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Practice Tips for Nurses in Aged Care



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PALLIATIVE CARE AGED CARE EVIDENCE

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**Decision-Making
& Communication**

Tips for Nurses: Advance Care Planning



What it is: Advance care planning (ACP) is where a person plans for their future care by discussing and/or recording their preferences and values. An advanced care directive (ACD) is a written advance care plan. In different states and territories of Australia an ACD may have a different name. An ACD may include care preferences and values, and instructions about future treatment. What can be included and the forms to be used depends on the relevant state or territory law.

An older person can name someone to make decisions for them about health and personal care if later they are unable to. This person is called a substitute decision-maker (SDM). Some states and territories include this in an ACD.

An ACD is sometimes known as a living will because it is completed and signed by a competent adult and records their preferences for the future.

Why it matters: Advance care planning helps people receive the care that they would wish to receive. Nurses have a role in ensuring ACDs are referred to when planning care. It is particularly important for an older person who may:

- have advanced illness
- have multiple chronic illnesses
- be frail
- have cognitive impairment or live with dementia
- have unplanned admission(s) to hospital
- lose the capacity to make decisions or express their wishes.

What I need to know: It is not compulsory to have an ACD. ACDs only go into effect when a person is unable to make decisions for themselves. They do not replace the SDM.

A person may choose to forgo treatment. This is not giving up nor does it mean that care will stop. It means the focus of care will be on comfort, dignity and the support of the person and their family and carer(s).

Actions

ACDs can be changed whenever the person wants and should be reviewed when circumstances change. 'We had a conversation where we decided on A, B and C, is that still current and what you want? If so, are you happy to record these changes so that they can be referred to if you cannot express your wishes?'

An assessment of capacity may be needed. This should occur at a time of day when the person is most likely to understand and when they are free of pain or other distressing symptoms. This assessment is usually made by the person's GP.

A person is considered competent or to have competency or have capacity if they can:

- understand the information
- retain information long enough to indicate their wishes, and
- express their wishes.

Remember to:

- store ACDs safely
- have ACDs accessible to staff who make decisions about care
- have ACDs accessible to visiting service providers including GPs
- make sure that a current ACD accompanies the older person moving to or from hospital or residential aged care.

Have clearly documented and accessible the contact details of the substitute decision-maker and person to contact in case of an emergency or death. These may not be the same person. Be clear about who you should contact.

Tools

Visit Advance Care Planning Australia for state and territory forms and information on requirements.

Name:

My reflections:

How many of the older people I care for have an ACD? Where are they kept, and have I read them?

When should I implement an ACD?

What is the ACD legislation in my state/territory?

Have I thought about advance care planning for myself or my family?

My notes:

See related palliAGED Practice
Tip Sheets:
After-Death Choices
Palliative Care
Talking about Dying

For references and the latest version of all the Tip Sheets visit
www.palliaged.com.au/Practice-Centre/For-Nurses

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Tips for Nurses: After-Death Choices



What it is: Planning and managing what happens after the death of an older person.

Why it matters: The person may have expressed their wishes in an advance care directive (ACD). Some decisions may also need to be taken by members of the family. Planning can help with a healthy grieving process and nurses can refer to the person's ACD in support of this.

What I need to know: Before a body can be moved the death must be verified. Once the death has been verified, a funeral company can take the body into their care. Consider any cultural practices that may be important to the person and their family.

There may be requirements for reporting a death to the coroner. Relevant legal requirements are not the same across Australia. It is important to know what is required in your state/territory.

All relevant people need to be advised about the death and consulted as to actions following the death.

Income support may be available to spouses or carers through the Bereavement Allowance, Bereavement Payment or Pension Bonus Bereavement payment. See Department of Human Services.

Some people may decide to donate their body or brain to medical science or research. Written consent is needed from the person before their death. This may appear in the person's ACD. If not, the family may need to decide and provide written consent.

A body donation may be refused if:

- the person had a certain infectious illness
- it is not feasible or possible to transport the body within 24 hours
- the donation facility is full
- the person was very thin and weak.

It is important that the doctor is aware of a person's intention to be a donor. Contact the university, research or pathology service without delay regarding body or brain donation.

Actions

Include in the care plan details of actions that care staff will need to take at time of death including contact details for donor organisations (if relevant).

The RN needs to ensure that all relevant people (including GPs, home/community nurses and services) have been consulted and all special needs at the time of death have been attended to.

The body of the client or resident needs to be verified as dead by an authorised person, and a certificate signed to officially confirm the death.

You can use the Residential Aged Care End of Life Care Pathway (RAC EoLCP) for residents to guide care delivery.

Be aware of possible needs including religious and cultural practices following death, and time needed for the family to be with the deceased.

It is important that any medicines are disposed of safely, often returned to a pharmacy.

Family members may:

- need time to accept the death
- need time to travel to the site of death
- want to sit with the deceased person
- want to respect certain traditions
- need help to cancel any health appointments or arrangements.

It is important to have a plan in place, because if an authorised person is not available to verify a death, then the police need to be called and the coroner involved.

Name:

My reflections:

Does my organisation have a clear policy on procedures following the death of a client or resident?

Does my organisation have post-death rituals or memorial practices?

How can I recognise if a death of a client or resident has significantly affected a member(s) of my team?

My notes:

See related palliAGED Practice
Tip Sheets:
Advance Care Planning
End-of-Life Care Pathways
Grief and Loss among Older
People, Families and Residents

For references and the latest version of all the Tip Sheets visit
www.palliaged.com.au/Practice-Centre/For-Nurses

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Tips for Nurses: Case Conferences



What it is: A palliative care case conference is a meeting held between the older person (if able to attend), their family and their legal substitute decision-maker (SDM), and members of the care team including the doctor to assess care plans and clinical care needs.

Why it matters: They can be a useful way to:

- help the person and family members to understand the goals of care
- discuss options for future care
- share information
- help families to deal with distress
- assess relevant options and choices in the case of an emergency
- check if there is an advance care directive (ACD)
- check if the ACD needs to be updated.

What I need to know: Clear communication is an essential part of good aged and palliative care.

Palliative care provides physical, social, spiritual and psychological care. A multidisciplinary team including allied health can help to meet these varied care needs. A person's needs may frequently change. This means that decisions need to be made about treatments that include the wishes of the person and the needs of the family. It is helpful and important that the SDM and/or support person is aware of these decisions.

Family meetings or case conferences can be a comfortable way to:

- ask questions
- discuss issues
- make decisions.

Knowing who you can share client or resident information with is important.

Talking through issues in a case conference may stop them from becoming major issues. This way, emergencies or crises can be avoided.

Staff in residential aged care facilities often meet with families to discuss routine care of residents.

Actions

Holding a case conference can assist with communication between the person receiving care, substitute decision-maker(s), key family members, and the care team.

The aim of the case conference is to:

- discuss issues and identify unmet needs
- raise concerns about the person's condition
- review the person's ACD
- agree on clear goals for the person's future care
- support families.

Clearly record the organisation and content of the case conference.

Case conferences are held when the older person's health status is changing, they are also held when death is expected within days. Look out for and report any changes in a person's mood, ability to function, swallow, move, breathe etc.

Knowing who you can share client or resident information with is important.

Family meetings differ from case conferences. Family meetings focus on the person and their family's needs and preferences to establish goals of care.

Tools

If organising a case conference, use of standardised forms can be useful to document activities and decisions. Check if your organisation has a preferred set of forms.

Name:

My reflections:

When I last met with a family to discuss changes in a client or resident, who gave me current information about the person?

What are the triggers for a case conference?

Does a member of my team have skills in conducting case conferences?

My notes:

See related palliAGED Practice
Tip Sheets:
Advance Care Planning
Continuity of Care
Palliative Care

For references and the latest version of all the Tip Sheets visit
www.palliaged.com.au/Practice-Centre/For-Nurses

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Tips for Nurses: Continuity of Care



What it is: Continuity, coordination and transition of care are part of providing quality care to older adults at the end of life. Continuity refers to the exchange of knowledge between carers, the person and health professionals so that care is not interrupted or compromised.

Continuity of care has three main parts:

1. The care provider knows and follows the care of the older person.
2. There is good exchange of relevant information between different care providers.
3. Different care providers cooperate so that care is connected care.

Why it matters: Continuity of care helps care providers to be aware of a person's preferences and care needs. It also helps with the smooth coordination of a person's care. It is particularly important for the care of a person who may be at the end of life. It also helps care providers to have the information they need so that the person's choices are respected.

What I need to know: Continuity of care can:

- avoid unnecessary hospitalisations
- ensure the older person receives uninterrupted care based on their needs
- make sure that important treatments continue when a person is moved to or from a care setting (home, hospital, residential aged care)
- make sure that a person's preferences and needs are considered
- regular meetings between team members and with the family helps to maintain a good level of communication.
- transition between acute care and home/ residential aged care (RAC) should include early discharge planning with advice for self-care, medications, and community support as appropriate.

Actions

Document the person's goals of care and regularly review these as a person's care needs change.

Prepare plans for managing exacerbations of their health condition. Also review the person's advance care directive (ACD).

Clarify your role in the palliative care team and how you will stay 'in the loop' with care planning.

Make certain that all care providers understand the goals of care for the older person.

If you identify signs of imminent death communicate the person's end-of-life stage to the GP.

Ensure that all appropriate documents accompany a person when transferred between care settings.

Tools

Continuity of care can be supported by use of an end-of-life care pathway such as Residential Aged Care End of Life Care Pathway (RAC EoLCP).

iSoBAR is a structured mnemonic tool that provides a framework for communicating the minimum information needed at handovers.

Name:

My reflections:

What processes are in place in my organisation that assist continuity of care?

My notes:

See related palliAGED Practice
Tip Sheets:

Advance Care Planning

End-of-Life Care Pathways

Talking within the Aged Care Team

For references and the latest version of all the Tip Sheets visit

www.palliaged.com.au/Practice-Centre/For-Nurses

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Tips for Nurses: Culturally Responsive Care – Communication



What it is: Culture describes the beliefs and behaviours that are part of relationships within social groups including families.

Culturally responsive care pays attention to the social and cultural characteristics of people from culturally and linguistically diverse (CALD) backgrounds.

It is a form of person-centred care and effective communication is a key element.

Why it matters: Health care that respects a person's cultural and spiritual heritage can positively impact overall health and wellbeing. Nurses and care providers can directly influence how care is provided.

The Aged Care Quality Standards require that people are treated with dignity and respect, and that their identity, culture, and diversity are valued.

What I need to know: Approximately one in three older Australians were born outside Australia. One in five were born in a non-English speaking country.

Almost two in five people over 65 years of age who do not speak English at home are not proficient in spoken English.

Across cultures, what is normal to one person may not be normal to another person. This may also be true for people within the same cultural group or even the same family. The only way to know is to ask.

Providing culturally responsive care at the end of life requires:

- nurses to be aware of the influence of their own cultural beliefs on their practice
- sensitivity to the cultural practices and beliefs of others
- staff with training and skills in culturally safe practices
- organisational recognition and support for cultural diversity among residents and staff.

Actions

Build rapport and trust:

- always introduce yourself
- listen actively
- do not be judgemental
- show empathy
- show respect.

Ask the person about their specific needs as an individual.

Ask what the illness means to the person and to the family.

Remember that a person may prefer that another family member or community member is with them whenever possible and/or to speak on their behalf.

You can begin the conversation by asking 'Are there religious or cultural practices that affect the way you wish to be cared for?'

Be open and ask the older person:

- how they would like to be called
- what is appropriate physical contact
- what special days are important to them
- what food is culturally appropriate for them.

Be conscious of male/female physical contact; there are rules about what part of the body you can and cannot touch.

Where possible, in conversations involving issues of significant information use professional interpreting services (not family) with residents for whom English is their second or subsequent language.

Name:

My reflections:

How many of the people I care for speak a language other than English? How many of the people I work with speak a language other than English?

What are some of the ways that help me communicate well with people from a CALD background?

When an older person in my care speaks a language other than English how do I arrange for an interpreter?

My notes:

See related palliAGED Practice
Tip Sheets:
First Australians - Communication
People with Specific Needs
Person-Centred Care

For references and the latest version of all the Tip Sheets visit
www.palliaged.com.au/Practice-Centre/For-Nurses

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Tips for Nurses: End-of-Life Care Pathways



What it is: A care pathway is a tool which outlines what is recognised as best practice for a certain disease or condition with an expected course. A care pathway guides and monitors a person's journey of best practice care between health professionals and across sectors. End-of-life care pathways can help prompt terminal care and encourage discussion with the person and their family.

Why it matters: Care pathways aim to:

- prompt and guide clinical decisions
- improve the timeliness of the start of care
- improve the consistency of care between different professionals
- reduce the risk of errors
- prevent unnecessary emergency treatments
- streamline care and therefore may reduce costs
- give confidence that the right care is being provided.

For long-term or chronic conditions, care pathways can guide healthcare professionals on when and/or how to:

- start treatment
- follow-up
- monitor change
- check for and monitor complications
- refer to other health professionals.

What I need to know: Care pathways differ from care plans. Care plans are based on the needs and preferences of an individual, and on the services available. advance care directives should be included in planning.

Understanding the most common plans and pathways, and factors that influence these transitions can help medical practitioners and others to inform and advise older Australians who are:

- about to start using aged care services
- already using the aged care services.

Actions

End of life pathways guide terminal care. Recognising deterioration or signs of imminent death in the final days or weeks of life is critical.

Care pathways are based on available guidelines and evidence. They support clinical judgement but do not replace it.

When implementing a care pathway, remember to discuss it with the person and their family, and ensure that GPs and relevant staff are aware of this change. Discuss any changes or concerns and remember that **a person can come off a pathway**.

A care pathway represents the ideal way to manage people with a specific problem or long-term condition.

A care plan is based on the individual, and on the services available.

Care pathways use documents, sometimes flowcharts, to outline the steps of care to be followed by members of multidisciplinary teams.

Good communication within the care team and between the team and the person and their family is essential so that the person and the family understand the benefit of the care pathway.

Tools

The Residential Aged Care End of Life Care Pathway (RAC EoLCP) – this tool guides the provision of good quality terminal care in residential aged care. It includes guidance on comprehensive planning, delivery, evaluation and documentation of terminal care.

Name:

My reflections:

How do care pathways and care plans differ?

When was the last time I used a care pathway for an older person, and how did this improve care?

My notes:

See related palliAGED Practice
Tip Sheets:
Advance Care Planning
Case Conferences
Continuity of Care

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Tips for Nurses: First Australians – Communication



What it is: Appropriate care for Aboriginal and Torres Strait Islander peoples is person-centred and meets their needs, expectations, rights, and those of their family. Cultural safety further provides people with power to influence care and support positive patient-centred outcomes. Communication is central to providing safe and appropriate care.

Why it matters: Aboriginal and Torres Strait Islander peoples have high risk of life-limiting conditions including cardiovascular, kidney and respiratory disease, and dementia. Communication with nurses supports the person and their family to influence care decisions.

What I need to know: For Aboriginal and Torres Strait Islanders, 'family' members may not be related by blood but be related through traditional kinship or cultural groupings.

If an Aboriginal or Torres Strait Islander patient is close to death, it is important that they do not die alone. Family presence is culturally important.

Building good relationships is important. Listen more than you speak. Introduce yourself and begin by simply 'having a yarn'.

Post-death practices or requirements will differ across communities. If these are not met, there can be significant cultural consequences and distress caused to the family and the community. If an Aboriginal or Torres Strait Islander person dies away from country, it is important to have the details of the correct family member who plans to escort the deceased back to country.

Acceptable terms to describe Aboriginal and Torres Strait Islander peoples are Aboriginal person, Torres Strait Islander person, and First Australian.

Actions

Ask the person if they want to hear information about what is happening now; or whether they prefer you to talk to family members instead.

Ask who has the right and obligation to make decisions on behalf of the person; this may not be the 'next-of-kin'.

You might like to ask:

- 'Are there cultural or spiritual practices that affect the way you wish to be cared for?'
- 'How can I provide the best care for you?'
- 'Are there other people that should be included in talks about your health care?'

Tips for talking together:

- check the person's understanding of what you're saying
- don't be too direct as this may be seen as confrontational and/or rude
- some people culturally avoid eye contact, even if they're not looking at you they may still be listening
- deal in practical, real issues, not uncertainties
- talk about what is happening now rather than the future or past
- avoid questions requiring a 'yes' or 'no' answer
- be a listener more than a speaker
- take time to build relationships.

Tools

The Kimberley Indigenous Cognitive

Assessment - a culturally sensitive tool developed to access the cognitive function of older Aboriginal people living in rural and remote areas.

Name:

My reflections:

When I first meet with an older Aboriginal or Torres Strait Islander person what could I do to make them feel comfortable?

What should I remember when talking with First Australians?

My notes:

See related palliAGED Practice
Tip Sheets:
Culturally Responsive Care –
Communication
People with Specific Needs
Person-Centred Care

For references and the latest version of all the Tip Sheets visit
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Tips for Nurses: People with Disability - Communication



What it is: Here we refer to people with an intellectual or developmental disability or limited communication ability.

Why it matters: An increasing number of older people with an intellectual disability have co-morbid conditions or advanced illnesses requiring palliative care.

Language and communication skills vary between people with an intellectual disability hence care needs to be taken to understand each other as much as possible.

What I need to know: In some cases, people with an intellectual disability may be admitted to residential aged care because of:

- ageing carers or death of a family carer
- supported care, independent living or community services no longer meeting care needs
- lack of appropriate local services or accommodation.

Older people with an intellectual disability:

- have high rates of illnesses like epilepsy, diabetes, and heart disease
- may have difficulty with communication, both in understanding and speaking
- are likely to experience premature ageing
- experience high rates of depression and dementia
- are likely to have difficulties with hearing, vision, mobility, and stamina
- may find that standard aged care or usual activity programs do not meet their needs
- may have difficulty accessing specific disability services in an aged care facility.

People with Down syndrome are at risk of developing Alzheimer's disease at a younger age, hypothyroidism, loss of vision, loss of hearing, arthritis, instability of the neck joint leading to pain and spinal cord damage and in women, early menopause.

Actions

Always give the person your full and complete attention and make sure you introduce yourself and let the person know why you are there. Do not talk over the person as though they are not there.

Look at the person and not the disability.

Establish communication needs and preferences for the person. Ensure a communication assessment has been completed. A speech pathologist may be able to assist.

Give clear and simple information. Use language that fits with the person's communication level.

Use pictures and diagrams to clarify explanations if this is an appropriate way to communicate with the person.

Tools

Disability Distress Assessment Tool (DisDat)

Talking End of Life with people with disability (TEL) – includes education modules and information on person-centred thinking tools to establish a better understanding of the person's needs, likes, relationships and mood signals.

Name:

My reflections:

What could I do to better understand a person with intellectual disability?

Have I ever used childish language to speak with older people with intellectual disability?

My notes:

See related palliAGED Practice
Tip Sheets:
People with Specific Needs
Person-Centred Care
Talking about Dying

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Tips for Nurses: Person-Centred Care



What it is: Person-centred care reflects the related concepts of dignity, worth and human rights. It sees care providers listening and responding to the needs and preferences of those in their care. In this way, person-centred care supports quality of life and enables people to live a meaningful life based on what they value.

Why it matters: Person-centred care is a key element of many national guidance documents including the Aged Care Quality Standard and the Aged Care Diversity Framework. Quality care is more than good symptom control and emotional support. It includes assisting the older person to live well and maintain self-determination, relationships, and social connections as their dependence on others increases.

What I need to know: Palliative care focuses on quality of life and includes dignity, respect, compassion and valuing the whole person.

Person-centred care:

- acknowledges uniqueness and individuality in care coordination and planning, and through shared decision-making and communication
- shows empathy and respect
- is professional care that respects autonomy, dignity, privacy, relationships, and the rights of the person
- identifies strengths and positive aspects, rather than weaknesses and problems
- has a holistic focus that acknowledges the person's lived world and what they and others important to them value about their life.

Helping people retain dignity as they die includes:

- symptom control
- psychological and spiritual support
- care of the family.

Language and terminology are very important.

Actions

Always greet the person and introduce yourself. Let them know why you are there. Ask their permission to interact with them, provide care or undertake any procedure.

Always give the person your full and complete attention.

Respect a person's need for privacy.

When speaking with the person try to be seated at the person's eye level when possible.

Address people by their preferred name and avoid pet names or generic terms like 'love' or 'dear'.

To promote a sense of dignity, value people as the person they are, rather than just the illness they have.

Ask questions such as:

- 'What should I know about you as a person to help me take the best care of you that I can?'
- 'What are the things at this time in your life that are most important to you or that concern you most?'
- 'Who else should we get involved at this point, to help support you through this difficult time?'

Implementing a person-centred approach to care is more likely to succeed when management demonstrates a person-centred approach to staff.

Name:

My reflections:

What can I do when speaking with an older person that would make them feel valued and listened to?

What situations have I observed that have not been person-centred or preserved dignity?
What could I do to improve things, so this doesn't occur again?

My notes:

See related palliAGED Practice
Tip Sheets:
Advance Care Planning
Case Conferences
People with Specific Needs

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Tips for Nurses: Quality of Life with Change and Deterioration



What it is: Quality of Life (QoL) is a person's perception of their life in the context of their health, culture, and values and in relation to their goals, hopes, fears, values, and beliefs. So, QoL will mean different things to different people. It often includes:

- feeling valued and respected
- being comfortable and pain free
- being able to socialise or spend time with loved ones
- having as much independence as possible
- not feeling like a burden
- feeling emotionally well and supported.

Why it matters: QoL is central to palliative care. Across the course of life-limiting illness, support to live well while adapting to functional decline is about QoL.

The Aged Care Quality Standards also emphasise QoL.

What I need to know: To assess QoL, you need to know what issues are of most concern to the person at the time. Where possible, the older person should rate their own experiences. Family and health professionals may not always rate these the same.

Older people can experience deterioration in QoL as their disease progresses. Often this reflects changes in their ability to complete daily activities or to socialise and form relationships with others. Changes in QoL may be slow with diseases like dementia that progress slowly (over a long period).

Others may not register a change in QoL. Their goals and expectations may adapt to what is currently possible.

Actions

Regularly ask what is currently important to the older person and their family.

Use ongoing assessment with a validated tool for QoL.

Engage with the older person to set individual goals and support them with activities that are meaningful to them.

Provide families with information about changes.

Help the older person to stay connected with family and friends.

If language is a barrier try to match them with staff who speak their language.

Assist them to maintain their spiritual perspectives and spiritual connections.

Encourage them to remain active with tasks that they can manage. Adapt personal interests and activities as functional abilities change.

If tasks become more difficult, help rather than doing it for them.

Tools

ICEpop CAPability Index for Older people (ICECAP-O) measures five dimensions (attachment, security, role, enjoyment, and control)

Quality of Life - Aged Care Consumers (QOL-ACC) instrument, visit www.qol-acc.org/

Name:

My reflections:

What tools are used in my organisation to measure QoL?

How often do I re-assess what is important to the people I care for?

My notes:

See related palliAGED Practice
Tip Sheets:
People with Specific Needs
Person-Centred Care
Recognising Deterioration

For references and the latest version of all the Tip Sheets visit
www.palliaged.com.au/Practice-Centre/For-Nurses

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Tips for Nurses: Supporting Families



What it is: Family can still be unprepared for decline and death even when the older person is becoming frailer and less active. They need support to understand what is happening (including what happens as a person is dying), share experiences, make care decisions, and cope with loss.

Why it matters: Supporting carers and family members is part of palliative care. It acknowledges the older person's life and connection with family as being an important part of who they are. It recognises the physical and emotional support and assistance that family members provide.

What I need to know: Carers often look to health professionals to help them understand the disease, symptom management, and end-of-life care planning. Frequent, short conversations with small amounts of information may be helpful.

Family members can also experience many emotional issues that they need your help with including:

- guilt and/or relief if they can no longer manage care at home and an older person needs to move into residential aged care
- sadness and distress at the person's deteriorating condition
- anticipatory grief in response to impending death
- grief due to death of a loved one, an end to their role as carer, and changes to their daily routine
- distress from a sense that:
 - the person's dignity and identity are not being maintained
 - they are not seen as a partner in providing care
 - carers are 'cold' and 'clinical'
 - not enough care is being provided.

It can help if you welcome family as partners in providing care and acknowledge their understanding of the older person.

Actions

Reassure family that you care:

- Be available to talk and actively listen to the older person and their family.
- Establish a trusting relationship with the older person and treat them with respect.
- Support the older person's dignity by attending to essential and spiritual care needs. This includes attention to physical appearance and involving them in making daily choices.

Identify the substitute decision-maker and the key contact. Establish regular communication with them and notify them of changes in health or to care.

Frequently provide small 'chunks' of clear and honest information about the person's condition and any deterioration. Be sensitive and show empathy, but do not give false hope.

In family discussions, check what they have understood. Refer to previous discussions and confirm continuing appropriateness. Invite family to actively participate in family meetings and case conferences. Ask for their perspective about what they are seeing before offering your own.

Acknowledge:

- grief that starts before death
- cultural needs of the person and family.

Tools

Carer Support Needs Assessment Tool (CSNAT)

Carers' Alert Thermometer (CAT)

Needs Assessment Tool for Carers of People with a Chronic Condition (NAT-CC)

Visit CarerHelp for resources for carers.

Communicating with families - a training video from the Education on the Run series

Name:

My reflections:

Would my family members be happy to receive the level of care I provide to the older people I care for?

What do I do to support relatives of people in my care? What guides my choices?

My notes:

See related palliAGED Practice
Tip Sheets:
Grief and Loss among Older People,
Families and Residents
Psychosocial Assessment
and Support
Talking About Death and Dying

For references and the latest version of all the Tip Sheets visit
www.palliated.com.au/Practice-Centre/For-Nurses

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

Tips for Nurses: Talking about Dying



What it is: Talking about death and dying can be challenging for everyone involved. It can be difficult to tell someone that care will be about comfort, not cure.

Why it matters: These conversations can help the person and their family to make decisions about future care and improve the care that the person receives. Many people may know or suspect that they are dying. Acknowledging that a person is dying allows them to express their fears and concerns. Nurses can provide support and information and explain any changes in care.

What I need to know: Cultural considerations may influence how and if talking about dying is appropriate. Acknowledging the role of family and talking with the family can improve the care of the person, their family and carers.

Effective communication:

- allows staff to identify individualised needs and to provide individualised care
- may reduce agitated behaviour in older people with impaired cognition
- requires specific skills that can be developed with training.

When talking about a person, aged care workers need to remember:

- the person's right to privacy and autonomy
- the organisation's policies and relevant legislation
- the Charter of Aged Care Rights.

Developing effective communication skills requires training, practice, reflective learning, and a supportive working environment.

Many relatives find comfort in talking about their loved one as they were in the past and appreciate someone listening to their story. It helps them to feel that staff understand the person he or she was and to treat them as an individual.

Actions

When talking about dying remember to:

- check if the person wants to talk about this
- make appropriate eye contact
- keep your face in view if appropriate
- be aware of sensory impairments, check that the person has their glasses and/or hearing aid if needed
- speak slowly or as loudly as needed
- use an appropriate tone of voice and gestures
- check a person's understanding of what is being discussed.

Refer to the person's advance care directive (ACD) to identify the substitute decision-maker and a family member with whom you can discuss death and dying.

Record and report a person's likes and dislikes, behaviours, and responses to care. That way, their preferences can be respected when they cannot communicate.

Actively listen to the person and their family and allow feelings to show. Acknowledging their feelings and yours can be beneficial to care.

When an older person or resident dies, other older people or residents may be sad, fear that they will be next, become angry or withdrawn. Listening to their concerns can help them to feel comfortable again.

Tools

Tools that may be useful include:

SPIKES – a tool for breaking bad news.

Name:

My reflections:

How comfortable am I with talking about death and dying and, if needed, what might be done to improve my confidence and that of my staff?

Does my organisation have support such as pastoral care or counsellors that I can call on to help with difficult discussions about death and dying?

Do I know where to find the Charter of Aged Care Rights?

My notes:

See related palliAGED Practice
Tip Sheets:
Advance Care Planning
Palliative Care
Spiritual Care

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Tips for Nurses: Talking within the Aged Care Team



What it is: Talking with members of the care team taking care of an older person. The team caring for a person with palliative care needs may include people with different skills including nurses, carers, GPs, allied health, and spiritual care practitioners.

Why it matters: Good communication between careworkers and other staff helps the quality of palliative care provided to clients or residents. It means everyone knows what to do and why. It also helps people to feel confident that staff know and understand what to do, and that they are providing appropriate care. The nurse has a leadership role within the team.

What I need to know: Often the Registered Nurse (RN) will pass information between team members, management, the older person and their family.

Effective communication is:

- open, honest, accurate
- respectful and sensitive
- may be formal (team meetings) or informal (casual meetings in the work area or staff room).

Written records are a common way for teams to communicate.

Effective communication:

- supports understanding between the sender and receiver of information
- is part of good teamwork.

Technology including electronic care records, email communication, telehealth meetings, and social media are changing the way people communicate. These new technologies need to be used carefully and in line with policies at your organisation.

Actions

Case conferences are one way to share information among the care team members.

If organising a case conference, document notes on the discussions and any decisions made.

Provide staff with tools to facilitate and document case conferences. This might include an invitation and questionnaire for families, and planning checklists and communication sheets for staff.

Support all staff involved in the care of a person to talk with the team and to share the information they have about the person.

Seeking advice from or observing more experienced colleagues communicate is one way to improve communication skills.

Tools

iSoBAR - a structured framework for communicating the minimum information needed at handovers.

Name:

My reflections:

Improved team communication may lead to more effective care, better outcomes for the older person and greater staff satisfaction. How is information about a person being cared for communicated within care teams in my organisation?

My notes:

See related palliAGED Practice
Tip Sheets:
Case Conferences
Continuity of Care
Talking about Dying

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