



# **palliAGED Practice Tips for Careworkers in Aged Care**

**2**

**Decision-Making  
& Communication**



## Tips for Careworkers: 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 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 if later they are unable to. This person is called a substitute decision-maker (SDM). Some states and territories include this in an ACD.

**Why it matters:** Advance care planning helps people receive the care that they would want to receive. Writing down preferences is important because if a person can no longer make or express decisions, the people around them will know what they would want. Careworkers can support older people and their families by referring questions about ACDs to nursing/supervisory staff.

**What I need to know:** A person does not have to plan or have an ACD. An ACD is only used if the person cannot make or express decisions.

ACDs can be changed whenever the person wants to change them or when their health or circumstances change.

A person may choose to refuse treatment. This is not giving up and does not 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).

**Do** Make sure that a current ACD accompanies the older person moving to or from hospital or place of care.

**Do** Make sure you have the contact details of the:

- substitute decision-maker
- person to contact in case of an emergency.

These may not be the same person.

**Do** If someone wants to discuss health planning, tell nursing/supervisory staff.

**Do** Visit Advance Care Planning Australia's online learning modules for aged care.

**Name:**

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## My reflections:

Can an Advanced Care Directive (ACD) be changed?

What should I do when an older person is moved to a new place for care?

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 Tip Sheets visit  
[www.palliaged.com.au/PracticeTipSheets](http://www.palliaged.com.au/PracticeTipSheets)



## Tips for Careworkers: After-Death Choices

**What it is:** Care of an older person and their family does not end when the person dies. There are arrangements that need to be made in line with their wishes.

**Why it matters:** The person may have written down their wishes in an Advance Care Directive (ACD) but some decisions may need to be taken by members of the family. Planning can assist the family with their grief and bereavement. Support from careworkers can also help.

**What I need to know:** The Registered Nurse (RN)/supervisor needs to speak with all relevant people and make sure all special needs at the time of death are attended to.

Families may wish to spend time with the person's body.

An authorised person needs to make sure the person is dead, and a document signed to officially confirm the death. After this, a funeral company can take the body into their care.

There may be requirements for reporting a death to the coroner. Relevant legal requirements are not the same across Australia.

**Do** Respect and support the family members who may:

- need time to accept the death
- need time to travel to the site of death
- want to sit with the deceased.

**Do** Report to nursing/supervisory staff any needs including religious and cultural practices that may be important for the family.

**Do** Know your organisation's policy about when and what to tell others following the death of an older person in your care.

**Note** 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:**

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## My reflections:

When a person dies, who should speak with relevant people and take control?

Staff working in aged care look after many people who die. What can I do for my own self-care?

## 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 Tip Sheets visit  
[www.palliaged.com.au/PracticeTipSheets](http://www.palliaged.com.au/PracticeTipSheets)



## Tips for Careworkers: Case Conferences

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

**Why it matters:** A palliative care conference can:

- 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
- plan responses to emergencies or crises.

**What I need to know:** Knowing who you can share information with is important. Staff in residential aged care facilities and providers of home care often meet with families. This is to talk about routine care, or when the older person's health status is changing, or death is expected within days.

You may be invited to attend a family conference. As you are likely to know the day-to-day care needs of the person, this can be very helpful.

### Note

Family meetings are different to case conferences. Family meetings focus on the care goals of the person and their family.

### Do

Look out for and report to nursing staff, any changes in a person's:

- mood
- normal daily activity
- ability to swallow, move, or breathe.

### Do

Report to nursing staff comments that the person may make about their health or future wishes.

### Do

Support the person and family before and after a case conference and refer any concerns or questions to nursing/supervisory staff.

**Name:**

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## My reflections:

What is the difference between a case conference and a family meeting?

What are some of the changes in a person I should report to nursing/supervisory staff?

## My notes:

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

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[www.palliaged.com.au/PracticeTipSheets](http://www.palliaged.com.au/PracticeTipSheets)





## Tips for Careworkers: Continuity of Care

**What it is:** Continuity of care has three main parts:

1. The care provider knows and follows the care of a person, client or resident.
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 for 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.

**Do**

Ask your supervisor about any documents that should accompany a person when transferred between settings.

**Do**

Talk clearly with the family, carers, nurses and management to ensure you and others are aware of any new goals of care.

**Do**

Report to nursing/supervisory staff any changes that you notice in the person or requests made by the older person or their family.

**Do**

Ask your supervisor about the SPIC4ALL tool. This helps you to identify people who are declining in health and might benefit from better supportive and palliative care.



**Name:**

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## My reflections:

How do I report to nursing/supervisory staff any changes that I notice or any questions that family members may have?

## My notes:

See related palliAGED Practice  
Tip Sheets:

Advance Care Planning

End-of-Life Care Pathways

Talking within the Aged Care Team

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# Tips for Careworkers: Culturally Responsive Care – Communication



**What it is:** Culture describes the beliefs and behaviours that are part of social groups.

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 how we talk with people is important.

**Why it matters:** Health care that respects a person's cultural and spiritual heritage can positively impact overall health.

**What I need to know:** Many older Australians were born in a non-English-speaking country.

Across all cultures, what is normal to one person may not be normal to another. 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:

- careworkers to be aware of the influence of their own cultural beliefs on their practice
- sensitivity to the cultural practices and beliefs of others.

## Note

A person may prefer another family member or community member with them when possible and/or to speak on their behalf.

## Do

Respect the rules about what part of the body you can and cannot touch.

## Do

Build rapport and trust by:

- listening actively
- showing empathy and respect.

## Do

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

## Do

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 to eat.

## Do

Let nursing/supervisory staff know if English is not a person's first language. Professional interpreting services can help with discussions where lots of information is shared.

**Name:**

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## 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?

## 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 Tip Sheets visit  
[www.palliaged.com.au/PracticeTipSheets](http://www.palliaged.com.au/PracticeTipSheets)



# Tips for Careworkers: End-of-Life Care Pathways

**What it is:** A care pathway is a tool to plan best care for a person with a disease or condition where we know what to expect. End-of-life care pathways guide the care you will provide to the person who is dying.

**Why it matters:** Care pathways aim to:

- guide clinical decisions
- start care as soon as possible
- make sure everyone works to the same plan
- prevent unnecessary emergency treatments
- make care more efficient
- give you confidence that you are providing the right care.

**What I need to know:** A care pathway is different from a care plan. A care pathway represents the ideal way to manage most people with a specific problem or long-term condition. A care plan is made for an individual person and might not be the same as a care pathway.

The Residential Aged Care End of Life Care Pathway (RAC EoLCP) guides the provision of good quality terminal care in residential aged care.

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

**Do**

Look out for changes in a person's physical condition and mental and emotional state.

**Do**

Report to nursing/supervisory staff any changes in the person's

- skin, eyes, ear, nose, throat
- mobility
- eating, sleeping, or toilet habits
- odours, discharge, itching, swelling, burning
- hands or feet (if numb or cold)
- mood or behaviour (agitation, restlessness).

**Do**

Discuss regularly with nursing/supervisory staff what you should do to support the person on their care pathway.

**Name:**

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## My reflections:

Name two aims of care pathways?

What changes in a person should I report to nursing staff?

## My notes:

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

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# Tips for Careworkers: First Australians – Communication



**What it is:** Appropriate care for Aboriginal and Torres Strait Islander peoples includes talking with them in a culturally sensitive way. It also includes cultural safety. This is about recognising, respecting, and nurturing their cultural identity.

Culturally appropriate care for Aboriginal and Torres Strait Islander peoples:

- has people and their needs at the centre
- includes the context of their family, community, and culture.

**Why it matters:** Aboriginal and Torres Strait Islander people have high risk of life-limiting conditions. This includes advanced heart, kidney, and lung disease, and dementia. Being able to talk with the person and their family is important.

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

To build good relationships, introduce yourself and begin with a relaxed conversation. This is sometimes known as 'having a yarn'.

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

**Note** Post-death practices or requirements will differ across communities. Only certain people can touch or move a dead body.

**Do** Ask the person if they want to hear information about their care; or whether they prefer you to talk to family members instead.

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

**Do** You might like to ask:  
'Are there cultural or spiritual practices that affect the way you wish to be cared for?'  
'Are there other people we should include in talks about your care?'

**Do** Tips for talking together:

- don't talk too fast or be too direct
- some people avoid eye contact; this doesn't mean they aren't listening
- listen, ask questions rather than giving answers
- avoid questions requiring a 'yes' or 'no' answer.

**Name:**

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## 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 are important things to 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

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# Tips for Careworkers: People with Disability - Communication



**What it is:** Here, we mean talking with people with an intellectual or developmental disability or limited communication.

**Why it matters:** Many older people with an intellectual disability have more than one medical condition or advanced illness requiring palliative care.

Many people with intellectual disability are cared for by family carers and as they age, may need more support. In some cases, people with intellectual disability may be admitted to aged care because of:

- increasing care needs
- ageing carers or death of a family carer
- previous arrangements no longer providing enough support
- a lack of appropriate local services or accommodation.

**What I need to know:** Older people with intellectual disability:

- often have poorer health due to other illnesses like epilepsy and diabetes
- may show signs of early ageing
- often have depression and dementia
- may have difficulties with hearing, eyesight and mobility
- may find it difficult to join in a usual activity program
- may have limited access to disability services once in residential aged care
- may have difficulty with communication, speaking, and understanding what is said.

**Do** Always give the person your full and complete attention and make sure that you have their attention before speaking.

**Do** Do not talk over the person as though they are not there.

**Do** Give clear and simple information.  
Use language that fits with the person's communication level.  
Look at the person not the disability.

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

**Name:**

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## My reflections:

Do I speak to people with disability in an age-appropriate way?

What can I do when speaking with a person with disability to help them understand what I am saying?

## My notes:

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

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# Tips for Careworkers: Person-Centred Care

**What it is:** Person-centred care is about dignity, worth and human rights. Sometimes called 'patient-centred care'; it involves treating people the way they want to be treated and listening to their needs and preferences. This supports quality of life. It helps people to live a meaningful life based on what they value.

**Why it matters:** Quality care is more than good symptom control and emotional support. It is about helping the older person to live well and maintain control over their life, relationships, and social connections.

**What I need to know:** Palliative care is focused on quality of life. Being treated with dignity and respect is essential to quality of life. Being compassionate and valuing people as the person they are, rather than just the illness they have promotes a sense of dignity.

Helping people retain dignity as they die includes:

- symptom control
- psychological and spiritual support
- attending to privacy, respect and choice
- care of the family.

**Do**

Always introduce yourself and give the person your full and complete attention.

**Do**

Respect a person's need for privacy.

**Do**

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

**Do**

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

**Do**

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?'

**Name:**

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## My reflections:

What could 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? 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 Careworkers: Quality of Life with Change and Deterioration

**What it is:** Quality of Life (QoL) is how a person feels about their life 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 family and friends
- being as independent as possible
- not feeling like a burden
- feeling supported.

**Why it matters:** QoL is part of palliative care. As a person's illness deteriorates their QoL can worsen. Their ability to do what is important to them can change.

Standards 1 and 4 of the Aged Care Quality Standards also emphasise QoL.

**What I need to know:** QoL is personal. What the older person values as part of QoL may not be the same as other people.

As their disease progresses, their QoL can change. The disease might stop them from doing their usual activities. It might mean they cannot socialise in the same way or form relationships with others. Changes in QoL may be slow with diseases like dementia that progress slowly (over a longer period).

Other people might not register a change in QoL. They may adapt to what is currently possible and not compare it to what they could do before.

## Do

Talk with the person and family

- Regularly ask what is now important to the older person and their family
- Talk with the older person to set individual goals and support them with activities that are meaningful to them
- If families are concerned, ask your supervisor to help you support family members with information about the changes
- Help the older person to stay connected with family and friends
- If language is a barrier, ask your supervisor if there are staff who speak their language.

## Do

Support the older person to maintain their spiritual perspectives and spiritual connections.

## Do

Encourage them to remain active with tasks that they can manage.

- If tasks become more difficult offer help rather than doing it for them
- Help the person to adapt personal interests and activities as functional ability changes.

**Name:**

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## 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

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# Tips for Careworkers: 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. For an older person, family is part of who they are. They provide physical and emotional support and help.

**What I need to know:** Carers and family often look for support to understand the disease and symptom management, and end-of-life planning. Frequent, short conversations with small amounts of information can help.

Family members might need your help with emotional issues including:

- Guilt and/or relief if they are unable to continue caring and the older person needs to move into residential aged care
- Sadness and distress at the older person's deteriorating condition
- Anticipatory grief before the older person's death
- Grief due to loss of a loved one, an end to their role as carer, and changes to their daily routine
- Distress if the family think:
  - The person's dignity and identity are not being maintained
  - the family is not seen as a partner in providing care
  - the care provided is 'cold' and 'clinical'
  - not enough care is being provided.

Welcoming family as partners in providing care will help them to feel respected.

Identify the substitute decision-maker and the key contact. Let your supervisor know.

## Note

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.

Support decision-making by asking what they understand. Refer to what family have discussed previously with the person.

## Do

Tips for talking:

- Actively listen to the older person and their family
- Be available to talk with family members
- Let your supervisor know if they need more information
- Ask them what they think before offering your own thoughts.

## Do

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



**Name:**

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## 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:  
Case Conferences  
Grief and Loss among Older People,  
Families and Residents  
Talking About Dying

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# Tips for Careworkers: Talking about Dying

**What it is:** Talking about death and dying is not easy for everyone.

**Why it matters:** It can be hard to tell someone that care will be about comfort, not cure. But these conversations can help the person and their family to make decisions about future care and to improve the care that the person receives.

Acknowledging the role of family and talking with them can improve the care of the person, their family and carers. Careworkers can support the person and their family and let nursing/supervisory staff know when they have questions.

**What I need to know:** Effective communication or talking:

- allows staff to identify a person's needs and to provide care for that person
- may reduce agitated behaviour in older people with impaired cognition (poor understanding).

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

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

## Note

When talking with people, remember to:

- be aware of sensory impairment and make sure the person is wearing their glasses and/or hearing aid if needed
- make appropriate eye contact
- keep your face in view
- speak slowly or as loudly as needed.

## Do

Take the time to listen to people. This helps people feel that they are valued and treated as an individual.

## Do

Report to nursing/supervisory staff a person's likes, dislikes, behaviours and responses to care. Their preferences can then be respected when they can no longer communicate.

## Do

Consider a person's culture before talking about dying. Not all cultures talk about dying and death in the same way.

**Name:**

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## My reflections:

Before talking about dying with a person what should I consider?

What can I do to help people feel more comfortable when talking about death?

Who can I call on to help me with difficult discussions about death and dying or if people in my care have questions that I cannot answer?

## My notes:

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

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# Tips for Careworkers: 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 (talking) between careworkers and other staff helps the quality of palliative care provided to clients or residents. It means everyone involved in the care of a person 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.

**What I need to know:** Written records are a common way for teams to communicate. Case conferences are another way to communicate. Often the Registered Nurse (RN)/supervisor 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).

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.

**Note** Know with whom you can share information.

**Do** Check what needs to be reported or recorded.

**Do** Ask questions if you are not sure of something.

**Name:**

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## My reflections:

What are two ways that information about a person I am caring for could be communicated?

What should I do if I'm not sure of something relating to the care of someone in my care?

## My notes:

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

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