ELDAC
End of Life Directions for Aged Care

What is the Home Care Toolkit?

The ELDAC Home Care toolkit is designed for health professionals and care staff providing palliative care and supporting advance care planning for older Australians living with advanced life limiting illnesses, their families and carers.

The Home Care toolkit is online and user-friendly and has been developed and reviewed by aged care experts.

The ELDAC Home Care toolkit has evidence based resources on palliative care and advance care planning that can assist you and your organisation in meeting the Aged Care Quality Standards.

The Home Care toolkit is divided into three main sections:

- **Clinical Care**
- **Education and Learning**
- **Organisational Support**

Within the three sections of the toolkit, you will find information, assessment tools, forms, fact sheets, and family resources. Some features of the Home Care toolkit include:

- Clinical assessments and resources for palliative care and advance care planning
- A Personal Learning Assessment and Learning Plan
- Organisational and After Death Audits

Access the Home Care toolkit at the ELDAC website: www.eldac.com.au

ELDAC is funded by the Australian Government Department of Health and Aged Care

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Education and Learning

The 'Education and Learning' section of the ELDAC Home Care toolkit provides links to online education and other types of resources to help you improve your knowledge, skills and confidence in providing palliative care and advance care planning for your clients.

The resources available in the 'Education and Learning' section include:

- **A Personal Learning Assessment and Plan**
- **Online training**
- **Information and links for educators**
- **Links to trusted online websites and resources**
- **Ways to gain experience through conferences, events short courses, workshops and clinical experiences.**

The Home Care Toolkit provides an opportunity for you to evaluate your learning and development needs and create a personal learning plan.

The 'Education and Learning' section has a self-care page on the importance of looking after yourself for overall health and wellbeing so you can continue to provide quality care to your clients and their families.

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Organisational Support

The 'Organisational Support' section provides resources to support your organisation in providing quality palliative care and advance care planning for your clients and their families.

A coordinated approach is outlined to assist you and your organisation to support palliative care and advance care planning across four areas:

- **Support Systems** – Five easy actions
- **Quality Improvement** – Includes three audit tools to assist your organisation in providing quality palliative care services
- **Standards and Funding** – Linking aged care accreditation standards and funding arrangements to support palliative care and advance care planning
- **Work Together** – Connecting with other external services and creating partnerships

There are three audit tools to support quality improvement:

- **ELDAC Palliative Care and Advance Care Planning Organisational Audit**
- **ELDAC After Death Audit**
- **Advance Care Planning Continuous Quality Improvement Audit Tool**

The Home Care toolkit has resources on palliative care and advance care planning that can assist you and your organisation in meeting the Aged Care Quality Standards.

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Clinical Care

The 'Clinical Care' section of the Home Care Toolkit provides you with the latest information and clinical tools on how to provide palliative care and advance care planning for people living at home and their families.

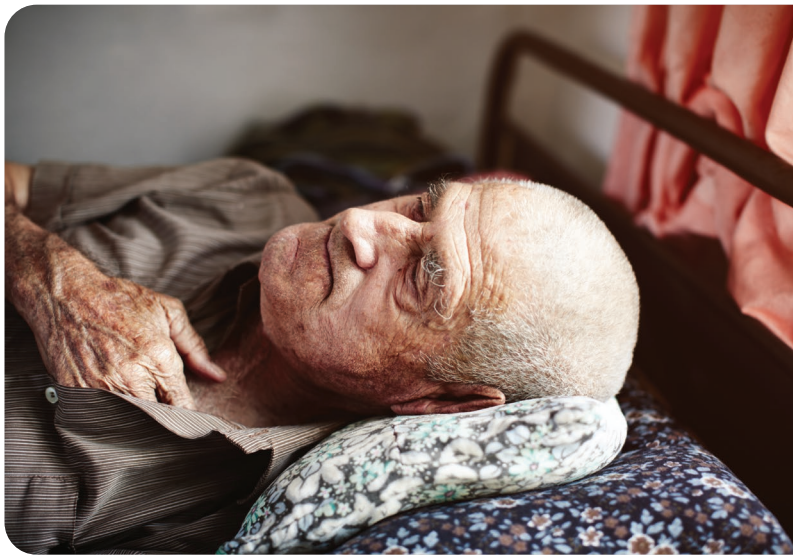
The 'Clinical Care' section is divided into eight areas that include evidence based resources available to you to use with your clients and their families.

The clinical care domains for end of life include:

- **Advance care planning**
- **Recognise end of life**
- **Assess palliative care needs**
- **Provide palliative care**
- **Work together**
- **Respond to deterioration**
- **Manage dying**
- **Bereavement**

Key features of the 'Clinical Care' section are:

- **Clinical tools to assist with assessing palliative needs**
- **Clinical forms and templates**
- **Management of physical symptoms; social and occupational wellbeing; psychosocial and spiritual well-being**
- **Fact sheets and resources that are downloadable and printable to hand out and review with your clients and their families.**



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ELDAC After Death Audit (Version 2)

Please use a new form for each client.

Date Completed: DD/MM/YYYY	Client Identifier:

About the Client		
Question		**Response**
1.	Date of Birth	DD/MM/YYYY
2.	Date of admission to Home Care	DD/MM/YYYY
3.	Date of Death	DD/MM/YYYY
4.	Life-limiting conditions (tick all that apply)	☐ Cancer ☐ Dementia ☐ Frailty ☐ Neurological disease excluding Dementia (e.g. Stroke, MND, Progressive Supranuclear Palsy, Parkinson's, Huntington's) ☐ Heart/vascular disease (e.g. Heart Failure, Angina, Atrial Fibrillation, Peripheral Vascular Disease, Hypertension) ☐ Respiratory disease (e.g. COPD, Emphysema, Pneumonia) ☐ Kidney disease (e.g. Kidney failure) ☐ Liver disease ☐ Other condition or complications not listed above that are not reversible or where treatment will have a poor outcome (please state): ☐ Unknown
5.	Gender	☐ Male ☐ Female ☐ Non-Binary ☐ Not stated

6.	Client's preferred language	☐ English ☐ Other (please state): ☐ Unknown
7.	Country of Birth	☐ Australia ☐ Other (please state): ☐ Unknown

Aspects of Care		
Question		**Response**
8.	Was the client referred to other services in the 3 months before they died? (tick all that apply)	☐ No referrals ☐ General Practitioner ☐ After hours GP (Locum) ☐ Allied Health (e.g. Occupational Therapist, Physiotherapist, Podiatrist, Dietician, Exercise Physiologist, Social Worker, Speech Pathologist) ☐ Medical Specialist (including Geriatrician) ☐ Pharmacist ☐ Pathology ☐ Radiology ☐ Internal Specialist Palliative Care Provider ☐ External Specialist Palliative Care Service ☐ Dementia Support Australia ☐ Ambulance ☐ Extended Care Paramedics ☐ Geriatric Rapid Response ☐ Other (please state): ☐ Unknown
9.	Was the client admitted to hospital in the ***last week*** of life?	☐ Yes (complete Questions 10-13) ☐ No (skip to Question 14) ☐ Unknown (skip to Question 14)
10.	Person requesting transfer to hospital in the last week of life?	☐ Client ☐ Family ☐ General Practitioner ☐ Other Medical Practitioner ☐ Nursing Staff ☐ Ambulance ☐ Other (please state): ☐ Unknown

11.	Principal medical reason for hospitalisation in the last week of life?	☐ Symptom management (e.g. pain, shortness of breath, dehydration, urinary infection) ☐ Sudden unexpected deterioration ☐ Following a fall ☐ Abnormal pathology ☐ Abnormal radiology ☐ Other (please state): ☐ Unknown
12.	Was the hospital admission avoidable?	☐ Yes ☐ No ☐ Unsure Comment to support answer:
13.	Number of days in hospital in the last week of life?	☐ Days: ☐ Unknown

Advance Care Planning		
Question		**Response**
14.	Was there documented evidence of an Advance Care Plan (ACP) or Advance Care Directive (ACD)?	☐ Yes ☐ No ☐ Unknown
15.	Was there documented evidence that the client's ***diagnosis*** was discussed with the client and family?	☐ Yes ☐ No ☐ Unknown
16.	Was there documented evidence that the client's ***prognosis*** was discussed with the client and family?	☐ Yes ☐ No ☐ Unknown
17.	Was there documented evidence that CPR/ intubation versus comfort care was discussed with the client and family?	☐ Yes ☐ No ☐ Unknown
18.	Where did the client wish to be cared for should their condition deteriorate?	☐ Home ☐ Residential Aged Care ☐ Hospital ☐ Other (please state): ☐ Unknown

19.	Did the client appoint a Substitute Decision Maker (SDM)?	☐ Yes ☐ No ☐ Unknown

Care Planning		
Question		**Response**
20.	Was a Family Meeting/Case Conference (includes the family/SDM and/or client) discussing palliative and/or end of life care held within 6 months prior to the client's death?	☐ Yes (complete date) ☐ No ☐ Unknown Date: DD/MM/YYYY (If more than one case conference, use the date of the first occurrence within the six months.)
21.	Was a Team Case Conference (includes the team and other health professionals, but not client or family/SDM) discussing palliative and/or end of life care held within 6 months prior to the client's death?	☐ Yes (complete date) ☐ No ☐ Unknown Date: DD/MM/YYYY (If more than one case conference, use the date of the first occurrence within the six months.)
22.	Was the client commenced on an End of Life Care Pathway/Care Plan?	☐ Yes (complete date) ☐ No ☐ Unknown Date: DD/MM/YYYY

About the Client's Death		
Question		**Response**
23.	Place of Death	☐ Home ☐ Hospital ☐ Residential Aged Care ☐ Inpatient Palliative Care Unit ☐ Other (please state): ☐ Unknown
24.	Was this the client's preferred place of death?	☐ No preference stated ☐ Yes ☐ No ☐ Unknown

25.	Were the palliative care needs of the client met in the last week of life?	☐ Yes, fully ☐ Yes, partially ☐ No ☐ Unknown
26.	Were the family's palliative care needs met in the last week of life?	☐ Not applicable ☐ Yes, fully ☐ Yes, partially ☐ No ☐ Unknown
27.	Was the family assessed for bereavement risk? (specific bereavement tool not required)	☐ Not applicable ☐ Yes ☐ No ☐ Unknown
28.	Was the family referred to a bereavement service or other support after the client's death?	☐ Not applicable ☐ Yes ☐ No ☐ Unknown
29.	Barriers to effective palliative care (tick all that apply)	☐ No barriers to palliative care ☐ No ACP/ACD ☐ Did not recognise end of life ☐ Sudden death or acute event ☐ Conflicts around goals of care ☐ Unable to manage symptoms ☐ EOL medication (e.g. not prescribed, not available, no equipment) ☐ Registered Nurse unavailable ☐ Clinical review by GP/Nurse Practitioner unavailable when needed ☐ Home Care Package unable to support ☐ CHSP unable to support ☐ No Specialist Palliative Care support ☐ No Family Meeting/Case Conference ☐ Family needs not met ☐ Lack of bereavement services ☐ Absence of family/carer ☐ Staff not trained/confident in EOL ☐ Other (please state): ☐ Unknown

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ELDAC Advance Care Planning and Palliative Care Organisational Audit (Version 2)

Instructions: The statements below are grouped by five organisational domains. Provide two ratings for each of the statements. Repeat the audit yearly to monitor continuous quality improvement.

A. For each item rate how your service is currently meeting each statement using the four point scale.

B. Rate the priority of action (low, medium or high) required for your service to meet each statement. High priority action items may form the basis for a continuous improvement plan.

C. Where there are multiple high priority items, the working group will need to rank the items in order of importance. Select an assortment of actions needing different timeframes to complete (e.g. combining some actions requiring extensive work and those where change can occur rapidly).

Date of Completion: DD/MM/YYYY	Date of Review: DD/MM/YYYY

Domain		Rating for currently met				Priority for action
Clinical Care		**1**	**2**	**3**	**4**	
1.	There are regular conversations about decision making and advance care planning with clients/families at set times, as well as when required.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
2.	There is a process for flagging, storing, retrieving and transferring to other services advance care plan/advance care directives.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
3.	Reviews of clients' advance care plans occur at least every 12 months and any changes are documented.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
4.	There is a process for identifying when clients require palliative care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Clinical Care		**1**	**2**	**3**	**4**	
5.	Tools are available to staff for assessing common symptoms in palliative care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
6.	There is a process for conducting family meetings/case conferences about palliative and/or end of life care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
7.	Care plans have capacity to include the palliative care needs of clients/families.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
8.	There is a process for conducting multidisciplinary team case conferences for people requiring palliative and/or end of life care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
9.	There is a process for referring clients to other agencies (non-specialist palliative care) that can support clients who require palliative care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
10.	There is a process for referring clients to specialist palliative care services.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
11.	Staff are able to assess and respond immediately to clients whose condition is deteriorating.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
12.	There is a routine review to assess the appropriateness of clients transferred to acute care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Clinical Care		**1**	**2**	**3**	**4**	
13.	There is a documented process for identifying when clients are in the last days/weeks of life.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
14.	Staff are able to provide care and effective symptom management for clients in the last days/weeks of life.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
15.	There is a process to proactively identify the bereavement needs of families.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
16.	There is a process to honour clients after their death (e.g. memorial service which involves families and staff).	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Education and Workforce Development		**1**	**2**	**3**	**4**	
17.	There is an advance care planning and palliative care working group that meets regularly.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
18.	There are written and visual educational materials available to clients/ families on advance care planning and palliative care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
19.	There is an in-service education program for staff that includes advance care planning and palliative care education sessions at least every year.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Education and Workforce Development		**1**	**2**	**3**	**4**	
20.	There is an in-service education program for new staff as part of orientation that includes advance care planning and palliative care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
21.	There are processes to identify staff self-care needs and resources to support staff.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
22.	Staff are educated in trauma-informed approaches to palliative care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
23.	Staff are educated in diversity, inclusivity, and cultural safety to provide holistic palliative care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Policies and Procedures		**1**	**2**	**3**	**4**	
24.	There are policies/guidelines for advance care planning.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
25.	There are policies/guidelines for palliative and end of life care (e.g. administration of subcutaneous medications; withdrawing artificial nutrition and hydration).	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
26.	Equipment is suitable and there is enough equipment to support the delivery of quality palliative care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Policies and Procedures		**1**	**2**	**3**	**4**	
27.	There is a policy/procedure for verification of death.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Information Systems		**1**	**2**	**3**	**4**	
28.	There is an option in the electronic records system to identify if people have an advance care plan/advance care directive.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
29.	There are palliative and end of life ***assessment tools*** in the electronic records system.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
30.	There are palliative and end of life care ***planning tools*** in the electronic records system.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Continuous Improvement		**1**	**2**	**3**	**4**	
31.	There is a process for reviewing policies and procedures relevant to advance care planning.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

Domain		Rating for currently met				Priority for action
Continuous Improvement		**1**	**2**	**3**	**4**	
32.	There is a process for reviewing policies and procedures relevant to palliative and end of life care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
33.	There is a regular audit of clients' advance care plans and if their wishes were followed.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
34.	There is a regular review of clients' palliative and end of life care needs (see ELDAC After Death Audit).	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High
35.	The organisation regularly seeks input and feedback from clients/families and uses the input and feedback to inform continuous improvements for palliative and end of life care.	No not yet ◯	Somewhat ◯	Mostly ◯	Completely ◯	◯ Low ◯ Medium ◯ High

ELDAC Personal Learning Plan

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Remember to make a plan that is achievable. Review your Personal Learning Assessment and focus on the areas that you rated as a '1' (Section 1: I don't know anything about this topic or Section 2: I do not feel confident). You can use the learning assessment and learning plan to discuss your knowledge, skills and confidence in palliative care and advance care planning with your supervisor. Once you have created your learning plan and identified your learning needs and areas where further training is required, browse the links provided in this section on various types of education and resources that are recommended by the ELDAC team.

Here is an example of how to fill out the form:

Section 1: Knowledge of Palliative Care and Advance Care Planning

Name		Date Completed (Day / Month / Year)	18/01/2019

Knowledge Need Learning Priority	How will this be met?	Target Date (Day / Month / Year)	Date Completed (Day / Month / Year)	Evidence of Completion	How have you applied your knowledge in advance care planning and palliative care? Provide specific examples
Improve my knowledge about grief and bereavement.	E-Learning	18/01/2019	18/01/2019	Certicate received after completing module that I downloaded for my records.	I have more of an understanding of the grieving process, which enables me to assist families in managing their grief and offer bereavement support.

ELDAC Personal Learning Plan

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Section 1: Knowledge of Palliative Care and Advance Care Planning

Name	Date Completed (Day / Month / Year)

Knowledge Need Learning Priority	How will this be met?	Target Date	Date Completed	Evidence of Completion	How have you applied your knowledge in advance care planning and palliative care? Provide specific examples
	☐ E-Learning ☐ Short Course ☐ Clinical Experience ☐ Further Education ☐ In-Service ☐ Other	Day / Month / Year	Day / Month / Year		
	☐ E-Learning ☐ Short Course ☐ Clinical Experience ☐ Further Education ☐ In-Service ☐ Other	Day / Month / Year	Day / Month / Year		
	☐ E-Learning ☐ Short Course ☐ Clinical Experience ☐ Further Education ☐ In-Service ☐ Other	Day / Month / Year	Day / Month / Year		

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Section 2: Skills and Confidence in Advance Care Planning and Palliative Care

Skills and Confidence Priority	How will this be met?	Target Date	Date Completed	Evidence of Completion	Provide examples of when you have demonstrated increased confidence in advance care planning and palliative care?
	☐ E-Learning ☐ Short Course ☐ Clinical Experience ☐ Further Education ☐ In-Service ☐ Other	Day / Month / Year	Day / Month / Year		
	☐ E-Learning ☐ Short Course ☐ Clinical Experience ☐ Further Education ☐ In-Service ☐ Other	Day / Month / Year	Day / Month / Year		
	☐ E-Learning ☐ Short Course ☐ Clinical Experience ☐ Further Education ☐ In-Service ☐ Other	Day / Month / Year	Day / Month / Year		

ELDAC Personal Learning Assessment

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There are two sections of the Personal Learning Assessment to complete:

Section 1: Knowledge of palliative care and advance care planning

Section 2: Skills and confidence in providing palliative care and advance care planning

It is recommended that you complete the assessment at least annually as your learning and development needs change. The assessment can be used as part of your performance review. You should use your completed assessment to assist you in completing the ELDAC Personal Learning Plan.

Section 1: Knowledge of Palliative Care and Advance Care Planning

This section of the tool asks you to rate your **knowledge** on a three point scale:

1. I don't know anything about this topic
2. I could learn more about this topic
3. I am happy with what I know about this topic

It is recommended that any areas you rate as a '1' (I don't know anything about this topic) should be considered for inclusion in your Personal Learning Plan.

Name	Date Completed (Day / Month / Year)

	Knowledge Area	Rating Level		
		1	2	3
1	What is palliative care and end-of-life care			
2	Advance care planning legislation and processes relevant to your state/territory			
3	Ethical issues that impact on palliative and end-of-life care (e.g. withdrawing treatment, family conflict)			
4	Recognising that a person needs end-of-life care			
5	How to recognise/assess the physical, psychological, social and spiritual needs of a person requiring palliative or end-of-life care			
6	Develop/implement a care plan to meet the identified palliative care needs of a person at end-of-life			
7	Palliative symptom management			
8	Communication skills (e.g. active listening, questioning, attending and empathy)			
9	Respect for and ability to meet the requirements of individual resident/client cultural, religious and spiritual beliefs and values			
10	Working effectively as a team to provide palliative and end-of-life care			
11	Able to identify that support from specialist palliative care or other agencies may be required			
12	How to recognise that the condition of a person receiving palliative care has further deteriorated			

13	Care for a person in the last week of life			
14	Legal, cultural, religious issues when caring for a person's body after death			
15	Bereavement needs of families			
16	Self-care in the workplace			

Section 2: Skills and Confidence in Palliative Care and Advance Care Planning

This section of the tool asks you to rate your **skills and confidence** on a three point scale:

1. I do not feel confident
2. I feel somewhat confident
3. I feel very confident

It is recommended that any areas you rate as a '1' (I do not feel confident) should be considered for inclusion in your Personal Learning Plan.

Skills and Confidence Area		Rating Level		
		1	2	3
1	What is palliative care and end-of-life care			
2	Discussing advance care planning legislation and processes relevant to your state/territory with residents/clients and families			
3	Addressing ethical issues that impact on palliative and end-of-life care (e.g. withdrawing treatment, family conflict)			
4	Recognising that a person needs end-of-life care			
5	Utilising appropriate, validated tools to inform a holistic, person-centred palliative care assessment requiring palliative or end-of-life care			
6	Developing and implementing a care plan to meet the identified palliative care needs of a person			
7	Managing palliative care symptoms within my scope of practice			
8	Use open and sensitive communication to develop a relationship with residents/clients and family			
9	Respecting and meeting the requirements of individual resident/client cultural, religious and spiritual beliefs			
10	Working effectively in a team to provide palliative and end-of-life care			
11	Understanding when and how to refer to specialist palliative care or other agencies within my scope of practice			
12	Recognising that the condition of the person receiving palliative care has further deteriorated			
13	Caring for a person in the last week of life within my scope of practice			
14	Understanding the legal, cultural, religious issues when caring for a person's body after death			
15	Assessing family bereavement needs and refer if necessary			
16	Recognising the need for support for yourself or others in the workplace			