



palliAGED
PALLIATIVE CARE AGED CARE EVIDENCE

Companion manual to palliAGED Introduction Modules and Tip Sheets

palliAGED and palliative care practice

palliAGED is the aged care companion website to [CareSearch](#). Both are funded by the Australian Government as part of the [National Palliative Care Projects](#). Collectively, these projects support the [National Palliative Care Strategy 2018](#) by addressing workforce education and training, quality improvement, increasing support in rural and regional areas, and encouraging advance care planning.

The palliAGED website offers aged care professionals free access to a wealth of evidence-based resources tailored to support care across residential and aged care settings. The palliAGED Practice Tip Sheets are suitable for nurses and careworkers new to palliative care and can be a useful adjunct to other structured learning offerings such as [PEPA placements](#).

The short online palliAGED Introduction Modules complement the Tip Sheets and, together with the Education on the Run training videos, provide concise information and insights into palliative care practices.

This companion manual provides more detailed information about the selected tools and processes referred to the modules, including the SPICT tools, case conferences, and useful communication tips. Accessible exclusively online, this manual is designed with embedded links to facilitate easy exploration of additional resources and information.

For more on these resources and others, visit [palliAGED](#).

For Nurses: Palliative Care



What is palliative care?

Palliative care is an approach to care that focuses on improving the quality of life of people living with a life-limiting illness. It provides relief from pain and symptoms while helping address emotional, social, and spiritual needs. It also offers a support system for families and other carers during the person's illness and beyond into bereavement. Palliative care affirms life by helping people live their life as comfortably and as fully as possible.

Why it matters

People retain a sense of dignity and meaning in life when they are involved in planning for their care and are supported to cope and live as well as they can.

Understanding that a person may be nearing the end of their life gives them the opportunity to say goodbyes, seek spiritual guidance, or complete unfinished tasks. Recognising signs of decline or imminent death allows for better management of symptoms and care. Palliative care is about seeing the person as an individual and assisting them in focusing on what matters most as their needs evolve.

Key stages across the advanced course of serious illness:

Planning

The older person is living with one or more life-limiting illnesses which will likely lead to death sometime within the next 12 months. **Advance care planning** and **communication** are important at this time.

Declining

The older person's health has declined, and it is expected that they will die soon but timing is uncertain. Tools such as **SPICT** are useful at this time to monitor for changes in a person's condition. **Case conferences** can also be helpful in coordinating care needs.

Dying

The older person's health has declined, and they are expected to die within a few days or weeks. Care might now be termed 'terminal care'. At this time, an **end-of-life pathway** might be useful to optimise care. **Pain** is often a common clinical symptom during this stage. clinical symptoms.

Grief and bereavement

Following the older person's death, their family, carers, and staff may need support to accept their loss. It is important to focus on **self-care** and allow time to remember the person and acknowledge the loss.

For Nurses:

Advance Care Planning



What it is

Advance care planning (ACP) can range from discussions to formal documentation. If a person loses their ability to express their wishes and make decisions in the future, an advance care plan helps to keep their voice in the decision-making process. In this way the person can influence what happens.

Implementation

The different elements of advance care planning include:

Advance care discussions: Advance care planning (ACP) includes conversations and planning related to possible future health-related events.

Advance care plans: A possible outcome of care planning discussions is an Advance Care Plan. Advance care plan documents can be in a written or oral form and state:

- a person's preferences about their health and personal care and
- what they consider their preferred health outcomes to be.

Advance care directives (ACDs): a legal record of a person's preferences for care and treatment and can be one of two types of document, instructional or appointing.

- Instructional advance care directives enable a person to make decisions about their future medical treatment. In Australia there is legislation or statutory law covering these documents.
- Appointing ACDs enable a person to appoint someone to make health care decisions on their behalf in the event they are unable to do so themselves. All states and territories have legislation that cover these documents and state specific forms.

Substitute decision-maker: A substitute decision-maker is a person who is nominated in an ACD to make a decision(s) on behalf of a person who lacks the capacity to make or express their own decisions. In Australia, the legal requirements relating to this differ between each state and territory.

Remember

ACPs and ACDs are not 'set and forget' documents. A person's preferences may change as their illness progresses and circumstances change. Reviewing these documents on a regular basis ensures that they truly reflect the person's wishes.

Ask: "Six months ago, we talked about what care you would want to receive if things got worse. Is this still what you would want?"

An ACP should only be referred to if the person lacks the capacity to make a decision or express their preferences or wishes.

[Advance Care Planning Australia](#) provides state and territory specific improvement toolkits for organisations



Example: Advance Care Planning Policy

Pre-entry/initial contact

Provide families with information packs, introduce ACP and/or request copies of existing documents



On entry

Offer opportunity for ACP discussion, file copies of existing documents including certified copies of legally binding ACP documents



4-6 Weeks post entry

Undertake ACP discussions with the resident, their family and/or substitute decision maker if they agree



Ongoing review

Encourage ongoing discussions and review ACP documents every 12 months or when clinical changes occur



Clinical decision-making

Completed ACP documentation should only be used if the resident is unable to participate in decision-making

Advance Care Planning

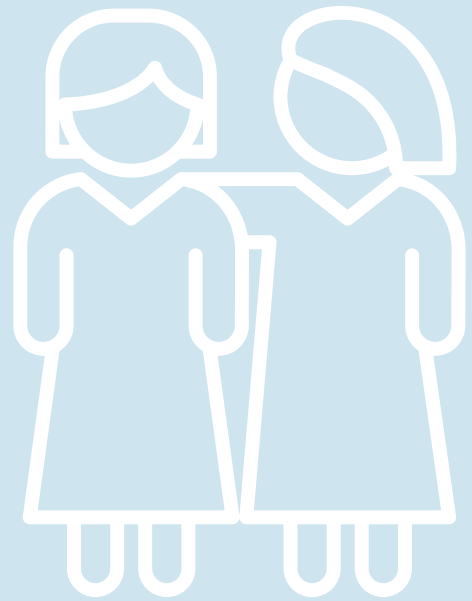


Communication tips

Many people find it difficult to discuss death and dying. Advance care planning can be a series of conversations rather than just one conversation.

It can be difficult accepting that someone is going to die. A person may feel overwhelmed if they believe that they need to make decisions about future care in the space of one conversation.

These discussions do not have to finish with clear decisions about all aspects of future care. Over time, these discussions can help the person and family adapt to the changing course of the illness and what it means for them and discuss how they will need to adapt to the person's deteriorating health.



Advance care planning conversations can start:

- when there is a death or serious illness in the family or circle of friends
- when the person receives a diagnosis of a condition with a poor prognosis
- when there is a diagnosis of early dementia or a disease which could result in loss of capacity
- when a person or family member asks about current or future treatment options and goals
- if the person's health is deteriorating and it is affecting their ability to do or enjoy things or look after themselves
- if the person doesn't "bounce back" after an acute illness
- if there the person is hospitalised or admitted to a residential aged care facility.



Start a conversation by asking the following:

A focus on the person

- (Person's name), what things are important for you to live well?
- Is being able to....the most important thing to you?

A focus on life

- What do you value most in life?
- What does a good day look like to you?

A focus on choices

- If (insert change or event) happened to you, what would you want?
- Who would you want to make medical or care decisions on your behalf if you were unable to?

Based on the Advance Care Planning Australia resource on what to say and how to structure the ACP conversation.
<https://www.advancecareplanning.org.au/understand-advance-care-planning/starting-the-conversation>

For Nurses: Using the SPICT Tool

What it is

The Supportive and Palliative Care Indicators Tool (SPICT) can assist doctors, nurses and allied health professionals to identify people with deteriorating health and their carers who might benefit from better supportive and palliative care. SPICT4ALL is a plain language version of SPICT using simple language with less medical terms. SPICT4ALL is suitable for use by care assistants, patients, carers, and families to identify when things are changing.



Implementation

The need for palliative care depends on the stage of illness and any co-existing conditions. The SPICT tool can help identify decline or deterioration in a person's condition. This in turn can trigger important discussions including planning for future care.

When to use SPICT or SPICT-4ALL

- After an unplanned hospital admission or a decline in health status
- For people with poorly controlled symptoms
- To identify people who are increasingly dependent on others due to deteriorating function, general frailty and/or mental health problems for additional care and support
- To identify people (and carers) with complex symptoms or other needs
- To assess decision-making capacity
- To identify people who need proactive, coordinated care in the community from the primary care team and/or other community staff and services
- To agree, record and share an advance/anticipatory care plan.



Using SPICT or SPICT-4ALL

SPICT asks if there are clinical signs that the health of this person with one or more progressive conditions is deteriorating.

On the form you will find:

- Six observations relating to general indicators of deteriorating health and increasing care needs including trigger events.
- Clinical indicators of deterioration across seven specific life-limiting conditions. Use these to decide if this person needs a review or to discuss what matters to them.
- Five prompts for reviewing current care and care planning.

If the answer is YES to any of these questions, then this indicates that it is time to assess the person's holistic needs and start planning future care with them.

Getting started with SPICT or SPICT-4ALL

You can download the latest interactive SPICT form in a number of different languages from <https://www.spict.org.uk/>. You can also arrange to add your organisation's logo to the page or download a SPICT App for your mobile device.

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.

Other conditions

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

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.

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.

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 had 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.

Using the SPICT tool

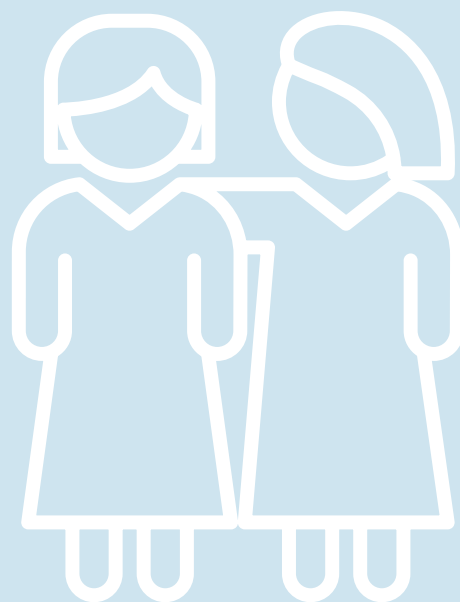
SPICT is not a structured needs assessment tool. Before calling a palliative care case conference you can combine it with a tool such as:

1. The [Palliative care Outcome Scale \(POS\)](#) - a collection of measures specifically developed for use among people with advanced diseases such as cancer; respiratory, heart, and renal diseases; liver failure; and neurological diseases. IPOS is also available (Integrated Palliative Care Outcome Scale).
2. [IPOS](#) integrates the most important questions from POS, POS-S and the APCA African POS.
3. [Australia-modified Karnofsky Performance Scale \(2.68MB pdf\)](#) - a tool for monitoring functional decline in Activities of Daily Living.
4. [Palliative Care Phase Tool \(326 kb pdf\)](#) - developed to identify clinically meaningful phases in a person's condition.



Communication tips for discussing deteriorating health - what to say³

- What do you know about your health problems and what do you think might happen in future?
- If you did get more unwell, what would be the most important things for you and your family?
- Is there anything that is particularly important for you or your family that we should know about?
- Sometimes people choose a family member or a close friend to make decisions for them if they get less well...Is that something you've thought about? Have you talked to your family about it?
- I am glad you feel better and I hope you will stay well, but I am worried about what might happen if...
- Can we talk about how we might cope with not knowing exactly what will happen and when? What would be the best way for us to talk about that?
- I wish we had more treatment for (insert name of condition here), could we talk about what we can do if that is not possible/ is not going to help you?



³ From: SPICT Using SPICT™ <https://www.spict.org.uk/using-spict/>

For Nurses:

Organising case conferences



What it is

A family meeting or case conference is a structured discussion between an aged care client or resident (if possible), member(s) of the family who are involved in the person's care, the substitute decision-maker(s), and members of the aged care team including the GP.

The aim of the case conference is to discuss issues and raise concerns about the person's condition, to review the person's advance care plan, and to agree on clear goals for the person's future care. It can also provide the opportunity for the family to be encouraged to work with the aged care service in providing quality and personalised care.

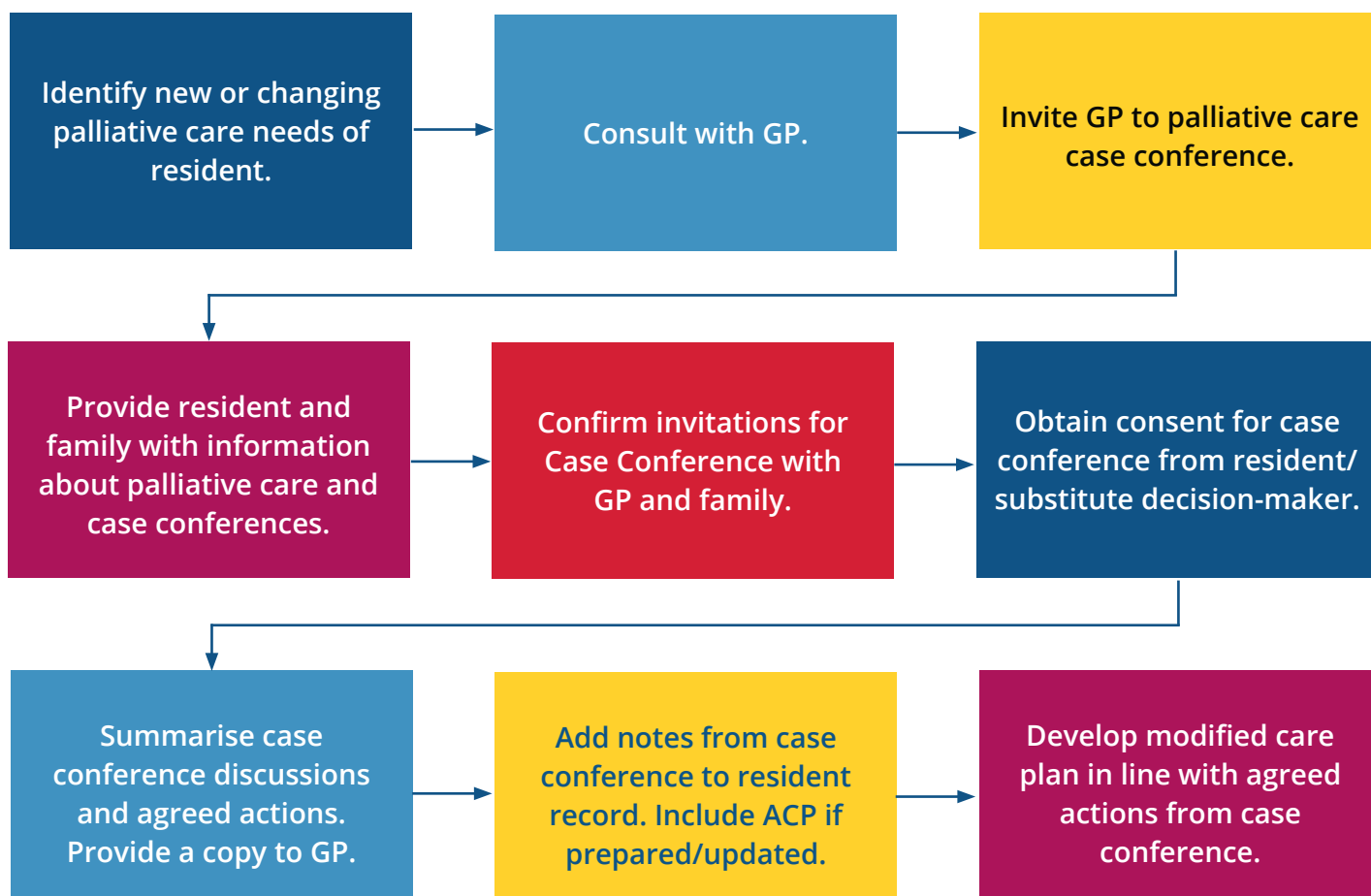
Implementation

The case conference planning process and forms may differ between organisations, but many steps will be common.

There is no right or wrong time for a case conference, but it will often be arranged when a person moves into an aged care facility/home or because they have a significant change in function or health.

Arranging these regularly helps to provide care that is planned and allows issues to be dealt with before they escalate.

Implementation



Organising case conferences

Getting GPs involved is important and means working with their schedules and the needs of the person.

If you are organising the meeting, then let the GP know how long you expect the case conference to take. Aligning this with the Medicare Benefits schedule (MBS) items can be helpful. There are six MBS case conferencing items based on duration of the service and whether the GP is organising and coordinating or participating in the case conference. MBS item numbers are shown below.

Relevant MBS Items for GPs	at least 15 and less than 20 minutes.	at least 20 and less than 40 minutes.	at least 40 minutes.
Organise and coordinate a case conference	735	739	743
Participate in a case conference	747	750	758

Communication tips - what to say

Resources like [Vital Talk](#) and [SPIKES \(72kb pdf\)](#) can help to structure discussions, and include examples of how to start conversations, show empathy, and how to deliver bad news.

Allow the discussion to start with the group gaining an understanding of the person's perspective and the most appropriate language to use:

- "So that I know where to begin, what do you already know about your/their condition?"

Acknowledge emotions:

- "I'm sorry to tell you that (person's name here) condition indicates that (person's name here) is entering the terminal or last stage of life. This is sad but common in advanced (insert condition)."
- "I can imagine how saddening/scary this must be for you."
- "I can see this is a huge shock for you." Or
- "I can see that this is not the news that you expected, I'm so sorry."

Show support:

- "I wish we had a treatment for (insert condition), but could we talk about what we can do to support (person's name here)?" or
- "We are here to support (person's name here) and yourself with what is important to you. If you are ready, we could discuss what that might look like."



Case conference forms

palliAGED provides a series of case conference forms for you to use in your practice. Forms are also available for home-based care.

Checklist:

Use the palliAGED [Case Conference Checklist for residential care \(404kb pdf\)](#)

Communication:

Speak with the person and their family about the need for a case conference. Provide [information on palliative care and case conferences \(163kb pdf\)](#)

Collaboration:

Involving the person's GP is important. Use the [GP invitation form \(186kb pdf\)](#) to invite them to attend, and/or to suggest a suitable time.

Confirmation:

Closer to the date of the Case Conference send a letter [confirming details to the person and their family \(141kb pdf\)](#), and [send confirmation to the GP \(173kb pdf\)](#).

The Case Conference:

To guide the meeting and to make sure that all steps following the conference are completed use the palliAGED [Palliative Care Case Conference Summary for residential care \(225kb pdf\)](#).

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.

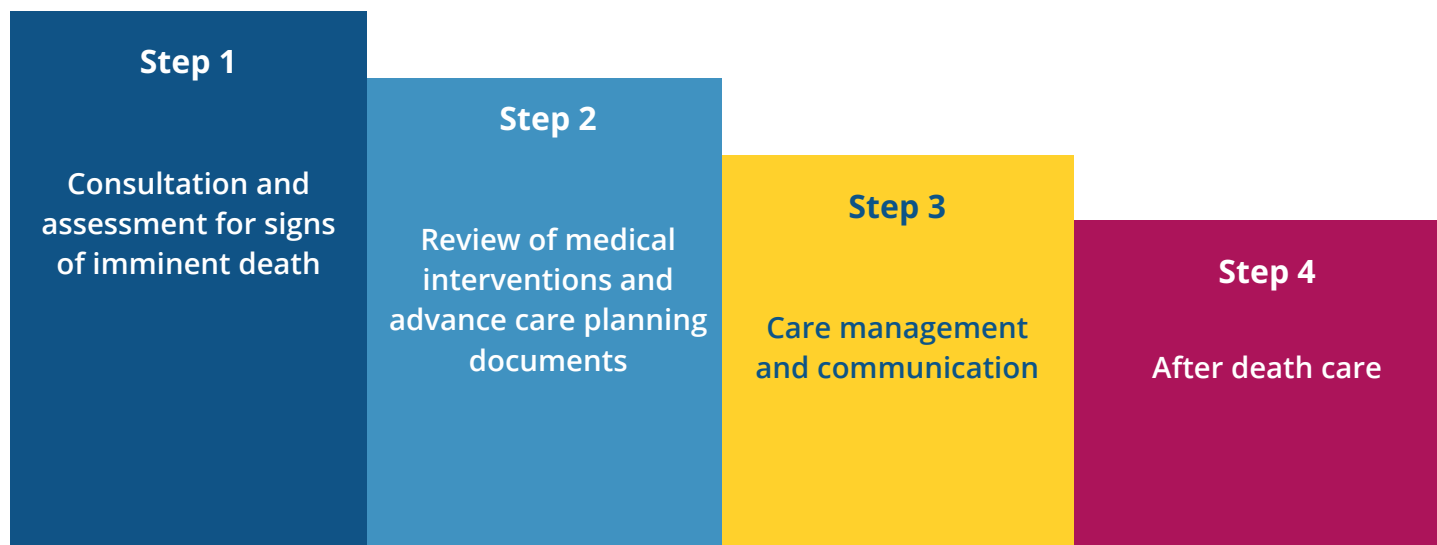
- Care pathways differ from care plans. A care plan is based on the individual's condition and needs, and on the services available. The care pathway provides recommendations which should be included and enacted within a care plan where possible and appropriate.
- Care pathways use documents, sometimes flowcharts, to guide the steps of care to be followed by members of multidisciplinary teams.

Note: People can come off an EoLC pathway. If the person's condition improves, a discussion with the family and/or the substitute decision-maker may lead to the decision to take the person off the pathway. In this case, routine care will resume.

Implementation⁴

Medical assessment and good communication with the person, their family of choice, and care team are essential.

Basic steps across most end-of-life pathways include:



⁴ The Residential Aged Care End of Life Care Pathway (RAC EoLCP) 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. RAC EoLCP is available online at no cost at: <https://www.health.qld.gov.au/clinical-practice/referrals/statewide-specialist-services/brisbane-south-palliative-care-collaborative/residential-aged-care-end-of-life-care-pathway>

End-of-Life Care Pathways

Implementation

A person may be started on a pathway when there are signs of imminent death or they experience symptoms or show physical changes suggesting that they may be dying including:

- Decreasing activity
- Physical decline and weakness - totally bed-bound and requiring extensive nursing care
- drowsy, poorly responsive, or unconscious
- difficulty with swallowing or inability to swallow
- diminished intake of food and fluids, reduced or no urine output
- unintended weight loss
- changes in breathing pattern including noisy secretions (death rattle) and Cheyne-Stokes (several breaths followed by a long pause)
- skin that is cool to touch or waxy in appearance.



The final decision to commence a person on a pathway is made by the doctor and care team after talking with the person (where possible), their substitute decision-maker, and family of choice.

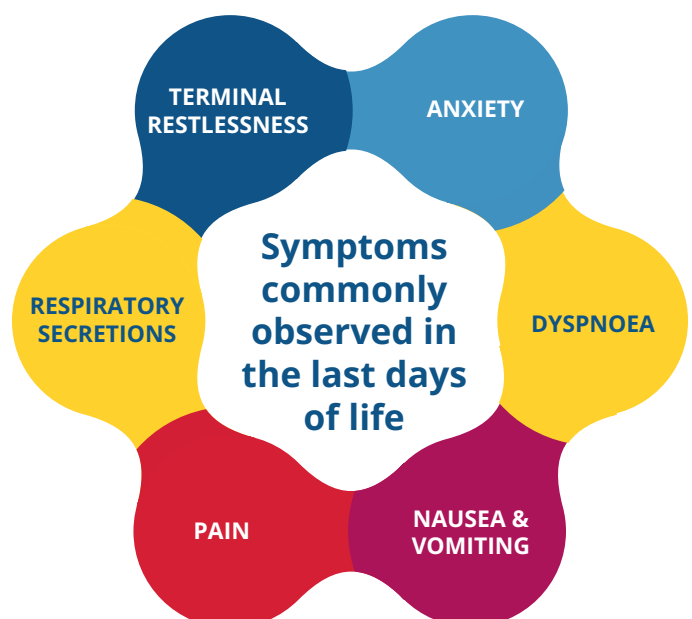
EoLC pathway documentation is to be placed in the resident's notes and forms part of their medical record. Advance care planning documentation should also be included.

Examples of End-of-Life Care pathways include;

- the [Metro South Residential Aged Care End of Life Care Pathway](#) (Australia),
- and [Care Plan for the Last Days of Life \(835kb pdf\)](#) (Government of South Australia, SA Health).

The [Gold Standards Framework](#) for Care Homes (UK) also provides useful information to guide approaches to palliative care at the end of life.

Note: For evidence-based guidance with care of older people in the last days of life you can refer to [palliAGED Symptom Management](#).



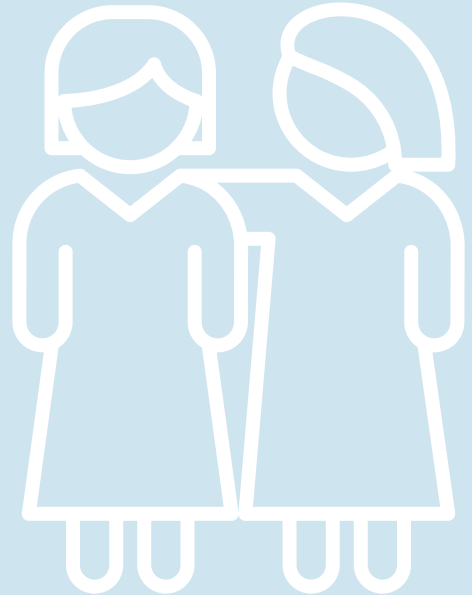
End-of-Life Care Pathways



Communication tips

Good communication is essential between the care team and the person, their substitute decision-maker, and family so that the benefit of the care pathway is clearly understood.

- At the palliative care case conference:
 - be clear and concise and use easily understood language
 - let family know that their loved one has entered the terminal or last stage of their life and that there is little time left.
 - Explain that the focus on care is to ensure that the person is as comfortable and as pain-free as possible.
 - Explain that managing symptoms in the last days of a person's life is generally a continuation of what is already being done with attention to symptoms that worsen or new symptoms which develop. This includes pain, dyspnoea, delirium, agitation, and respiratory secretions.
- If wanted provide family members with information about physical changes that occur as a person is dying, including:
 - Changes in breathing patterns, including the possibility of terminal secretions ('death rattle')
 - Changes in skin colour and temperature
 - Changes in level of consciousness, including the possibility of terminal delirium
- Let family know that the person's appetite and interest in food will likely diminish and perhaps disappear. This can be quite distressing for the family, but they can help to provide care if they feel comfortable with this.



For Nurses: Pain Management



What it is

Pain is an unpleasant sensory and emotional experience. This includes physical and spiritual pain.

People with advanced disease often experience many types of pain requiring multiple treatment approaches. Registered nurses are responsible for pain assessment.

Pain is whatever a person says it is. Its negative effects extend beyond the person's unpleasant physical and emotional experience as it can limit physical activity including walking and activities of daily living, restrict participation in activities and socialisation, disturb sleep, result in depression, anxiety or cause agitation in people who cannot communicate their suffering or needs.

Psychological and spiritual support can help along with medication based analgesia. Opioids are the mainstay of pain management. Uncontrolled pain can hasten death.

Implementation⁶

Some basic principles of pain management in the palliative care patient and at end of life:

- Where possible use multi-modal analgesics (use of multiple analgesic drugs with different modes of action)
- Prescribe regular analgesics
- Recognise and treat breakthrough pain (pain which "breaks through" the base level of analgesia)
- Three consecutive doses of breakthrough analgesic without relief should prompt urgent review
- Understand opioid analgesic equivalents
- Reassess regularly
- Do not mix opioids and make sure to actively treat any side-effects e.g. constipation



- Recognise red flags:
 - rapidly increasing opioid need
 - morphine requirement greater than 150 MME per day
 - dose limiting side effects
- Attention
 - do not crush slow release opioid capsules or tablets
 - Do not use transdermal opioid patches (due to longer time required to have an effect).

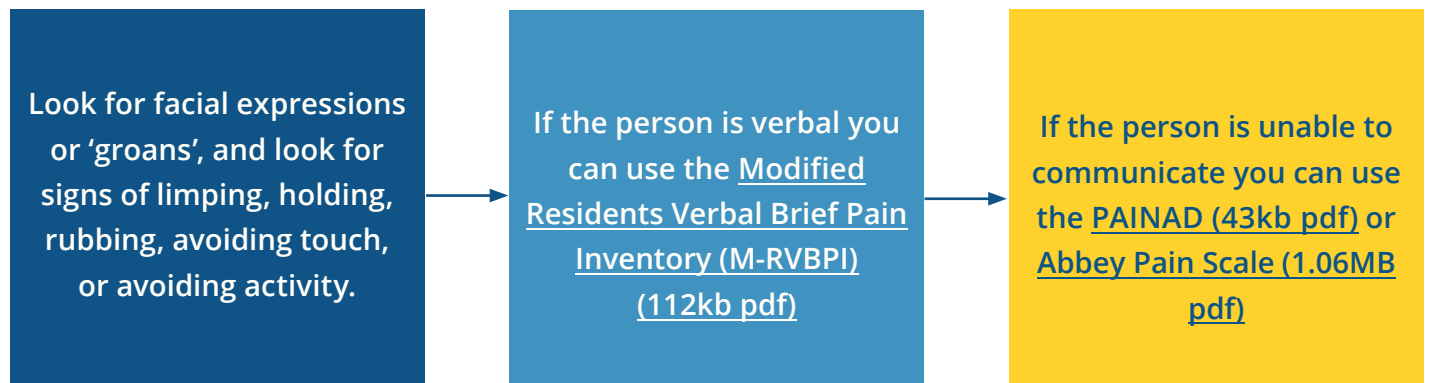
⁶Australian Pain Society, Pain in Residential Aged Care Facilities: Management Strategies, 2nd Edition

Pain Management

Assessment, re-assessment, monitoring for side-effects and understanding how medications work are all essential to good pain management.

Assessment

Self-reported pain assessment is the usual method for assessing pain but this is not always possible. Pain assessment tools can help. Many tools are available and no tool is considered superior.



Treatment

In palliative care common analgesics include paracetamol, non steroidal anti-inflammatory drugs (NS AIDs) and opioids. Morphine is the preferred pain medication at the end of life. Non-pharmacological approaches such as positioning to make a person comfortable can also help.

If you need to switch between opioids see the [Faculty of Pain Medicine ANZCA App](#) for opioid conversions.

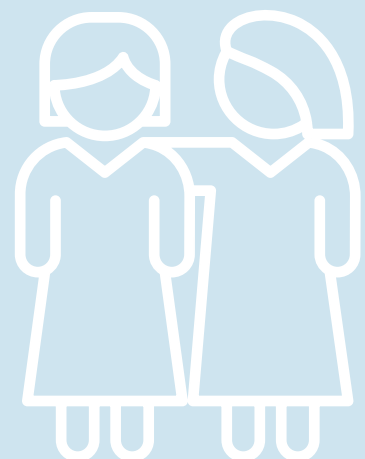
Monitoring

Ongoing monitoring of the person for side-effects and new or unresponsive pain is essential. Talk with your supervisor/GP/pharmacist if you have any questions or notice any changes.



Communication tips

- Explain to family and carers what is happening and any changes in care
- Discuss the many myths about morphine and provide clear responses to reassure family and carers
- Always explain to family and carers before responding with a breakthrough dose of analgesia.



For Nurses: Self-Care

What it is

Self-care is a range of knowledge, skills, and attitudes that health care professionals can use for themselves or to support others to maintain mental and physical wellbeing.

Nurses, including those who care for only a few palliative care clients, may experience:

- difficulty shifting from curative mode to a palliative and supportive role, accepting death as an inevitable and appropriate outcome
- guilt, if perceiving that a diagnosis was missed or delayed
- stress, if unable to relieve difficult symptoms or intense distress in the patient or their family
- difficulty in handling their own mortality.

Self-care can help.



Implementation

Signs that a person is not coping include:

- physical and emotional exhaustion
- poor sleep
- headaches
- negativity and cynicism
- lack of enjoyment
- not working effectively
- absenteeism
- use of drugs or alcohol as ways of coping.

Looking after yourself is part of looking after others. Making a self-care plan can help.

Practical resources

The [ELDAC Self-care room](#) has comprehensive information and resources for aged care workers to look after themselves while caring for others.

The [Self-Care Matters \(Aged Care\)](#) resource by Palliative Care Australia includes six informational videos and a [self-care planning tool \(2.04MB pdf\)](#). There is also a set of audio clips to guide mindfulness, relaxation and self-compassion practice.



Self-Care

Make a plan that you can stick with and based on what you like to do, use this to guide how you take care of yourself. palliAGED has a quick plan template to help you get started: [self-care for the aged care team form \(3.48MB pdf\)](#).

The palliAGED self-care form helps you to make a plan for yourself based on what matters to you across:

- workplace activities
- physical self-care
- psychological self-care
- emotional self-care
- spiritual self care, and
- relationship self-care.



Communication tips⁵

Talk with yourself and those around you. If you or your colleagues answer 'yes' to any of the following questions, then self-care may be needed:

- Do you have extreme fatigue after leaving a shift?
- Do you have trouble sleeping?
- Do you worry or feel anxious about current or past patients?
- Does your spouse or family remind you that there's a life outside of work?
- Do you have difficulty mentally leaving behind the tragedies of the day?
- Do you often think back to choices you made during the day to see how they could have gone differently?
- Have you ever had difficulty empathising with your patients and their families?



⁵Calvary Hospital, A gentle reminder to take care of yourself. <https://www.calvaryhospital.org/self-care-for-palliative-care-professionals/>