End-of-Life and Palliative Care
Education and Training Framework

A reference tool for Service Providers.

Care at end-of-life is everyone’s business, whether it is provided by specialist palliative care or non-specialist healthcare providers.²

“All staff are prepared to care.”

WA End-of-Life and Palliative Care Strategy 2018 – 2028, Priority Five²
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Purpose of the Framework

The End-of-Life and Palliative Care Education and Training Framework, (the Framework) provides service providers with a reference tool to identify the knowledge and skills required by all health professionals and staff who care for people with end-of-life and palliative care needs.

This document describes the three key domains that are integral to end-of-life and palliative care across the lifespan, in all health care settings, and outlines the associated knowledge and skills required.

The Framework supports the building of service capacity in the provision of end-of-life and palliative care across all sectors, by clarifying organisational and individual education and training needs and enabling access to appropriate resources.

Intended for use:

- by service providers (organisations and individuals) as an overarching document in the identification of required education and training
- as the foundation document from which service providers may develop more detailed competency frameworks for knowledge and skills acquisition
- by health professionals and other staff, health care service and organisational managers, education and training organisations and health care educators
- in a range of settings including, but not limited to, primary care, hospital, community, disability, residential aged care and specialist palliative care
- in both specialist and generalist service areas.
Using the Framework

The Framework promotes a consistent, inclusive and flexible approach to learning and development in end-of-life and palliative care for service providers.

The varying level of knowledge, experience and skills that all health professionals and staff bring to practice is acknowledged within the Framework.

The place of both informal and formal learning in supporting the workforce to develop knowledge and skills is recognised.

It is the intention that the Framework complement existing sector and discipline specific standards and frameworks.

The Framework supports the education and training of health professionals and staff in end-of-life and palliative care by:

- guiding the identification of current knowledge, skills and experience
- clarifying future education and training needs
- guiding the acquisition and/or development of required education and training.

Users of the Framework will:

- work through the three domains, review the associated learning items to determine the existing level of knowledge and expertise of the individual/group requiring training
- identify gaps in knowledge and skills for the individuals/group requiring training
- identify education and training required, by topic and expertise level (foundation, consolidation and extension).

Resource links

Links to relevant education and training resources can be found in [appendix 1](#).

Case scenarios

Examples of how the Framework may be used in practice are provided in the following case scenarios on the next page.

Education and training

You can also access the end-of-life and palliative care education and training resources in alternative format categorised by topic, care setting and education and training provider by going to the Education and Training Resource Hub section at:
Case scenarios

1. Primary care, regional general practice
2. General hospital, intern education
3. Disability service provider
4. Residential aged care provider
5. Tertiary hospital, Medical Director, Renal Service
6. Specialist paediatric palliative care, allied health professionals
Domains

The three Framework domains reflect the core knowledge and skills (learning items) considered integral to the delivery of high-quality end-of-life and palliative care.

Learning items within the domains are grouped by learning focus areas. Some of the learning items are integral to all health care but are applied in this Framework in the context of end-of-life and palliative care.

Domain 1 – Principles of practice
This domain includes the underpinning principles and philosophy of a palliative care approach and incorporates elements essential to developing and improving end-of-life and palliative care service provision at an individual and service level.

Domain 2 – Clinical management
This domain includes the knowledge and skills required to provide holistic, high-quality clinical care of the person, their family and carers.

Domain 3 – Leadership and management
This domain covers the knowledge and skills required to support strategic growth and capacity building within the clinical speciality of palliative care.
Expertise levels within each domain and learning focus area

Learning items are presented within the three domains in three levels of expertise that outline what health professionals and staff need to know and do, depending on their degree of involvement, in the person’s care and their role responsibilities in caring for the person with end-of-life and palliative care needs, their family and carers.

Contents

- Using the Framework
- Domain 1 – Principles of practice
- Domain 2 – Clinical management
- Domain 3 – Leadership and management
- Case scenarios

Continuum of learning

**Foundation**

Learning items are relevant to those:
- with limited experience and expertise in end-of-life and palliative care
- working in primary care, hospital, community, or aged care non-specialist services
- providing end-of-life and palliative care.

**Consolidation**

Learning items are relevant to those:
- developing experience and expertise in end-of-life and palliative care
- with supervisory or team leadership responsibilities working in primary care, hospital, community, or residential aged care with an interest and/or experience in end-of-life and palliative care
- providing end-of-life and palliative care.

**Extension**

Learning items are relevant to those:
- with significant experience and expertise in end-of-life and palliative care
- managing/leading specialist palliative care services
- developing new palliative care services
- leaders and emerging leaders in specialist palliative care
- identified clinical leaders in primary, hospital, community, and aged care services with expertise in palliative and end-of-life care.

Learning items at each level are incremental, in relation to the depth and breadth of knowledge required, and the complexity of related skills increase at each expertise level.

An individual or group at extension level will therefore have the knowledge and skills defined at the preceding levels.
The End-of-Life Care Program, Health Networks, has developed the Framework in collaboration with key stakeholders, in response to the issues regarding education and training for end-of-life and palliative care highlighted in the following reports:

- The Sustainable Health Review: Final Report to the Western Australian Government 2019
- The West Australian End-of-Life and Palliative Care Strategy 2018 – 2028

The key messages relating to education and training presented in these documents include:

- West Australians are supported to achieve respectful and appropriate end-of-life care and choices
- all health professionals caring for a person at end-of-life are prepared and able, to provide confident, sensitive, and skilful care before, during and after death
- health professionals and staff require access to ongoing comprehensive and practical education and training, in order to provide appropriate end-of-life and palliative care.

The role of quality education and training in building service provision capacity has been a longstanding focus of the end-of-life and palliative care sector.

Acknowledgement is given to the considerable body of work done by the sector in this area that has led to the development of this Framework.

The National Palliative Care Standards, 5th Edition 2018, have been developed for use by specialist palliative care service providers to support the delivery of high-quality palliative care for the person receiving care, their family and carers. The nine standards are divided into two categories:

- Care Standards (Standard 1 – 6), which describe the systems and enablers necessary to deliver high quality clinical care.
- Governance Standards (Standards 7 – 9), which describe the expectation in regard to quality management, quality improvement and benchmarking.

The Framework will assist organisations to align service provision with the National Palliative Care Standards by addressing Standard 9, “Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles”.

The applicable National Standards are identified within the Framework domains.

The National Palliative Care Standards, 5th Edition 2018, can be viewed on the Palliative Care website at https://palliativecare.org.au
Core principles of the Framework

The following core principles underpin practice in end-of-life and palliative care.

Person, carer and family centred care

Person, carer and family centred care is “…an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, the patient and families”.

A person-centred approach gives consideration to the diverse needs of all people, recognising the importance of their beliefs, culture, goals, wishes, concerns, spirituality, religious, emotional, social and special needs.

It reflects the primacy of the person, placing them at the centre of care.

Communication

Communication is a critical clinical skill in providing end-of-life and palliative care. It is relevant to all interactions between the person, their family/carer(s) and the health professional.

Effective communication during end-of-life care facilitates shared decision-making and planning for dying and death.

Effective communication between health care professionals is essential for coordination of care that is responsive to changing priorities, phases and settings of care, transition between services and ultimately quality of care.

Safety, quality and risk management

All health professionals are responsible for delivering quality health care and all sectors must adhere to defined safety, quality and risk management principles defined in the relevant industry standards, including but not limited to:

- National Safety and Quality Health Service Standards (second edition)
- Aged Care Quality Standards
- National Standards for Disability Services
- National Safety and Quality Primary Health Care (NSQPHC) Standards (in development).

Ethical and legal decision-making

Health professionals are faced with a range of ethical issues in the context of providing end-of-life and palliative care.

A knowledge of the relevant legislation and sensitive management of these ethical issues is essential for the provision of high-quality care.

Building capacity

Building capacity is a strategic approach which allows individuals and health care teams to enhance existing knowledge, skills and confidence in supporting end-of-life and palliative care, at point of care through access to information, training and mentoring support.

It enables health professionals and staff to perform effectively and to adapt to change. It is a collaborative process which benefits from true partnering, building upon existing capacity and is inclusive of each health professional or group.
Core principles of the Framework

Planning ahead
Thinking about future healthcare choices and making decisions about future healthcare is known as advance care planning.

Advance care planning promotes care that is consistent with a person’s goals, values, beliefs and preferences.

It involves ongoing discussions between the person, their family/carer and health professionals, ideally leading to the completion of Advance Care Planning Documents, including:

- a written Advance Health Directive that records treatment decisions to ensure a person’s wishes are respected when they lose capacity to make or communicate their preferences
- an Enduring Power of Guardianship to appoint a substitute decision-maker to make healthcare decisions on the person’s behalf when they are no longer able to do so.

A Goals of Patient Care process should be commenced by clinicians during an episode of care to document the appropriate level of escalation of care, based on the person’s preferences in the context of their underlying medical condition.¹¹

Interprofessional collaboration
Interprofessional collaboration occurs when health professionals from different disciplines work together to identify needs, solve problems, make joint decisions on how best to proceed, and evaluate outcomes collectively.

It supports high quality person-centred care and achieves common goals through teamwork, within and across care sectors and settings.¹²
Domains and learning items

Domain 1 – Principles of practice

Learning focus 1.1. Models of contemporary care

National Palliative Care Standards 5 and 7

Foundation

1.1.1. Person, carer and family-centred care

1.1.2. Models of contemporary end-of-life and palliative care
  - Adult
  - Paediatric (perinatal – adolescent)

1.1.3. Models for delivery of care for:
  - Aboriginal people
  - people with a disability
  - culturally and linguistically diverse people
  - condition specific groups
  - marginalised groups including people experiencing homelessness
  - prisoners
  - children under the care of the Chief Executive Officer of the Department of Communities.

1.1.4. Integrative care and care partnerships

1.1.5. Delivering end-of-life and palliative care in different settings:
  - preferred place of care
  - inpatient care
  - specialist palliative care units
  - emergency departments
  - acute consultative care services
  - community/primary care
  - residential aged care
  - respite care facilities and in-home respite for children
  - older adult mental health
  - disability care
  - mental health
  - correctional facilities.

1.1.6. Rural and remote care

1.1.7. Different modes of end-of-life palliative care delivery
Consolidation

1.1.8. Providing end-of-life and palliative care at the right time, in the right place, with the right team

1.1.9. Embedding the end-of-life continuum and models of care into practice

1.1.10. Integrative care and care partnerships:
  • groups’ theories
  • team members’ roles and contributions.
  • shared care.

1.1.11. Intergenerational concepts of end-of-life and palliative care

1.1.12. Transitioning individuals from paediatric services to adult end-of-life and palliative care services

Extension

1.1.13. Partnerships with others (consumers, carers, other health professionals, organisations/services and communities) to improve end-of-life and palliative care

1.1.14. Formal strategies to support end-of-life and palliative care through:
  • capacity building
  • care in the preferred setting
  • innovation and evidence-based practice.
Domain 1 – Principles of practice

Learning focus 1.2. Professional responsibilities
National Palliative Care Standards 5 and 9

Foundation

1.2.1. Respecting the person, their family and/or carers and colleagues

1.2.2. Working with others:
   - working within and with other teams
   - professional accountability and boundaries
   - identifying own limitations.

1.2.3. Informing professional practice through:
   - research and evidence-based practice
   - legal and legislative requirements
   - privacy and confidentiality
   - use of social media
   - public relations.

1.2.4. Self-care and work-life balance

Consolidation

1.2.5. Facilitating personal autonomy

1.2.6. Facilitating personal and family resilience

1.2.7. Collegiate practice

1.2.8. Respecting and promoting the expertise and contribution of colleagues, teams and other disciplines

1.2.9. Relationship building

1.2.10. Building clinical capacity

1.2.11. Fostering professional development

1.2.12. Professional and team boundaries

Extension

1.2.13. Building cultures of professional practice through:
   - development of emerging professional leaders
   - planned formal training in end-of-life and palliative care
   - structured mentoring programs
   - sustaining teams (e.g. values, goals)
   - sustaining strategies for healthy teams (e.g. values, goals, professional supervision, team building).
Domain 1 – Principles of practice

Learning focus 1.3. Communication
National Palliative Care Standards 2 and 5

Foundation

1.3.1. Developing communication skills in end-of-life and palliative care through training in:
- effective communication
- cultural and linguistically diverse needs
- needs of Aboriginal people
- use of interpreters and other language services and supports
- verbal and written
- use of telehealth
- in challenging situations with, individuals, children, siblings, families and/or carers and colleagues
- developmental and age-specific communication.

1.3.2. Communicating during care transitions
- Goals of Patient Care process
- with other care providers/settings supporting care
- difficult conversations
- curative to palliative care
- increasing decline to terminal phase
- care of the dying person
- loss, grief and bereavement.

1.3.3. Clinical handover:
- timely, relevant and structured handover

Consolidation

1.3.4. Facilitating individual, family/carer(s) communication in:
- Advance Care Planning conversations
- initiating and reviewing Goals of Patient Care
- key transitions in care
- family meetings
- family conferences
- intra and interfacility transfer
- death and bereavement reviews
- use of interpreters and other language services
- breaking bad news and difficult conversations
- discussions regarding prognosis
- times of crisis and conflict.

1.3.5. Facilitating team communication:
- complex case and death review
- team meetings
- interdisciplinary and inter-agency meetings
- clinical handover.

1.3.6. Transitioning from paediatric to adult services
Extension

1.3.7. Developing advanced team communication skills

1.3.8. Anticipating and managing conflict:
   - between teams, the person and their family/carer(s)
   - within teams
   - with other services and stakeholders
   - dispute and conflict resolution
   - complaints management.

1.3.9. Instituting formal processes for effective communication in practice:
   - reflective practice and experiential learning
   - clinical mentoring programs
   - clinical supervision
   - critical thinking and problem solving
   - clinical handover
   - Goals of Patient Care
   - involvement of the child in Goals of Patient Care conversations
   - formal communication processes across care settings.
Domain 1 – Principles of practice

Learning focus 1.4. Ethics and decision-making
National Palliative Care Standards 2 and 4

Foundation

1.4.1. Own beliefs and values and how these affect decision-making and influence practice

1.4.2. Ethical and decision-making frameworks

1.4.3. Ethical issues in end-of-life and palliative care:
  - primacy of the person
  - personal autonomy
  - benefits and burdens of treatment in determining Goals of Patient Care
  - non-beneficial treatments
  - integrative care
  - principle of double effect
  - withdrawing/withholding treatment
  - withdrawal of artificial fluids and nutrition
  - transition from curative to non-curative care including end-of-life care
  - Voluntary Assisted Dying (VAD).

1.4.4. Legislation related to end-of-life and palliative care

Consolidation

1.4.5. Using ethical principles and frameworks in practice

1.4.6. Participating in ethical decision-making in end-of-life and palliative care:
  - with the person and family/carer(s)
  - with children
  - advocacy for the person
  - capacity
  - mature minors
  - informed consent
  - within and between health care teams
  - clinical ethics committees.

1.4.7. Interpreting and applying legislation in end-of-life and palliative care.

Extension

1.4.8. Using ethical decision-making frameworks in service delivery

1.4.9. Supporting establishment and use of clinical ethics committees
1.4.10. Leading ethical decision-making processes at service level:

- supporting clinical governance
- benefits versus burdens of treatment
- non-beneficial treatments
- economic rationalism in service provision
- conflict resolution in decision-making with the person, families/carer(s) and teams.

1.4.11. Risk management, including media interest and public relations
Domain 2 – Clinical management

Learning focus 2.1. Impeccable assessment
National Palliative Care Standard 1

Foundation

2.1.1. Holistic palliative care assessment of the person which includes:
- clinical history
- physical examination
- developmental assessment including communication (children)
- identifying deterioration across the continuum
- recognising frailty
- clinical investigations
- family/siblings/carer(s)
- psychosocial
- spiritual
- cultural
- loss and grief.

2.1.2. Use of evidence-based, standardised clinical assessment tools and methods, e.g. Palliative Care Outcomes Collaboration (PCOC) assessment tools

2.1.3. Use of Goals of Patient Care process

2.1.4. Use of disease-specific triggers

2.1.5. Identifying and reporting clinical and psychosocial risks

2.1.6. Applying palliative care assessment during increasing decline and in the last days of life

Consolidation

2.1.7. Analysing ongoing assessment and prioritising the care needs of the person, family/carer(s):
- identifying Goals of Patient Care
- identifying and responding to actual and anticipated needs of the person and their family/carer(s)
- clinical investigations
- identifying deterioration and transition to the terminal phase
- identifying complexity
- anticipating disease trajectories and mitigating risks.

2.1.8. Equipping the team to respond to the assessment needs of the person, family/carer(s) through:
- palliative care triage
- receiving and making referrals
- inter-team referral
- inter-hospital referral
- consultation with other specialties
- referral to other settings for care
- evaluation of care.
Extension

2.1.9. Responding to the needs of the individual and patient population:
   - prioritisation and resourcing
   - establishing appropriate modes of service delivery
     (e.g. consultancy versus direct care).

2.1.10. Plan, implement, monitor and evaluate clinical assessment processes:
   - quality improvement including audit analysis
   - clinical benchmarking and use of data (local, state,
     national and international), e.g. Palliative Care Outcomes
     Collaboration (PCOC).
Learning focus 2.2. Pre-emptive care planning and clinical practice
National Palliative Care Standards 2, 3 and 4

Foundation

2.2.1. Holistic care planning which considers:
- person, family/siblings/carer(s)
- a wellness model of care
- specific disease trajectories
- independence and supports the person’s wishes, their autonomy and locus of control
- cultural and spiritual needs
- rehabilitation
- pre-emptive care
- Advance Care Planning
- documenting and communicating.

2.2.2. Incorporates curative and other treatment, modalities, therapies and procedures

2.2.3. Care planning during transitions

2.2.4. Care planning during increasing decline and last days of life including the Care Plan for the Dying Person

2.2.5. Care planning to incorporate integrative/complementary care

Consolidation

2.2.6. Initiating and supporting the Goals of Patient Care process

2.2.7. Initiating Advance Care Planning conversations

2.2.8. Roles and responsibilities in multidisciplinary care planning

2.2.9. Rapid response to changing and escalating needs

2.2.10. Advance CPR decision-making

2.2.11. Integrating end-of-life and palliative care planning with other treatment modalities, procedures and therapies

2.2.12. Care planning for anticipated disease processes and trajectories

2.2.13. Condition specific end-of-life care planning

2.2.14. Review and evaluation of care plans

2.2.15. Pre-empting after hours care
Extension

2.2.16. Organisational policy, quality improvement and clinical governance that support the care planning needs of individuals and patient population including:

- clinical governance
- Advance Care Planning
- Advance Health Directives and Enduring Power of Guardianship
- Goals of Patient Care
- care throughout the end-of-life trajectory
- Care Plan for the Dying Person
- Voluntary Assisted Dying
- after hours care provisions
- planning for humanitarian crises, including a pandemic situation.

2.2.17. Formal processes to review, evaluate, reflectively practice, and improve care e.g. team meetings, Grand Rounds, audit and benchmarking

2.2.18. Policy development which underpins supportive care, including integrative care
Domain 2 – Clinical management

Learning focus 2.3. Prevention and relief of suffering
National Palliative Care Standards 2, 3 and 4

Foundation

2.3.1. Considers the person and the family/carer(s) to ensure the plan of care encompasses:
- the underlying disease, advancing illness and comorbidities
- related treatments (short- and long-term effects), therapies and modalities of care
- common and disease-specific symptoms
- pharmacology
- additional care needs e.g. malignant wound management
- person and family/carer(s) education
- integrative and complementary therapies
- cultural and spiritual needs.

2.3.2. Preventing, recognising and responding to holistic suffering including:
- differing perspectives (person, family/carer(s), team, staff)
- impact on family and community
- dealing with myths, the attitudes of others
- treatment modalities; benefits versus burdens
- hope/suffering
- impact on health professionals and staff.

Consolidation

2.3.3. Anticipates, responds to and reviews the impact on the person, family/carer(s) of:
- the disease, advancing illness and comorbidities
- related treatments (short- and long-term effects), therapies and modalities of care
- common and disease-specific symptoms and sequelae
- new and escalating symptoms
- pharmacology
- the meaning attached to symptoms and deterioration
- palliative care emergencies.

2.3.4. Advocating for the person, their family/carer(s) and colleagues

2.3.5. Managing critical incidents

2.3.6. Strategies to address the effects of suffering on colleagues and self
Extension

2.3.7. Managing complexity:
   - in individuals
   - in the patient population
   - during humanitarian crises e.g. pandemic.

2.3.8. Implications of resource management

2.3.9. Creating a climate for clinical reasoning, advocacy and consumer opinion

2.3.10. Formal strategies for risk mitigation

2.3.11. Systems for supporting existential distress in health professionals and staff including formal debriefing, accumulative impact and reflective practice

2.3.12. Governance of critical incidents
Domain 2 – Clinical management

Learning focus 2.4. Chronic disease management
National Palliative Care Standards 4 and 5

Foundation

2.4.1. Pathology of diseases during advancing illness and at end-of-life

2.4.2. Chronic disease from diagnosis to death:
   - natural history
   - pathophysiology
   - disease trajectories
   - co-morbidities and multi-morbidities
   - person’s perspectives and disease meaning.

2.4.3. Planning for and managing the person at home

2.4.4. Education of the person and family/carer(s)

2.4.5. Quality of life: wellness, independence and rehabilitation

2.4.6. Survivorship in palliative care

Consolidation

2.4.7. Prognosis in chronic diseases:
   - co- and multi-morbidities
   - treatment and management
   - identifying decline
   - managing transitions
   - predicting death.

2.4.8. Rationale in pharmacological interventions

2.4.9. Mentoring and fostering learning in end-of-life and palliative care across general healthcare and other specialities

2.4.10. Supporting quality of life in clinical practice:
   - individual autonomy
   - person, family/carer(s) education.

2.4.11. Implementing formal shared care practices
Extension

2.4.12. Promoting creative shared care models across systems:
   - developing a treating coalition
   - building capacity across specialties
   - supporting formal programs for clinical mentoring
   - LEAN principles in care i.e. improving patient satisfaction and care outcomes while reducing costs.

2.4.13. Leading and informing end-of-life and palliative care policy change across health

2.4.14. System planning for implementation of end-of-life choices
Domain 2 – Clinical management

Learning focus 2.5. Loss, grief and bereavement
National Palliative Care Standard 6

Foundation

2.5.1. Contemporary concepts in loss, grief, bereavement, mourning and trauma

2.5.2. Different grief responses and trajectories of experience including Prolonged Grief Disorder

2.5.3. Communicating with the bereaved

2.5.4. Communication about loss, grief and bereavement

2.5.5. Recognition of own experiences, values and beliefs about end-of-life choices, death, dying and grieving

2.5.6. Historical and cultural views on death, grief and mourning

2.5.7. Grief and bereavement services and resources

2.5.8. Care of the bereaved after death

2.5.9. Psychosocial and spiritual needs of individuals and groups

2.5.10. Implications of personal and professional grief

Consolidation

2.5.11. Loss, grief and bereavement at developmental stages across the lifespan:
  - perinatal, neonatal, paediatric, adolescent loss, adult and older adult loss.

2.5.12. Prolonged Grief Disorder

2.5.13. Bereavement risk assessment

2.5.14. Mental illness and loss, grief and bereavement

2.5.15. Cumulative and concurrent loss, grief and bereavement

2.5.16. Providing bereavement care

Extension

2.5.17. Grief and bereavement care including grief support, grief counselling and grief therapy:
  - evidence-based contemporary practice
  - planning, implementing and evaluation (internal)
  - formal links with external services
  - planning for humanitarian crises.
2.5.18. Prevention strategies for loss, grief and bereavement

2.5.19. Research in end-of-life and palliative care
Domain 3 – Leadership and management

Learning focus: 3.1. Management and supervision
National Palliative Care Standard 9

Foundation

3.1.1. Working within health care teams

3.1.2. Exploring team building strategies

3.1.3. Identifying stressors that impact on health care teams

3.1.4. Working with and developing volunteers

Consolidation

3.1.5. Introduction to leadership and management in health care services and organisations

3.1.6. Introduction to managing resources and budgets/funding

3.1.7. Managing people (supervisory roles) and conflict resolution

3.1.8. Managing and/or leading health care teams:
  • team building
  • formal strategies to debrief/reflect on practice

Extension

3.1.9. Managing people:
  • staff
  • health care teams
  • volunteers
  • human resource management
  • job and work design
  • performance management
  • conflict resolution
  • prevention of health professional and staff psychological morbidity and burn out
  • supporting health professionals providing palliative care to children infrequently.

3.1.10. Managing organisations:
  • information management
  • data management
  • financial management
  • funding models (e.g. Activity Based Funding)
  • contract management
  • business planning
  • project management.

3.1.11. Contemporary management theories in health services
Domain 3 – Leadership and management

Learning focus: 3.2. Strategic planning and service development

National Palliative Care Standard 7 and 8

Foundation

3.2.1. Historical development of end-of-life care and palliative care

3.2.2. Population-based approach and equity and access to care

3.2.3. Implications of funding for contemporary care delivery

3.2.4. Palliative care as a human right

3.2.5. Consumer partnerships in service development and design

3.2.6. Consumer partnerships with special needs and marginalised groups

3.2.7. Consumer involvement in organisational operation

Consolidation

3.2.8. Contemporary end-of-life and palliative care

3.2.9. Service design which responds to changing population needs

3.2.10. Use of outcome measures in service development

3.2.11. Health policy implications

3.2.12. Service design that supports equity and access

3.2.13. Organisational and clinical governance

3.2.14. Integrative health care

3.2.15. Supporting service and organisational change management

3.2.16. Engaging consumers in strategic planning and service development

Extension

3.2.17. Building sustainable quality health services

3.2.18. Applying a population-based approach to service design and delivery

3.2.19. Establishing and maintaining organisational and clinical governance
3.2.20. Conducting and analysing health service needs assessments

3.2.21. Involvement in outcome measure collaborations and use of data in service improvement e.g. Palliative Care Outcomes Collaboration (PCOC)

3.2.22. Health policy development

3.2.23. Strategic engagement with consumers, carers and community groups including those with special needs

3.2.24. Networking, liaison and negotiation with health sector and other stakeholders

3.2.25. Leading and managing change and innovation within the service and across health care
Domain 3 – Leadership and management

**Learning focus: 3.3. Safety, quality and risk management**

National Palliative Care Standard 8

**Foundation**

3.3.1. Applying safety, quality and risk management principles to practice

3.3.2. Using the continuous quality improvement cycle in practice

3.3.3. Standards for quality in health care including National Safety and Quality Health Service Standards, Palliative Care Australia Standards, Aged Care Quality Standards

3.3.4. Standards and Accreditation Standards

3.3.5. Medication safety in end-of-life care practice

**Consolidation**

3.3.6. Integrating safety, quality and risk management into practice

3.3.7. Integrating relevant standards and frameworks into practice

3.3.8. Benchmarking in end-of-life and palliative care

**Extension**

3.3.9. Corporate and clinical risk management principles

3.3.10. Medication safety and minimising harm in palliative care practice

3.3.11. Leading service-wide continuous quality improvement

3.3.12. Building and leading a culture change management

3.3.13. Provision of safe and high-quality end-of-life and palliative care

3.3.14. Applying corporate and clinical risk management strategies

3.3.15. Partnering with consumers and/or carers in quality improvement

3.3.16. Planning, implementing and evaluating operational strategies

3.3.17. Governance and quality improvement in medication management
Domain 3 – Leadership and management

Learning focus: 3.4. Workforce development and succession planning
National Palliative Care Standard 9

Foundation

3.4.1. Personal values and beliefs and their impact on practice

3.4.2. Self-care, work-life balance, grief and bereavement

3.4.3. Professional development

3.4.4. Time management skills

3.4.5. Introduction to mentoring skills in the workplace:
  - with students
  - with other staff
  - interdisciplinary
  - inter-specialty.

Consolidation

3.4.6. Building clinical and service capacity through:
  - inter-specialty
  - mentoring (formal and informal)
  - identifying opportunities for end-of-life care education, training and clinical mentoring
  - supporting the professional development of others
  - strategies for individual self-care and team building
  - developing teaching skills for use in education, training and clinical mentoring.

Extension

3.4.7. Creating and sustaining a culture that supports education and training:
  - guidance and leadership in professional development
    identifying and supporting emerging clinical leaders and educators
    succession planning.

3.4.8. Formal strategies for self-care at service level

3.4.9. Implementing and evaluating formal mentoring programs

3.4.10. Attracting and retaining specialist palliative care staff
**Advance care planning** is an ongoing discussion between a patient and their carers, family and health professionals about the patient’s values, beliefs, treatment and care options.

It focuses in particular on the patient’s preferences for their future treatment and care should they no longer be able to make or communicate their decisions at the time they are needed.13

**End-of-life** is the timeframe during which a person lives with, and is impaired by, a life-limiting/fatal condition, even if the prognosis is ambiguous or unknown.

Those approaching end-of-life will be considered likely to die during the next 12 months.1

**End-of-life care** is care needed for people who are likely to die in the next 12 months due to progressive, advanced or incurable illness, frailty or old age. During this period, people may experience rapid changes and fluctuations in their condition and require support from a range of people, including health services, as well as family and carers.1

**Loss, grief, bereavement and mourning**

**Loss** refers to the severing of attachment to someone or something.

**Grief** is the multidimensional responses to loss.

**Bereavement** is the situation of having lost a significant person through their death.

**Mourning** refers to expressions of grief, including social practices.

**Paediatric palliative care**

Palliative care for children, adolescents and young adults with life-limiting or life-threatening conditions is an active and total approach to care, from the point of diagnosis or recognition throughout the child’s life, death and beyond.

It embraces physical, emotional, social, and spiritual elements of quality of life for the child or young person and support for the family. It includes the management of distressing symptoms, provision of short breaks and care at the end-of-life and bereavement support.14

**Palliative care** is an approach that improves the quality of life of individuals, their families and carers facing problems associated with life-threatening illness/condition, through the prevention and relief of suffering.

Palliative care recognises the person and the importance and uniqueness of their family/carer. It serves to maximise the quality of life and considers physical, social, financial, emotional, and spiritual distress. Such distress not only influences the experience of having a life-limiting illness but also influences treatment outcomes.1

**Service provider organisation** or individual that provides health care or support services.

**Specialist palliative care** is undertaken by a professional palliative care team or service with recognised qualifications or accredited training in palliative care. They provide direct care to people, and their family/carer with complex palliative care needs and/or provide consultation services to support, advise and educate specialist and non-specialist teams providing end-of-life care.1

**Terminal care** refers to the care of a person in the last days or weeks before they die (i.e. the final part of palliative care).1
Standard 1
Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles.

Standard 2
The person, their family and carers work in partnership with the team to communicate, plan, set goals of care and support informed decisions about the care plan.

Standard 3
The person's family and carers needs are assessed and directly inform provision of appropriate support and guidance about their role.

Standard 4
Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles.

Standard 5
Care is integrated across the person’s experience to ensure seamless transitions within and between services.

Standard 6
Families and carers have access to bereavement support services and are provided with information about loss and grief.

Standard 7
The service has a philosophy, values, culture, structure and environment that supports the delivery of person-centred palliative care and end-of-life care

Standard 8
Services are engaged in quality improvement and research to improve service provision and development.

Standard 9
Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles.
Scenario 1
Primary care, regional general practice

1. Issue

General practitioners (GPs) in a large regional practice want to ensure the practice team is well-skilled and confident to deliver palliative care for their local community.

2. Using the Framework

The practice manager coordinates a meeting of all staff (doctors, practice nurses, administration staff).

- Working through the Framework together to examine current knowledge and gaps, the group determines further education and training regarding general palliative care provision is not required at this time.

- As the practice services a significant cohort of Aboriginal people, the team identify the need for education and training to improve the provision of culturally respectful and appropriate palliative care services for Aboriginal people.

3. Relevant learning items

Models of care:
- 1.1.3. Models of care delivery for Aboriginal people

Strategic planning and service development:
- 3.2.5. Consumer partnerships with special needs groups in service development

Communication:
- 1.3.1. Developing communication skills in end-of-life and palliative care through training in the needs of Aboriginal people

Impeccable assessment:
- 2.1.1. Holistic palliative care assessment including spiritual and cultural needs (of Aboriginal people)

Care planning:
- 2.2.1. Holistic care planning which considers cultural and spiritual needs (of Aboriginal people)

Prevention and relief of suffering:
- 2.3.1. Considers the person and the family/carer to ensure the plan of care encompasses cultural and spiritual needs

Loss, grief and bereavement:
- 2.5.5. Cultural views on death, grief and bereavement
- 2.5.8. Psychosocial and spiritual needs of individuals and groups

4. Next steps...

Using the resources linked to the Framework, the practice manager identifies a suitable education event in the Palliative and Supportive Care Education (PaSCE) program provided by the Program of Experience in the Palliative Approach (PEPA); Cultured Centred Palliative Care – an Aboriginal perspective.

She and one of the practice GPs attend the two-day training course with the intention of using the information gained to run an in-service for the practice staff and identify areas for the practice to address.
Case scenarios

Scenario 2
General hospital, intern education

1. Issue
A senior physician approaches the Director of Medical Education expressing concern about the decisions that some interns are making in relation to the management of patients approaching the end-of-life.

One intern chose to prescribe a large dose of sedative to a patient dying with pancreatic cancer.

Another initiates intravenous fluids at the end-of-life for all patients who are unable to swallow, and a third has disclosed information to a family member without the patient's permission.

The physician suggests that interactive education regarding ethical decision-making in palliative care be made available to the current cohort of interns.

2. Using the Framework
The Medical Education Department reviews the Framework learning items under learning focus 1.4. ethics and decision-making against the relevant undergraduate medical curricula. Previous learning is identified and any gaps in knowledge and skills are identified.

3. Relevant learning items

Ethics and decision-making

- 1.4.1. Own beliefs and values and how these effect decision-making and influence practice
- 1.4.5. Using ethical principles and frameworks in practice
- 1.4.6. Participating in ethical decision-making in end-of-life care
- 1.4.7. Interpreting and applying legislation in end-of-life care

4. Next steps…

The Medical Education Department develops a new in-house education module for interns on ethics and decision-making in end-of-life and palliative care.

The module is delivered via a multimodal approach including dedicated workshops, departmental teaching on end-of-life and palliative care from senior clinicians and clinical discussions during mortality and morbidity meetings.

Existing resources linked to the Framework including the End of Life Law for Clinicians training program are included within the module.
Case scenarios

Scenario 3
Disability service provider

1. Issue
A large disability service provider (group homes, community support and therapy service) identifies the need for increasing service capacity in the provision of palliative care to their clients.

2. Using the Framework
The executive team brings together a group of senior service managers from within the organisation to discuss the issue and consider the actions required to achieve organisational change.

Workforce education and training are identified as components that will be required in the development of enhanced palliative care services.

At a second meeting, the education and training coordinator uses the Framework to determine that the existing level of palliative care knowledge and skills varies considerably across the group of senior managers.

3. Relevant learning items
Strategic planning and service development:
- 3.2.1. Historical development of end-of-life and palliative care and implications for service models
- 3.2.8. Contemporary end-of-life and palliative care

Models of care:
- 1.1.13. Partnerships with others, organisations/services to improve palliative and end-of-life care

Communication:
- 1.3.2. Communication during care transitions
- 1.3.5. Facilitating team communication

Ethics and decision-making:
- 1.4.5. Using ethical principles and frameworks in practice
- 1.4.7. Interpreting and applying legislation on end-of-life care

Assessment:
- 2.1.8. Equipping the team to respond to the assessment needs of the person, family/carer

Care planning and clinical practice:
- 2.2.1. Holistic care planning

Loss, grief and bereavement:
- 2.5.1. Contemporary concepts in loss, grief and bereavement, ‘normal’ and ‘complicated’ grief
- 2.5.6. Grief and bereavement services and resources

4. Next steps...
Due to the breadth of variation in senior service manager knowledge and skills it is determined that select managers will attend a general palliative care education session accessed via the Palliative and Supportive Care Education (PaSCE) Service, provided by the Program of Experience in the Palliative Approach (PEPA) – Palliative care for Health Professionals working in Disability Services.

Now familiar with the Framework, senior managers use the tool to determine education and training needs within their service specific teams and identify appropriate education and training.
Case scenarios

Scenario 4
Residential aged care provider

1. Issue
The manager of a large residential aged care facility has conducted an audit of residents' records, of those who have died over the past 12 months. She has noted that despite an expressed wish of 90% of residents to die at the facility, only 23% did.

The audit results are tabled at the facility monthly staff meeting. Feedback from staff including nursing, allied health and personal care staff indicates a lack of confidence in identifying clinical deterioration, coordinating and delivering care during transition to and during the terminal phase.

2. Using the Framework
The manager determines that focussed learning incorporating advance care planning and establishing goals of care will be used to improve staff confidence in this area of service provision.

She uses the Framework to identify the current skills and knowledge level of staff, determining that expertise varies considerably across the different staff groups i.e. registered nurses (RNs), allied health and personal care staff.

3. Relevant learning items
For RNs:
Models of care:
  • 1.1.2. Contemporary palliative care

Ethics and decision-making:
  • 1.4.1. Own beliefs and values and how these affect decision-making and influence practice
  • 1.4.7. Interpreting and applying legislation in end-of-life care

Impeccable assessment:
  • 2.1.6. Applying palliative care assessment during increasing decline and in the last days of life

Clinical management:
  • 2.2.4. Care planning during increasing decline and last days of life including the Care Plan for the Dying Person
  • 2.2.9. Rapid response to changing and escalating needs

Prevention and relief of suffering:
  • 2.3.2. Preventing, recognising and responding to holistic suffering

Loss, grief and bereavement:
  • 2.5.16. Providing bereavement services

4. Next steps...
The manager determines education and training for registered nurses to be a priority in the first instance.

Using the resources linked to the Framework, she identifies suitable training sessions accessed via the Palliative and Supportive Care Education (PaSCE) Service: Principles of Palliative Care, Modules 1 and 2.

The RNs will be involved in the development and delivery of future informal in-house education to allied health and personal care staff.
Case scenarios

Scenario 5
Tertiary hospital, Medical Director, Renal Service

1. Issue
The new Medical Director, Renal Services comes to the position with extensive experience in renal care, having had a variety of senior roles in her specialty.

This is her first position in senior management. In addition to her usual responsibilities within the renal specialty she is now also responsible for developing a new advanced renal palliative care symptom clinic which is run by her department.

The medical director is keen for the renal palliative care clinic to be a success and is aware that members of the team have limited palliative care experience.

2. Using the Framework
The medical director brings together a group of senior clinicians to discuss strategies for development of the new clinic.

Together they discuss their learning needs. Using the Framework, they determine the priority to be education and training for senior staff in palliative care service planning and development.

3. Relevant learning items
Strategic planning and service development
- 3.2.17. Building sustainable quality health services
- 3.2.20. Conducting and analysing health service needs assessment

Workforce development and succession planning
- 3.4.7. Creating and sustaining a culture that supports education and training in palliative care
- 3.4.10. Attracting and retaining specialist palliative care staff

4. Next steps...
The medical director accesses the education and training required by senior managers from a number of sources including the Health Service Leadership and Management in-service program and directly from palliative care physicians.

Formal clinical mentoring is planned, resourced and implemented. Formal evaluation is supported by data.

Using the resources linked to the Framework, senior clinicians also access the Palliative Care Outcomes Collaboration (PCOC) Essentials Program and Clinical Leadership Workshops.

In further development of the clinic, the Framework will be used to determine the education and training required for other clinical staff within the service.
Case scenarios

Scenario 6
Specialist paediatric palliative care, allied health professionals

1. Issue

The family of a 7-year-old child who is at end-of-life and currently receiving specialist palliative care in a metropolitan tertiary hospital, wants to return to their home in a regional location, to be close to family and their community.

The local allied health team (physiotherapist, dietitian, social worker), who predominately care for adults, have not had experience in caring for a child at end-of-life with palliative care needs. They recognise they would benefit from paediatric palliative care education and request support from the Specialist Palliative Care Service at the tertiary hospital.

2. Using the Framework

The local allied health team express concerns regarding their current level of knowledge and experience around communication with the child and siblings, such as how to respond to questions if the child or sibling ask about death and dying and identifying the allied health needs of the child, e.g. the child’s feeding needs and equipment that may be required.

The local allied health team, with input from the Specialist Paediatric Palliative Care Service, work through the Framework to identify current knowledge and skills, gaps in knowledge/skills and learning needs.

3. Relevant learning items

Models of contemporary care:
- 1.1.1. Person, carer and family-centred care
- 1.1.2. Models of contemporary palliative care including paediatric (perinatal – adolescent)
- 1.1.4. Integrative care and care partnerships

Communication:
- 1.3.1. Developing communication skills in end-of-life and palliative care including in challenging situations with, individuals, children, siblings, families and/or carers and colleagues and developmental and age-specific communication

Impeccable assessment:
- 2.1.1. Holistic palliative care assessment of the person including developmental assessment
- 2.1.2. Use of evidence-based, standardised clinical assessment tools and methods

Pre-emptive care planning and clinical practice:
- 2.2.1. Holistic care planning which considers person, family/siblings/carer(s)

Prevention and relief of suffering:
- 2.3.1. Preventing, recognising and responding to holistic suffering including differing perspectives (person, family/carer(s), team, staff) and impact on family and community

Loss, grief and bereavement:
- 2.5.1. Contemporary concepts in loss, grief, bereavement, mourning and trauma
- 2.5.4. Communication about loss, grief and bereavement
- 2.5.5. Recognition of own experiences, values and beliefs about end-of-life choices, death, dying and grieving

4. Next steps...

The Specialist Paediatric Palliative Care Service liaises with the Regional Hospital Manager and Regional Palliative Care team to facilitate the education required by the allied health team. The education is delivered as a combination of face-to-face sessions with the Regional Palliative Care team and via relevant online learning resources linked to the Framework including the End-of-life Essentials Education Module – Paediatric end-of-life care and the PCC4U learning modules, focus topic 1, Caring for children with a life-limiting illness.


4. Palliative Care Australia 2018, National Palliative Care Standards 5th edn, PCA, Canberra.


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**Lauren Breen**
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The Framework builds on the 2015 End-of-Life and Palliative Care Learning Continuum created by the WACPCN, End-of-Life and Palliative Care Education Working Group 2012 – 2014, in addition to the longstanding and ongoing collective contribution of the sector.
Appendix 1 – Education and training opportunities mapped to learning focus areas/learning items

The table on the next page provides direct links to the key contemporary education and training resources, mapped to the Framework’s learning areas/learning items. To ensure the Framework and Hub remain up-to-date and comprehensive, we welcome feedback via EOLCare@health.wa.gov.au of any additional content to be considered for inclusion. Please note that the education and training resources provided are not exhaustive and do not imply endorsement, however they are key examples of those available.

Please note that users can also access the end-of-life and palliative care education and training resources in alternative format categorised by topic, care setting and education and training provider by going to the Education and Training Resource Hub section at: https://ww2.health.wa.gov.au/Articles/A_E/End-of-Life-and-Palliative-Care-Education-and-Training/End-of-life-palliative-care-training-and-education
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<th>Learning focus area/learning item</th>
<th>Resource</th>
<th>Also relevant to other learning focus areas/learning items</th>
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| 1.1. Models of contemporary care  | CLiP adults worksheets [Current Learning in Palliative Care (CLiP UK)](https://www.stoswaldsuk.org/how-we-help/we-educate/education/resources/what-is-clip/clip-adults-worksheets) | • 2.2. Care planning and clinical practice  
• 2.3. Prevention and relief of suffering  
• 2.5. Loss, grief and bereavement |
|                                  | Core module 1: Principles of palliative care [Palliative Care Curriculum for Undergraduates (PCC4U)](https://pcc4u.org.au/learning/modules/module1) | • 1.4. Ethics and decision-making                                                                                       |
• 1.3. Communication  
• 1.2.4. Loss, grief and bereavement                                                                                        |
|                                  | Principles of palliative care module 1 [Palliative and Supportive Care Education (PaSCE)](https://www.cancerwa.asn.au/articles/calendar/calendar-health-professional-training-seminars-and/) |                                                                                                                          |
|                                  | Self-directed learning palliative care – Getting started (online) module [Centre for Palliative Care](https://www.centreforpallcare.org/page/93/online-courses) |                                                                                                                          |
| 1.1.2. Models of contemporary end-of-life and palliative care  
• paediatric | Focus topic 3: Caring for children [Palliative Care Curriculum for Undergraduates (PCC4U)](https://pcc4u.org.au/learning/topics/topic3) |                                                                                                                          |
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1.1.3. Models of care delivery for:

- Aboriginal people
  - Culture centred palliative care – an Aboriginal perspective
  Program of Experience in the Palliative Approach (PEPA) workshop
  *Resource offered as part of a fixed program of events, only available on certain dates*

- Focus topic 2: Caring for Aboriginal people with life-limiting illnesses
  Palliative Care Curriculum for Undergraduates (PCC4U)
  [https://pcc4u.org.au/learning/topics/topic2](https://pcc4u.org.au/learning/topics/topic2)

1.1.3. Models of care delivery for:

- people with a disability
  - Palliative care for health professionals working in disability services workshop
  Program of Experience in the Palliative Approach (PEPA)
  *Resource offered as part of a fixed program of events, only available on certain dates*

- Talking end-of-life with people with an intellectual disability (TEL)
  CareSearch

1.1.3. Models of care delivery for:

- culturally and linguistically diverse people
  - Focus topic 4: Culture-centred care for people with life-limiting illnesses
  Palliative Care Curriculum for Undergraduates (PCC4U)

   • 2.2. Care planning

   • 1.1. Models of contemporary care

   • 2.2. Care planning
| 1.1.5. Delivering end-of-life and palliative care in different settings: | Palliative care in residential aged care workshop  
Program of Experience in the Palliative Approach (PEPA)  
*Resource offered as part of a fixed program of events, only available on certain dates  
https://www.cancerwa.asn.au/articles/calendar/calendar-health-professional-training-seminars-and/ |
| --- | --- |
| 1.1.5. Delivering end-of-life and palliative care in different settings: | Emergency department end-of-life care  
End-of-Life Essentials Education Modules  
| 1.1.5. Delivering end-of-life and palliative care in different settings: | eLearning for general practitioners  
The Advance Project  
| 1.2. Professional responsibilities | Health professional education  
Caring@home  
| 1.2.2. Working with others | Palliative Care Online Training – The guidelines for a palliative approach to aged care in the community (COMPAC)  
Australian Health Care and Hospitals Association  
https://www.pallcaretraining.com.au |
| 1.2.2. Working with others | Focus topic 1: Multidisciplinary care  
Palliative Care Curriculum for Undergraduates (PCC4U)  
https://pcc4u.org.au/learning/topics/topic1 |
| 1.2.2. Working with others | Teams and continuity for the patient  
End-of-Life Essentials Education Modules  

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| 1.2.4. Self-care and work-life balance | **Grief, loss and self-care for Aboriginal health workers**  
Palliative and Supportive Care Education (PaSCE)  
*Resource offered as part of a fixed program of events, only available on certain dates*  
| | 2.5. Loss, grief and bereavement |
| | **Principles of palliative care module 1**  
Palliative and Supportive Care Education (PaSCE)  
*Resource offered as part of a fixed program of events, only available on certain dates*  
| | 1.1. Models of contemporary care  
1.3. Communication  
1.2.4. Loss, grief and bereavement |
| | **Self-care matters**  
Palliative Care Australia (PCA)  
| | 3.1. Management and supervision |
| 1.3. Communication | **Clinician communication program – Eliciting and responding to emotional cues**  
*Resource offered as part of a fixed program of events, only available on certain dates*  
| | **Core module 2: Communication**  
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<td>1.2.4. Professional responsibilities – self-care</td>
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<tr>
<td>Stanford palliative care training portal: The end-of-life curriculum project – US Stanford School of Medicine – Palliative care <a href="https://palliative.stanford.edu">https://palliative.stanford.edu</a></td>
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| 1.3.4. Facilitating individual, family/carer(s) communication in: | **Advance Care Planning Australia learning program**
The learning program delivers a range of online courses, face-to-face workshops and webinars for all those interested in learning more about advance care planning:
- Advance communication
- Module (2) Two: Advance Care Planning Conversations

Advance Care Planning Australia
| --- | --- |
| 1.3.5. Facilitating team communication | **Teams and continuity for the patient**
End-of-Life Essentials Education Modules
| 1.4. Ethics and decision-making | **Advance Care Planning online learning tool**
Department of Health, Western Australia
| 2.1. Impeccable assessment | **Core module 1: Principles of palliative care**
Palliative Care Curriculum for Undergraduates (PCC4U)
| **End of Life Law for Clinicians**
End of Life Law in Australia
[https://end-of-life.qut.edu.au](https://end-of-life.qut.edu.au) | 1.1. Models of contemporary care |
| **Core module 3: Assessing and managing symptoms**
Palliative Care Curriculum for Undergraduates (PCC4U)
[https://pcc4u.org.au/learning/modules/module3](https://pcc4u.org.au/learning/modules/module3) | 2.2. Care planning |
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| **Palliative care course**  
Australian Primary Health Care Nurses Association (APNA)  
[https://www.apna.asn.au/product/detail/b39abc31-4823-e811-80d4-005056be66b1](https://www.apna.asn.au/product/detail/b39abc31-4823-e811-80d4-005056be66b1) | • 1.3. Communication  
• 2.2. Care planning and clinical practice  
• 2.3 Prevention and relief of suffering | **Principles of palliative care module 2**  
Palliative and Supportive Care Education (PaSCE)  
*Resource offered as part of a fixed program of events, only available on certain dates [https://www.cancerwa.asn.au/articles/calendar/calendar-health-professional-training-seminars-and/](https://www.cancerwa.asn.au/articles/calendar/calendar-health-professional-training-seminars-and/)* | | |
| **2.1.2. Use of evidence-based standardised clinical assessment tools and methods** | • **The Essentials program** – short course for managers and clinicians learning about the PCOC assessment tools, implementing PCOC and reports  
• **Clinical leadership workshops**  
| **2.1.3. Use of Goals of Patient Care process** | **Goals of patient care – training video**  
| **2.1.10. Plan, implement, monitor and evaluate clinical assessment processes** | • **The Essentials program** – short course for managers and clinicians learning about the PCOC assessment tools, implementing PCOC and reports  
• **Clinical leadership workshops**  
| 2.2. Pre-emptive care planning and clinical practice | **CLiP Adults Worksheets**  
Current Learning in Palliative Care (CLiP UK)  
[https://www.stoswaldsuk.org/how-we-help/we-educate/education/resources/what-is-clip/clip-adults-worksheets](https://www.stoswaldsuk.org/how-we-help/we-educate/education/resources/what-is-clip/clip-adults-worksheets) | • 1.1. Models of contemporary care  
• 2.3. Prevention and relief of suffering  
• 2.5. Loss, grief and bereavement |
|---|---|---|
|  | **Core module 4: Optimising function in palliative care**  
Palliative Care Curriculum for Undergraduates (PCC4U)  
[https://pcc4u.org.au/learning/modules/module4](https://pcc4u.org.au/learning/modules/module4) | • 1.3 Communication  
• 1.4. Ethics and decision-making  
• 2.2. Pre-emptive care planning and clinical practice  
• 2.5. Loss, grief and bereavement |
|  | **Palliative care course**  
Australian Primary Health Care Nurses Association (APNA)  
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• 2.1. Assessment  
• 2.3. Prevention and relief of suffering |
|  | **Palliative care for health professionals working in disability services workshop**  
Program of Experience in the Palliative Approach (PEPA)  
*Resource offered as part of a fixed program of events, only available on certain dates*  
|  | **Tools and skills for embedding palliative care in residential aged care**  
Cancer Council WA  
*Resource offered as part of a fixed program of events, only available on certain dates*  
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<th>The spiritual dimension of palliative care</th>
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<td>• spiritual needs</td>
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<td>The learning program delivers a range of online courses, face-to-face workshops and webinars for all those interested in learning more about advance care planning.</td>
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| 2.1. Assessment | 2.1. Assessment | 1.3. Communication |
### Using the Framework

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<td><a href="https://www.stoswaldsuk.org/how-we-help/we-educate/education/resources/what-is-clip/clip-adults-worksheets">Current Learning in Palliative Care (CLiP UK)</a></td>
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| 2.5. Loss, grief and bereavement | Australian Centre for Grief and Bereavement (ACGB) education and training  
|                               | CLiP Adults Worksheets  
Current Learning in Palliative Care (CLiP UK)  
https://www.stoswaldsuk.org/how-we-help/we-educate/education/resources/what-is-clip/clip-adults-worksheets |
|                               | Principles of palliative care module 1  
Palliative and Supportive Care Education (PaSCE)  
*Resource offered as part of a fixed program of events, only available on certain dates  
https://www.cancerwa.asn.au/articles/calendar/calendar-health-professional-training-seminars-and/ |
|                               | Ways of working with grief and loss in Aboriginal communities  
Palliative and Supportive Care Education (PaSCE)  
*Resource offered as part of a fixed program of events, only available on certain dates  
https://www.cancerwa.asn.au/articles/calendar/calendar-health-professional-training-seminars-and/ |
|                               | Stanford Palliative Care Training Portal: The end-of-life curriculum project – US  
Stanford School of Medicine – Palliative care  
https://palliative.stanford.edu |

- 1.1. Models of contemporary care
- 2.2. Care planning and clinical practice
- 2.3. Prevention and relief of suffering
- 1.3. Communication
- 1.2.4. Professional responsibilities – self-care
- 1.1. Models of contemporary care
- 1.3. Communication
- 2.3. Prevention and relief of suffering

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Self-care matters
Palliative Care Australia (PCA)

- 1.2. Professional responsibilities

### 3.2. Strategic planning and service development

#### 3.2.10. Use of outcome measures in service development

Clinical leadership workshops
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