

ELDAC Primary Care Individual Self-Assessment

This self assessment tool is intended to help you, as a primary care professional, identify areas of the Primary Care Toolkit that may be of particular use for building your palliative care knowledge, skills and confidence.

To guide best practice across the diverse care settings that primary care professionals can provide palliative care, this self assessment tool aligns with standards 1-6 of the [National Palliative Care Standards for All Health Professionals and Aged Care Services](#), and is supported by key outcomes within the [Strengthened Aged Care Quality Standards](#).

This assessment should take 10-15 minutes to complete.

- **Step 1:** Answer 'Yes' or 'No' to each question below, reflecting on your experiences in and knowledge on providing palliative care. If you find yourself thinking about the answer to a question for more than 60 seconds, select 'No' and move to the next question.
- **Step 2:** Add up how many times you answer 'Yes' in the subtotal field at the end of each section.
- **Step 3:** If you answered '**Yes**' for **less than half** of the section, see the headings used in each section to identify the corresponding areas of the Primary Care Toolkit where you can find information, resources and support to assist in your understanding and practice of palliative care.

Note the following areas of the Primary Care Toolkit:

Clinical Action
Business and Practice Management
Continuing Professional Development

Section 1: Comprehensive assessment of needs

Initial and ongoing assessment comprehensively incorporates the person's physical, psychological, cultural, social, and spiritual experiences and needs. This section also reflects the following areas of the Strengthened Aged Care Quality Standards:

- Outcome 3.1: Assessment and planning
- Outcome 5.4: Comprehensive care
- Outcome 5.7: Palliative care and end-of-life care

Section 1: Comprehensive assessment of needs	YES	NO
Recognise End of Life		
Are there processes in place to support the early identification of older people approaching end-of-life, to support timely assessment of palliative care needs?	<input type="checkbox"/>	<input type="checkbox"/>
Assess Palliative Care Needs		
Does your assessment of palliative care needs include the assessment of spiritual, psychosocial, and social/occupational needs as well as physical health needs?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use core clinical tools to assess palliative care needs?	<input type="checkbox"/>	<input type="checkbox"/>
Are the older person's values, preferences, and goals of care centred in your approach to assessing their palliative care needs?	<input type="checkbox"/>	<input type="checkbox"/>
Work Together		
If the older person is receiving palliative care from multiple providers, is there written clarification of who has responsibility for initial and ongoing assessments of care needs?	<input type="checkbox"/>	<input type="checkbox"/>
Are assessments of care needs securely stored to the older person's health record and shared with all members of the care team, including the older person, their family and carer?	<input type="checkbox"/>	<input type="checkbox"/>
Are there established processes to support effective and ongoing communication between members of the care team, such as case conferences?	<input type="checkbox"/>	<input type="checkbox"/>
Respond to Deterioration		
Are there processes for regular or routine reassessments of care needs, as well as for reassessments triggered by clinical changes or deterioration?	<input type="checkbox"/>	<input type="checkbox"/>
Please enter in the box the number of YES answers:	[] / 8	

Section 2: Developing the comprehensive care plan

The person, their family and carers and substitute decision-maker(s) work in partnership with multidisciplinary teams to communicate, plan, set goals of care and support informed decisions about the comprehensive care plan. This section also reflects the following areas of the Strengthened Aged Care Quality Standards:

- Outcome 1.1: Person-centred care
- Outcome 3.1: Assessment and planning
- Outcome 3.4: Planning and coordination of funded aged care services
- Outcome 5.4: Comprehensive care
- Outcome 5.7: Palliative care and end-of-life care

Section 2: Developing the comprehensive care plan	YES	NO
Assess Palliative Care Needs		
Is development of the care plan informed through a holistic assessment of the older person's physical, psychosocial, spiritual, and cultural needs?	<input type="checkbox"/>	<input type="checkbox"/>
Work Together		
Are there processes in place (such as the availability of information or support resources) to ensure that the older person, their family and carer/s, are informed about their role/s as part of the care team?	<input type="checkbox"/>	<input type="checkbox"/>
Are communications about goals of care, both formal and informal, captured and used to support ongoing decision-making between members of the care team in development and delivery of the care plan?	<input type="checkbox"/>	<input type="checkbox"/>
Provide Palliative Care		
Do you manage symptoms in a way that is tailored to the older person's individual needs, values, and preferences, ensuring their comfort and dignity remain central to care?	<input type="checkbox"/>	<input type="checkbox"/>
Respond to Deterioration		
Are there processes for review of the care plan as part of routine care, as well as for reassessments triggered by changes in the care needs of the older person (such as unplanned hospitalisation)?	<input type="checkbox"/>	<input type="checkbox"/>
Older Person, Family and Carer Support		
Do you have readily available information for the older person, their family and carer/s on the following topics:		
a. Expectations about palliative care and end-of-life	<input type="checkbox"/>	<input type="checkbox"/>
b. Local support services (such as aged care, specialist palliative care, or after hours and emergency information)	<input type="checkbox"/>	<input type="checkbox"/>
c. Having difficult conversations	<input type="checkbox"/>	<input type="checkbox"/>
d. Home care	<input type="checkbox"/>	<input type="checkbox"/>
e. Grief and bereavement	<input type="checkbox"/>	<input type="checkbox"/>

Does development of the care plan consider the values, preferences and goals of care for diverse populations (such as CALD communities, Aboriginal and Torres Strait Islander peoples, LGBTIQ+)?	<input type="checkbox"/>	<input type="checkbox"/>
Digital Tools		
Are processes in place for the secure storage and sharing or accessing of the care plan between all members of the care team, including the older person, their family and carer?	<input type="checkbox"/>	<input type="checkbox"/>
Please enter in the box the number of YES answers:	[] / 12	

Section 3: Caring for carers

The needs and preferences of the person's family and carers and substitute decision-maker(s) are assessed and directly inform provision of appropriate support and guidance about their role. This section also reflects the following areas of the Strengthened Aged Care Quality Standards:

- Outcome 2.4: Risk management
- Outcome 3.3: Communicating for safety and quality
- Outcome 5.7: Palliative and end-of-life care

Section 3: Caring for carers	YES	NO
Work Together		
Is there a process to support carers in their caring role, including ensuring they receive up to date information and relevant contact information, are educated about providing or managing care safely and have a safe caring environment?	<input type="checkbox"/>	<input type="checkbox"/>
Assess Palliative Care Needs		
Do you have a process to identify carers, assess their needs through <u>core clinical tools</u> , for example the NAT-CC, and document those details?	<input type="checkbox"/>	<input type="checkbox"/>
Older Person, Family and Carer Support		
Do you have information about the support and services available to carers stored and provided regularly to the person's family and carers and substitute decision-maker(s)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have carers support information that is specifically tailored to priority populations, such as CALD communities, Aboriginal and Torres Strait Islander Peoples, LGBTQIA+ identifying people and veterans?	<input type="checkbox"/>	<input type="checkbox"/>
Please enter in the box the number of YES answers:	[] / 4	

Section 4: Providing care

The provision of care is based on the assessed needs of the person, informed by evidence, and is consistent with the values, goals and preferences of the person as documented in their care plan. This section also reflects the following areas of the Strengthened Aged Care Quality Standards:

- Outcome 5.4: Comprehensive care
- Outcome 5.5: Safety of clinical care services
- Outcome 5.7: Palliative and end-of-life care

Section 4: Providing care	YES	NO
Business and Practice Management		
When required, do you have processes to undertake home visits for older persons who are no longer able to attend a primary care practice?	<input type="checkbox"/>	<input type="checkbox"/>
Advance Care Planning		
If care cannot be delivered in accordance with the goals, values, and preferences of the person, is there a procedure for this to be discussed with the older person, substitute decision-maker, their family, and carers?	<input type="checkbox"/>	<input type="checkbox"/>
Provide Palliative Care		
Do you have an evidence-based process for managing medications in palliative care? For example, anticipatory prescribing plans, or medication review processes reactive to changing needs and condition trajectory?	<input type="checkbox"/>	<input type="checkbox"/>
Are you confident in identifying and managing symptoms in a timely manner, based on ongoing assessments, in alignment with the older person's changing needs, documented care plan, and the goals and preferences of the person, their family, and any substitute decision-makers and/or carer/s?	<input type="checkbox"/>	<input type="checkbox"/>
Respond to Deterioration		
Are there clear protocols and procedures in place across practice settings for escalating care, such as when urgent or specialist intervention is required?	<input type="checkbox"/>	<input type="checkbox"/>
Work Together		
If the older person is receiving palliative care from multiple providers, do you ensure there is written clarification of who has responsibility for:		
a. Overall responsibility for leading and coordinating care?	<input type="checkbox"/>	<input type="checkbox"/>
b. Maintain prescriptions for palliative medications?	<input type="checkbox"/>	<input type="checkbox"/>
c. Reviewing symptoms and assessing care needs?	<input type="checkbox"/>	<input type="checkbox"/>
d. Ensuring availability of home visits for older persons no longer able to attend a practice visit?	<input type="checkbox"/>	<input type="checkbox"/>
e. Writing the death certificate if intent for an at-home death?	<input type="checkbox"/>	<input type="checkbox"/>
Please enter in the box the number of YES answers:		[] / 10

Section 5: Transitions within and between services

Care is integrated across the person's experience to ensure seamless transitions within and between services. This section also reflects the following areas of the Strengthened Aged Care Quality Standards:

- Outcome 2.7: Information Management
- Outcome 3.3: Communicating for safety and quality
- Outcome 5.7: Palliative and end-of-life care
- Outcome 7.2: Transitions

Section 5: Transitions within and between services	YES	NO
Work Together		
Are there formalised pathways of communication for coordination of care between practitioners and services in response to changing needs (e.g., admission to hospital, notification of death)?	<input type="checkbox"/>	<input type="checkbox"/>
Advance Care Planning		
Do you ensure that decisions about transitions between care settings, such as avoiding unnecessary hospital transfers, align with the person's goals, values, and preferences identified through pre-existing documents and conversations?	<input type="checkbox"/>	<input type="checkbox"/>
Older Person, Family and Carer Support		
Do you provide information and resources to support families and carer/s to provide care to the older person at-home or in the community?	<input type="checkbox"/>	<input type="checkbox"/>
Organisational Support		
Are referral pathways for older persons with palliative care needs regularly reviewed to identify opportunities for improvement in providing timely and appropriate care?	<input type="checkbox"/>	<input type="checkbox"/>
Digital Tools		
Is there a process in place for ACP documents and care plans to be uploaded, stored and shared as appropriate, in a timely manner (such as on My Health Record)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have access to and regularly use the HealthPathways site of your regional Primary Health Network?	<input type="checkbox"/>	<input type="checkbox"/>
Please enter in the box the number of YES answers:	[] / 6	

Section 6: Grief support

Families and carers have access to grief support services and are provided with information about loss and grief. This section also reflects the following areas of the Strengthened Aged Care Quality Standards:

- Outcome 5.7: Palliative and end-of-life care

Section 6: Grief support	YES	NO
Bereavement		
Are validated clinical tools, like the Bereavement Risk Assessment Tool, used to assess signs and symptoms of persistent and intense distress in grief or bereavement?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a process, pathway or strategy for referral for bereavement support if required?	<input type="checkbox"/>	<input type="checkbox"/>
Manage Dying		
Is information and resources about death, the dying process, and what to expect after-death available for the family, friends and carer/s of the older person?	<input type="checkbox"/>	<input type="checkbox"/>
Older Person, Family and Carer Support		
Are bereavement and grief resources and information provided to families and carers, including where to find regional support services?	<input type="checkbox"/>	<input type="checkbox"/>
Are bereavement and grief resources specific to diverse populations (such as CALD, Aboriginal and Torres Strait Islander, LGBTQIA+) available to be provided to families and carers?	<input type="checkbox"/>	<input type="checkbox"/>
Team Support		
Do you have access to bereavement support services and resources for clinicians within your practice?	<input type="checkbox"/>	<input type="checkbox"/>
Please enter in the box the number of YES answers:		[] / 6

CLEAR FORM