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PALLIATIVE CARE AGED CARE EVIDENCE

Residential Aged Care (RAC) Resources

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PALLIATIVE CARE AGED CARE EVIDENCE

Practical help to assist you to support older people at the end of life in residential aged care

Residential Aged Care Pack Contents

Residential aged care is a key provider of care and support for older people at the end of life. Ensuring that key palliative care steps are not missed, and processes are well documented is part of good practice.

To help you and your team to support older people in residential aged care, we have brought together this pack of resources.

Self-care plan for the aged care team

To care for others, you need to take care of yourself. This worksheet helps you to plan activities to maintain your balance in life.

Recognising changes

If you see clients regularly, it can be more difficult to notice subtle changes in their condition. These forms can be used to systematically assess for deterioration in a person's health and to identify unmet supportive and palliative care needs.

- SPICT Tool
- SPICT4ALL Tool.

Symptom control

The Abbey Pain Scale form for monitoring changes in pain status in residents living with dementia.

Palliative care case conferences

A series of practical checklists and forms to guide and document case conferences.

End-of-life-care

A practical list of PBS medicines for responding to unanticipated needs in the terminal phase.

MBS remuneration for palliative care services

- MBS items for nurse practitioners
- MBS remuneration for GPs providing a planned palliative care pathway for residential aged care patients

Download or order printed copies at palliaged.com.au/practiceforms

palliaged.com.au

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Self-care plan: Aged care team

Caring for others can be rewarding. However, staff working in aged care look after many people who die. You might find this loss hard to accept. You might find it hard to sleep, no longer enjoy your work, or feel tired. This can affect you and your family. Self-care is what we do to maintain balance in our life.

A self-care plan based on what you like to do can help. We have suggested a few things that you could try, but what you choose will depend on you.

Workplace self-care: Activities to help you at work

Some examples

- Regular meetings with supervisors or a more experienced colleague
- Join a support group with the people you work with
- Attend training programs

My activities:

Physical self-care: Activities that help you to stay fit and healthy

Some examples

- Develop a regular sleep routine
- Aim for a healthy diet
- Take lunch breaks and go for a walk
- Get some exercise before/after work regularly

My activities:

Self-care plan

Psychological self-care: Activities that help you to feel clear-headed and able to engage with workplace and personal challenges

Some examples

- Keep a reflective journal
- Seek regular meetings with supervisors or a more experienced colleague
- Turn off your email and work phone outside of work hours
- Make time to be with friends and family

My activities:

Emotional self-care: Allow yourself to safely express your emotions

Some examples

- Develop friendships that are supportive
- Write or think of three good things that you did each day
- Play a sport and have a coffee together after training
- Talk to your friends about how you are coping with work and life demands

My activities:

Self-care plan

Spiritual self-care: Develop a sense of perspective beyond the day-to-day of life which can include religion, but it is not always about religion

Some examples

- Engage in reflective practices like meditation
- Go on walks to connect with nature
- Go to church/mosque/temple
- Do yoga

My activities:

Relationship self-care: Maintain healthy, supportive relationships, and ensure that you are not only connected to work people

Some examples

- Prioritise close relationships in your life e.g. with partners, family and children
- Attend the special events of your family and friends
- Arrive to work and leave on time every day

My activities:

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Supportive and Palliative Care Indicators Tool (SPICT™)

CARESEARCH® palliative care knowledge network

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s). ☐
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.) ☐
- Depends on others for care due to increasing physical and/or mental health problems. ☐
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass. ☐
- Persistent symptoms despite optimal treatment of underlying condition(s). ☐
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life. ☐

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

- Functional ability deteriorating due to progressive cancer. ☐
- Too frail for cancer treatment or treatment is for symptom control. ☐

Dementia/ frailty

- Unable to dress, walk or eat without help. ☐
- Eating and drinking less; difficulty with swallowing. ☐
- Urinary and faecal incontinence. ☐
- Not able to communicate by speaking; little social interaction. ☐
- Frequent falls; fractured femur. ☐
- Recurrent febrile episodes or infections; aspiration pneumonia. ☐

Neurological disease

- Progressive deterioration in physical and/or cognitive function despite optimal therapy. ☐
- Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing. ☐
- Recurrent aspiration pneumonia; breathless or respiratory failure. ☐
- Persistent paralysis after stroke with significant loss of function and ongoing disability. ☐

Heart/ vascular disease

- Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort. ☐
- Severe, inoperable peripheral vascular disease. ☐

Respiratory disease

- Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations. ☐
- Persistent hypoxia needing long term oxygen therapy. ☐
- Has needed ventilation for respiratory failure or ventilation is contraindicated. ☐

Kidney disease

- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health. ☐
- Kidney failure complicating other life limiting conditions or treatments. ☐
- Stopping or not starting dialysis. ☐

Liver disease

- Cirrhosis with one or more complications in the past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds ☐
- Liver transplant is not possible. ☐

Other conditions

- Deteriorating with other conditions, multiple conditions and/or complications that are not reversible; any treatment available will have a poor outcome. ☐

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy. ☐
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage. ☐
- Agree a current and future care plan with the person and their family. Support carers. ☐
- Plan ahead early if loss of decision-making capacity is likely. ☐
- Record, share, and review care plans. ☐

For more on palliative care visit www.caresearch.com.au

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, 2022

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Supportive and Palliative Care Indicators Tool (SPICT-4ALL™)

CARESEARCH® palliative care knowledge network

The SPICT™ helps us to look for people who are less well with one or more health problems. These people need more help and care now, and a plan for care in the future. Ask these questions:

Does this person have signs of poor health or health problems that are getting worse?

- Unplanned (emergency) admission(s) to hospital. ☐
- General health is poor or getting worse; the person never quite recovers from being more unwell. (This means the person is less able to manage day to day life and often stays in bed or in a chair for more than half the day). ☐
- Needs help from others for care due to increasing physical and/ or mental health problems. ☐
- The person's carer needs more help and support.
- Has clearly lost weight over the last few months; or stays too thin. ☐
- Has troublesome symptoms most of the time despite good treatment of their health problems. ☐
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life. ☐

Does this person have any of these health problems?

Cancer

- Less able to manage usual activities; health getting poorer. ☐
- Not well enough for cancer treatment or treatment is to help with symptoms. ☐

Dementia/frailty

- Unable to dress, walk or eat without help. ☐
- Eating and drinking less; difficulty with swallowing. ☐
- Has lost control of bladder and bowels. ☐
- Not able to communicate by speaking; not responding much to other people. ☐
- Frequent falls; fractured hip. ☐
- Frequent infections; pneumonia. ☐

Nervous system problems

(eg Parkinson's disease, MS, stroke, motor neurone disease)

- Physical and mental health are getting worse. ☐
- More problems with speaking and communicating; swallowing is getting worse. ☐
- Chest infections or pneumonia; breathing problems. ☐
- Severe stroke with loss of movement and ongoing disability. ☐

Heart or circulation problems

- Heart failure or has bad attacks of chest pain. Short of breath when resting, moving or walking a few steps. ☐
- Very poor circulation in the legs; surgery is not possible. ☐

Lung problems

- Unwell with long term lung problems. Short of breath when resting, moving or walking a few steps even when the chest is at its best. ☐
- Needs to use oxygen for most of the day and night. ☐
- Has needed treatment with a breathing machine in the hospital. ☐

Other conditions

- People who are less well and may die from other health problems or complications. There is no treatment available or it will not work well. ☐

Kidney problems

- Kidneys not working well; general health is getting poorer. ☐
- Stopping kidney dialysis or choosing supportive care instead of starting dialysis. ☐

Liver problems

- Worsening liver problems in the past year with complications like:
  - fluid building up in the belly
  - being confused at times
  - kidneys not working well
  - infections
  - bleeding from the gullet ☐
- A liver transplant is not possible. ☐

What we can do to help this person and their family.

- Start talking with the person and their family about any help needed now and why making plans for care is important in case things change. ☐
- Ask for help and advice from a nurse, doctor or other professional who can assess the person and their family and help plan care. ☐
- We can look at the person's medicines and other treatments to make sure we are giving them the best care or get advice from a specialist if problems are complicated or hard to manage. ☐
- We need to plan early if the person might not be able to decide things in the future. ☐
- We make a record of the care plan and share it with people who need to see it. ☐

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT-4ALL™ 2023

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Abbey Pain Scale

Enter pain scores for each of the the following six areas:

Absent = 0; Mild = 1; Moderate = 2; Severe = 3

Patient details
Surname.....
Title.....
Given names.....
DOB..... MRN.....
Address.....
Suburb.....
Postcode.....

Enter date:					
Enter time:					
Sign entry					
1. Vocalisation e.g., whimpering, groaning, crying.					
2. Facial expression e.g., looking tense, frowning, grimacing, looking frightened.					
3. Change in body language e.g., fidgeting, rocking, guarding part of body, withdrawn.					
4. Behavioural change e.g., increased confusion, refusing to eat, alteration in usual patterns.					
5. Physiological change e.g., temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor.					
6. Physical changes e.g., skin tears, pressure areas, arthritis, contractures, previous injuries.					
Total scores					
Circle the range that matches the total pain score **0-2** No pain **3-7** mild **8-13** moderate **14+** severe	No pain ☐ Mild ☐ Moderate ☐ Severe ☐	No pain ☐ Mild ☐ Moderate ☐ Severe ☐	No pain ☐ Mild ☐ Moderate ☐ Severe ☐	No pain ☐ Mild ☐ Moderate ☐ Severe ☐	No pain ☐ Mild ☐ Moderate ☐ Severe ☐

Tick the box which matches the type of pain: Acute ☐ Chronic ☐ Acute on chronic ☐

About Abbey Pain Scale

Purpose: Developed to detect pain in elderly residents with dementia and inability to communicate verbally. It is a 6-item 3 point scale tool**.**

Description: The Abbey Pain Scale was developed for use in aged care and dementia care. The tool is best used as part of an overall pain management plan. As the tool does not differentiate between distress and pain measuring the effectiveness of any interventions is essential. Use the form to collate recordings across an extended period to facilitate monitoring of responses. The Australian Pain Society recommends using the tool as a movement-based assessment and conducting a **second evaluation one hour after any intervention taken.** Repeat hourly until a score of mild pain is reached and then 4 hourly for 24 hours with treatment for pain as required. Contact the GP or pain team if there is no improvement.

Acknowledgement: Abbey J, et al. The Abbey pain scale: A 1-minute numerical indicator for people with end-stage dementia. Int J Palliat Nurs. 2004 Jan;10(1):6-13.

Using the palliAGED palliative care case conference forms

A case conference or family meeting between the person, their family and care providers can help to explain what is happening and to plan care. The palliAGED forms can help.

1. Use the palliAGED case conference checklist for residential care or for home care to organise a palliative care case conference. Tick off items as they are completed.

2. Speak with the person and their family about the need for a case conference. Provide information on palliative care and case conferences.

3. Involving the person's GP is important. Use the GP invitation to invite them to attend, and/or to suggest a suitable time.

4. Closer to the date of the case conference, send a letter confirming details to the person and their family, and send confirmation to the GP.

5. To guide the meeting and to make sure that all steps following the conference are completed use the palliAGED case conference summary for residential care or case conference summary for home care sheet.

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Planning checklist: Residential care

Organisation:

Palliative care case conference

Full name of resident:

DOB (dd/mm/yy):

Date of case conference (dd/mm/yy):

Time:

Venue:

Room booked:

Dial-in telephone number:

Code:

Case conference facilitator:

Goals of case conference:

Family participants

Name	Role/relationship	Contact details

Health and care professionals

Name	Role/relationship	Contact details

Document (tick as appropriate)	Sent	Accepted/declined	N/A
Resident & family information	☐	A ☐ D ☐	☐
Resident & family confirmation	☐	A ☐ D ☐	☐
GP invitation	☐	A ☐ D ☐	☐
GP confirmation	☐	A ☐ D ☐	☐

	Needed	Obtained	N/A
Clinical record (including most recent medication chart)	☐	☐	☐
Advance care planning document (legal or non-legal)	☐	☐	☐
Other (specify)	☐	☐	☐

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GP invitation

Palliative care case conference

Organisation:

To:	**Email/fax number:**
From:	**No. of pages:** (including this page)
Subject: Palliative case conference	**Date sent: (dd/mm/yy):**

Dear Dr _____

A palliative care case conference is being organised for (resident/client name):

_____

Resident/client DOB (dd/mm/yy): _____

Proposed date (dd/mm/yy): _____ **Start time:** _____

Expected duration: _____ **Venue:** _____

As an important member of the care team for our resident/client, you are invited to participate.

Reason for case conference:

Please indicate availability to participate in this case conference by ticking one of the options below:

☐ Attending in person ☐ Unable to attend

☐ Attending via teleconference
Please provide your telephone number: _____

☐ Please reschedule so I can attend.
Proposed alternative date: (dd/mm/yy): _____ and time: _____

Please email/fax this back to (insert email/fax number): _____

Yours sincerely (name): _____

Role: _____ **Organisation:** _____

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GP confirmation

Palliative care case conference

Organisation:

To:	**Email/fax number:**
From:	**No. of pages:** (including this page)
Subject: Palliative case conference	**Date sent: (dd/mm/yy):**

Dear Dr _____

Following our recent correspondence with you a palliative care case conference has been organised for: (resident/client name):

_____

Resident/client DOB (dd/mm/yy): _____

Case conference date (dd/mm/yy): _____ **Start time:** _____

Expected duration: _____ **Venue:** _____

If you are joining by teleconference, please dial in using the following telephone number and code:

Telephone: _____ **Code:** _____

Reason for case conference:

Yours sincerely (name): _____

Role: _____ **Organisation:** _____

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Information for you and your family

Organisation:

Palliative care case conferences

It has been suggested that a case conference be held to discuss how you, or your family member might benefit from palliative care. The following explains what this is and why it is important.

Case conference: Case conferences or family meetings are an opportunity to discuss a person's care needs. They ideally include the person (if able to attend), their family and/or their substitute decision-maker, and members of the care team including the doctor.

Palliative care: Palliative care is person- and family-centred care that supports a person to live the best life they can with a life-limiting illness. A life-limiting illness means that the person has little or no prospect of cure and is expected to die. The focus is on quality of life.

Life-limiting illnesses include dementia, advanced heart, kidney, lung or liver disease, cancer, and motor neurone disease.

People can receive palliative care for days or weeks, or for months to years. Older people coming to the end of their life without illness may have some of the same care issues. They can also benefit from the approaches to care taken in palliative care.

Common care issues in palliative care include:

- pain
- dyspnoea (breathing difficulty)
- dysphagia (difficulty swallowing)
- constipation/incontinence (bowel and/or bladder management)
- depression
- delirium (sudden confusion)
- anxiety
- nausea (feel that you want to vomit)
- fatigue (tiredness).

Who should attend a case conference?

Staff in residential aged care facilities and providers of home care often meet with families. If possible, the person receiving care should attend, their GP, and any concerned family members or friends.

Your contact for this case conference is:

Name of staff member: **Role:**

Telephone:

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Invitation for you and your family

Organisation:

Palliative care case conference

A palliative care case conference has been organised for:

Name of resident/client: _____

Resident/client date of birth (dd/mm/yy): _____

Case conference date (dd/mm/yy): _____ **Start time:** _____

Location: _____

Please let us know if you can attend. If you would like to join by telephone, let us know and provide a suitable number to contact you.

Your contact for this case conference is:

Name of staff member: _____

Role: _____

Telephone: _____

On the next page you will find information on palliative care and palliative care case conferences

Invitation for you and your family

Palliative care case conference

Case conference: Case conferences or family meetings are an opportunity to discuss a person's care needs. They ideally include the person (if able to attend), their family and/or their substitute decision-maker, and members of the care team including the doctor.

Palliative care: Palliative care is person- and family-centred care that supports a person to live the best life they can with a life-limiting illness. This means that the person has little or no prospect of cure and is expected to die. The focus is on quality of life.

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- nausea (feel that you want to vomit)
- fatigue (tiredness).

Who should attend a case conference?

Staff in residential aged care facilities and providers of home care often meet with families. If possible, the person receiving care should attend, their GP, and any concerned family members or friends.

Confirmation for you and your family

Organisation:

Palliative care case conference

A palliative care case conference has been organised for:

Name of resident/client: _____

Resident/client date of birth (dd/mm/yy): _____

Case conference date (dd/mm/yy): _____ **Start time:** _____

Location: _____

Your involvement in planning care is important. If you are unable to attend in person but would like to join by telephone, please dial in using the following telephone number and code.

Dial-in telephone number: _____ **Code:** _____

Your contact for this case conference is:

Name of staff member: _____

Role: _____

Telephone: _____

Please write down if there are any issues you want to talk about and remember to bring this form with you to the meeting so that this can be included.

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Staff communication sheet

Organisation:

Palliative care case conference

A palliative care case conference has been organised for:

Name of resident/client: _____

Case conference date (dd/mm/yy): _____ **Start time:** _____

Location: _____

As valuable members of the care team your contribution to the case conference is important. Please list below any issues, concerns or suggestions you would like mentioned. Common issues include review of symptoms (e.g. pain, dyspnoea), concerns with nutrition or hydration, family issues, emotional concerns of the resident. If you are available and would like to attend the case conference, please contact the Case Conference Facilitator:

Name of facilitator: _____

Issue, concern or suggestion. Please be as specific as possible.	Designation

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Summary: Residential care

Palliative care case conference

Organisation:

Full name of client:

DOB (dd/mm/yy):

Purpose of case conference:

Resident consent/substitute decision-maker (SDM) consent

My care provider has explained the purpose of a case conference and I give permission for my care provider to prepare a case conference. I give permission to the providers listed below to participate in the case conference and discuss my/my family member's medical history, diagnosis, and current needs.

Signature:

Date:

Dial-in telephone number: **Code:**

Resident in attendance? Yes ☐ No ☐ **If no, give reason:**

Family members		
Name	**Relationship**	**Attending in person (P) or teleconference (T)**
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T

Health and care professionals		
Name	**Discipline/position**	**Attending in person (P) or teleconference (T)**
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T

Summary: Residential care

Palliative care case conference

Start time:

Need (as appropriate):

Key Issues	Description
Advance care plan Does this need to be reviewed? Does the person understand their diagnosis/prognosis?	
Symptoms For example: fatigue, anorexia, pain, nausea, dyspnoea, dysphagia	
Social/psychological needs For example: isolation, anxiety, depression What supports are being provided? What supports are needed?	
Assessments/investigations Can the client manage ADL's (Activities of Daily Living)? Do they need additional support?	
Carer/family issues or needs	
Other For example: general issues, housing issues, financial issues	

Summary: Residential care

Palliative care case conference

Agreed action plan

Goal	Actions	Key person(s) responsible	Description

Summary: Residential care

Palliative care case conference

Time completed:

General practitioner: _____

Tick appropriate box

- ☐ Original placed in the resident's clinical notes
- ☐ Copy provided to all participants
- ☐ Copy sent to GP
- ☐ Resident's care plan and assessment reviewed and updated

Palliative care case conference facilitator

Name: _____ **Position:** _____

Signature: _____ **Date (dd/mm/yy):** _____

PBS Prescriber Bag medicines for terminal phase symptoms

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These medicines are available through the PBS at no cost to prescribers. They can be provided free to patients during home visits for emergency use in managing symptoms or bridging the gap until a prescription is dispensed. Medicines shaded are part of the National Core Community Palliative Care Medicines List and are used to treat common symptoms in straightforward cases.

Medicine	Clinical uses in terminal phase	Strength and form	Pack size	Max qty (packs)
Adrenaline (Epinephrine)	Airway obstruction (nebulised), small volume malignant bleeding (topical)	1 in 1000 (1 mg/mL) injection	5 x 1mL	1
Clonazepam	Agitation, anxiety, distressing breathlessness, refractory distress, seizure	2.5 mg/mL drops	1 x 10mL	1
Furosemide	Oedema associated with heart failure	20 mg/2 mL injection	5 x 2mL	1
Haloperidol	Anxiety, delirium, nausea/vomiting, refractory distress, terminal restlessness	5 mg/mL injection	10 x 1mL	1
Hydrocortisone	Acute severe breathlessness/spinal cord compression, in place of dexamethasone	100 or 250 mg injection (reconstituted to 2mL)	1 x dual chamber vial	2 (100mg) or 1 (250mg)
Hyoscine butylbromide	Respiratory tract secretions, noisy breathing, managing cramps with bowel obstruction	20 mg/mL injection	5 x 1mL	1
Metoclopramide	Nausea/vomiting	10 mg/2 mL injection	10 x 2mL	1
Midazolam	Agitation, distressing breathlessness, refractory distress, seizure	5 mg/mL injection	10 x 1mL	1
Morphine	Distressing breathlessness (first line), pain	10, 15, 20, or 30 mg/mL injection	5 x 1mL	1
Naloxone	Reversing life-threatening opioid overdose	400 microgram/mL injection	5 or 10 x 1mL	2

Based on: caring@home/Pharmaceutical Society of Australia. National Core Community Palliative Care Medicines List [Internet]. Brisbane, QLD: caring@home; 2024 [cited 2025 Jun 2]. Available from: https://www.caringathomeproject.com.au/for-health-professionals/national-core-community-palliative-care-medicines-list

The PBS Prescriber Bag for palliative care

People with palliative care needs may choose to be cared for and die at home. This may include their private dwelling or a residential aged care facility. The evidence encourages the prescribing of all terminal phase medicines in advance, known as anticipatory prescribing. While it should not be a substitute for good advance planning, the PBS Prescriber Bag provides a safety net for those who deteriorate rapidly and unexpectedly at the end of life. This ensures rapid symptom management when needed, though deterioration can occur suddenly.

Prescriber Bag supply order forms allow monthly ordering of medicines and can be requested from Services Australia: https://www.servicesaustralia.gov.au/pbs-and-rpbs-official-stationery?context=20.
Complete the form, sign it, and give it to a community pharmacist for dispensing.

Dosing information

For specific dosing advice, refer to the CareSearchgp or palliMEDS apps (free to download), Palliative Care Therapeutic Guidelines, or Australian Medicines Handbook. You can also consult your local pharmacist.

Notes on use of specific medicines

- Morphine: avoid repeated dosing in people with serious kidney failure.
- Clonazepam or midazolam: may help with breathlessness if anxiety is present. They may also help to relieve rigidity associated with end-stage Parkinson's Disease if dopaminergic medication has ceased.
- Adrenaline in nebulised form may give temporary relief of stridor with breathlessness.

Practical tips

- Order your PBS Prescriber Bag medicines at the end of each month.
- Securely store S8 medicines (especially opioids) and follow local legislative guidelines.
- Consider carrying equipment to administer medicines subcutaneously.
- Limit subcutaneous injections to 1.5 mL to avoid causing pain at the injection site.
- Keep a notepad to record medication administration and any doses discarded.

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MBS items supporting nurse practitioner palliative care provision

MBS Item	Activities	MBS Benefit 100% (as of 01/08/24)
82200	Brief attendance Professional attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management. Telehealth: Item 91192. Phone: Item 91193.	$14.20
82205	Short attendance (<20 mins) Includes any of the following: taking a history; undertaking clinical examination; arranging any necessary investigation; implementing a management plan; or providing appropriate preventive health care, for one or more health related issues, with appropriate documentation. Telehealth: Item 91178. Phone: Item 91189.	$31.05
82210	Detailed consultation (>20 mins) Includes any of the following: taking a detailed history; undertaking clinical examination; arranging any necessary investigation; implementing a management plan; or providing appropriate preventive health care, for one or more health related issues, with appropriate documentation. Telehealth: Item 91179. Phone: Item 91190.	$58.85
82215	Extensive consultation (>40 mins) Includes any of the following: taking an extensive history; undertaking clinical examination; arranging any necessary investigation; implementing a management plan; or providing appropriate preventive health care, for one or more health related issues, with appropriate documentation. Telehealth: Item 91180. Phone: Item 91191.	$86.80

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MBS items supporting a planned general practice palliative care pathway in residential aged care

This document provides a suggested timeframe and pathway for aged care residents with palliative care needs based on the current MBS items available to the general practitioner.

Suggested timeframe	Medicare initiative	Activities	MBS Item	MBS Benefit 100% (as of 01/08/24)
0 months	Comprehensive medical assessment	On admission, then annually. Identify who is appointed to assist with healthcare decisions for patients who do not have capacity for palliative care discussions. Select relevant item based on complexity and PN + GP time.	701 (<30 mins)	$67.60
			703 (30-45 mins)	$157.10
			705 (45-60 mins)	$216.80
			707 (>60 mins)	$306.25
	Residential Medication Management Review (RMMR)	GP participation in a medication management review for someone in a residential aged care facility. Candidates for this review include residents for whom quality use of medicines may be an issue, or those at risk of medication misadventure due to a significant change in their condition or medication regimen.	903	$120.80
1st month	Care plan contribution	GP contribution to a multidisciplinary care plan prepared by a residential aged care facility for managing terminal medical conditions.	731	$80.20
2nd month	GP-organised and coordinated multidisciplinary case conference	An opportunity for an holistic informed approach to ongoing care for the resident. Should involve the resident, the resident's significant others, the GP, and at least two other health and/or care providers.	735 (15-20 mins)	$80.55
			739 (20-40 mins)	$137.75
			743 (>40 mins)	$229.65

Suggested timeframe	Medicare initiative	Activities	MBS Item	MBS Benefit 100% (as of 01/08/24)
4th month	Long patient consultation (Level D or E)	Attendance and consultation at the residential aged care facility with the purpose of managing palliative care and end-of-life care needs, discussing goals of care, advance care planning, or for completing an Advance Care Directive based on earlier discussions.	90051 (Level D: 40-60 mins)	$122.15
			90054 (Level E: >60 mins)	$197.90
6th month	Care plan contribution	Review of the resident's multidisciplinary plan	731	$80.20
8th month	GP-organised and coordinated multidisciplinary case conference	An opportunity for a 'real time' discussion of the resident's ongoing care involving the multidisciplinary team (GP + 2 others) and, where possible, the resident and the resident's family or significant others.	739 (20-40 mins)	$137.75
After 12 months	Repeat comprehensive medication assessment, case conferences and care plan contributions where clinically required.		As above.	

Based on information from: PHN North Western Melbourne. MBS remuneration to support planned palliative care for patients: A guide for health professionals working in general practice and residential aged care. Melbourne: NWMPHN; 2017 [cited 2024 May 27]. Available from: https://nwmphn.org.au/wp-content/uploads/2020/12/NWMPHN-Palliative-Care-For-GP-and-RAC5.pdf