ELDAC Primary Care Individual Self-Assessment

This self assessment tool is intended to help you, as a primary care professional, identify areas of the Primary Care Toolkit that may be of particular use for building your palliative care knowledge, skills and confidence.

To guide best practice across the diverse care settings that primary care professionals can provide palliative care, this self assessment tool aligns with standards 1 6 of the National Palliative Care Standards for All Health Professionals and Aged Care Services, and is supported by key outcomes within the strengthened Aged Care Quality Standards.

This assessment should take 10-15 minutes to complete.

- **Step 1:** Answer 'Yes' or 'No' to each question below, reflecting on your experiences in and knowledge on providing palliative care. If you find yourself thinking about the answer to a question for more than 60 seconds, select 'No' and move to the next question.

- **Step 2:** Add up how many times you answer 'Yes' in the subtotal field at the end of each section.

- **Step 3:** If you answered **'Yes' for less than half** of the section, see the headings used in each section to identify the corresponding areas of the Primary Care Toolkit where you can find information, resources and support to assist in your understanding and practice of palliative care.

Note the following areas of the Primary Care Toolkit:

Clinical Action
Business and Practice Management
Continuing Professional Development

Section 1: Comprehensive assessment of needs

Initial and ongoing assessment comprehensively incorporates the person's physical, psychological, cultural, social, and spiritual experiences and needs. This section also reflects the following areas of the strengthened Aged Care Quality Standards:

- Outcome 3.1: Assessment and planning
- Outcome 5.4: Comprehensive care
- Outcome 5.7: Palliative care and end-of-life care

Section 1: Comprehensive assessment of needs	YES	NO
Recognise End of Life		
Are there processes in place to support the early identification of older people approaching end-of-life, to support timely assessment of palliative care needs?	○	○
Assess Palliative Care Needs		
Does your assessment of palliative care needs include the assessment of spiritual, psychosocial, and social/occupational needs as well as physical health needs?	○	○
Do you use core clinical tools to assess palliative care needs?	○	○
Are the older person's values, preferences, and goals of care centred in your approach to assessing their palliative care needs?	○	○
Work Together		
If the older person is receiving palliative care from multiple providers, is there written clarification of who has responsibility for initial and ongoing assessments of care needs?	○	○
Are assessments of care needs securely stored to the older person's health record and shared with all members of the care team, including the older person, their family and carers, and substitute decision-maker(s)?	○	○
Are there established processes to support effective and ongoing communication between members of the care team, such as case conferences?	○	○
Respond to Deterioration		
Are there processes for regular or routine reassessments of care needs, as well as for reassessments triggered by clinical changes or deterioration?	○	○
Please enter in the box the number of YES answers:	[ ] / 8	

Section 2: Developing the comprehensive care plan

The person, their family and carers and substitute decision-maker(s) work in partnership with multidisciplinary teams to communicate, plan, set goals of care and support informed decisions about the comprehensive care plan. This section also reflects the following areas of the strengthened Aged Care Quality Standards:

- Outcome 1.1: Person-centred care
- Outcome 3.1: Assessment and planning
- Outcome 3.4: Planning and coordination of funded aged care services
- Outcome 5.4: Comprehensive care
- Outcome 5.7: Palliative care and end-of-life care

Section 2: Developing the comprehensive care plan	YES	NO
Assess Palliative Care Needs		
Is development of the care plan informed through a holistic assessment of the older person's physical, psychosocial, spiritual, and cultural needs?	○	○
Work Together		
Are there processes in place (e.g. for the availability of information or support resources) to ensure that the older person, their family and carers and substitute decision-maker(s), are informed about their role/s as part of the care team?	○	○
Are communications about goals of care, both formal and informal, captured and used to support ongoing decision-making between members of the care team in development and delivery of the care plan?	○	○
Provide Palliative Care		
Do you manage symptoms in a way that is tailored to the older person's individual needs, values, and preferences, ensuring their comfort and dignity remain central to care?	○	○
Respond to Deterioration		
Are there processes for review of the care plan as part of routine care, as well as for reassessments triggered by changes in the care needs of the older person (e.g. unplanned hospitalisation)?	○	○
Older Person, Family and Carer Support		
Do you have readily available information for the older person, their family and carers and substitute decision-maker(s) on the following topics:		
a. Expectations about palliative care and end-of-life?	○	○
b. Local support services (e.g. aged care, specialist palliative care, or after-hours and emergency information)?	○	○
c. Having difficult conversations?	○	○
d. Home care?	○	○
e. Grief and bereavement?	○	○

Does development of the care plan consider the values, preferences and goals of care for people from diverse populations (e.g. CALD communities, Aboriginal and Torres Strait Islander peoples, LGBTIQA+)?	○	○
Digital Tools		
Are processes in place for the secure storage and sharing or accessing of the care plan between all members of the care team, including the older person, their family and carers and substitute decision-maker(s)?	○	○
Please enter in the box the number of YES answers:	[ ] / 12	

Section 3: Caring for carers

The needs and preferences of the person's family and carers and substitute decision-maker(s) are assessed and directly inform provision of appropriate support and guidance about their role. This section also reflects the following areas of the strengthened Aged Care Quality Standards:

- Outcome 2.4: Risk management
- Outcome 3.3: Communicating for safety and quality
- Outcome 5.7: Palliative care and end-of-life care

Section 3: Caring for carers	YES	NO
Work Together		
Is there a process to support carers in their caring role, including ensuring they receive up-to-date information and relevant contact information, are educated about providing or managing care safely and have a safe, caring environment?	○	○
Assess Palliative Care Needs		
Do you have a process to identify carers, assess their needs through core clinical tools (e.g. the NAT-CC), and document those details?	○	○
Older Person, Family and Carer Support		
Do you have information about the support and services available to carers stored and provided regularly to the person's family and carers and substitute decision-maker(s)?	○	○
Do you have carers support information that is specifically tailored to priority populations (e.g. CALD communities, Aboriginal and Torres Strait Islander Peoples, people who identify as LGBTQIA+, and veterans)?	○	○
Please enter in the box the number of YES answers:	[ ] / 4	

Section 4: Providing care

The provision of care is based on the assessed needs of the person, informed by evidence, and is consistent with the values, goals and preferences of the person as documented in their care plan. This section also reflects the following areas of the strengthened Aged Care Quality Standards:

- Outcome 5.4: Comprehensive care
- Outcome 5.5: Safety of clinical care services
- Outcome 5.7: Palliative care and end-of-life care

Section 4: Providing care	YES	NO
Business and Practice Management		
When required, do you have processes to undertake home visits for older persons who are no longer able to attend a primary care practice?	○	○
Advance Care Planning		
If care cannot be delivered in accordance with the goals, values, and preferences of the person, is there a procedure for this to be discussed with the older person, their family and carers and substitute decision-maker(s)?	○	○
Provide Palliative Care		
Do you have an evidence-based process for managing medications in palliative care (e.g. anticipatory prescribing plans, medication review processes reactive to changing needs and condition trajectory)?	○	○
Are you confident in identifying and managing symptoms in a timely manner, based on ongoing assessments, in alignment with the older person's changing needs, documented care plan, and the goals and preferences of the person, their family and carers and any substitute decision-maker(s)?	○	○
Respond to Deterioration		
Are there clear protocols and procedures in place across practice settings for escalating care (e.g. when urgent or specialist intervention is required)?	○	○
Work Together		
If the older person is receiving palliative care from multiple providers, do you ensure there is written clarification of who has responsibility for:		
a. Overall responsibility for leading and coordinating care?	○	○
b. Maintaining prescriptions for palliative medications?	○	○
c. Reviewing symptoms and assessing care needs?	○	○
d. Ensuring availability of home visits for older persons no longer able to attend a practice visit?	○	○
e. Writing the death certificate if intent for an at home death?	○	○
Please enter in the box the number of YES answers:	[ ] / 10	

Section 5: Transitions within and between services

Care is integrated across the person's experience to ensure seamless transitions within and between services. This section also reflects the following areas of the strengthened Aged Care Quality Standards:

- Outcome 2.7: Information Management
- Outcome 3.3: Communicating for safety and quality
- Outcome 5.7: Palliative care and end-of-life care
- Outcome 7.2: Transitions

Section 5: Transitions within and between services	YES	NO
Work Together		
Are there formalised pathways of communication for coordination of care between practitioners and services in response to changing needs (e.g. admission to hospital, notification of death)?	○	○
Advance Care Planning		
Do you ensure that decisions about transitions between care settings, such as avoiding unnecessary hospital transfers, align with the person's goals, values, and preferences identified through pre-existing documents and conversations?	○	○
Older Person, Family and Carer Support		
Do you provide information and resources to support families and carer(s) to provide care to the older person at home or in the community?	○	○
Organisational Support		
Are referral pathways for older persons with palliative care needs regularly reviewed to identify opportunities for improvement in providing timely and appropriate care?	○	○
Digital Tools		
Is there a process in place for Advance Care Planning (ACP) documents and care plans to be uploaded, stored and shared as appropriate, in a timely manner (e.g. on My Health Record)?	○	○
Do you have access to and regularly use the HealthPathways site of your regional Primary Health Network (PHN)?	○	○
Please enter in the box the number of YES answers:	[ ] / 6	

Section 6: Grief support

Families and carers have access to grief support services and are provided with information about loss and grief. This section also reflects the following areas of the strengthened Aged Care Quality Standards:

- Outcome 5.7: Palliative care and end-of-life care

Section 6: Grief support	YES	NO
Bereavement		
Are validated clinical tools (e.g. the Bereavement Risk Assessment Tool) used to assess signs and symptoms of persistent and intense distress in grief or bereavement?	○	○
Is there a process, pathway or strategy for referral for bereavement support if required?	○	○
Manage Dying		
Are resources and information about death, the dying process, and what to expect after death available for the family and carers and substitute decision-maker(s) of the older person?	○	○
Older Person, Family and Carer Support		
Are bereavement and grief resources and information provided to families and carer(s), including where to find regional support services?	○	○
Are bereavement and grief resources specific to diverse populations (e.g. CALD, Aboriginal and Torres Strait Islander, LGBTQIA+) available to be provided to the family and carers and substitute decision-maker(s)?	○	○
Team Support		
Do you have access to bereavement support services and resources for clinicians within your practice?	○	○
Please enter in the box the number of YES answers:	[ ] / 6	

CLEAR FORM