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Five steps to prepare for Outcome 5.7

Follow these five practical steps to help your organisation deliver quality palliative and end-of-life care.

Step 1: Becoming familiar with requirements

Outcome 5.7 (Palliative Care and End of Life care) is a new responsibility in Clinical Standard 5. Use our checklist for action to keep your preparation on track. If you work in home care, read the Support at Home Program End of Life Pathway summary.

Step 2: Plan how you will address Clinical standard 5 and Outcome 5.7

Providers have specific responsibilities that are outlined in the standards. Our action roadmap details provider responsibilities and actions. Use the Evidence, education and clinical resources mapping document to find trusted resources on all the key care and service requirements in providing quality palliative care.

Step 3: Supporting a capable workforce

As a provider you need to make sure your staff are trained and aware of of what quality care at the end of life looks like. Getting started with palliAGED provides an overview of resources and actions you can take to develop your staff.

Step 4: Taking Care of your staff

Providing care to a person at the end of life can be challenging and distressing for staff. Tips for Supporting Staff provides suggestions for how organisations can build workforce wellbeing.

Step 5: Demonstrating how you are working with the requirements

Plan how you will document what you are doing to address the requirements of Clinical Standard 5 and Outcome 5.7. The Aged Care Safety and Quality Commission has guidance on their expectations. Being able to describe how you have established, implemented and monitor your systems and processes is important as are relevant policies and procedures.

Need more information visit palliAGED's Supporting Services section.

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Being prepared checklist: Palliative care and end of life

Being prepared means you need to plan and check on how you are going.
Self-assess what you already have in place and which items you may need to develop.

Activity or Process	Person responsible	Already in place	Need to develop
Decide on whether a specific role will lead the preparation or if you need a team to have all activities in place for the new requirements.			
Become familiar with the Strengthened Quality Standards and understand your provider category and responsibilities.			
Make sure your Board or owner is familiar with their responsibilities. Prepare a brief on palliative care and end-of-life care and how your service will manage responsibilities.			
Check your workforce capability, review education resources and develop a training plan.			
Establish what clinical care processes need to be developed or modified to address Outcome 5.7. Think about your current structure and processes.			
Make sure you are aware of your local specialist palliative care services and how your GPs can support end-of-life care.			
Set up a process for documenting palliative care training and implementing key care processes. Think about how to seek feedback from older people and their families			
Consider what data is already being collected for reporting. See if your clinical information system has end of life data points.			

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Support at Home: End-of-Life Pathway

The End-of-Life Pathway supports older people who have been diagnosed with 3 months or less to live and wish to remain at home by providing funding to access in-home aged care services. The aged care services complement services available under state and territory based palliative care schemes.

A total of $25,000 is available per eligible participant over a 12-week period.

Eligibility criteria

An older person is eligible to access the End-of-Life Pathway if they meet the following criteria:

- A doctor or nurse practitioner advising estimated life expectancy of 3 months or less to live, and
- Australian-modified Karnofsky Performance Status (AKPS) score (mobility/frailty indicator) of 40 or less.

The End-of-Life Pathway form will be available on the Department's website from 1 November 2025.

What if someone is already in the Support at Home Program?

The End-of-Life Pathway is available to participants already accessing Support at Home services as well as older people not currently accessing services.

Funding for the End-of-Life Pathway is discrete from other Support at Home classifications.

If eligible, existing Support at Home participants can transition from an ongoing classification to the End-of-Life Pathway via a high-priority Support Plan Review. The End-of-Life classification replaces the previous ongoing classification and a budget of $25,000 is allocated to the participant under the End-of-Life Pathway.

Planning Care

End-of-Life Pathway participants can access services from the Support at Home service list, determined on a needs basis in accordance with their high-priority aged care assessment or high-priority Support Plan Review.

A care plan should be developed for participants receiving services under the End-of-Life Pathway, in the same way as for ongoing classifications. The older person must also receive care management through a Support at Home provider, by a staff member known as a care partner.

Participant contribution arrangements apply for independence and everyday living services accessed under the End-of-Life Pathway.

The pathway period commences from the start date outlined on the Aged Care Entry.

How does someone exit from this pathway?

Exit from the End-of-Life Pathway may take place for one of the following reasons:

- the participant has passed away;
- the participant no longer wishes to, or is no longer able to, remain at home;
- the participant has a change in medical circumstances and services under the End-of-Life Pathway are no longer required;
- the period of funding for the End-of-Life Pathway has finished (maximum 16 weeks).

Where can I find out more?

The Support at Home program manual is a guide designed to assist registered providers to understand and comply with the Support at Home program rules, procedures and obligations. Section 14 deals with the End-of-Life Pathway.

The Aged Care Quality and Safety Commission has information on the reform agenda and all aspects of the pending changes.

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Action roadmap for Outcome 5.7: Palliative care and end-of-life care

Providers have three main responsibilities with respect to Outcome 5.7 of the Strengthened Aged Care Quality Standards:

- To recognise and address the needs, goals and preferences of individuals for palliative care and end-of-life care and preserve the dignity of individuals in those circumstances
- To ensure that the pain and symptoms of individuals are actively managed, with access to specialist palliative and end-of-life care when required
- To make sure that supporters of individuals and other persons supporting individuals are informed and supported, including during the last days of life.

What needs to be in place?

Five sets of processes need to be in place:

1. Processes to recognise the need for palliative care
2. Processes that facilitate end-of-life planning conversations
3. Care processes to plan and deliver palliative care
4. Processes for effective communication
5. Care processes that recognise and respond to last days of life

Continue for more detailed information of the five sets of process that you can follow.

Five sets of processes need to be in place:

1 Processes to recognise the need for palliative care that support the person approaching the end of life and respond to changing needs

- Use the palliAGED products to develop workforce capability around end of life.
- Embed risk prediction tools, trigger tools and questions that can indicate the person is entering the last months of life. Consider using the SPICT Tool (321kb pdf), The Surprise Question (SQ) (367kb pdf) and Stop and Watch.
- Palliative Care Needs Rounds are used in some residential aged care services. This Needs Rounds Checklist (399kb pdf) suggests end-of-life indicators.

2 Processes that facilitate end-of-life planning conversations, consider options and choices, and review advance care planning goals and documents

- Provide the older person and their families with information about end of life.
- Make use of Advance Care Planning Australia's resources and training to support conversation and determine how you will document and record discussions and decisions.
- Consider uploading advance care documents to MyHealthRecord where possible and agreed.

3 Comprehensive care processes to plan and deliver palliative care which is focused on comfort, dignity, and holistic needs of the older person

- Order the palliAGED Practice Tips for Nurses and for Careworkers to support staff who are new to aged care or to palliative care. Recommend staff complete the palliAGED Introduction Modules or embed them in your own Learning Management System.
- The palliAGED Evidence Centre provides a summary of palliative care evidence for practice on clinical and service issues in the aged care context. Issues are mapped to the strengthened standards.
- Download Outcome 5.7: Evidence, Education and Clinical resources (6.33MB pdf) for palliative care and end-of-life care to find evidence-based products and resources.

4 Processes for effective communication so the older person and family are aware of end of life and have access to loss and bereavement information

- Make use of the palliAGED products to develop skills in communication. Recommend staff complete the palliAGED Introduction Modules or embed them in your own Learning Management System.
- Provide or recommend the following resources to the older person and their family: Grief and loss for families booklet (5.34MB pdf), Grief Australia's My Grief App, CareSearch Older Australia.

5 Care processes that recognise and respond to last days of life, ensure medications are available to manage symptoms, provide care that supports the person physically and minimises undesired transfers to hospitals

- Prepare staff with information from the Terminal Care page to help them recognise signs of approaching death. Good communication is essential with the family, others in the care team, and health can services who may also be supporting the person.
- Adopting the Residential Aged Care End of Life Care Pathway (RAC EoLCP) can guide teams in delivering consistent, compassionate support.
- You can strengthen community-based end-of-life care support by making GPs aware of the Supporting a planned home death: The GP's checklist (309kb pdf).
- Ensure any advance care planning documentation is available if the person cannot communicate so their wishes can be respected.
- Make sure staff are aware of processes that need to be followed after a death.
- Consider use of the ELDAC After Death Audit to review end-of-life care in Residential Aged Care (655kb pdf) or HomeCare (655kb pdf).

Finding out more

More detailed information and additional resources to help you prepare for Outcome 5.7 can be found in the palliAGED Service Solutions section.

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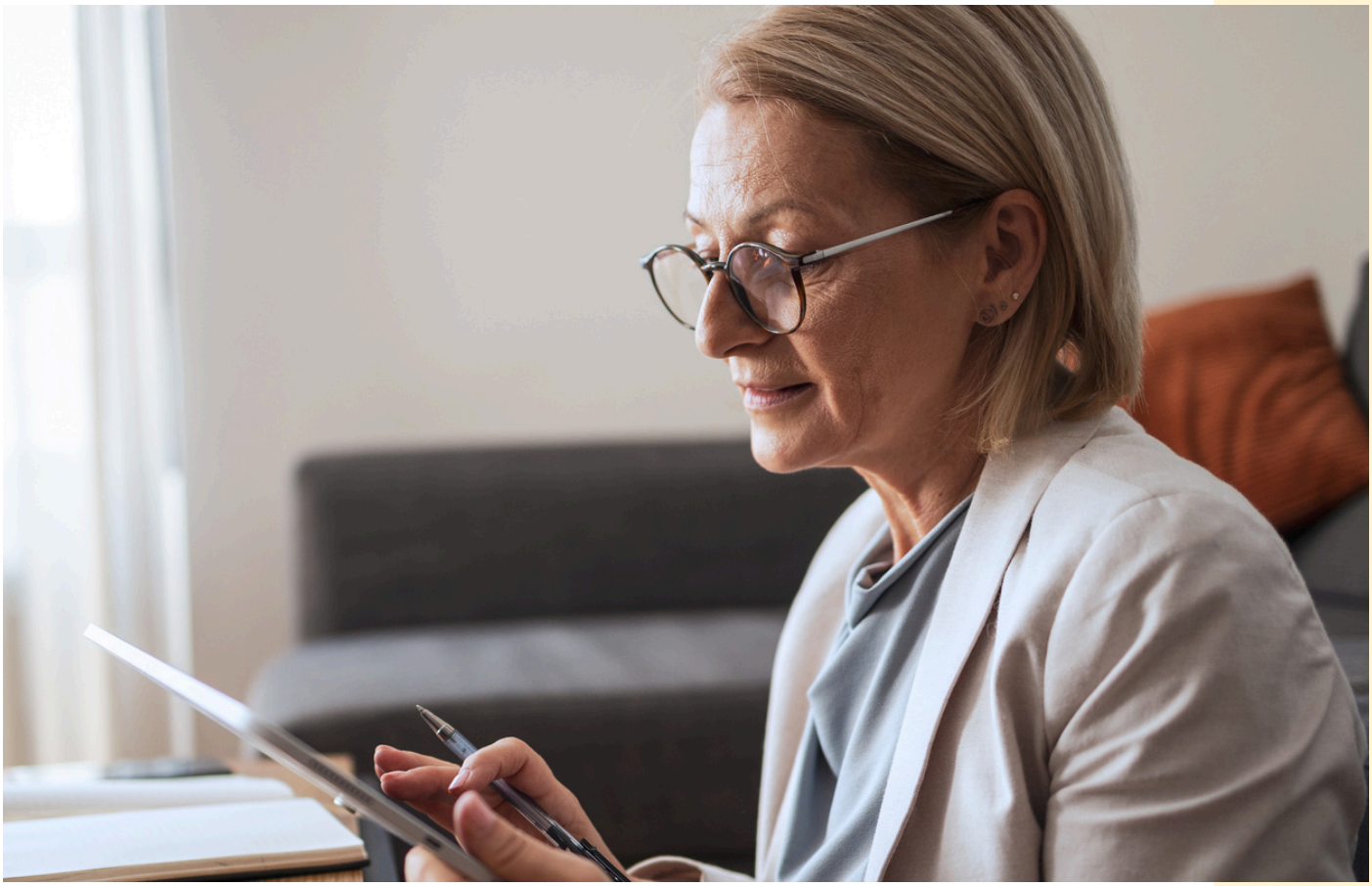

Outcome 5.7: Evidence, education and clinical resources mapping

Quality palliative care and end-of-life care relies on organisational processes and systems, workforce capability and culture, and proactive management and leadership.

The resources below have been mapped to aspects of palliative care and end-of-life care that have been acknowledged in Outcome 5.7 of the Strengthened Aged Care Quality Standards. These resources are free to access.

Contents page

Advance Care Planning

Advance care planning (ACP) involves discussions of preferences for future care, including end-of-life care. It does not always result in the creation of written documents but if it does, the documentation should be easy to find and written in a way that it is easy to enact.

- Read the palliAGED Evidence Summary: Advance Care Planning
- Read palliAGED Evidence Summary: Talking about End of Life
- The palliAGED Practice Tip Sheets give helpful guidance on supporting older people with ACP near the end of life - there is a version for nurses as well as careworkers
- Advance Care Planning Australia has courses and webinars and The Advance Project courses focus on ACP for people with dementia
- The ELDAC End-of-Life Law Toolkit provides practical information about the law at end of life for the aged care sector including ACP.

Bereavement

Grief is a deeply personal experience that varies for each individual.

- Read the palliAGED Evidence Summary Grief and Bereavement
- Read and share this booklet with families:
  When someone dies in residential aged care: Grief and loss for families
- You can provide family and friends with information about Grief Australia's My Grief App and share the CarerHelp factsheet When grief doesn't go away
- Remember that aged care staff can be affected by grief and bereavement. Download Organisational Tips: Supporting Staff Wellbeing (2.74kb pdf) for practical ideas on creating a supportive culture and preventing burnout.

Care environment

Care environments that balance privacy, safety, comfort, and social connection support dignity, emotional wellbeing, and meaningful interactions at the end of life. Consider any individual needs relating to culture or religious requirements. Look at how to support family and friends who may be visiting to say their goodbyes.

- Read the palliAGED Evidence Summary: Care Environment
- The National Aged Care Design Principles and Guidelines (6.9MB pdf) provide a comprehensive, evidence-based resource to guide accommodation design that support high-quality, safe, respectful and dignified care for older people.

Carers and families

Family and carers can still be closely involved with an older person living at home or in an aged care residence. Understanding the stress and concerns felt by carers is important.

- Read the palliAGED Evidence Summary: Talking About End of Life
- You can suggest the Older Australia section of CareSearch or CarerHelp as good online resources
- You can also order print copies of Resources for Families (474kb pdf) to share with family members
- You can check carer needs with the Carer Support Needs Assessment (CSNAT) or with the Needs Assessment Tool for Carers (NAT-C) (342kb pdf).

Comfort and dignity

Dignity is a core right in aged care and includes respect for an older person's autonomy and choices to foster a sense of self-worth, independence and participation in meaningful activities.

- Read the palliAGED Evidence Summary: Dignity and Respect
- Read and reflect on the Patient Dignity Inventory as a way of understanding the person
- Dignity in Care provides tools and practical ideas to support a culture of compassion and respect throughout the health and care system.

Complex needs

Care for older people is increasingly complex, with multimorbidity, mental illness, and dementia often coexisting and requiring coordinated multidisciplinary support.

- Read the palliAGED Evidence Summary: Advanced Dementia
- Read the palliAGED Evidence Summary: Multimorbidity
- Check the RACGP Silver Book section on Multimorbidity for practical guidance on care issues
- Consider a system for regularly assessing symptom burden and its impact on the person's quality of life - use tools like the: Instrument for Patient Capacity Assessment (ICAN) (334kb pdf) to understand care complexity
- Conduct a Residential Medication Management Review or the Home Medication Review for older people with complicated medication regimes.

Cultural safety

Culturally safe care ensures that older people from diverse backgrounds feel respected, valued, and free from discrimination in aged care settings.

- Read the palliAGED Evidence Summary Culturally Safe Care
- Make use of the Gwandalan Dillybag and learn how to work in a culturally safe manner with Aboriginal and Torres Strait Islander peoples
- The Indigenous Program of Experience in the Palliative Approach (iPEPA) has learning resources to develop palliative care capabilities for the Aboriginal and Torres Strait Islander health workforce and enhance the capacity of the non-Indigenous workforce to provide culturally-responsive palliative care
- caring@home has resources to support First Nations people and families receiving palliative care at home.

Education and training

Palliative care training prepares aged care staff to provide person-centred, holistic care, including symptom management, communication, and support for families and carers.

- Read the palliAGED Evidence Summary: Staff Education and Training
- Order palliAGED resources including Practice Tips for Nurses and for Careworkers
- For Educators and Managers looks at how to use the palliAGED suite of information and resources to support your staff and your service
- The National Palliative Care Program resources (3.09kb pdf) is a summary of resources in these projects relevant to aged care.

End-of-life care planning

Understanding a person's wishes early helps plan care, manage distressing symptoms such as pain effectively, and avoid unwanted and burdensome treatment that reduce quality of life. Effective communication and shared care plans prevent care gaps, reduce unnecessary hospital visits, and improve transitions between care settings.

- Read the palliAGED Evidence Summary: Talking about End of Life
- Read the palliAGED Evidence Summary: Care Coordination
- Palliative Care Case Conferences give everyone a chance to be on the same page - Case conference forms are available for residential aged care (1.29kb pdf) and for home care (1.29kb pdf)
- End-of-life discussions can be hard - SPIKES (72kb pdf) is a six-step protocol to help deliver bad news
- Visit the ELDAC End-of-Life Law Toolkit to review any legal concerns you may have about end-of-life care.

Evaluation and feedback

Providers through their governing body are accountable for the delivery of quality funded aged care services. A quality system is needed to enable and drive continuous improvement of the provider's delivery of funded aged care services.

- Read the palliAGED Evidence Summary: Quality Improvement
- Make use of data that is already collected for Quality Indicators and other reporting to understand your service performance
- Consider a quality improvement exercise to assess your end-of-life care activities
- Consider using the ELDAC's After Death Audit to review end-of-life care available for Residential Aged Care (655kb pdf) and Home Care (655kb pdf).

Identifying end of life

For some older people, recognising end of life may result from a new diagnosis or an exacerbation of an existing condition. This can be marked and signal the need for palliative care. Deterioration in older adults can also involve a slow decline in their physical and mental abilities. This can indicate they are nearing the end of life. Recognising these changes early is important for discussing care options.

- Read the palliAGED Evidence Summary: Recognising deterioration
- Review tools that can support early identification - consider the use of The Surprise Question (SQ) (367kb pdf), SPICT Tool (321kb pdf), and Stop and Watch in your service
- Both AN-ACC Class 1 and the End-of-Life Pathway in the Support at Home Program use Australian-modified Karnofsky Performance Scale (2.68MB pdf) to assess status
- Consider introducing palliative care needs rounds. Use this checklist (399kb pdf) to consider triggers for inclusion of the older person in a needs round discussion.

Last days of life

Care in the last days of life focuses on managing symptoms and supporting emotional, social, and spiritual wellbeing, ensuring comfort and dignity in a person's final days. It is guided by the individual's values and preferences, involving their families and carers to ensure a person-centred approach.

- Read the palliAGED Evidence Summary: Terminal Care
- Visit the ELDAC End-of-Life Law Toolkit to review any legal concerns you may have about end-of-life care
- Encourage GPs to download the CareSearchgp app which can be used in home care or a residential aged care facility
- Supporting a planned home death (309kb pdf) is an interactive checklist for GPs that can help in planning for a home death.

Medications including anticipatory prescribing

Palliative care medications play an important role in ensuring management of symptoms at the end of life. Anticipatory medications may need to be discussed.

- The National Core Community Palliative Medicines List identifies four medicines to manage common symptoms in the terminal phase for home-based patients requiring urgent symptom relief
- Review the Medication Management in Residential Aged Care Facilities for recommended parameters and procedures
- caring@home supports quality and timely end-of-life care for home-based patients with practical and evidence-based resources around medication management
- Implement screening of polypharmacy for older adults in Residential Aged Care (RAC) with multimorbidity. Consider using STOPP/START [Screening Tool of Older Persons Prescriptions/Screening Tool to Alert doctors to Right Treatment] or the Beers Criteria Medication List which includes considerations for older people (payment required to access this resource).

Multidisciplinary teams

The capacity to deliver comprehensive care at the end of life to older people depends on care teams. They may cross different services and funding arrangements. Establishing relationships with primary care providers including GPs, nurse practitioners and allied health professionals as well as state-based health services including palliative care services is critical.

- Read the palliAGED Evidence Summary: Care Coordination
- Review the CareSearch Primary Healthcare section on Multidisciplinary Teams which provides information on care responsibilities by role and remuneration avenues
- Consider applying for an ELDAC Linkages project which looks at how to enhance linkages between aged, primary and specialist palliative care providers.

Needs assessment

A needs assessment identifies physical, psychological, social, and spiritual needs that can be used to guide personalised palliative care. Validated tools help identify key needs early and guide referrals. Regular assessment should occur.

- Read the palliAGED Evidence Summary: Needs Assessment
- Simple clinical tools such as the Symptom Assessment Scale (173kb Word) can help assess specific symptoms causing concern
- The Palliative Care Needs Assessment Guidance gives details about assessment tools, prompt questions and how to use them
- The Prompts for End-of-Life Planning (PELP) Framework guides proactive, quality end-of-life care across all care settings.

Palliative care services

Palliative care services can be involved in providing care to older people. Generalist palliative care is provided by any healthcare professional as part of standard practice, while specialist palliative care is offered by professionals with specific training and expertise, often in the management of complex cases.

- To find a service in your local area go to Palliative Care Australia's National Service Directory
- Palliative Care Australia has developed National Palliative Care Standards for specialist palliative care and, the other, for all health professionals and aged care services
- Specialist palliative care can be accessed through a referral from your local doctor (GP), medical specialist or other health provider. In some states and territories, self-referral to palliative care services is possible.

Person-centred care

Person-centred care aligns care with an individual's preferences, values, and goals, promoting dignity and respect in aged care.

- Read the palliAGED Evidence Summary: Person-Centred Care
- Read the palliAGED Evidence Summary: Culturally Safe Care
- Recommend staff complete the short palliAGED eLearning module on Person-Centred Care or the Equip Aged Care Learning Modules which include a 10-minute introductory topic titled Person-Centred Care
- Review the Aged Care Diversity Framework initiative to ensure your service responds to the diverse needs of all older Australians in your care
- Make sure information about the person's values and wishes is recorded and can be accessed when needed.

Quality of life

Quality of life considers the older person's perception of their position in life, taking into consideration their environment and their goals, expectations, standards, and concerns. It includes their emotional, physical, material, and social wellbeing. Quality of life still needs to be considered in the context of end of life.

- Read the palliAGED Evidence Summary: Person-Centred Care
- Read the palliAGED Evidence Summary: Dignity and Respect
- Read the palliAGED Evidence Summary: Culturally Safe Care
- Quality of life relates to the older person's perception. Resources such as What Matters Most for Older Australians discussion starters or the Care Companion Toolkit remind us of care in the context of the person.

Spiritual, cultural and psychosocial needs

A comprehensive approach to care considers emotional, cultural, social and spiritual aspects that influence a person's health and functioning.

- Read the palliAGED Evidence Summary: Psychosocial Care
- Read the palliAGED Evidence Summary: Spiritual Care
- The CareSearch Diversity section helps users to find culturally appropriate resources in palliative care
- The HOPE Spiritual Assessment Tool can be used by health professionals to explore people's spiritual beliefs, practices, and needs near the end of life
- ConnecTo is a tool adapted by Meaningful Ageing Australia to identify spiritual strengths and capacities, and spiritual weaknesses and vulnerabilities (not restricted to religion, requires payment).

Symptom management

Older people may experience one or more symptoms associated with their conditions or treatments. They can be distressing for the person and their family and friends.

- Visit the palliAGED Evidence Summary: Symptom Management which deals with anxiety, appetite problems, constipation, delirium, depression, dyspnoea, fatigue, nausea, pain, respiratory secretions, and sleeping problems
- Download palliMeds and the CareSearchgp app for point-of-care access to end-of-life prescribing
- The Medication Management pages in For Pharmacists to review pharmacists professional services, the rationalisation of medicines and care in the last days of life
- caring@home and CarerHelp provides resources for carers on symptoms and medication management.

Workforce wellbeing

The capacity to deliver quality care at the end of life relies on the aged care workforce. Providing end-of-life care can be challenging for staff.

- Read the palliAGED Evidence Summary: Workforce Wellbeing
- Visit the ELDAC Self-care room and learn self-care approaches to increase wellbeing and find resources to cope with death/dying
- Consider implementing this palliAGED resource: Organisational Tips for Supporting Staff Wellbeing (2.74kb pdf).

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Getting Started with palliAGED products

When you are looking to improve palliative and end of life care, it can be hard to know where to get started. palliAGED resources are built on research evidence and have been developed with input from the sector. Trusted resources can make it quicker for you to support training in your service or to look at how else to develop your service as a manager. Use our question list to identify the issue and we will connect you to the right resources.

Meeting your needs ...

As an educator

How can I introduce new staff to basic concepts in palliative care?

- Start with the palliAGED Introductory Modules
- Direct them to Improving My Care in palliAGED

What are the best resources to have for staff induction?

- Practice Tips for Nurses and for Careworkers
- Select and order palliAGED packs for your staff

Where can I send more experienced nurses for clinical information?

- Suggest they download the palliAGEDnurse app
- Direct them to palliAGED's Evidence Centre
- Remind them about the CareSearch Nurses Hub and the Evidence Summaries

What can I use for in house training activities?

- Use the palliAGED forms to discuss care processes
- Play an Education on the Run video and discuss

What resources do you have for GPs?

- For GPs provides basic practical guidance
- Suggest they download the CareSearchgp App

As a manager

What can I use to create evidence informed guidance and palliative processes?

- Start with the evidence in the palliAGED Evidence Centre
- Make use of palliAGED's Forms for your practice

What do I need to think about for the Standard 5 and Outcome 5.7?

- Visit palliAGED's Understanding the Standards page
- Download Outcome 5.7: Evidence, education and clinical resource mapping (769kb pdf)

Where can I find trustworthy information to share with older people and families?

- Check out the Resources for Families page in palliAGED
- Order palliAGED's Where can I find information brochure to share
- Suggest families visit the Patients and Carers section and Older Australia in CareSearch

How can we organise palliative care case conferences?

- You can make use of a pack of case conference forms for home care and for residential aged care

How can I support change in my organisation?

- The Supporting Change section has information on change processes and tools to get you started

CareSearch is a palliAGED partner project and has extensive palliative care resources.

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Organisational Tips: Supporting staff wellbeing

While staff find meaning and value in their work in aged care services, they can also feel pressures. Some stresses arise from individual characteristics and circumstances while others can result from organisational practices and processes. Burnout contributes to staff turnover.

Caring for people coming to the end of their life or who are dying can be an additional source of sadness and distress. This is, however, an important part of aged care. Below we have put together a series of ideas that organisation can implement to support their workforce.

Tip 1 Let's talk about it

Provide opportunities for staff to talk about moral distress or ethical concerns. Aged care workers come from many different backgrounds and can have different cultural or religious perspectives. Getting together to talk about how the team felt about a recent death can provide you with important insights into concerns or worries.

Tip 2 Check in

Check in with those who provided care at end of life to an older person living in your facility or who was receiving care in their home. Acknowledging the loss is validating. It is also a good way to see if the staff member felt comfortable and confident in their skills.

Tip 3 Sort out formal Employee Assistance options

If you have an Employee Assistance program, make sure staff are aware that it is available. Early engagement can help them recognise and manage their sense of grief and loss. Make a list of groups providing support to health and aged care professionals.

Tip 4 Make sure workloads are okay

Work conditions can contribute to burnout in aged care. This can be too much work and too many time pressures. It can also be about the feeling that the staff member did not have the time or skills to provide the care they would have wanted.

Tip 5

Build your teams

Your staff work in teams, and their work team is generally the first point of contact when someone is distressed. Be flexible if someone needs a bit of time and support to manage their feelings.

Tip 6

Acknowledge what they do

Providing care to someone who is dying requires human engagement. As well as considering formal reward systems, make sure you respect, value and care about your teams. Remember your staff represent your service.

Tip 7

Help them grow

Give staff the chance to develop their knowledge and skills. Support them when they are providing end-of-life care for the first time. Offer opportunities for them to learn more.

Tip 8

Encourage self-care

Suggest staff visit the ELDAC Self-Care Room or consider completing palliAGED's Self-care plan. Self-care encourages them to be active in monitoring their personal wellbeing at the same time you are providing a supportive and responsive employment environment.

Finding out more

palliAGED: There is an evidence summary on Workforce Wellbeing that summarises current evidence.

ARIIA: The Knowledge and Implementation Hub has an aged care theme on Staff Burnout.

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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: