



Questions and answers: 25 June 2024 webinar – Delivering high quality, person-centred palliative care in aged care

This webinar discussed education and training opportunities that will help the health and aged care workforce deliver high-quality, person-centred palliative care in aged care.

Contents

Questions and answers: 25 June 2024 webinar – Delivering high quality, person-centred palliative care in aged care	1
Questions about the strengthened Aged Care Quality Standards	3
Links to information – strengthened Aged Care Quality Standards	4
Questions about palliative care education and training	5
Palliative Aged Care Outcomes Program (PACOP)	7
Program of Experience in the Palliative Approach (PEPA).....	8
End of Life Directions for Aged Care (ELDAC)	9
Palliative care in the home	10
Palliative care in residential aged care	11
Working with primary care	13
Advance care planning	16
Rural and remote communities.....	17
What’s new in palliative care	18
Links to information – Palliative Care	19

Questions about the strengthened Aged Care Quality Standards

Question: What changes can be expected from the current standards compared to the new strengthened standards? How can we prepare to be in line with the strengthened standards?

The changes include:

- an enhanced focus on person centred care with direct linkage to the Statement of rights (Outcome 1.2)
- strengthening expectations for 5 focus areas including dementia care, governance, food and nutrition, diversity and clinical care
- dedicated standards for Food and Nutrition (Standard 6) and Clinical Care (Standard 5) with a dedicated outcome for Palliative Care (Outcome 5.7)
- enhanced structure of the strengthened standards:
 - Each standard has an intent statement to add context, and an expectation statement which outlines in first person what older people can expect.
 - Each standard also contains several outcomes with an Outcome Statement and a number of actions.
 - The Outcome Statements are intended as the enforceable element of the Quality Standards in legislation, with actions representing what providers may demonstrate to meet the outcome.
 - Overall, the Quality Standards have reduced from 8 to 7. The current Quality Standards have 42 requirements while the strengthened Quality Standards have 33 outcomes with 146 supporting actions.

If you have not already, please review the [Aged Care Quality and Safety Commission's draft guidance material](#) and other resources. These will help providers and workers to understand and meet their obligations under the strengthened Quality Standards.

The Aged Care Quality and Safety Commission's suite of documents includes a [framework analysis](#). This maps the requirements of the strengthened Quality Standards to current expectations and will help you to understand the changes in more detail.

Question: Will palliative care training be mandated in the strengthened Aged Care Quality Standards under the proposed Aged Care Act?

Under the strengthened Aged Care Quality Standards, Standard 2 - The Organisation, providers are required to ensure their workers are skilled, competent, hold relevant qualifications and experience to provide quality care and services.

Workers must be provided with training and supervision to effectively perform their role (Outcome 2.9).

Providers can achieve this by ensuring their workers regularly receive competency-based training in relation to core matters, including training on person centred care, culturally safe and healing informed care (Action 2.9.6).

The department is also committed to continuing to support the workforce by providing free access to high quality palliative care education and training.

In addition, the revised Aged Care Qualifications have been revised and include:

- The key vocational qualifications for the care sector have been reviewed to ensure that they reflect the skills and knowledge required to provide care and support in a person-centred manner.
- The Certificate III in Individual Support (Ageing) will include units of study in palliative care. This will increase the knowledge of the care support workforce who undertake vocational training.

Question: How do you become a provider of home care?

Currently, to be a Home Care Package provider you need to be an approved provider under the *Aged Care Act 1997*.

Approved providers must meet their obligations, including the Aged Care Quality Standards.

Residential aged care services need accreditation to receive government subsidies. Read about [approval and accreditation](#).

The Australian Government is developing a new Aged Care Act to strengthen Australia's aged care system. As part of the new Aged Care Act, there will be a new regulatory model for aged care. The new regulatory model will introduce universal provider registration – a single registration of each provider across all aged care programs. This will replace the current approved provider and accreditation processes.

There will be 6 registration categories, which group service types based on similar care complexity and risk. This means registration requirements, the related provider obligations, and regulatory oversight will be proportionate to the registration categories. This includes targeting of the application of the strengthened Aged Care Quality Standards. It is expected that the strengthened Quality Standards will apply to services in both the home and community settings (through Categories 4 and 5) and the residential setting (Category 6).

Providers will need to renew their registration to continue operating in the sector. The standard registration period for all providers will be 3 years. Providers will need to demonstrate their suitability, capability, viability, and propriety to deliver aged care services to the Aged Care Quality and Safety Commission at entry, and then again at renewal. For providers seeking registration in Categories 4, 5 or 6, registration and renewal will include an audit against the strengthened Quality Standards. [Read more about the new regulatory model](#).

Links to information – strengthened Aged Care Quality Standards

- [The strengthened Aged Care Quality Standards – Final draft](#)
- [Draft strengthened Quality Standards guidance, digital toolkit](#)
- [The Aged Care Quality and Safety Commission](#)
- [Consultation to strengthen the Aged Care Quality Standards](#)
- [About the strengthened Aged Care Quality Standards](#)
- [Lodge a complaint, Aged Care Quality and Safety Commission](#)
- [Strengthened Quality Standards framework analysis](#)

Questions about palliative care education and training

Question: When will you fund palliative care training for Clinical Nurse Specialists, Clinical Nurse Consultants, and Nurse Practitioner training?

Palliative care education and training mentioned in the webinar and on the [department's website](#) is free for all health and aged care workers to access, including Clinical Nurse Specialists, Clinical Nurse Consultants, and Nurse Practitioners.

Question: Is there a required entry level standard of clinical practice skills expected/required for carers, Enrolled Nurses and Registered Nurses? Having baseline standards will assist in knowing if all levels of staff are competent and have the right skills to provide excellent care.

It is recognised that palliative care is a key part of the training that nurses will need in aged care, and although not mandated, palliative care can be part of the curriculum in undergraduate nursing courses.

The Australian Government funded program Palliative Care Curriculum for Undergraduates (PCC4U) provides curriculum, including case studies for any undergraduate health course, and vocational training course that can be used by all Australian universities and vocation education and training facilities.

To practice as a nurse in Australia, graduates must have completed a program of study accredited by the Australian Nursing and Midwifery Accreditation Council (ANMAC) and be registered with the Nursing and Midwifery Board of Australia (Board). Both the Board and ANMAC operate independently of Government. The accredited programs of study ensure nurses can meet the registered or enrolled nurse standards for practice which are published by the Board. Registered Nurse education enables them to use critical thinking to make evidence-based decisions for person-centred care and practice with preventative, curative, formative, supportive, restorative, and palliative elements.

The Registered Nurse is educated to take a holistic approach to the needs of the individual, incorporating all aspects of their health, including end of life.

The revised Aged Care Qualifications stipulates that Certificate III in Individual Support (Ageing) will include units of study in palliative care. This will increase the knowledge of the care support workforce who undertake vocational training.

Question: Why isn't there more face-to-face training done by Government Organisations for Assistant In Nursing (AIN) and Personal Care Assistants (PCA)?

The Australian Government funds a number of palliative care projects that offer education and training to the health and aged care workforce, including AINs and PCAs. The format of training offered is dependent on the funded organisation. Face to face training is delivered by the [Program of Experience in the Palliative Approach - Aged Care](#).

Question: How do you motivate staff to see the importance of education, the benefit it has to satisfaction in their employment and the delivery of person-centred/family centred care, instead of mandating education?

Note this question was answered during the webinar. Transcript response below:

Some of the ways that we can start to see the importance of education is at the leadership level and helping our leaders to really appreciate that end of life care is core business for aged care providers. And I think the strengthened Standards is one way in which we're going to make that truly visible. I think then our leaders really appreciating the value is critical.

Then I think in terms of staff. Part of what our experience is actually really about people feeling a little bit nervous around this as it is an uncomfortable topic. And so we try and actually offer learning opportunities which are very safe, which is really about trying to demystify some of the aspects of end of life care and helping people see that they can actually do this and that they will be supported. So we do think it's about the right leadership and culture in an organisation which really values and sees end of life care as core and then secondly it's working with staff to really build their confidence.

I can't emphasise the importance enough of engaging with the senior members of an organisation as well as the people who are on the coalface, the importance that everybody is sold about improving the care that they deliver. Our experience has been that people who are working in residential aged care, want to improve what they are doing. They are very motivated. The barrier that happens occasionally is how do we fit this into our schedule, hence the need to make the learning really applicable to meet the needs of the staff and to demonstrate to them that actually understanding and delivering palliative care in an organised framework can reduce your time because you're not doing things that aren't really necessary. It's very targeted and very helpful.

So also the education needs to be logical as I was saying to meet the needs of the aged care home and the staff.

Question: What is the best evidenced based training and education model for large multi-site aged care providers?

The department funds a range of organisations to develop and provide high quality and evidence-based education, training and quality improvement programs. The specific program that will suit your organisation will depend on a range of individual factors. The programs presented in the webinar, End of Life Directions for Aged Care, Program of Experience in the Palliative Approach and Palliative Aged Care Outcomes Program, are specifically designed for aged care.

A Reverse PEPA Placement may be of particular interest for a large aged care provider. Reverse PEPA Placements involve a palliative care specialist coming to your workplace to provide customised learning for small groups. More information on [Reverse PEPA Placements](#).

For further information on a range of other education and training opportunities to determine what will best suit the needs of your organisation, please refer to the department's [palliative care education and training matrix](#). This document outlines the education and training options

available to anyone who works in aged care, and provides information on the expected learning outcomes and target audience of each program.

Question: How do we empower registered staff if some GPs themselves are also quite uncomfortable in talking about death and dying? How do we speak to the families who are not willing to talk about palliative/comfort care?

Education and training on a palliative approach to care, and how to navigate difficult conversations can help health professionals feel more empowered to initiate difficult conversations. In addition, talking to health care professionals about the benefits of early discussion and referral to palliative care can help them to feel more empowered.

There are a range of education and training programs that have developed specific resources for health professional to build skills in communication, including how to have challenging conversations about death and dying. Further information can be found at:

- [PalliAged – communication skills](#)
- [End of Life Essentials – communication resources](#)
- [CareSearch – communication with patients, carers and families.](#)

Palliative Aged Care Outcomes Program (PACOP)

Question: Will PACOP initiate the PalCentre Platform to include home and community care palliative and end of life care?

The current focus of PACOP is residential aged care, however, the value of the PACOP model being extended into home and community-based palliative aged care is acknowledged and may be explored in the future.

Question: Are there any plans to work with popular clinical documentation systems to integrate PACOP forms into the system?

This question was answered during the webinar. Transcript response below:

Yes. In fact we are working quite collaboratively with a number of IT vendors to get the assessment tools embedded into their care management systems but to also make sure that the information that goes into the care management system can be extracted appropriately for reporting at the reporting periods. So it's a two way process and we are working in that – mind you we would be always encouraged by aged care homes and organisations who encourage their IT vendors to negotiate and to be part of the program and work with us to embed the tools.

Question: Are the staffing levels of Aged Care Homes appropriate for good end of life care? If you compare it to hospital and hospice staffing, it is perhaps the best place environmentally, but is it resourced effectively?

In recognition that staffing is critical to the delivery of quality care for residents, the Australian Government committed to the implementation of aged care reforms recommended by the Royal

Commission into Aged Care Quality and Safety, to introduce minimum staff care time requirements for all residential aged care homes.

Since 1 October 2023, residential aged care homes have been required to meet mandatory care minute targets, set at sector average of 200 care minutes, including 40 registered nurse (RN) minutes, per resident per day. This will increase to 215 minutes, including 44 RN minutes from 1 October 2024. The intent of the mandatory care minute requirement is to ensure that older Australians in residential aged care are receiving the appropriate direct care from RNs, enrolled nurses (EN) and personal care workers (PCW) that supports their personal health and care needs.

Each aged care home has its own care minute target based on the assessed needs of their residents. This means a home with mostly high needs residents will have higher targets than those with lower care needs residents. [View how each home performed compared to its targets.](#)

In addition to these care minutes requirements, approved providers are responsible for ensuring they have sufficient staff on duty to always meet the care needs of all residents, as required by their obligations under the [Aged Care Act 1997](#), the [Quality of Care Principles 2014](#) and the associated [Aged Care Quality Standards](#).

Question: Is there any evidence yet that PACOP assessments and tools have improved the prescribing of anticipatory medications due to the prescriber being more comfortable/reassured with the resident's likely trajectory

This question was answered during the webinar. Transcript response below:

We can say that there have been improvements already that we can demonstrate with PACOP but one of the things that we don't assess in the PACOP assessment suite is what prescribing has taken place. We have the assess, respond, plan protocol which highlights areas in a particular assessment that may indicate an intervention is necessary in a particular field but we don't track those. We track the outcome which is symptom distress and symptom severity.

Program of Experience in the Palliative Approach (PEPA)

Question: Could you please just clarify where PEPA fits into ELDAC?

This question was answered during the webinar. Transcript response below:

They are two separate programs however we have the privilege as part of a national palliative care program of actually really trying to make sure that all of our projects and our work complements each other. So people can apply for a PEPA program itself, for PEPA aged care and just have an education workshop, but for other services they really would like to undertake a full 12 month ELDAC journey and go through a full organisational change and systems improvement activity. Part of that journey might be that they draw on a PEPA experience to build the staff capability so you can actually enrol in both. They're two separate programs. And that's a good thing because we know that services are at all different sort of levels. And for ELDAC we often have a lot of expressions of interest and then when we talk people through the commitment they say 'Maybe not just now. But we want to get there' so maybe building their

confidence and a bit of education of staff is a starting point and then down the track we find that often six or 12 months later they say 'Look now we're ready. Things have settled. Please take us on this journey'. So they're two separate programs but are related and definitely are aimed to complement each other rather than duplicate.

Question: Are there funds for PEPA training for home care? If an aged care facility has already utilised the funding for PEPA training, are they eligible to apply again?

This question was answered during the webinar. Transcript response below:

At this stage because we have such high demand we are aiming to reach new services. But we are always aware that sometimes there's been such significant change in a service in terms of turnover of staff or new things that are going on in terms of expansion or change that we would always look at an application on merit to see whether that would actually add value. But I would say that we do have such demand and a waitlist.

Home care providers can get some funding assistance to have PEPA education. We work with the provider to work out what that funding will look like so it's individual for each site that applies.

End of Life Directions for Aged Care (ELDAC)

Question: Is it possible to access ELDAC data (de-identified) on transfers to hospital of RACF residents and death data?

This question was answered during the webinar. Transcript response below:

The data we collect, one of our audits is we have an after-death audit where we ask the service to look at the five most recent deaths in their service and to look at what happened – and we've got some criteria – and to assess the extent to which the management of that end of life journey matched the sort of standards that we have. And we ask providers to do that prior to implementing and following implementing. We also have a range of data which we collect around organisational readiness. And we don't directly collect the service's data around – specifically on a routine basis – around referrals and things like that but through our other audits and tools we assess organisational readiness, the quality of care, the learning needs and how that's improved of staff. But eventually our goal we would like to build this into other data systems so that by working with PACOP for example that services will actually have much more routinely collected ways of measuring what's going on against the sort of quality that we're hoping to achieve. So short answer, yes, we collect a whole range of data but not necessarily directly about referrals.

Question: Is Death Literacy part of the ELDAC audits pre and post?

This question was answered during the webinar. Transcript response below:

The audits assess knowledge and confidence of staff and define that across a broad range of domains. And so that in essence does mean death literacy and confidence in actually being able to understand what end of life means and the sort of care that people need. So our learning needs assessment tools do assess all of those knowledge, confidence and skills capabilities.

Palliative care in the home

Question: Is the PEPA project and PACOP relevant to in home service providers?

This question was answered during the webinar. Transcript response below:

At the moment PACOP is targeting residential aged care. We are funded by the Australian Government Department of Health (and Aged Care) to focus on our delivery of PACOP for the residential sector. We do get a lot of questions around its relevance for the home care sector and we have made the tools and the resources available to everybody to use there in the public domain. And that will be an area of study for us in the future.

And from the PEPA perspective our educators will go to home care services. Sometimes it's a little bit harder to organise the logistics but we do make a real effort to make sure that we are providing this education to all aged care providers.

Question: Could you please provide details of organisations providing support with end of life/palliative care in the home? What palliative care services available for seniors living at home?

To find specific organisations that provide palliative and end of life care in the home, Palliative Care Australia has a [National Service Directory](#).

For more information on specific services in your area visit your local state/territory government website.

Question: How much help is available at home e.g. how often can someone be seen by the palliative care team?

State and territory governments are responsible for providing specialist palliative care and community nursing services in the community. Details on each state and territory government's palliative care services, including the types of programs they run, can be sourced through their websites.

In addition, a client/resident treating medical practitioner can provide information on local palliative care services and supports. Local services can also be identified through Palliative Care Australia's [National Service Directory](#).

Question: What resources are available for clinicians from a home care service provider providing palliative care for a client at home?

Many of the palliative care education and training programs funded by the Australian Government provide information and resources relevant to the delivery of palliative care at home. Some specific resources that may be of assistance include:

- [PalliAGED – Home Care Resources](#)
- [ELDAC Home Care Toolkit](#)
- [caring@home](#) provides resources for health care professionals to provide to families and carers to assist them to care for a loved one at home
- [CarerHelp](#) is a resource for carers that health care professionals can provide to the family and carers of a person receiving palliative care in the home.

Palliative care in residential aged care

Question: Australia modified Karnosky Performance Scale (AKPS) versus Rockwood Frailty Scale: Which one is preferred in Australian residential aged care and why? Which one is the Australian Government Department of Health and Aged Care using to measure palliative care provision, standards met, quality indicators and Australian National Aged Care Classification (AN-ACC) funding?

The AKPS and Rockwood Frailty Scale are two tools used to assess characteristics of residents that drive care costs in residential aged care. The department uses both in varying ways.

The AKPS is a measure of an individual's overall performance status or ability to perform their activities of daily living. It is a single score between 10 and 100 assigned by a clinician based on observations of an individual's ability to perform common tasks relating to activity, work and self-care. A score of 100 signifies normal physical abilities with no evidence of disease. Decreasing numbers indicate a reduced performance status.

The AKPS is used by the department as part of a medical assessment conducted by a medical practitioner or nurse practitioner as part of determining eligibility for Class 1 funding for new aged care residents entering for the purpose of receiving palliative care. Residents given Class 1 status are not required to have a face to face AN-ACC assessment, with the aged care provider receiving maximum care funding from the date of entry. If an existing (non- Class 1) resident becomes palliative after entering a residential aged care home, the provider can request a reclassification, which will trigger a new AN-ACC assessment to ensure appropriate funding is provided to support any increased care needs.

Rockwood Clinical Frailty Scale is a global clinical measure of an individual's level of vulnerability to poor outcomes. Identification of frailty helps to improve both long and short term health management. Individuals with frailty require a more personalised approach to their needs. The scale ranges from Very Fit to Terminally Ill. The Rockwood Frailty Scale forms part of the AN-ACC assessment process for class 2-13. The tool is easy to use and is not clinical in nature.

In response to the [Royal Commission into Aged Care Quality and Safety](#) recommendations, an urgent review of the current [Aged Care Quality Standards](#) was completed. The final draft [Strengthened Aged Care Quality Standards](#) has been developed, and will be implemented at the commencement of the [new Aged Care Act](#). The strengthened Quality Standards incorporate key requirements to support concerns surrounding palliative care delivery and ensure the needs of older people are at the centre of care. Within the strengthened Quality Standards, [Standard 5 'Clinical Care'](#), includes a specific requirement related to palliative care and end-of-life care (Outcome 5.7). The older person's needs, goals and preferences for palliative care and end-of-life care must be recognised, addressed and their dignity preserved.

Question: I'm very concerned about the prescribed 3-month timeframe for provision of palliative care. Community expectations are 6 months. People living with dementia have different disease trajectory, and death cannot be accurately predicted. Is there room for the timeframe to be opened to upon resident request and physician support?

The Australian Government funds the care component of residential aged care homes using the Australian National Aged Care Classification (AN-ACC) funding model. AN-ACC includes 13 casemix funding classes, with the highest funding applying for residents with a Class 1 or Class 13 classification. Eligibility for Class 1 is determined by a medical assessment and eligibility for Class 13 is determined by a face to face AN-ACC assessment. The three-month estimated life expectancy applies to Class 1 eligibility only and is not intended to represent a definition of palliative status more generally.

If an existing (non-Class 1) resident becomes palliative after entering a residential aged care home, the provider can request a reclassification, which will trigger a new AN-ACC assessment to ensure appropriate funding is provided to support any increased care needs. In most cases, residents needing end of life care are assessed as Class 13 and receive maximum AN-ACC casemix funding.

Further detail can be found in the [Guide to palliative care entry into aged care homes](#).

Question: When can we have HYPROMorphone in the urgent medications list in New South Wales (NSW)?

Information relating to specific medications lists for NSW can be found at [Residential care facilities - Pharmaceutical services](#).

Question: Going through PACOP and it prompts us for an urgent AN-ACC reclassification, however the external assessors that come into facility to assess the residents AN-ACC status don't make it in time and our residents sadly pass away. It means we end up not funded appropriately for that time. How can this be done better?

There are three AN-ACC assessment pathways for assessing and classifying a resident in permanent residential aged care requiring palliative care. Refer to the [AN-ACC assessment pathways fact sheet](#).

A current resident approaching imminent end of life is recognised as an urgent assessment pathway for a resident whose condition is rapidly deteriorating, with end of life expected imminently.

The aged care home can submit a reclassification request for the resident through the My Aged Care Service and Support Portal, and contact ANACCassessments@health.gov.au identifying that the resident is approaching end of life and requires an urgent reclassification assessment.

As part of the urgent reclassification request process, the provider must acknowledge that the resident has an end-of-life care plan in place, and that this has been communicated with the resident, their family and/or carers.

The department works with Assessment Management Organisations in the area to arrange an AN-ACC assessment as soon as possible.

The classification determined by the assessment will apply from the date of the reclassification request.

As end of life can happen quickly, not all requests for an urgent assessment will be able to be completed.

Working with primary care

Question: How can providers work collaboratively with GPs to ensure appropriate resources (e.g. anticipatory prescribing, planned hospital-based interventions for symptom control) are available to facilitate a smooth palliation?

This question was answered during the webinar. Transcript response below:

Part of the PACOP program is to identify those residents who are deteriorating and who have increasing palliative care needs. And one of the things that we encourage aged care homes to do in response to identifying palliative care needs or the need for palliative care is what do we do with this information. It's great having knowledge but we want to know what are we going to do to help this particular resident. In the profile collection we have a list of ideas. Do we need to have a good conversation with the family? Do we need an external consultation either with the GP or with a palliative care service? What other things do we need to bring in to be able to support this person as their condition changes, including advanced care planning? So at each stage of the PACOP program we are encouraging aged care homes to think about what does this mean? Where do we change? What do we need to do to respond to the needs and problems that have been identified?

These are the sort of conversations that both PEPA and ELDAC facilitators have on a day-to-day basis with services.

I talk about building a body of evidence for your case. And one of the principles of palliative care is around advocacy and empowerment. So you need to advocate for your resident or your person in the bed at the centre of that care. And you build this by assessments. These tools build your body of evidence that then you take to the GP. It's the age old question. How do we get someone who's time poor and perhaps doesn't see the need for education to do education? PEPA does have some GP sessions, education sessions. It's got learning guides. I often give

them to facilities to leave for their GPs so hopefully there's some pickup that way. We talk about what's out there with apps, the GP palliMEDS apps and things like that. And I empower the staff hopefully to then work with their GPs.

It is really about upskilling the staff and giving them the knowledge and confidence to have these conversations with GPs, sharing those apps as well. But part of the ELDAC linkages program is when we do undertake the service mapping the service has a look at who is around them that influences their palliative care and advanced care planning and end of life care and often or always, I would even say GPs are one of those external stakeholders. We often will invite them to participate in the working group that is formed and to really come along on the ride, on the journey with the service. Obviously there's not a lot of capacity a lot of the time but they're definitely included in working groups and in the improvement cycle with the services.

Question: How can we educate GPs to understand anticipatory prescribing to reduce delaying medication, leaving unrelieved symptoms for periods of hours to days? How can we address barriers to anticipatory prescribing? So many of my conversations are around barriers to the earlier anticipatory prescribing whereby residential aged care staff are recognising that the resident is declining. The GP is called to review, but does not prescribe anticipatory meds. What is the answer?

End of Life Directions for Aged Care (ELDAC) provides information and practical tools for General Practitioners (GPs) regarding recognition of deterioration and appropriate symptom management [ELDAC Primary Care Toolkit - Clinical Action](#).

GPs can also access free palliative care education and training through projects such as [Program of Experience in the Palliative Approach \(PEPA\) placements](#).

Aged care services can also work in partnership with GPs to support anticipatory prescribing and medication management.

More information can be found in the [Palliative care education and training – Communication toolkits](#).

Question: I'd like to know more about anticipatory prescribing for end of life care.

Anticipatory medicines are injectable or sublingual medicines prescribed to a community-based palliative care patient in the last phase of their life. These medicines are proactively prescribed and dispensed in preparation for a time when a person may need them. They are used to help manage distressing symptoms with the goal of providing rapid relief and to avoid unplanned or unwanted admissions to inpatient facilities.

Aged care providers can work with a GP, Nurse Practitioner or Medical officer (upon discharge or transfer from inpatient facilities) for the management of palliative care anticipatory medicines.

Community pharmacy also plays an important role in the dispensing and supply of anticipatory medicines in a timely fashion to facilitate optimal palliative care symptom management.

More information on medicine handling and state-based differences in legislation can be found at [Medicine handling guidelines](#).

Question: What government funds are available for Occupational Therapy palliative care services

Allied health professionals play an important role maintaining and improving community health and wellbeing. They work in a variety of settings, including hospitals, private practice, residential aged care services, community care, schools and universities.

Allied health services are included as part of services available through home care packages and in residential care. Information about allied health can be found at:

- [Allied health under AN-ACC](#)
- [Home Care Packages Program Operational Manual: A Guide for Home Care Providers](#).

Question: At what stage of decline does the Palliative team become involved?

Palliative care can be provided from point of diagnosis until death, and then beyond with grief and bereavement care.

Each state and territory is responsible for specialist palliative care service delivery in their jurisdiction. Given this, the specific services and models of care available to people can vary between locations.

Involving the client/resident's GP as part of the conversations is an important part of providing care. GPs have many of the required skills to provide advanced disease management and palliative care through to end of life with involvement of specialist teams when necessary.

Where possible, linking in with palliative care services early can assist in the management of a person with a life limiting illness and ensure a seamless transition between care teams when health is declining.

Many of the education and training programs funded by the Australian Government have resources to help health and aged care workers recognise deterioration and decline in a person's function. These include:

- End of Life Essentials: [Recognising Dying - Training Resources](#)
- [End of Life Direction for Aged Care \(ELDAC\)](#)
- PalliAGED: [Recognising Changes](#).

Advance care planning

Question: Can family members or Power of Attorney request or decline specific comfort medications for a person?

Yes, it can be lawful for a person's substitute decision-maker to ask that life-sustaining treatment be withheld or withdrawn from the person if they can no longer make treatment decisions themselves.

A person who has capacity may appoint someone in their Advance Care Directive or other legal document e.g. an Enduring Power of Attorney to be their substitute decision maker. The substitute decision-maker 'stands in the shoes' of the person to make medical treatment decisions when the person no longer has capacity. Increasingly, it is recognised in law and practice that a person should be supported to make their own decision before substitute decision making occurs. Sometimes a person without capacity will not have an Advance Care Directive that makes a decision about the proposed treatment, or have appointed a substitute decision-maker. In those situations, the guardianship and medical treatment decision-making legislation in each State and Territory sets out an order of who can be the substitute decision-maker (e.g. a spouse, family member or friend, or a statutory body, such as the Public Guardian or Public Advocate, or a court or tribunal).

End of Life Law for Clinicians (ELLC) is a training program for medical practitioners, students, nurses, allied health, and other health professionals that focuses on the law relating to end of life decision-making. ELLC has education modules on "Substitute decision making for medical treatment" and "Advance Care Planning and Advance Care Directives". ELLC educational modules can assist you to gain a greater understanding of the law relating to end-of-life decision making.

You can also visit the [Advance Care Planning Australia](#) website for further information on advance care planning and advance care directives.

Question: How do we encourage staff to have advance care planning discussions with residents and families?

This question was answered during the webinar. Transcript response below:

It's all about building confidence through specialised education and training programs. This could be an online advanced care planning module or through programs such as PEPA that include advanced care planning in their training. In addition to building confidence through education and training, experiential learning opportunities are also important and can help staff feel more equipped to have these discussions. For example, providing your staff with opportunities to watch somebody undertake an advanced care planning discussion. In different states and territories there are different approaches to facilitate that learning.

Question: Is it reasonable to expect advance care plans to be completed pre-admission into RACF to assist staff in a medical emergency situation?

Advance care planning involves a person planning for their future health care. It enables a person to document decisions about what they want for their health care while they are well

enough, so that if they become seriously ill and unable to communicate their preferences or make treatment decisions their wishes are respected. At all times, care and services must be delivered in line with the older person's needs, goals, preferences and wishes. An older person may choose not to undertake advance care planning at the time of pre-admission. In any situation, the older person's choice and preferences must be respected.

Many aged care facilities find admission a good time to talk to older people and their families about the importance and significance of advance care planning, so they can make informed choices if they would like to put an advance care plan in place. An older person may choose not to have an advance care plan completed at that time and their decision must be respected. All workers must be aware of an older person's advance care plan if they have one. Education and training on advance care planning can assist aged care workers to provide information and education to people and their families on advance care planning. It can also ensure health and aged care workers understand their obligations in relation to advance care planning. For more information on advance care planning, and to find short courses for health care professionals visit [Advance Care Planning](#).

Under the Aged Care Quality Standards, Standard 2 - The Organisation, providers are required to undertake initial and ongoing assessment and planning for care and services in partnership with the older person. Assessment and planning must have a focus on optimising health and wellbeing in accordance with the older person's needs, goals and preference, including advance care planning and end of life planning if the older person wishes (Requirement (3)(b)).

Rural and remote communities

Question: How do community care organisations create strong palliative pathways for our clients in rural and remote communities?

Community care organisations, particularly in rural and remote areas often have strong connections with all the local services in the area. Utilising multidisciplinary care teams and primary care services in the community can contribute to creating strong palliative care pathways for people in rural and remote areas.

In addition, Primary Health Networks (PHNs) are funded under the Greater Choice for At Home Palliative Care program to improve palliative care coordination through:

- facilitating and coordinating improved access to quality palliative and end of life care at home, in their regions (including Residential Aged Care services)
- building capacity in the health and aged care workforce (including general practice) to deliver quality palliative and end of life care at home
- linking and supporting end-of-life care systems and services in primary and community care settings
- improving community awareness of palliative care services and supports available in their regions.

To find out more, contact your local [PHN](#) or read about the [Greater Choice for At Home Palliative Care Program](#).

Another component of creating strong pathways is ensuring that at all levels of care, and across all care sectors, health care professionals have the necessary education and training on a palliative approach to care.

More information on palliative care pathways.

Question: I work both in aged care and community in rural/remote Australia. There is never enough continuity in dedicated staff. How do we overcome this?

The Department of Health and Aged Care recognises the unique challenges faced by aged care facilities, and particularly the retention of staff in rural and remote areas.

The department is implementing a range of workforce reforms to support the recruitment and retainment of high-quality staff in rural and remote areas.

You can find more information about what we are doing to support aged care in rural and remote settings on our website: Delivering aged care in rural and remote settings.

What's new in palliative care

Question: What are the new trends/approaches in palliative care? What are examples of best practice globally that Australia can learn from in the delivery of palliative care in aged care?

All over Australia there are new and innovative approaches to palliative care being implemented in aged care settings.

PACOP and ELDAC Linkages (who presented within the webinar) are two examples of how new and innovative approaches are improving palliative care for people in residential aged care homes.

PACOP is targeted specifically for aged care, but is based on the world renown Palliative Care Outcomes Collaborative (PCOC). PCOC aims to improve patient outcomes and has enabled clinicians to achieve significant improvements in patient and carer outcomes over time. PCOC's core framework and protocol for clinical assessment and response create a common clinical language, helping to identify and address needs effectively.

In addition, the Department of Health and Aged Care has been working closely with the Australian Institute of Health and Welfare to develop a new set of care measures which will allow for the first time an assessment of the current state of the system and provide an essential tool for sector improvements.

The Comprehensive Palliative Care in Aged Care (CPCiAC) program is also an example of a relatively new approach for the delivery of palliative care in residential aged care:

Comprehensive Palliative Care in Aged Care measure.

The CPCiAC program is a matched funding arrangement with the states and territories that aims to improve the delivery of palliative care to older Australians living in residential aged care homes. Some examples of successful models of care contributing to this work include palliative care needs rounds, case conferencing and improved referral pathways for in-reach specialist

palliative care services. [Watch a video showing an example of how CPCiAC is empowering aged care providers in the delivery of palliative care.](#)

Links to information – Palliative Care

- [Palliative Aged Care Outcomes Program](#)
- [Program of Experience in the Palliative Approach - Aged Care](#)
- [End of Life Directions for Aged Care - ELDAC](#)
- [Linkages - End of Life Directions for Aged Care](#)
- [Palliative care education and training | Australian Government Department of Health and Aged Care](#)
- [Palliative care education and training – Communication toolkits | Australian Government Department of Health and Aged Care](#)
- [National Service Directory - Palliative Care Australia](#)

Let's change aged care together

We invite Australians to continue to have their say about the aged care reforms.



Visit agedcareengagement.health.gov.au



Phone **1800 318 209** (Aged care reform free-call phone line)

For translating and interpreting services, call 131 450 and ask for 1800 318 209. To use the National Relay Service, visit nrschat.nrscall.gov.au/nrs to choose your preferred access point on their website, or call the NRS Helpdesk on 1800 555 660.