to improve the quality of life for individuals with a life-limiting illness and their families by reducing suffering through early identification, assessment and treatment of pain, physical, cultural, psychological, social and spiritual needs.<sup>2</sup>
- Is not restricted to the last days or weeks of a resident's life.<sup>2</sup>



### Key Point

In considering a resident's palliative care needs it's important to distinguish between a palliative approach, specialised palliative service provision and end of life (terminal) care. Make sure that you have a clear understanding of the differences between these three forms of palliative care as this is particularly important for care planning and in clarifying a resident's treatment goals.<sup>2</sup>

### Three Forms of Palliative Care

#### 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 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.

Adapted from Guidelines for a Palliative Approach in Residential Aged Care (2006)<sup>2</sup>

## Why implement a palliative approach in residential aged care?

A palliative approach offers many benefits to residents, their families and the RACF team including:

- Offering the resident and family consistent and continued care by staff with whom they have developed a rapport and positive therapeutic relationship.
- Facilitating advance care planning.
- Increasing the involvement of the resident and their family in decision-making about their care.
- Encouraging open and early discussion on death and dying.
- Providing opportunities, especially for improved control of pain and other symptoms, in a setting that is familiar to the resident.
- Reducing potential distress to residents and their families caused by transfer to an acute care setting (hospital).
- Reducing the admission and/or transfers of residents to acute care settings (hospital) as RACF staff develop the skills to manage the palliative care of residents.<sup>3</sup>

## 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 an individual resident and the focus is on symptom management and comfort care. Once it has been agreed by the appropriate decision makers (i.e. the resident's general practitioner in consultation with the care team, the resident - if possible, and the resident's substitute decision maker) to commence a palliative approach, the resident's estimated prognosis can be used as a trigger to implement the three key processes involved in a palliative approach: advance care planning, palliative care case conferences and use of an end of life care pathway (as described in the PA Toolkit).

Using the palliative approach framework set out in the PA Toolkit, three care trajectories can be applied to all residents based on their estimated prognosis (see Figure 1).

Residents in Trajectory A have an estimated prognosis of more than six months. Advance care planning for these residents will assist in identifying future care wishes. Advance care plans for these residents should be reviewed at least every six months.

Residents in Trajectory B have an estimated prognosis of six months or less. These residents may be considered to be in the palliative phase of their lives and applying a palliative approach to their care is likely to increase their quality of life.

### Markers for a Prognosis of Six Months or Less<sup>2,4</sup>

- Answering "no" to the question: "Would you be surprised if the resident died within the next six months?"
- If there has been significant functional or medical decline.
- If there is emerging conflict concerning whether goals of care should be curative or palliative in intent (e.g. after an acute event).
- If the resident is transferred or admitted to the RACF specifically for comfort or palliative care.

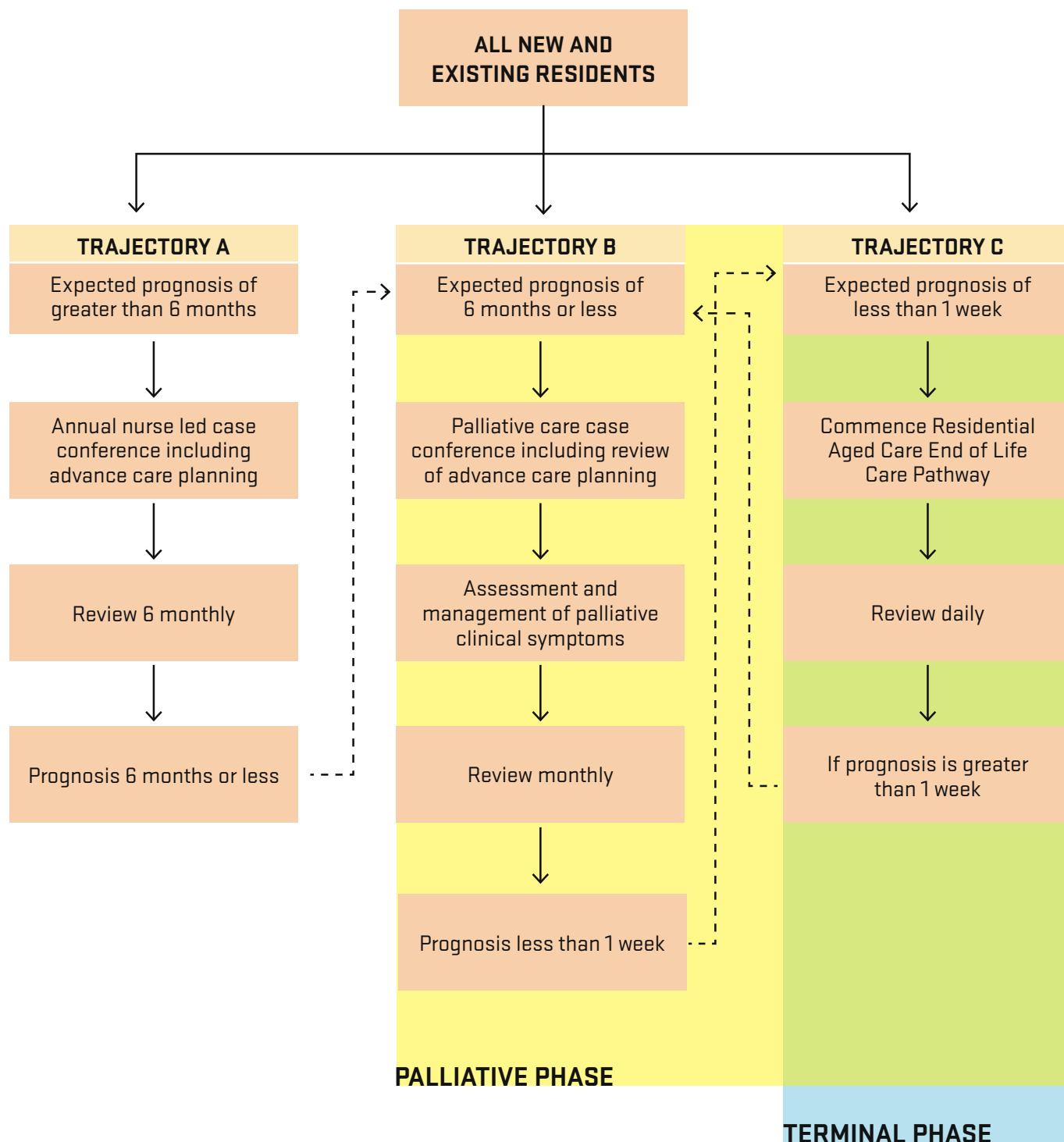
Residents in Trajectory C have an estimated prognosis of less than one week. They are in the terminal phase of their illness and it is appropriate to commence them on an end of life care pathway.

### Criteria for Commencing a Resident on the Residential Aged Care End of Life Care Pathway<sup>5</sup>

The existence of three or more of the following signs and symptoms:

- experiencing rapid day-to-day deterioration that is not reversible
- requiring more frequent interventions
- becoming semi-conscious with lapses into unconsciousness
- increasing loss of ability to swallow
- refusing or unable to take food, fluids or oral medications
- irreversible weight loss
- an acute event has occurred requiring revision of treatment goals
- profound weakness
- changes in breathing patterns

**Figure 1:** Palliative Approach Trajectories Framework





### Key Point

Irrespective of their estimated prognosis, it's important that all residents are regularly assessed for changes in their clinical condition and that strategies are put in place (if required) to immediately address issues of pain management, symptom relief, and spiritual/cultural needs.<sup>6</sup>

## Overview of the Ten Steps for Implementing a Palliative Approach in Your RACF

We have simplified the process for implementing a palliative approach in residential aged care by breaking it into ten steps (see Table 1). The order of the steps listed in Table 1 reflects the need to prioritise the appointment of staff within your facility to 'lead' the implementation process, and the importance of actively engaging both internal and external stakeholders at all stages of this process.

While we have listed the steps in a recommended order for implementation, there is flexibility to re-order and adapt the steps to your facility's particular needs.

In addition to listing the ten implementation steps, Table 1 identifies the PA Toolkit resources relevant to each step. A worksheet to assist you in planning and undertaking each step is provided at the end of this document (see Appendix A).

**You will find it useful to familiarise yourself with the other resources in the PA Toolkit prior to commencing the implementation process. A complete list of current PA Toolkit resources is provided on the inside back cover of this document.**

The remainder of this document addresses each implementation step by highlighting key considerations when undertaking each step and providing templates/tools (where relevant) to guide you in completing each step. 'Thinking Point' boxes describing fictional residential aged care scenarios and including reflective questions have also been included.



### Key Point

The information presented in this Workplace Implementation Guide is not designed to be prescriptive – rather it is intended to help guide your thinking and raise your awareness about key issues when planning and undertaking each implementation step.

There is flexibility to re-order and adapt the ten implementation steps to meet your facility's specific needs.



**Table 1:** Ten Steps for Implementing a Palliative Approach in Residential Aged Care Facilities

Implementation Step	Relevant PA Toolkit Resource(s)*
1. Appoint a Palliative Approach Link Nurse(s) and identify key staff in your facility to form a Palliative Approach Working Party.	<ul style="list-style-type: none"> <li>• Module 1</li> </ul>
2. Identify and engage internal and external stakeholders who will facilitate/support implementation of a palliative approach.	<ul style="list-style-type: none"> <li>• Module 1</li> </ul>
3. Develop or review your policy and procedures for providing a palliative approach.	<ul style="list-style-type: none"> <li>• Module 1</li> </ul>
4. Develop or review policies and procedures for timely access to and administration of medications to manage end of life (terminal) symptoms.	<ul style="list-style-type: none"> <li>• Pharmacological Guide</li> </ul>
5. Review clinical assessment tools and procedural forms in the PA Toolkit for possible inclusion in your care documentation.	<ul style="list-style-type: none"> <li>• Module 3</li> <li>• Pharmacological Guide</li> </ul>
6. Determine how the three key processes addressed in the PA Toolkit will work in your facility.	<ul style="list-style-type: none"> <li>• Module 2</li> <li>• Pharmacological Guide</li> <li>• 'All on the Same Page' DVD</li> <li>• 'End of Life Care Pathway' DVD</li> </ul>
7. Use the Palliative Approach Trajectories Framework to assist in key process selection.	<ul style="list-style-type: none"> <li>• Modules 1, 2 and 3</li> </ul>
8. Review clinical care domains for each resident (including pain, dyspnoea, nutrition and hydration, oral care, and delirium) and identify how these will be monitored as each resident's condition changes.	<ul style="list-style-type: none"> <li>• Module 3</li> <li>• Pharmacological Guide</li> </ul>
9. Review your current staff education and training strategy in relation to implementing a palliative approach and identify how to incorporate PA Toolkit resources into this strategy.	<ul style="list-style-type: none"> <li>• Self-Directed Learning Packages</li> <li>• Training Support Guide</li> <li>• Pharmacological Guide (i.e. Symptom Management Flowcharts)</li> <li>• 'Suiting the Needs' DVD</li> <li>• 'All on the Same Page' DVD</li> <li>• 'End of Life Care Pathway' DVD</li> <li>• Flipcharts</li> </ul>
10. Conduct audits as part of continuous improvement and quality control.	<ul style="list-style-type: none"> <li>• Module 1</li> </ul>

**\*Note:** This table abbreviates the titles for PA Toolkit resources. Refer to the inside back cover of this document for a list of PA Toolkit resources using their full titles.

## STEP 1: IDENTIFY KEY STAFF IN YOUR FACILITY

**Step 1: Appoint a Palliative Approach Link Nurse(s) and identify key staff in your facility to form a Palliative Approach Working Party.**

**In Step 1 you will:**

- **Develop, implement and sustain a Palliative Approach Link Nurse role**
- **Develop, implement and sustain a Palliative Approach Working Party**

### Key Considerations: Palliative Approach Link Nurse

To establish and sustain a Palliative Approach Link Nurse role it's important for you to address the following questions:

- How will you select the Palliative Approach Link Nurse?
- Does your Palliative Approach Link Nurse require preparation to take on this role?
- How can you attract staff to the Palliative Approach Link Nurse role?
- How many Palliative Approach Link Nurses does your facility require?
- How can you provide ongoing support for your Palliative Approach Link Nurse(s)?

#### How will you select the Palliative Approach Link Nurse?

Selecting a Palliative Approach Link Nurse is a strategic decision – your success in implementation is largely attributable to this choice. Consider calling for expressions of interest from staff about taking on this role. Remember, a 'volunteered' Link Nurse may not have the motivation and interest to develop and promote the role. Also, without a call for expressions of interest, some staff may resent not having the opportunity to apply for the role.

Template 1 provides an example role description for a Palliative Approach Link Nurse. It outlines the Link Nurse role, key attributes required to undertake the role, commitment expectations, and potential benefits to the staff member in accepting the role. You can use this role description to guide your selection of a suitable candidate(s).

**Template 1:** Example Role Description - Palliative Approach Link Nurse

The Role	<ul style="list-style-type: none"> <li>• promote and model the palliative approach to resident care</li> <li>• act as a resource for other staff</li> <li>• convene or co-convene the Palliative Approach Working Party</li> <li>• coordinate the implementation of the PA Toolkit</li> <li>• act as the 'link' person between external stakeholders (e.g. general practitioners, specialist palliative care services, allied health professionals, pastoral care staff)</li> <li>• assist with auditing and quality improvement processes</li> <li>• conduct in-service education and training for staff</li> </ul>
Required Attributes	<ul style="list-style-type: none"> <li>• registered nurse or enrolled nurse in possession of a current practicing certificate</li> <li>• employed in a permanent position working a minimum of 0.5 FTE</li> <li>• currently employed in a clinical area</li> <li>• minimum of 12 months experience in residential aged care</li> <li>• ability to communicate and collaborate effectively with internal and external stakeholders</li> <li>• ability to introduce and drive evidence-based practice in the facility</li> <li>• ability and enthusiasm to mentor other staff in the facility</li> <li>• ability to work with and lead teams</li> <li>• commitment and strong motivation to improve care provision and resident outcomes</li> <li>• willingness to actively seek and participate in increasing own knowledge and skills in the delivery of palliative care to residents</li> </ul>
Commitment Expectations	<ul style="list-style-type: none"> <li>• completion of PA Toolkit Self-Directed Learning Packages (Nurse Introduction and Nurse Advanced)</li> <li>• commitment to actively engage in clinical and educational activities in the workplace related to palliative care</li> <li>• willingness to continue ongoing education and training in palliative care</li> </ul>
Benefits to the Link Nurse	<ul style="list-style-type: none"> <li>• professional development (leadership, communication, clinical skills)</li> <li>• networking with other professionals within the facility and community</li> <li>• opportunities to undertake education and training to enhance palliative care knowledge and skills</li> </ul>



**Thinking Point**

Given the size of her facility, Sue, the Director of Nursing, decided to recruit two Palliative Approach Link Nurses. Expressions of interest in taking on the Link Nurse role were sought through the staff newsletter. Carly, a recently graduated registered nurse with limited aged care experience, volunteered for the role. When no one else raised their hand, Sue asked Jean to take on the second Palliative Approach Link Nurse role. Jean accepted the role to help Sue out. Sue admits feeling uncomfortable about asking Jean to add another role to her workload because Jean is already coordinating the facility's Dementia Working Group and has part-time study commitments.

How appropriate are these appointments to the Link Nurse role and why?

### Does your Palliative Approach Link Nurse require preparation to take on this role?

Ensure that your Palliative Approach Link Nurse has adequate time to familiarise themselves with each resource in the PA Toolkit and, in particular, to work through the PA Toolkit Self-Directed Learning Packages (Nurse Introduction and Nurse Advanced). Encourage the development or strengthening of a relationship between your facility and your local specialist palliative care service (where available) to ensure ongoing support for your Link Nurse. Refer to Step 2 in this Workplace Implementation Guide for detailed information about how to engage external stakeholders. Consider whether your Link Nurse requires further professional development (e.g. in advance care planning, staff training and mentoring, quality improvement) to be effective in the role.

### How can you attract staff to the Palliative Approach Link Nurse role?

The Palliative Approach Link Nurse role provides significant professional development opportunities. For example, taking on this role will enhance leadership, clinical, staff training and liaison skills. The Link Nurse will collaborate with a multidisciplinary team of internal and external stakeholders (e.g. specialist palliative care services, allied health professionals, pastoral care staff and managers in non-clinical roles) providing further avenues for ongoing skill development. Offering the Link Nurse opportunities for further formal education and training may also be an incentive.



#### Key Point

The Program of Experience in the Palliative Approach (PEPA) offers clinical placements in Specialist Palliative Care Services (community and inpatient) and tailored workshops to health professionals from a range of disciplines including: nurses, aged care staff, allied health practitioners and Aboriginal & Torres Strait Islander health professionals. PEPA placements and palliative approach workshops are offered free of charge. PEPA is funded by the Australian Government Department of Health. For further information visit the PEPA website at: [www.pepaeducation.com](http://www.pepaeducation.com)

### How many Palliative Approach Link Nurses does your facility require?

When determining the number of Palliative Approach Link Nurses required at your facility, it's important to consider issues of 'coverage' and adequate support for all staff. For example:

- If you have a large facility, are Palliative Approach Link Nurses required for each unit?
- How will after hours and weekend staff be supported by a Palliative Approach Link Nurse?
- Can a Palliative Approach Link Nurse be contacted off duty to respond to urgent queries?
- Who takes on this role when the Palliative Approach Link Nurse is off duty or on leave?

Where possible, we recommend that you recruit multiple Palliative Approach Link Nurses. In addition to addressing issues of coverage, recruiting multiple staff to take on the Link Nurse role will allow them to support each other and work together on palliative care initiatives within the facility.

If you don't have access to multiple RNs/ENs to take on the Palliative Approach Link Nurse role, consider recruiting a careworker(s) to support the appointed Palliative Approach Link Nurse.



#### Key Point

As a minimum, one Palliative Approach Link Nurse for every 50 to 60 licenced beds in your facility is desirable.



## Thinking Point

Mrs Brown's condition has deteriorated and Paul (the registered nurse on duty in the unit) believes that it may be necessary to commence her on an end of life care pathway. Paul is a new staff member at the facility and hasn't used the end of life care pathway before. Paul wants to seek some advice from the Palliative Approach Link Nurse at his facility. However, it's Thursday night and the facility's Palliative Approach Link Nurse only works Monday to Wednesday on day shifts. Mrs Brown is not commenced on the end of life care pathway.

How could this outcome be improved?

### How can you provide ongoing support for your Palliative Approach Link Nurse(s)?

Ongoing support from management is essential in maintaining the viability and effectiveness of the Palliative Approach Link Nurse role. Involve management at all points in developing and implementing Link Nurse-led initiatives. Suggest specific ways in which management can endorse and sustain the Link Nurse role. For example, by supporting training and development opportunities for Palliative Approach Link Nurses, and providing dedicated paid time for nominated staff to attend to their Link Nurse responsibilities.

It's also important to promote the Palliative Approach Link Nurse throughout your facility. Some suggestions include:

- Develop an introductory letter or memo for staff and external providers including general practitioners and specialist palliative care services about the role of the Palliative Approach Link Nurse.
- Post notices around the facility with a photograph of your Palliative Approach Link Nurse(s), a role description and contact details.
- Ask the Palliative Approach Link Nurse(s) to regularly contribute to your facility's newsletter.
- Discuss the role of the Palliative Approach Link Nurse at staff and resident/family meetings.

### Key Considerations: Palliative Approach Working Party

To assist your Palliative Approach Link Nurse(s), we recommend that you form a Palliative Approach Working Party. In doing this, it's important to consider:

- What is the purpose of the Palliative Approach Working Party?
- Who will be the members of the Palliative Approach Working Party?
- How often will the Palliative Approach Working Party meet?

### What is the purpose of the Palliative Approach Working Party?

The purpose of the Palliative Approach Working Party is to:

- Support the facility's Palliative Approach Link Nurse(s).
- Work through the ten steps for implementing a palliative approach (set out in this Workplace Implementation Guide) in collaboration with the facility's Palliative Approach Link Nurse(s).
- Guide evaluation/continuous improvement activities within the facility relevant to delivering a palliative approach and provide ongoing monitoring of best practice in palliative care.
- Provide input into the facility's policies and procedures governing the delivery of a palliative approach.
- Identify the specific palliative care education and training needs of facility staff, and work with the facility manager and Palliative Approach Link Nurse(s) to ensure that relevant workforce development activities routinely occur.

## Who will be the members of the Palliative Approach Working Party?

Identify key staff at the facility to form a Palliative Approach Working Party. A diverse membership will better equip this group to identify issues of importance to particular stakeholders and offer a broad range of knowledge and skills in developing solutions/strategies.<sup>7</sup> As with the role of the Palliative Approach Link Nurse, advertising within the facility for expressions of interest in joining the Palliative Approach Working Party may be the most appropriate recruitment method.

Likely members of a Palliative Approach Working Party include:

- The facility's Palliative Approach Link Nurse(s)
- A management representative (e.g. director of nursing, nurse unit manager)
- A careworker representative
- An allied health representative
- A lifestyle coordinator or diversional therapist
- A hospitality staff representative
- A pastoral care representative
- A consumer representative (resident and/or relative)

External stakeholders, including general practitioners and specialist palliative care services, can be invited to attend particular meetings of the Palliative Approach Working Party (e.g. to inform the implementation process and as an engagement strategy). Refer to Step 2 in this Workplace Implementation Guide for detailed information on how to engage external stakeholders.



### Key Point

The Palliative Approach Working Party should ideally be led by the facility's Palliative Approach Link Nurse(s) and involve liaison with facility management.<sup>7</sup>

High level 'buy-in' from management is important for resourcing/supporting the Palliative Approach Working Party and will reinforce the importance of Link Nurse-led initiatives.<sup>7</sup>



### Thinking Point

Sunfield House is a large RACF with three units that essentially function independently. Three nurses from one of these units became interested in implementing a palliative approach and decided that they would comprise the facility's Palliative Approach Working Party. Over time the nurses noticed resistance from the other units at the facility and from other staff including the careworkers.

How could this resistance be overcome?

## How often will the Palliative Approach Working Party meet?

Your Palliative Approach Working Party may need to meet more regularly in the initial implementation phase – at least weekly over the first one to two months to get traction. Monitor the progress of the group and increase/decrease meetings as required.

## STEP 2: IDENTIFY AND ENGAGE STAKEHOLDERS

**Step 2: Identify and engage internal and external stakeholders who will facilitate/support implementation of a palliative approach.**

**In Step 2 you will:**

- **Identify internal and external stakeholders**
- **Engage internal and external stakeholders**

### Key Considerations: Internal and External Stakeholders

To address this implementation step you will need to consider:

- Who are your internal and external stakeholders?
- How can you engage your internal and external stakeholders?
- How will you introduce the palliative approach to your staff and maintain their support for its ongoing implementation?
- How will you gather feedback from nursing and other facility staff?
- How will you engage residents and families in implementing a palliative approach?
- How will you engage general practitioners in implementing a palliative approach?
- How will you collaborate with your local specialist palliative care service?

#### Who are your internal and external stakeholders?

Your internal stakeholders may include the following:

- management
- nurses
- careworkers
- lifestyle staff or diversional therapists
- residents and their families
- pastoral care staff
- allied health professionals
- hospitality staff.

Your external stakeholders may include:

- general practitioners
- specialist palliative care services
- other specialist services
- pastoral care staff
- allied health professionals
- pharmacists.

#### How can you engage your internal and external stakeholders?

Exchange information with your stakeholders. Listen to and learn from your stakeholders. Your aim is to build understanding and trust on issues of mutual interest. Remember you have a common goal – to improve palliative care outcomes for your residents and their families.

Stakeholders have the potential to help or hinder the process of integrating a palliative approach at your facility. Stakeholders will be more likely to support your palliative approach implementation plans if they are involved in, and consulted about, the process.

Identify potential stakeholders and consider their motivations for participating in your implementation of a palliative approach. Your engagement strategy should take these motivations into account. A template to assist your Palliative Approach Working Party in identifying stakeholders and relevant engagement strategies is provided below (Template 2). Some examples are included on the template to get you started.

**Template 2:** Example Stakeholder Engagement Strategies

Stakeholder	Motivations for Participating	Example Engagement Strategies
Management	<ul style="list-style-type: none"> <li>Implementing a palliative approach will meet accreditation/continuous improvement requirements</li> </ul>	<ul style="list-style-type: none"> <li>Clarify the role of management in the implementation of a palliative approach (be specific e.g. rostering support)</li> <li>Provide summaries of relevant evaluation and continuous improvement data</li> </ul>
Registered Nurses (RNs) and Enrolled Nurses (ENs)	<ul style="list-style-type: none"> <li>Implementation of efficient, best practice clinical care</li> <li>Improved outcomes for residents</li> <li>Enhanced knowledge and skills in palliative care delivery</li> <li>Opportunity to provide feedback on the facility's clinical and related care practices and policies</li> </ul>	<ul style="list-style-type: none"> <li>Education and training sessions (formal and informal)</li> <li>Provide summaries of relevant evaluation and continuous improvement data</li> <li>Ask for RN/EN input/feedback prior to and during implementation</li> <li>Provide information on the palliative approach in the facility newsletter</li> </ul>
Careworkers (CWs)	<ul style="list-style-type: none"> <li>Improved outcomes for residents</li> <li>Enhanced knowledge and skills in care delivery</li> <li>Opportunity to provide feedback on the facility's care practices and policies</li> </ul>	<ul style="list-style-type: none"> <li>Education and training sessions (formal and informal)</li> <li>Provide summaries of relevant evaluation and continuous improvement data</li> <li>Provide information on the palliative approach in the facility newsletter</li> <li>Ask for CW input/feedback prior to and during implementation</li> <li>Include CW representative on Palliative Approach Working Party</li> <li>Include CWs in palliative care case conferences as a mentoring opportunity</li> </ul>
Residents and Families	<ul style="list-style-type: none"> <li>Improved outcomes for residents</li> <li>Support, engagement and 'peace of mind' for families</li> </ul>	<ul style="list-style-type: none"> <li>Provide information on the palliative approach (e.g. Palliative Care Australia has many useful brochures able to be ordered free of charge)</li> <li>Provide information on a palliative approach in resident/family meetings</li> <li>Conduct resident/family satisfaction with care surveys</li> </ul>
General Practitioners (GPs)	<ul style="list-style-type: none"> <li>Efficient use of GP time</li> <li>Improved outcomes for residents</li> </ul>	<ul style="list-style-type: none"> <li>Provide relevant information on the palliative approach to the GP and include specific details suggesting how the GP can be involved</li> <li>Be responsive to the GP's schedule</li> <li>Inform the GP that your facility has an onsite end of life (terminal) care medication imprest system (if applicable)</li> <li>Demonstrate efficient use of the GP's time in palliative care case conferences</li> <li>Provide summaries of relevant evaluation and continuous improvement data (when relevant)</li> </ul>
Specialist Palliative Care Services (SPCSs)	<ul style="list-style-type: none"> <li>Appropriate use of the SPCS by facility staff</li> </ul>	<ul style="list-style-type: none"> <li>Clarify with the SPCS the type(s) of assistance they can provide to your facility</li> <li>Engage the SPCS to deliver staff education (if appropriate)</li> <li>Invite the SPCS to attend a Palliative Approach Working Party meeting</li> </ul>



### How will you introduce the palliative approach to your staff and maintain their ongoing support for its implementation?

Use multiple methods to inform your staff about the palliative approach: newsletters, staff meetings, initial orientation, in-service and externally provided education and training, and clinical reviews. Explain the benefits of the palliative approach and their specific roles in its implementation at the facility. Sell the change! 'Up-skill' your staff as necessary – a confident staff member will be less resistant. Involve staff (where appropriate) in monthly clinical reviews of residents assigned to Trajectory B (refer to Figure 1). Use your Palliative Approach Link Nurse(s) to model and teach the three key processes addressed in the PA Toolkit (see Module 2 in the PA Toolkit) and clinical care (see Module 3 in the PA Toolkit).

### How will you gather feedback from nursing and other facility staff?

Ask staff the following questions:

- What's working well?
- What improvements could be made and how?

Consider asking staff to write down their ideas in a suggestion book and/or meet with individual staff members/groups for a series of informal discussions. Remember to respond to all ideas respectfully and with due consideration.

### How will you engage residents and families in implementing a palliative approach?

Approximately seventy-five per cent of Australians do not understand the term 'palliative care'.<sup>8</sup> It's important, therefore, to provide information about a palliative approach at family/resident meetings. Recruit a consumer representative to your facility's Palliative Approach Working Party. Use the 'Palliative Care Case Conference Invitation and Family Questionnaire' from the PA Toolkit. Provide residents/families with relevant brochures in an appropriate language/format.



#### Key Point

Palliative Care Australia has developed a number of consumer information brochures (including multilingual resources). Titles include:

- 'What is palliative care?'
- 'About pain and pain management'
- 'Facts about morphine and other opioids in palliative care'
- 'What can I say? What can I do?'

These resources can be ordered or downloaded from the Palliative Care Australia website: [www.palliativecare.org.au](http://www.palliativecare.org.au)



#### Thinking Point

Janet, a Palliative Approach Link Nurse, is in charge of organising palliative care case conferences. She often received quite anxious responses from families invited to participate in a case conference. It appeared family members were generally confused about the concept of palliative care. Many thought that a 'palliative approach' indicated that their loved one had only days or weeks to live.

How could Janet address these misconceptions to reduce the potential distress for residents and their families?

## How will you engage general practitioners?

Invite the general practitioner to be involved (where appropriate) in your implementation of the three key processes set out in the PA Toolkit (i.e. advance care planning, palliative care case conferences, use of an end of life care pathway). An example of a letter inviting a general practitioner to participate in the implementation of a palliative approach at a residential aged care facility is provided in Template 3. You may wish to use this template as an initial stakeholder engagement strategy.

Remember, general practitioners have substantial time restrictions. Facilitate engagement with your facility's palliative approach initiatives by, for example, scheduling palliative care case conferences when the relevant general practitioner usually visits the facility and streamline the process for these meetings. For instance, consider dividing the case conferences into two parts: (1) clinical issues can be discussed with the general practitioner present; and (2) psychosocial issues can be addressed by nursing staff after the general practitioner leaves. Alternatively, schedule a further meeting to discuss the psychosocial care of the resident so that the general practitioner can be present. Remember, general practitioners can attend meetings via teleconference if more convenient.

When a general practitioner attends a case conference, ensure that you are well prepared with a current and detailed assessment of the resident's condition and a clearly itemised meeting agenda. Competent and efficient facilitation of a case conference will encourage a general practitioner to take part again.



### Key Point

The Royal Australian College of General Practitioners (RACGP) has developed a resource to provide general practitioners, general practice staff and RACF staff with advice regarding best practice for collaborative arrangements for the care of RACF residents. 'A best practice guide for collaborative care between general practitioners and residential aged care facilities' can be downloaded from the Royal Australian College of General Practitioners website: [www.racgp.org.au/agedcare](http://www.racgp.org.au/agedcare)

### Template 3: Example Letter – Invitation to General Practitioner

Dear Dr <Insert Name>

The complex needs of residents and their families have prompted recognition of the importance of using a palliative approach in residential aged care settings.

<Insert Name of Facility> is implementing this palliative approach to care. It focuses on three key processes:

1. Advance care planning.
2. Palliative care case conferences.
3. Use of an end of life care pathway.

Given that you treat residents living at this facility, we would like you to be aware of these three components of our palliative approach model of care.

#### **Advance care planning**

To ensure that each resident's wishes for future care are known, we will be discussing and documenting these preferences in an advance care plan to be completed as soon as practicable after the resident moves into our facility. The resident and/or their family may approach you to assist with this process. Some residents may also want to complete a legally binding advance directive or establish a legally appointed substitute decision maker.

#### **Palliative care case conferences**

For each resident with an estimated prognosis of 6 months or less, a palliative care case conference will be considered to clarify goals of care and review the resident's advance care plan. If you are invited to be involved in such a case conference, please note that you are able to claim a Medicare rebate (see <http://www.health.gov.au/mbsprimarycareitems> for detailed information on case conferencing items).

#### **Use of an end of life care pathway**

When a resident enters the terminal phase of their life they will be commenced on a care pathway called the Residential Aged Care End of Life Care Pathway (RAC EoLCP). The RAC EoLCP is an evidence-based clinical tool used to plan and guide the care provided to a resident in the last few days of their life. It was specifically developed by the Brisbane South Palliative Care Collaborative for use in Australian residential aged care settings, has been extensively trialled, and has been evaluated positively in terms of resident care.\* The RAC EoLCP document has sections for you to authorise including that it is appropriate for the resident to commence the RAC EoLCP.

A Palliative Approach Link Nurse, <Insert Name>, has been appointed to support the implementation and continuous improvement of a palliative approach model of care within our facility. This nurse can liaise directly with you as required.

For further information please contact our Palliative Approach Link Nurse <Insert Name> on: <Insert Telephone Number> or <Insert Email>.

Yours sincerely

\* Reference: Reymond L, Israel F & Charles M (2011) A residential aged care end-of-life care pathway (RAC EoLCP) for Australian aged care facilities. Australian Health Review, 35, 350-356.

Remind your general practitioners that Medicare will reimburse their participation in case conferences.



### Key Point

#### **MBS Primary Care Items: Multidisciplinary Case Conference Medicare Items for General Practitioners**

Case conferencing items (735-758 as set out in the Medicare Benefits Schedule) are for general practitioners to organise and coordinate (or to participate in) a meeting or discussion held to ensure that their patient's multidisciplinary care needs are met through a planned and coordinated approach.

Patients with a chronic or terminal medical condition and complex care needs requiring care or services from their usual general practitioner and at least two other health or care providers are eligible for a case conference service.

A 'chronic medical condition' is one that has been or is likely to be present for at least six months, including but not limited to asthma, cancer, cardiovascular disease, diabetes mellitus, musculoskeletal conditions and stroke.

Case conferences can be undertaken for people living in RACFs. The case conferencing team must include a general practitioner and at least two other health or community care providers, one of whom can be another medical practitioner. Each team member should provide a different kind of care or service to the patient. Examples of persons who may be included in a multidisciplinary team are nurses, allied health professionals and personal careworkers.

A case conference can occur face-to-face, by phone or by video conference, or through a combination of these.

More detailed information on the case conferencing items is available at:  
<http://www.health.gov.au/mbsprimarycareitems>



### Thinking Point

Kathy, a Palliative Approach Link Nurse, is trying to engage Dr Martin in palliative care case conferences. Dr Martin states that she is too busy to attend and is also concerned about being caught up in family disputes. How could you reassure Dr Martin that you will use her time efficiently?

## How will you collaborate with your local specialist palliative care service?

Specialist palliative care services can be a source of support and guidance for your Palliative Approach Link Nurse(s) and Palliative Approach Working Party.



### Key Point

Palliative Care Australia has developed the National Palliative Care Service Directory to assist the community and health professionals to access information about palliative care services:

<http://pallcare.gky.com.au/c/pc?a=apps&ap=bd>

If you have not already done so, contact your local specialist palliative care service to open a dialogue. Explain your goal to establish/strengthen a palliative approach within your facility and ask about the services they offer.

### \* Note

It's important to remember that specialist palliative care services will differ in what assistance they can provide to residential aged care facilities because every service will have its own operating guidelines, staffing profile and resource availability.

The information in Table 2 may be used as a guide to open discussions with your local specialist palliative care service. Ask them for specific guidance about their referral criteria and check if they offer education or other services that may be of use to residents, families or your facility.

**Table 2:** Guidance for Using a Specialist Palliative Care Service (SPCS)

Criteria for Referral	<ul style="list-style-type: none"> <li>• Every SPCS is likely to have specific referral criteria, including but not limited to: <ul style="list-style-type: none"> <li>- The resident has an advanced life-limiting illness.</li> <li>- The resident's general practitioner is aware of and has agreed to the referral.</li> <li>- The resident and/or family are aware of and have agreed to the referral.</li> </ul> </li> </ul>
Examples of Specific Reasons for Referring a Resident to a SPCS	<ul style="list-style-type: none"> <li>• Management of persistent pain related to an advanced life-limiting disease that is not responding to routine measures. Examples: <ul style="list-style-type: none"> <li>- A thorough pain assessment has been carried out by RACF staff. Pharmacological strategies (including opioids if appropriate) and non-pharmacological strategies have been trialled but these are ineffective or only partially effective.</li> <li>- A resident is requiring high dose opioid therapy to manage pain symptoms. Staff/general practitioners require advice regarding opioid titration or rotation to another opioid or appropriate breakthrough doses.</li> </ul> </li> <li>• Management of severe symptoms related to exacerbation of an existing disease process where the decision has been made to focus on comfort care rather than cure. Examples: <ul style="list-style-type: none"> <li>- Severe breathlessness related to advanced respiratory/cardiac disease.</li> <li>- Nausea and vomiting.</li> </ul> </li> <li>• Contribution to a care plan for a resident who has an advanced life-limiting illness where it is anticipated that complex problems may arise. Examples: <ul style="list-style-type: none"> <li>- Advanced ovarian or bowel cancer leading to possible obstruction.</li> <li>- Cessation of renal dialysis.</li> </ul> </li> <li>• Provide support and advice at a palliative care case conference where the resident and family are experiencing complex physical/psychosocial issues.</li> <li>• End of life (terminal care) support and advice. Examples: <ul style="list-style-type: none"> <li>- Advice regarding commencing a residential aged care end of life care pathway if general practitioner not available.</li> <li>- Assess resident and prescribe medication to manage end of life symptoms if general practitioner not available or if symptoms are complex.</li> </ul> </li> </ul>
Palliative Care Education	<p>SPCSs may offer education sessions on:</p> <ul style="list-style-type: none"> <li>• Understanding advanced disease processes</li> <li>• Pain and symptom management</li> <li>• Understanding the use of analgesic medication including opioids</li> <li>• End of life (terminal) care</li> <li>• Psychosocial/bereavement issues</li> </ul>
Counselling Services	<p>There are Medicare benefits that support a psychologist referral by a general practitioner. SPCSs have limited resources – some may be able to provide short-term counselling support for residents and families.</p>

## STEP 3: DEVELOP OR REVIEW PALLIATIVE APPROACH POLICY AND PROCEDURES

**Step 3: Develop or review your policy and procedures for providing a palliative approach.**

**In Step 3 you will:**

- **Establish or refine (where appropriate) your palliative approach policy and procedures**

### Key Considerations: Policy Development and Review

The following questions will guide you in addressing this implementation step:

- Do you have a palliative care policy?
- Does the policy require amending or updating?
- Have you set up a timeframe for policy review and who will undertake this review?
- Do you require specific policy/procedure documents (e.g. advance care planning, guidelines for use of artificial nutrition/hydration)?



#### Key Point

Policies and procedures are designed to influence and determine all major decisions and actions, and all activities take place within the boundaries set by them. Procedures are the specific methods employed to express policies in action in the day-to-day operation of the organisation.

Together, policies and procedures ensure that a point of view held by the governing body of an organisation is translated into steps that result in an outcome compatible with that view.<sup>9</sup>

#### Do you have a palliative care policy?

Document your facility's 'vision' for palliative care in a clear and concise policy. It's useful to include important definitions and to record sources of evidence used in the policy, as well as to list key procedures associated with the day-to-day 'actioning' of the policy. Template 4 shows an example palliative care policy. You are welcome to adapt this document for your facility or use it in its entirety.

#### Does the policy require amending or updating?

How often do you review and update your facility's care-related policies? Policies should be regularly reviewed and modified in response to new evidence (e.g. internal facility audits and best practice clinical guidelines) and amendments in government legislation/regulations.

#### Have you set up a timeframe for policy review and who will undertake this review?

Scheduling an annual policy review is recommended. Your Palliative Approach Working Party can undertake and assume responsibility for this task.

#### Template 4: Example Policy - Palliative Approach in Residential Aged Care

<b>Vision</b>	A palliative approach aims to improve the quality of life for individuals with a life-limiting illness and their families, by reducing their suffering through early identification, assessment and treatment of pain, physical, cultural, psychological, social and spiritual needs. A palliative approach is not confined to the end stages of an illness. Rather, a palliative approach provides a focus on active comfort care and a positive approach to reducing an individual's symptoms and distress, which facilitates residents' and their families' understanding that they are being actively supported through this process.
<b>Evidence</b>	The following two evidence-based reference documents will be used to inform care plans and protocols associated with this policy: <ul style="list-style-type: none"> <li>• National Health and Medical Research Council's 'Guidelines for a Palliative Approach in Residential Aged Care (May 2006)'</li> <li>• Australian Pain Society's 'Pain in Residential Aged Care Facilities: Management Strategies (August 2005)'</li> </ul> Resources from the Residential Aged Care Palliative Approach Toolkit will be used to guide strategies associated with the implementation of the policy.
<b>Definitions</b>	It is important to distinguish between a palliative approach, specialised palliative care service provision, and end of life (terminal) care. <ul style="list-style-type: none"> <li>• 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.</li> <li>• Specialised palliative care service provision 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 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.</li> <li>• End of life (terminal) 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.</li> </ul>
<b>Associated Procedures</b>	<ol style="list-style-type: none"> <li>1. An advance care plan is completed within 28 days of admission and reviewed regularly.</li> <li>2. Any advance directive (legally binding), where one exists, is clearly documented and accessible.</li> <li>3. The resident (where possible) and their family and/or substitute decision maker are involved in all decision-making about the resident's appropriate care, and their wishes are respected.</li> <li>4. The resident is assessed as requiring a palliative approach using prognostic markers.</li> <li>5. A palliative care case conference is scheduled for residents with an estimated prognosis of six months or less.</li> <li>6. Residents with a prognosis of six months or less are reviewed monthly (sooner if there is a significant decline).</li> <li>7. All residents with a prognosis of less than one week should be commenced on the Residential Aged Care End of Life Care Pathway (RAC EoLCP).</li> <li>8. Residents with a prognosis of less than one week are reviewed daily.</li> <li>9. A Medication Imprest System containing drugs for use in the management of terminal symptoms experienced by residents is maintained onsite at the facility.</li> <li>10. Specialised palliative care is arranged if available and appropriate.</li> <li>11. Care is delivered by a multidisciplinary team including medical, nursing and allied health professionals, pastoral care and ministers of religion, operational staff and volunteers (if available and appropriate).</li> <li>12. In consultation with the resident and/or the resident's family/substitute decision maker, staff clarify and document in the care plan the social, cultural and spiritual needs of the resident.</li> <li>13. Contact names and phone numbers for families and/or substitute decision maker are kept current, and any changes in condition or care are promptly communicated to the appropriate family member or significant other.</li> <li>14. Clinical care including the assessment and management of pain, dyspnoea, nutrition and hydration, oral care and delirium is implemented as indicated.</li> <li>15. Information is provided to support the bereavement needs of family, staff and other residents.</li> <li>16. Quality assurance and continuous improvement activities are regularly undertaken.</li> </ol>
<b>Related Forms and Templates</b>	<ul style="list-style-type: none"> <li>• Withholding/withdrawing life sustaining measures policy</li> <li>• Life extinct/death certification policy</li> <li>• Advance care planning policy</li> </ul>
<b>Consultations</b>	<ul style="list-style-type: none"> <li>• Palliative Approach Working Party</li> <li>• Residential Aged Care Service Management Committee</li> <li>• Local Specialist Palliative Care Service</li> </ul>
<b>Document Creator</b>	Palliative Approach Link Nurse
<b>Approved by</b>	Care Director
<b>Document History</b>	Version: V2.01 (supersedes V1.05) Issued: June 2013 Modified by: Palliative Approach Working Party
<b>Review Cycle &amp; Responsibilities</b>	To be reviewed by the Palliative Approach Working Party annually in June.



**Do you require specific policy and procedure documents (e.g. advance care planning, guidelines for use of artificial nutrition/hydration)?**

In implementing a palliative approach, you may find it useful to develop a set of companion policies and associated procedural documents. Companion policies could include:

- The three key processes addressed in the PA Toolkit (i.e. advance care planning, palliative care case conferences, and use of an end of life care pathway).
- Symptom assessment and management.
- Establishing and maintaining a Medication Imprest System containing drugs for use in terminal symptom management for residents.
- Withholding/withdrawing life-sustaining measures (e.g. artificial nutrition and hydration).
- Life extinct/death certification.



**Thinking Point**

In reviewing documentation from palliative care case conferences, the facility's Palliative Approach Working Party noted several areas of concern: advance care planning preferences were not always discussed, the palliative care case conference invitation and family questionnaire (PA Toolkit resource) was not always provided and/or followed up, and general practitioners were not always invited to attend. The Palliative Approach Working Party also wanted to see greater involvement of careworkers in the case conference process.

Would a written policy and associated set of procedures assist? Why?

## STEP 4: DEVELOP OR REVIEW POLICIES AND PROCEDURES FOR MEDICATIONS TO MANAGE END OF LIFE (TERMINAL) SYMPTOMS

**Step 4: Develop or review policies and procedures for timely access to and administration of medications to manage end of life (terminal) symptoms.**

**In Step 4 you will:**

- **Establish and review measures to ensure the immediate availability of medications to manage end of life (terminal) symptoms experienced by residents**
- **Educate staff on the appropriate and timely use of medications to control end of life (terminal) symptoms experienced by residents**

### Key Considerations: End of Life (Terminal) Symptom Management for Residents

Use the following questions to guide your response to this implementation step:

- What clinical and related principles should underpin your policies and procedures to ensure optimal and timely pharmacological management of symptoms in residents who are dying?
- What processes will be put in place to ensure that residents have optimal and timely access to medications for symptom control during the terminal phase of life?
- What are the roles and responsibilities of facility staff in the provision of optimal and timely symptom control during the terminal phase of residents' lives?
- What medications are suitable for use in residential aged care for the management of symptoms in residents who are in the terminal phase?
- How will you educate and train staff about the pharmacological management of terminal symptoms in residents?
- How will you ensure the ongoing review/auditing and continuous improvement of your policies and procedures related to the pharmacological management of terminal symptoms in residents?

**Detailed information and educational materials related to the pharmacological management of symptoms commonly experienced by residents in the terminal phase of life are provided in the PA Toolkit resource 'Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents'.**

### What clinical and related principles should underpin your policies and procedures to ensure optimal and timely pharmacological management of symptoms in residents who are dying?

To provide optimal end of life (terminal) care for residents, it's essential that your facility's policies and procedures for the pharmacological control of terminal symptoms reflect current best practice. Consult the 'Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents' in the PA Toolkit for a detailed set of clinical best practice principles that should be incorporated into and underpin the day-to-day implementation of your medication-related policies and procedures. Ensure that you have routine measures in place to address each of these principles.

### **What processes will be put in place to ensure that residents have optimal and timely access to medications for symptom control during the terminal phase of life?**

Review your current processes for obtaining medication orders, prescriptions and drug stocks to ensure timely access to medications afterhours and on weekends/public holidays. In addition:

- Educate staff and general practitioners about pre-emptive ordering of medications.
- Develop a working relationship with your local specialist palliative care service (SPCS) to obtain twenty-four hour advice and support about medications to control terminal symptoms (see Step 2 of this Workplace Implementation Guide for further information about engaging your local SPCS).
- Confirm with your locum general practice service and pharmacist the process for ordering and accessibility of end of life medications to ensure timely symptom control after hours and on weekends/public holidays.

Also, ensure that you have processes in place for immediately accessing appropriate equipment (e.g. syringe drivers) to administer medications via the subcutaneous route. If necessary, seek funding from your organisation to purchase a syringe driver or consider the possibility of a share arrangement with other facilities in your organisation.

### **What are the roles and responsibilities of facility staff in the provision of optimal and timely symptom management during the terminal phase of residents' lives?**

It's important for residential aged care managers and clinical staff to be aware of their roles and responsibilities with respect to the pharmacological management of terminal symptoms experienced by residents. When addressing this implementation step, it will be important for your Palliative Approach Working Party to:

- Identify, clearly document and communicate the specific roles and responsibilities of staffing groups within the facility in regards to terminal symptom management.
- Support facility staff in accessing the education, training and resources required to successfully undertake their respective roles and responsibilities.

Key roles and responsibilities of nursing staff and facility management in relation to terminal symptom management are set out in the PA Toolkit resource: 'Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents'.

### **What medications are suitable for use in residential aged care for the management of symptoms in residents who are in the terminal phase?**

A consensus-based list of eight medications suitable for use in residential aged care for the management of terminal symptoms, and that has been endorsed by the peak body, The Australian and New Zealand Society for Palliative Medicine (ANZSPM), is included in the PA Toolkit resource 'Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents'. Key pharmacological information about each of these medications (i.e. uses, doses, routes of administration) and symptom management flowcharts incorporating their use are also provided in this resource.



#### **Key Point**

Management needs to establish a strategy that ensures immediate access to appropriate medications as residents in the terminal phase are clinically unstable and distressing symptoms can emerge rapidly.

### **How will you educate and train staff about the pharmacological management of terminal symptoms in residents?**

Management needs to provide access to ongoing education and training for all nursing staff to ensure the required level of knowledge and skills to appropriately manage medications. This is particularly important in palliative care where high risk medications such as opioids are commonly used. Also, management should ensure that appropriately qualified nurses are available onsite to monitor and supervise the administration of medications to manage terminal symptoms experienced by residents.

Consider using the four symptom management flowcharts and pharmacological information in the 'Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents' (PA Toolkit resource) as part of in-service training for your nursing staff.

### **How will you ensure the ongoing review/auditing and continuous improvement of your policies and procedures related to the pharmacological management of terminal symptoms in residents?**

Your policies and procedures for the pharmacological management of terminal symptoms in residents should be continually reviewed/audited and updated (if required) to ensure that they are in line with current best practice recommendations.

Most RACFs have a process for medication review of their residents (e.g. via a Medication Advisory Committee and/or appropriately credentialed pharmacist). Consider how to directly involve this committee/pharmacist in developing and implementing an ongoing process of review with respect to the medication management strategies used at your facility – including those related to end of life (terminal) care. Consider also engaging members of your Medication Advisory Committee and/or a pharmacist in the development and delivery of staff education related to the appropriate use of medications.



#### **Thinking Point**

Mrs Palmer's condition deteriorated suddenly on Sunday afternoon. She was experiencing pain, breathlessness and restlessness. Her doctor was unavailable and facility staff did not have access to the necessary medications (i.e. opioids and anxiolytics) to provide symptom relief. Mrs Palmer was transferred to hospital for symptom management and died in hospital the next day. Her family were very distressed that she had been transferred to hospital.

How often has your facility experienced a similar situation? How can such situations be avoided?

## STEP 5: REVIEW CLINICAL ASSESSMENT TOOLS AND PROCEDURAL FORMS

**Step 5: Review clinical assessment tools and procedural forms in the PA Toolkit for possible inclusion in your care documentation.**

**In Step 5 you will:**

- Review the clinical assessment tools and procedural forms recommended in the PA Toolkit
- Decide whether to use the tools/forms recommended in the PA Toolkit, retain your existing tools/forms, and/or source additional tools/forms suited to your facility

### Key Considerations: New Clinical Tools and Procedural Forms

For this implementation step you will need to consider:

- Have the assessment tools and procedural forms in Module 2 and Module 3 of the PA Toolkit been reviewed by your Palliative Approach Working Party?
- What is the approval process to add new tools to your facility's assessment protocol?
- How will staff be trained to use new assessment tools and procedural forms?

#### **Have the assessment tools and procedural forms in Module 2 and Module 3 of the PA Toolkit been reviewed by your Palliative Approach Working Party?**

Your Palliative Approach Working Party should review the clinical assessment tools and procedural forms in Modules 2 and 3 of the PA Toolkit, and decide whether and how to incorporate these into the palliative approach procedures used by your facility.

The clinical tools recommended in the PA Toolkit are listed in Template 5. Review and compare these measures with the current tools used at your facility. You may also wish to review your current key process documentation against forms provided in the PA Toolkit (see Template 6).

#### **What is the approval process to add new tools to your facility's assessment protocol?**

Some aged care providers have strict requirements about the introduction of new clinical tools and procedural forms. The approval process may take time. If this is the case for your facility, prioritise this authorisation task to ensure the timely completion of this key implementation step.

#### **How will staff be trained to use the new assessment tools and procedural forms?**

Staff will need to be trained to correctly use new clinical tools and forms. Training can be provided in group workshops and/or peer mentors can work with staff on the floor. Access a sample of completed clinical forms and examine the accuracy of their completion by staff. Look for common errors in how forms are used and/or completed. Troubleshoot any problems immediately. You need to correct errors and misconceptions quickly so that these don't become entrenched behaviours. Provide clear feedback on errors and give suggestions about how to improve the accurate use and completion of clinical tools and procedural forms.



#### **Thinking Point**

The Residential Aged Care End of Life Care Pathway (RAC EoLCP) was implemented at Banksia Aged Care Facility. After six months of using the RAC EoLCP, the Palliative Approach Working Party decided to review some of the completed forms as part of an internal auditing process to support quality control and continuous improvement. The Palliative Approach Working Party noticed that certain sections of the RAC EoLCP form were not routinely completed and that a number of coding errors were made by staff when completing the 'Comfort Care' section of the form.

How could the Palliative Approach Working Party improve this outcome?

### Template 5: Example Review Form - Clinical Tools

	PA Toolkit Recommendation	Facility's Current Clinical Tools	Decision and Rationale**
Pain*	<ul style="list-style-type: none"> <li>Abbey Pain Scale</li> <li>Modified Residents Verbal Brief Pain Inventory</li> <li>Numeric Rating Scale</li> </ul>		
Dyspnoea	<ul style="list-style-type: none"> <li>Assessment of Dyspnoea</li> </ul>		
Oral care	<ul style="list-style-type: none"> <li>Oral Health Assessment Tool</li> <li>Oral Health Care Plan</li> </ul>		
Nutrition and hydration*	<ul style="list-style-type: none"> <li>'MEALS-ON-WHEELS' mnemonic</li> <li>Tube Feeding Decision Aid</li> </ul>		
Delirium	<ul style="list-style-type: none"> <li>Confusion Assessment Method: Shortened Version</li> </ul>		
End of life (terminal) care	<ul style="list-style-type: none"> <li>Modified Bereavement Risk Index</li> </ul>		

**Notes:** \* Other tools that you might consider using include the PAINAD and Mini Nutritional Assessment Tool. These tools are recommended in the Natframe (previously known as the Draft National Framework for Documenting Care in Residential Aged Care Services).<sup>10</sup>

\*\* Use this column to record the outcome of your review process (i.e. list the tools selected as a result of your review process and briefly outline why each tool was chosen for use at your facility).

### Template 6: Example Review Form - Key Process Documents

	PA Toolkit Recommendation	Facility's Current Documentation	Decision/Rationale/Modifications**
Advance care planning	<ul style="list-style-type: none"> <li>Good Palliative Care Plan</li> </ul>		
Palliative Care Case Conference*	<ul style="list-style-type: none"> <li>General Practitioner Invitation</li> <li>Staff Communication Sheet</li> <li>Planning Checklist</li> <li>Summary</li> <li>Invitation and Family Questionnaire</li> </ul>		
End of Life Care Pathway	<ul style="list-style-type: none"> <li>Residential Aged Care End of Life Care Pathway (RAC EoLCP)</li> </ul>		

**Notes:** \* You are free to modify the palliative care case conference documents in the PA Toolkit to suit your facility's requirements.

\*\* Use this column to record the outcome of your review process (i.e. list the documents selected as a result of your review process, briefly outline why each document was chosen, and summarise any modifications required for each document prior to its use at your facility).

## STEP 6: REVIEW PALLIATIVE APPROACH KEY PROCESSES

**Step 6: Determine how the three key processes addressed in the PA Toolkit will work in your facility.**

**In Step 6 you will:**

- **Identify how advance care planning, palliative care case conferencing and use of an end of life care pathway will be undertaken in your facility**

### Key Considerations: Key Process Implementation

In planning, undertaking and reviewing your response to this implementation step, it will be important to address the following questions:

- Does every resident have an advance care plan?
- Does the facility have a policy and procedure document for obtaining and reviewing advance care plans? Is this followed through?
- Is the current advance care plan for each resident readily accessible to all clinical staff (including casual staff)? And if not, how will you accomplish this?
- How will palliative care case conferences be arranged?
- How will an end of life care pathway be implemented?
- Which end of life care pathway will you implement?

**Module 2 in the PA Toolkit has detailed information about how to implement the three key processes identified in the Palliative Approach Trajectories Framework (see Figure 1):**

- **Advance care planning**
- **Palliative care case conferences**
- **Use of an end of life care pathway**

**Module 2 includes templates to assist you in developing clinical and related documentation relevant to these three key processes.**

### Does every resident have an advance care plan?

Residents should be given the opportunity to express their personal wishes and preferences in relation to future goals of care including end of life care. If residents require time to think about their wishes, systematic reminders should be in place to follow up with residents on a regular basis. Residents' preferences for care cannot be respected and followed if they are not known.



#### Key Point

Residents' preferences for care cannot be respected and followed if they are not known. Ensure each resident's needs for end of life care are assessed and reviewed on an ongoing basis.

## Does the facility have a policy and procedure document for obtaining and reviewing advance care plans? Is this followed through?

A legal document is not essential, but residents' preferences should be clearly documented in their charts. Module 2 of the PA Toolkit includes a copy of a non-legal option, the 'Good Palliative Care Plan', which may be acceptable to residents, families and substitute decision makers. There are many advance care planning documents available (see [www.respectingpatientchoices.org.au](http://www.respectingpatientchoices.org.au)).



### Key Point

Each Australian State and Territory has different legislation, regulations and guidelines related to advance care planning. It's important to review and align your facility's advance care planning processes and documentation with the specific requirements in your jurisdiction.

Aim to document an advance care plan and identify a substitute decision maker within the first month of a resident's admission. Remember to review these wishes on a regular basis. The palliative care case conference is an excellent opportunity to conduct this review, but reviews should not be limited just to this occasion.

### What is a Substitute Decision Maker?

A substitute decision maker is a person who has legal power to make decisions on behalf of an adult who is no longer able to decide for themselves. Their powers and terminology will vary in different jurisdictions. Substitute decision makers can include:

- A guardian appointed by a guardianship tribunal.
- An enduring guardian and attorney who was appointed by the resident when they had decision making capacity.
- A default health decision maker (often called a person responsible) where no-one has been formally appointed to decide.

It is important to identify the appropriate substitute decision maker for a resident and that they have authority to make the decision in question (e.g. some substitute decision makers can only make financial or health decisions and not both).

Remember, a resident's substitute decision maker may not always be a family member.

Residents often mention their concerns about hospitalisation and future treatment to careworkers. Train your careworkers to listen for these comments and to report back to nursing staff for further assessment. Set up a procedural policy indicating when advance care plans will be reviewed and monitor the occurrence of these reviews.





## Thinking Point

Mr Peters was admitted to your facility two years ago. His primary diagnosis was advanced heart failure. He indicated on admission that he'd like aggressive medical treatment should he experience exacerbation of his cardiac disease because that treatment had always worked in the past. Since that conversation, Mr Peters has been hospitalised several times due to his deteriorating condition. One morning when his daughter was visiting, Mr Peters was experiencing respiratory distress. Based on the information taken on admission, the nurse decided to send him to the emergency department and called an ambulance. His daughter became distraught saying her father had recently said he doesn't want to go back to hospital and doesn't want to be "kept alive by machines". There is no record of this in Mr Peters' notes.

How could this situation have been avoided?

### **Is the current advance care plan for each resident readily accessible to all clinical staff (including casual staff)? And if not, how will you accomplish this?**

In an emergency, staff do not have time to rifle through a resident's chart to access an advance care plan or advance directive. Make sure these documents are at the front of residents' charts or set up an electronic system so this information can be readily accessed.

### **How will palliative care case conferences be arranged?**

Palliative care case conferences should be arranged for residents assigned to Trajectory B (refer to Figure 1). This requires careful planning:

- When will your facility undertake palliative care case conferences (e.g. for residents with an estimated prognosis of six months or less)?
- Who will arrange the date and time for the case conference and liaise with attendees?
- Who will facilitate the case conference? For example, do you want your Palliative Approach Link Nurse to facilitate all case conferences or will other nurses be mentored to take on this facilitator role?
- Who will prepare the meeting agenda for the case conference and collect up-to-date resident assessments and clinical summaries for discussion at this meeting?
- Will you use the palliative care case conference templates in Module 2 of the PA Toolkit?

### **How will an end of life care pathway be implemented?**

All residents assigned to Trajectory C (refer to Figure 1) should be commenced on an end of life care pathway. Remember, commencement of an end of life care pathway is a clinical decision and it is important that the resident's family/substitute decision maker and general practitioner are involved in this decision.

### **Which End of Life Care Pathway will you implement?**

The PA Toolkit recommends the Residential Aged Care End of Life Care Pathway (RAC EoLCP). For detailed information about when and how to use the RAC EoLCP refer to the PA Toolkit resource: 'Educational DVD: How to Use the Residential Aged Care End of Life Care Pathway'.



## Key Point

The final decision to commence the RAC EoLCP is a clinical one, supported by the views of the general practitioner and multidisciplinary care team in consultation with the resident and/or the resident's substitute decision maker.

The effectiveness of the RAC EoLCP has been evaluated against best practice standards set out by Palliative Care Australia.<sup>11</sup> This comprehensive evaluation provided some of the first evidence internationally that the use of end of life care pathways improves resident outcomes of care. It was found that, when implemented in conjunction with a supportive framework, dying residents were significantly less likely to be transferred to hospital and were therefore more able to die in-place in the familiar environment of their residential aged care facility with carers who were known to them.<sup>11</sup> This evaluation study also showed that use of the RAC EoLCP improved the quality of palliative care provided by facilities and that clinical staff found the tool easy to use and improved their confidence in delivering end of life (terminal) care.<sup>11</sup>



### Key Point

It is critical for your staff to be trained in the process of commencing a resident on an end of life care pathway particularly as regards to consent to commence the pathway. Staff must also be trained to accurately use and complete pathway documentation.

### Pace Your Implementation of the Key Processes

An enthusiastic team sometimes makes the mistake of taking on too much too soon. If your facility is planning to introduce both palliative care case conferences and an end of life care pathway, consider commencing the implementation of these new processes one at a time (rather than in parallel). Staff will require education and training to increase their confidence in applying these key processes. Allow time to review your progress in implementing one key process, and troubleshoot any problems, before implementing the second key process.

## STEP 7: USE THE PALLIATIVE APPROACH TRAJECTORIES FRAMEWORK TO ASSIST KEY PROCESS SELECTION

**Step 7: Use the Palliative Approach Trajectories Framework to assist in key process selection.**

**In Step 7 you will:**

- **Use the Palliative Approach Trajectories Framework (set out in Figure 1) to identify when to implement key processes in the care of each of your residents**

The Palliative Approach Trajectories Framework (see Figure 1) illustrates how a resident's estimated prognosis can be used as a trigger to implement the three key processes involved in a palliative approach: advance care planning, palliative care case conferences and use of an end of life care pathway (as described in the PA Toolkit).

### Key Considerations: Resident Prognosis

In planning and undertaking this implementation step consider the following questions:

- How will you determine a resident's estimated prognosis?
- How will staff be made aware of a resident's estimated prognosis?
- How often should a resident's estimated prognosis be reviewed?

#### How will you determine a resident's estimated prognosis?

Key prognostic markers for residents are provided at the beginning of this Workplace Implementation Guide. Clinical staff at your facility should be aware of these markers. Your Palliative Approach Link Nurse, with support from other experienced practitioners, can undertake the task of assigning residents to the relevant Palliative Approach Trajectory (see Figure 1). Assistance can be sought from the resident's general practitioner and/or your local specialist palliative care service.



#### Key Point

Remember that prognostication is often imprecise and, for this reason, residents should be reviewed frequently for changes in their clinical condition.

Consider placing a poster in each of your facility's nursing stations listing the prognostic markers and prompting staff to be mindful of changes in a resident's condition.

#### How will staff be made aware of a resident's estimated prognosis?

Knowing that a resident requires a palliative approach, or has entered the terminal phase of life, will affect the nature of care provision. The resident's estimated prognosis should be understood by all care team members. Staff should be made aware of any changes in a resident's condition at the start of each shift. All of the procedures used by staff to record and communicate a resident's estimated prognosis and current clinical condition must be kept private and confidential. These procedures should also align with the aged care providers broader policies and processes regarding clinical record keeping.

### How often should a resident's estimated prognosis be 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.

It may be useful to set up a system alerting care team members as to when a resident review is due.

However, whenever a resident experiences an acute event or illness they must be re-reviewed. Refer to Implementation Step 8 for related information about the review of residents' clinical care.



#### Key Point

As mentioned, prognostication is often imprecise. For this reason residents should be reviewed frequently for changes in their clinical condition.

Whenever a resident experiences an acute event or illness their prognostication must be re-reviewed.

## STEP 8: REVIEW EACH RESIDENT'S CLINICAL CARE

**Step 8: Review clinical care domains for each resident (including pain, dyspnoea, nutrition and hydration, oral care and delirium) and identify how these will be monitored as each resident's condition changes.**

**In Step 8 you will:**

- Familiarise yourself with the clinical care domains outlined in Module 3 of the PA Toolkit
- Set up a system to review these clinical care domains

### Key Considerations: Clinical Care Practices

To plan and undertake this implementation step it will be important for you to consider:

- What areas of residents' clinical care should be assessed and reviewed regularly?
- How often should a resident's clinical care be reviewed?

#### What areas of residents' clinical cares should be assessed and reviewed regularly?

The PA Toolkit provides detailed information on five clinical care domains:

- pain
- dyspnoea
- nutrition and hydration
- oral care
- delirium

Module 3 in the PA Toolkit provides detailed information about these five clinical care domains and includes recommendations on evidence-based assessment tools for each.

It's important for all residents to be regularly assessed across these five clinical care domains, and that, if required, an appropriate management plan is put in place.



#### Key Point

These five clinical care domains are not the only aspects of a resident's care that should be addressed by staff. They are designed to highlight key areas that you should consider for residents requiring a palliative approach.

Consider using Template 5 and Template 6 in this Workplace Implementation Guide to review and, if appropriate, update or modify your existing clinical assessment tools and related care documentation (refer to Implementation Step 5).

#### How often should a resident's clinical care be reviewed?

A resident's clinical care should be reviewed on a regular basis. The frequency of that review is determined by the individual resident's condition. Any change reported by the resident/family or observed by staff in the resident's condition should prompt a clinical review of the resident and their care needs.

A resident should always be medically re-reviewed after an acute event or observed clinical deterioration either behavioural or physiological.

## STEP 9: REVIEW STAFF EDUCATION AND TRAINING IN A PALLIATIVE APPROACH

**Step 9: Review your current staff education and training strategy in relation to implementing a palliative approach and identify how to incorporate PA Toolkit resources into this strategy.**

**In Step 9 you will:**

- **Review your current staff education and training program in relation to implementing a palliative approach**
- **Plan how to incorporate PA Toolkit resources into your initial orientation and ongoing training and development for staff**

### Key Considerations: Integrated Workforce Education and Training Program

To plan and undertake this implementation step you will need to consider:

- What content related to implementing a palliative approach will be included in your staff education and training program and how will you prioritise content delivery?
- What methods will you use to train staff in implementing a palliative approach?
- How will you identify and evaluate the outcomes from your staff education and training program?
- How can PA Toolkit resources be used in your staff education and training activities?

The answers to these questions will vary across facilities and aged care organisations. For instance, some large facilities may conduct half-day education workshops while others may rely on ten minute education sessions at handover. There are no 'hard and fast rules' when answering these questions. Clearly the answers will be influenced by your facility's existing policies/procedures, staff needs and available resources.

**The Training Support Guide in the PA Toolkit provides detailed information on how to design, deliver and evaluate a staff education and training strategy related to implementing a comprehensive and evidence-based palliative approach in residential aged care.**

### What content related to implementing a palliative approach will be included in your staff education and training program and how will you prioritise content delivery?

Ongoing staff education and training is critical for introducing and maintaining a palliative approach in your facility. Topics relevant to implementing a palliative approach include:

- Features of a palliative approach and subsequent implications for the care of residents and their families in residential aged care settings.
- Legal and other regulations pertaining to advance care planning/advance directives.
- Clinical symptom (e.g. pain, dyspnoea, delirium) assessment and management for residents requiring a palliative approach (i.e. pharmacological and non-pharmacological methods).
- Issues related to oral care, nutrition and hydration for residents requiring a palliative approach.
- Recognising and addressing the psychosocial, cultural, spiritual and religious needs of residents requiring a palliative approach and their families.
- Communication skills for supporting dying residents and their families.
- Facilitating and supporting advance care planning.
- Facilitating and participating in palliative care case conferences.
- Use of an end of life care pathway.

Clearly, whether and the depth to which these topics are covered will depend on the scope of practice of participants attending a particular education session. When undertaking the key steps set out in this Workplace Implementation Guide, it will be important:

- To identify key areas of knowledge, skill and competence required for staff to successfully 'action' each step; and
- To ensure that, where necessary, your staff have adequate access to informal and formal training opportunities to build the requisite knowledge, skills and competencies for each step.

**The Training Support Guide in the PA Toolkit provides detailed information on how to identify, prioritise and address staff knowledge, skills and competencies related to implementing a palliative approach.**

### **What methods will you use to train staff in implementing a palliative approach?**

Some key issues to consider when choosing staff education and training methods include:

- The number of staff members requiring a specific area of knowledge or skill.
- The scope of practice and level of formal education of participants.
- The specific content area for education and training sessions.
- The resources available to support education and training activities within the organisation.

When a particular area of knowledge or skill is required by a large number of your staff, consider incorporating it into your initial orientation program and/or your annual mandatory training sessions. Remember, staff with different levels of formal education and/or scopes of practice may also differ in their preferred learning styles. For example, using experiential ('hands on') strategies to train staff in comfort care skills is likely to be optimal for careworkers. Due to the financial implications of needing to 'backfill' staff, it may not be possible for your facility to use half-day workshops as a standard training method. Instead, consider developing a series of brief 'micro-teaching' sessions on key topics in implementing a palliative approach that can be delivered during handover. Asking staff to complete self-directed learning activities may also be an option for your facility.

### **How will you identify and evaluate the outcomes from your staff education and training program?**

Use multiple methods to evaluate the outcomes from your staff education and training initiatives. This could include asking staff to complete pre-/post-training surveys to identify changes in knowledge and confidence with respect to a particular area of content. Ask experienced staff to observe less experienced staff in the delivery of care (e.g. oral care) to monitor and mentor skill development. Use audit processes to check compliance with clinical protocols and the use/completion of clinical tools and related documentation.

### **How can PA Toolkit resources be used in your staff education and training activities?**

The PA Toolkit includes a number of staff education and training resources that have been designed to support both self-directed and facilitated training activities with regards to implementing a palliative approach in residential aged care. The key content and primary target audience(s) for each of these staff education and training resources is summarised in Table 3.



#### **Thinking Point**

Jason, a clinical nurse with experience in delivering nurse education, has been asked to develop a staff education and training strategy focusing on a 'Palliative Approach Model of Care'.

What issues should he consider when developing the strategy?

**Table 3:** Staff Education and Training Resources in the PA Toolkit

PA Toolkit Resource*	Summary of Key Content	Primary Target Audience(s)*
<b>Learning Modules</b>		
Module 1: Integrating a Palliative Approach	Introduces key policies and strategies for implementing a palliative approach in residential aged care.	Staff with clinical and non-clinical management responsibilities working in Australian residential aged care facilities.
Module 2: Key Processes	Focuses on three key processes essential for implementing a palliative approach in residential aged care: advance care planning, palliative care case conferences, and use of an end of life care pathway.	Care team staff working in Australian residential aged care facilities.
Module 3: Clinical Care	Focuses on the assessment and management of five clinical care domains: pain, dyspnoea, nutrition and hydration, oral care, and delirium.	Care team staff working in Australian residential aged care facilities.
<b>Self-Directed Learning Guides</b>		
Self-Directed Learning Packages	Use a range of self-directed learning strategies to assist residential aged care staff in systematically working through the content covered in the PA Toolkit Learning Modules.	Three Self-Directed Learning Packages aimed at staff with different scopes of practice and levels of experience are included in the PA Toolkit: Nurse (Introduction), Nurse (Advanced) and Careworker.
<b>Educational DVDs</b>		
Suiting the Needs: A Palliative Approach in Residential Aged Care	This 12 minute video uses a fictional scenario to demonstrate key principles related to the delivery of a palliative approach in residential aged care.	All staff working in Australian residential aged care facilities.
All on the Same Page: Palliative Care Case Conferences in Residential Aged Care	This 14 minute video uses a fictional scenario to demonstrate key principles in convening effective palliative care case conferences in residential aged care.	Care team staff working in Australian residential aged care facilities.
How to Use the Residential Aged Care End of Life Care Pathway (RAC EoLCP)	This multimedia resource includes a 26 minute video using a fictional scenario to demonstrate how each section of the RAC EoLCP should be completed and contributes to the high quality care of dying residents. A learning guide is also included in this resource to assist in using the video for staff orientation and ongoing professional development activities.	Care team staff working in Australian residential aged care facilities.

\* **Note:** In addition to the resources summarised in Table 3, the PA Toolkit also provides resources appropriate for residents and their families.



**Table 3 (cont.):** Staff Education and Training Resources in the PA Toolkit

PA Toolkit Resource*	Summary of Key Content	Primary Target Audience(s)*
<b>Educational Flipcharts</b>		
Introduction to a Palliative Approach	Provides introductory-level information about key concepts and issues in the delivery of high quality palliative care in residential aged care.	Careworkers in Australian residential aged care facilities.
Clinical Care Domains	Provides introductory-level information about five clinical care domains: pain, dyspnoea, nutrition and hydration, oral care, and delirium.	Careworkers in Australian residential aged care facilities.
<b>Implementation Guides</b>		
Workplace Implementation Guide	Sets out ten steps for implementing a palliative approach in residential aged care facilities and provides detailed guidance on how to plan, undertake and evaluate each of these steps.	Residential aged care managers, Palliative Approach Link Nurses and Palliative Approach Working Parties.
Training Support Guide	Provides detailed information and tools to guide the design, delivery and evaluation of a staff education and training strategy related to implementing a palliative approach in residential aged care.	Staff involved in designing, delivering and/or evaluating education and training activities in Australian residential aged care facilities.
Guidelines for a Palliative Approach in Residential Aged Care (Order Form)	Complete and submit this form to the Australian Government Department of Social Services to order the current version of these guidelines for the evidence-based delivery of a palliative approach in residential aged care.	All staff working in Australian residential aged care facilities.
<b>Clinical Practice Guidelines</b>		
Guide to the Pharmacological Management of End of Life (Terminal) Symptoms in Residential Aged Care Residents	Focuses on the pharmacological management of symptoms commonly experienced by residents in the terminal phase of life. Provides flowcharts to guide symptom management in dying residents.	Registered and enrolled nurses working in Australian residential aged care facilities. General practitioners and staff from specialist palliative care services.
Therapeutic Guidelines: Palliative Care (Version 3)	Provides evidence-based guidelines for symptom management and related clinical issues in palliative care provision.	Clinical staff working in Australian residential aged care facilities. General practitioners and staff from specialist palliative care services.
<b>Other Resources for Residential Aged Care Staff</b>		
Bereavement Support Booklet for Residential Aged Care Staff	With a focus on self-care strategies for staff, this booklet provides information on recognising and addressing negative impacts of grief following the death of a resident.	All staff working in Australian residential aged care facilities.

\* **Note:** In addition to the resources summarised in Table 3, the PA Toolkit also provides resources appropriate for residents and their families.

## STEP 10: CONDUCT AUDITS AS PART OF CONTINUOUS IMPROVEMENT AND QUALITY CONTROL

**Step 10: Conduct audits as part of continuous improvement and quality control.**

**In Step 10 you will:**

- **Understand what audits could be conducted**
- **Understand how to use audits in continuous improvement activities**
- **Plan your implementation process using the '10 Implementation Steps Worksheet'**

### Key Consideration: Selecting and Using Audit Tools

It's important to think carefully about:

- What audits could be conducted at your facility?
- When should particular audits be conducted at your facility?



#### Key Point

Evaluation and review are vital components of performance improvement. They help you understand how you are performing, whether you are reaching your goals, and inform your decisions about what to do next.

#### What audits could be conducted at your facility?

Audits that you conduct need to be directly relevant to the service areas that your facility considers important to review.

Below we provide two audit tools that could get you started:

1. **After Death Audit Tool:** Involves auditing individual resident outcomes.
2. **Organisational Policies and Structures Audit Tool:** Involves auditing key organisational policies and structures relevant to the effective implementation of a palliative approach at your facility.

Instructions on how to use these audit tools are provided below.

#### When should particular audits be conducted at your facility?

Audits can be completed at any time. Developing an audit schedule (or timeline) will ensure that these are conducted regularly. You may find it useful to link your auditing schedule with internal and external reporting requirements (e.g. accreditation cycles).

### Key Considerations: Auditing Individual Outcomes Using the After Death Audit Tool

It's important to consider the following questions:

- What information should be collected as part of an after death audit?
- How can results from the After Death Audit Tool be used as a continuous improvement activity?

#### What information should be collected as part of an after death audit?

Following the death of a resident, we recommend that (at a minimum) your facility record the information on the next page (see Template 7). Remember to collect a 'baseline sample'. For instance, conduct a chart review on the last five residents dying prior to the implementation of a palliative approach in your facility. This will provide your 'baseline sample'.

## Template 7: After Death Audit Tool

1. Facility assigned resident ID\*: \_\_\_\_\_  
[\*Please enter the resident's unique identifier assigned by your facility.]
2. Date of death  
(dd)/(mm)/(yyyy)
3. Was this a sudden, unexpected death?  
 Yes  
 No
4. Place of death  
 Residential aged care facility  
 Hospital  
 Other
5. Was the resident transferred to hospital in the last week of their life?  
 Yes  
 No (If no, skip to question 8)
6. Principal reason for hospitalisation  
 Symptom management  
 Sudden, unexpected deterioration or event  
 Following a fall  
 Request of resident and/or family  
 Request of the general practitioner  
 Other, specify \_\_\_\_\_
7. Length of hospital stay  
 Not admitted  
 1 to 3 days  
 Greater than 3 days
8. Were the resident's preferences for end of life care documented?  
[N.B. Documentation of a funeral provider is not sufficient to check "yes" for this item.]  
 Yes  
 No
9. Was a palliative care case conference\*\* conducted within the last six months of the resident's life?  
[\*\*A palliative care case conference focuses on end of life issues. The resident and/or family should be in attendance.]  
 Yes  
 No (If no, skip to question 11)
10. Date of palliative care case conference  
(dd)/(mm)/(yyyy)
11. Was the resident commenced on an end of life care pathway?  
 Yes  
 No (If no, skip to Question 13)
12. Date commenced end of life care pathway?  
(dd)/(mm)/(yyyy)
13. Did the facility claim Complex Health Care Palliative Care through ACFI for this resident?  
 Yes  
 No

### **How can results from the After Death Audit Tool be used as a continuous improvement activity?**

Results from the After Death Audit Tool can be used in several ways in order to quantify continuous improvement at your facility. For example:

- Over time you would hope to see an increase in advance care planning, palliative care case conferences, use of an end of life care pathway and ACFI claims for Complex Care Palliative Care. You would also hope to see a decrease in unnecessary hospitalisations.
- In addition, calculating the time difference between the date of death and palliative care case conference could give you an indication of the accuracy of your prognostication. Similarly, calculating the time difference between the date of death and the commencement of an end of life care pathway will provide an indication of whether you have accurately diagnosed the terminal phase.

### **Key Considerations: Auditing Organisational Outcomes Using the Organisational Policies and Structures Audit Tool**

It's important to consider the following questions:

- What information should be collected as part of an organisational policies and structures audit?
- How can results from the Organisational Policies and Structures Audit Tool be used as a continuous improvement activity?

### **What information should be collected as part of an organisational policies and structures audit?**

Attention to organisational policies and structures will facilitate the implementation of a palliative approach (see Implementation Step 3 in this Workplace Implementation Guide). We recommend that the facility manager (or their delegate) complete the Organisational Policies and Structures Audit Tool (see Template 8) prior to implementation of a palliative approach (as described in the PA Toolkit) and post-implementation (e.g. at six or twelve months after the commencement of a palliative approach) to monitor progress.

### **How can results from the Organisational Policies and Structures Audit Tool be used as a continuous improvement activity?**

Completing the organisational policies and structures audit prior to commencing your implementation provides you with baseline information about what current activities you are engaged in to provide a palliative approach. Completion of this audit every six to twelve months will allow you to track your progress in implementing a comprehensive palliative approach. This information will assist you in your accreditation process.

#### **Additional Continuous Improvement Activities**

As part of your implementation of a palliative approach and continuous improvement activities, you may wish to audit specific key processes and clinical care issues in detail. Visit the PA Toolkit website for some additional audit tools ([www.caresearch.com.au/PAToolkit](http://www.caresearch.com.au/PAToolkit)).

## Template 8: Organisational Policies and Structures Audit Tool

### IMPORTANT

1. For each question in this audit, please circle either “YES” (=1) or “NO” (=0). If the answer is “YES” most of the time, circle 1, otherwise circle 0.

2. Please read and keep the following definitions in mind when completing this audit.

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.

Terminal 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.

1)	Workforce development	YES	NO
a.	Do you have a staff member(s) (e.g. palliative approach link nurse) responsible for promoting and facilitating a palliative approach in your facility?	1	0
b.	Do you have a palliative approach working party responsible for promoting and facilitating a palliative approach in your facility?	1	0
c.	Does ongoing in-service education for your nursing and care staff (RN/EN/AIN/careworker) include:		
	1. Basic knowledge of legal and other regulations pertaining to advance care planning/ advance directives?	1	0
	2. Communication skills for understanding and supporting dying residents and their families (e.g. conducting a palliative care case conference)?	1	0
	3. Pain assessment and management for residents requiring a palliative approach?	1	0
	4. Assessment of non-pain symptoms and complications for residents requiring a palliative approach (e.g. shortness of breath, delirium)?	1	0
	5. Issues related to nutrition and hydration for residents requiring a palliative approach (e.g. dysphagia, the benefits and risks of feeding tubes)?	1	0
	6. Issues related to oral care for residents requiring a palliative approach?	1	0
	7. Use of an end of life care pathway (e.g. the Residential Aged Care End of Life Care Pathway)?	1	0
	8. Cultural, religious and spiritual beliefs and preferences related to palliative and end of life care?	1	0
	9. Bereavement care for staff and families?	1	0

2)	Engaging stakeholders	YES	NO
a.	Are the following stakeholders engaged in planning and providing a palliative approach:		
	1. Specialist palliative care services?	1	0
	2. General practitioners?	1	0
	3. Residents and families?	1	0
	4. Pastoral care?	1	0
b.	Are there educational materials available for residents/families on decision-making and care for those requiring a palliative approach and/or terminal care?	1	0

3)	Policies and procedures	YES	NO
a.	Do you have a written statement of the facility's principles or policy regarding care of residents requiring a palliative approach?	1	0
b.	Is this written statement of the facility's policy/principles provided to:		
	1. Staff?	1	0
	2. Residents?	1	0
	3. Families/substitute decision makers?	1	0
	4. General practitioners?	1	0
c.	Does your care planning process include:		
	1. Establishing and documenting the goals of care for each resident, consistent with resident's personal preferences or values?	1	0
	2. Reviewing the residents' preferences with regard to future hospitalisation?	1	0
	3. Reviewing the residents' preferences with regard to life sustaining or prolonging treatments (e.g. Do Not Resuscitate order, artificial nutrition)?	1	0
d.	Do you have specific policies/guidelines or protocols for:		
	1. Identifying when a resident requires a palliative approach?	1	0
	2. Assessing and managing pain?	1	0
	3. Assessing and managing shortness of breath or dyspnoea?	1	0
	4. Assessing and managing delirium?	1	0
	5. Assessing and managing nutrition and hydration issues (e.g. dysphagia)?	1	0
	6. Assessing and managing oral health?	1	0
	7. Arranging for specialist palliative care when appropriate?	1	0
	8. Palliative care case conferences (a meeting held between a resident, their family and aged care team to identify clear goals of care including a review of advance care plans)?	1	0
	9. Terminal care (last weeks or days of life)?	1	0
	10. When to commence an end of life care pathway (e.g. the Residential Aged Care End of Life Care Pathway)?	1	0
	11. Assessing and managing the emotional, spiritual and cultural needs of residents?	1	0

4)	Evaluation and continuous improvement	YES	NO
a.	Have quality improvement mechanisms been established for:		
	1. Documenting completion and compliance with advance care plans and/or relevant advance directives?	1	0
	2. Monitoring delivery of palliative care, such as pain control, management of distressing symptoms (e.g. shortness of breath, anxiety)?	1	0
	3. Monitoring outcomes for palliative care case conferences?	1	0
	4. Monitoring outcomes related to the use of end of life care pathways?	1	0
	5. Transferring residents' advance care plan (e.g. Do Not Resuscitate order, enduring power of attorney) across settings from residential aged care facility to hospital?	1	0
b.	When residents are transferred to acute care, there is a routine review to assess the appropriateness of transfer?	1	0
c.	Are residents' deaths reviewed to assess quality of care at the end of life?	1	0

**Note:** Based on measure by Temkin-Greener et al. (2009)<sup>12</sup>







## REFERENCES

- <sup>1</sup> AIHW (2012) Residential aged care in Australia 2010-11: A statistical overview. Aged Care Statistics Series No. 36. Cat. No. AGE 68. Canberra: AIHW.
- <sup>2</sup> Commonwealth of Australia (2006a) Guidelines for a Palliative Approach in Residential Aged Care – Enhanced Version, Canberra.
- <sup>3</sup> Commonwealth of Australia (2006b) Guidelines for a Palliative Approach in Residential Aged Care: Self-Directed Learning Package – Manual, Canberra.
- <sup>4</sup> Lyon J (2006) Living long in fragile health: The new demographics shape end of life care. Improving End of Life Care: Why Has It Been So Difficult? Hastings Centre Report [Special Report], 35(6), S14-S18.
- <sup>5</sup> Brisbane South Palliative Care Collaborative (2013) Residential Aged Care End of Life Care Pathway (RAC EoLCP), Brisbane: State of Queensland (Queensland Health).
- <sup>6</sup> Commonwealth of Australia (2006c) Guidelines for a Palliative Approach in Residential Aged Care – A Navigational Tool, Canberra.
- <sup>7</sup> Andrews S, McInerney F, Leggett S, Donohue C & Robinson A, Dementia-Palliative Care Resource Nurse Resource Kit. Accessed online 13/08/2013: [www.caresearch.com.au](http://www.caresearch.com.au)
- <sup>8</sup> Campbell Research & Consulting (2006) Community Attitudes Toward Palliative Care, Victoria: Commonwealth of Australia.
- <sup>9</sup> Business Dictionary: [www.businessdictionary.com](http://www.businessdictionary.com) Viewed: 13/08/2013.
- <sup>10</sup> Commonwealth of Australia (2005) The National Framework for Documenting Care in Residential Aged Care Services, Canberra. Accessed online 03/09/2013: <http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-rescare-natframe.htm~ageing-rescare-natframe02.htm>
- <sup>11</sup> Reymond L, Israel F & Charles M (2011) A residential aged care end-of-life care pathway (RAC EoLCP) for Australian aged care facilities. Australian Health Review, 35, 350-356.
- <sup>12</sup> Temkin-Greener H, Zheng N, Norton S, Quill T, Ladwig S & Veazie, P (2009) Measuring end-of-life care processes in nursing homes. The Gerontologist, 49(6), 803-815.
- <sup>13</sup> Aged Care Standards and Accreditation Agency (2009) Audit Handbook, Parramatta.



## APPENDIX A: TEN IMPLEMENTATION STEPS WORKSHEET

The Aged Care Standards and Accreditation Agency Plan-Do-Check-Act cycle<sup>13</sup> is a useful process to apply to each implementation step set out in this PA Toolkit Workplace Implementation Guide. We briefly describe this cycle in Module 1 of the PA Toolkit. You may find it a useful way to structure your implementation and continuous quality improvement activities with regard to a palliative approach.



In **planning** the implementation step consider:

- Key actions required to achieve this step.
- The timeframe in which each of these actions will be completed.
- The person(s) responsible for each action.
- Is the plan realistic and achievable based on the time and resources available?

In implementing or **doing** the step consider:

- Is the implementation of the step documented in any way?
- Is the implementation of the step progressively monitored and reviewed against clearly specified interim milestones?
- Is the achievement of interim milestones in the implementation of the step documented in any way?

In evaluating or **checking** the outcomes:

- Check how effective the implementation step has been.
- How has the impact of the implementation step been evaluated?
- What do these evaluation measures show?
- What impact has there been for residents, for staff, for others?
- How have changes associated with the implementation of the step been incorporated into staff work practices?

In deciding next steps or **acting** there are at least two possible situations to consider:

- The implementation step has been successful and management wants to 'close the loop', usually by ensuring the changes become a permanent part of the system.

or

- The implementation step has been unsuccessful or only partially successful – requiring amendments to be made in the implementation process.

### Key Point

When planning, undertaking and evaluating each of the implementation steps, it is essential to have specific, concrete and realistic goals.

The following '10 Implementation Steps Worksheet' is provided as a working document to be completed by your Palliative Approach Working Party.

## Ten Implementation Steps Worksheet

Under each step, identify concrete actions required, who is responsible for each action, and the review date to monitor progress in completing each action.

Step	Key Person Responsible	Review Date
1. Appoint a Palliative Approach Link Nurse(s) and identify key staff within your facility to form a Palliative Approach Working Party.		
2. Identify and engage internal and external stakeholders who will facilitate/support implementation of a palliative approach.		
3. Develop or review policies and procedures for providing a palliative approach.		
4. Develop or review policies and procedures for timely access to and administration of medications to manage end of life (terminal) symptoms.		
5. Review clinical assessment tools and procedural forms in the PA Toolkit for possible inclusion in your care documentation.		

Step	Key Person Responsible	Review Date
6. Determine how the three key processes addressed in the PA Toolkit will work in your facility.		
7. Use the Palliative Approach Trajectories Framework to assist in key process selection.		
8. Review clinical care domains for each resident (including pain, dyspnoea, nutrition and hydration, oral care, and delirium) and identify how these will be monitored as each resident's condition changes.		
9. Review your current staff education and training strategy in relation to implementing a palliative approach and identify how to incorporate PA Toolkit resources into this strategy.		
10. Conduct audits as part of continuous improvement and quality control.		



## 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](http://www.caresearch.com.au/PAToolkit)

