***[EXAMPLE ONLY – To be modified by the relevant organisation to suit]***

# Palliative and End-of-Life Care for Residents

Add agency logo.

Modify as required.

---

## 1 PURPOSE

1.1 When residents of disability residential services are diagnosed with a life limiting condition, or as they age, their need for end-of-life care increases. (Enter agency name) staff play a pivotal role in supporting residents who are approaching or reaching end of life.

1.2 A respectful and supportive approach enables the resident to have a quality end-of-life experience. In this way, disability residential service staff, with the support of specialist palliative care services, are able to maintain the resident's lifestyle for as long as possible.

1.3 The resident's right to choose their place of death will be respected and supported as much as possible by (enter agency name).

1.4 (Enter agency name) must abide by all relevant legislation to enable a resident to die in the disability residential service. (Enter agency name) supports the principles and philosophy as documented in the Department of Health and Human Services Disability Residential Services Palliative Care Guide and the Victorian Government end-of-life and palliative care framework.

## 2 SCOPE

2.1 There are many important areas to be considered when a person with a disability (resident) has been diagnosed with a life limiting condition, and wishes to remain in, or die in the home. This policy and its associated procedures have been developed to assist disability residential service staff, and their Managers, to confidently plan and care for a resident at the end of their life. This policy has been developed to provide an outline of legal requirements, provide resources, and also describe how disability and specialist palliative care staff can work together in providing end of life care.

## 3 POLICY STATEMENT

3.1 (Enter agency name) is committed to providing supportive and compassionate end of life care for every person in disability residential services.

3.2 (Enter agency name) actively supports personal choice about care at end of life for people residing in disability residential services.

3.3 (Enter agency name) is committed to working collaboratively with all stakeholders [including the resident, carers, specialist palliative care services, primary care services and chronic disease support services] to provide quality end-of-life support to residents with a life limiting illness.

## 4 PROCEDURES

### Planning

4.1 Planning ahead enables a resident's views and preferences to be respected and followed (see Advance care planning; sections 4.2 to 4.15). The resident's family and friends should be included in these discussions, as appropriate. Planning at the earliest point enables the resident to express preferences regarding their future care. This planning should be self-directed and enable the resident's involvement throughout their end-of-life care. Depending on the condition, it might not be possible for the resident to make their views known at the time decisions need to be made, however, staff must work with the resident, their decision makers and health professionals to ensure planning is in accordance with legal requirements.

**Additional resources for end of life conversations:**
The Southern Metropolitan Region Palliative Care Consortium has developed a factsheet to support end of life conversations: How to care and listen/end of life conversations.

### Advance care planning

4.2 Advance care planning promotes care that is consistent with a person's goals, values, beliefs, and preferences. Advance care planning allows people to clearly express their values and preferences to inform clinical decision-making when they are unable to directly participate. The Medical Treatment Planning and Decisions Act 2016 enshrines advance care directives in Victorian law and creates clear obligations for health practitioners caring for people who do not have decision-making capacity.

4.3 In Victoria, an Advance Care Directive is the only legally recognised document that a person can record their medical treatment preferences in. However, should a person lose decision making capacity, any written record of their values or medical preferences must be considered by their medical treatment decision maker.

### Decision making in advance care planning

4.4 In accordance with the Medical Treatment and Decisions Act 2016, if the resident is unable to make decisions about their own health care, substitute decision-makers can make decisions on their behalf.

The substitute decision-maker may be: Nominated by the resident (an **agent or attorney or medical treatment decision-maker**), Appointed by a tribunal (a **guardian**), or; Appointed by default under legislation (a **medical treatment decision-maker**). A medical treatment decision-maker is the person designated under Victorian law if there is no guardian, agent, attorney or appointed medical treatment decision-maker.
For further information refer to the checklist of steps for appointing a support person in medical treatment decision making.

4.5 (Enter agency name) staff are not authorised to assume the role of agent or attorney or medical treatment decision-maker, guardian or medical treatment decision-maker for any resident of the service, where the relationship has been formed by being a 'consumer' of the service.

### Refusal of Treatment Certificate

4.6 The Refusal of Treatment Certificate is the form prescribed by Victorian law until new laws came into effect on 12 March 2018. This certificate remains binding after 12 March 2018 unless revoked.

### Advance Care Directive

4.7 The Advance Care Directive is a formal document prescribed by Victorian law (from 12 March 2018). It only comes into effect if the person is unable to make their own decisions. The Advance Care Directive allows the person to refuse or withdraw medical treatment and consent to commencement of treatments. The directive allows for instructional and values directives.

4.8 To be legally binding, the Advance Care Directive must be witnessed by a medical practitioner and another adult (but not the Medical Treatment Decision Maker). There are prescribed forms to use when completing the directive, which will be provided by the health practitioner.

4.9 (Enter agency name) staff should support residents to regularly review their Advance Care Directive, in consultation with their health professional.

4.10 Residents can upload their Advance Care Directive to "My Health Record". Staff are encouraged to support residents to do this. A copy should also be provided to any substitute decision-makers, the General Practitioner and/or hospital, the Disability service and the Specialist Palliative Care Service involved.

4.11 At the residential service, the resident's Advance Care Directive should be kept (enter where this would be printed and available). All staff are required to be familiar with a resident's Advance Care Directive, and these will be regularly discussed at house care plan/ team meetings. Minutes must be maintained to document this discussion.

### Amending or revoking advance care planning documents

4.12 From March 2018, a person can amend the original, or prepare a new directive, which will revoke a previous directive. Staff are required to support a resident to consult with a health professional or a general practitioner if an Advance Care Directive needs to be amended or revoked.

### Health care professionals' obligations in advance care planning

4.13 From 12 March 2018, a health practitioner must give effect to any instructional directive in an advance care directive unless:

- circumstances have changed since the person gave the advance care directive so that the practical effect of the instructional directive would no longer be consistent with the person's preferences and values;
- the delay that would be caused by an application to VCAT as to whether the directive is applicable would result in a significant deterioration of the person's condition.

4.14 A health care professional must comply with a Refusal of Treatment Certificate. If the person who gave the Refusal of Treatment Certificate no longer suffers from the "current condition", the Refusal of Treatment Certificate will not apply.

### Mental health matters under Advance Care Directives

4.15 In Victoria, a person receiving treatment under the Mental Health Act 2014 can make a separate Advance Statement in relation to treatment preferences. Alternatively, the Advance Care Directive can include preferences relating to mental health treatment.

### Dying at home (at the residential service)

4.16 Choosing to die at the disability residential service can be a realistic option. Staff should consider the advantages and challenges when supporting a resident to make this choice.

4.17 Where the resident has elected to die at the disability residential service, staff at (enter agency name) will support the resident to explore all possible options and avenues of support, in order to support this decision.

4.18 Access to an inpatient palliative care unit is arranged by the specialist palliative care provider or the General Practitioner.

4.19 Circumstances prompting reconsideration of the plan to die at the disability residential service might include:

- a significant increase in the complexity of care.
- symptoms have increased in severity and staff are having difficulty managing the resident's symptoms
- staff are not able to provide comfort to the resident
- the resident has changed their mind
- other residents are very distressed and not able to be comforted.

4.20 Details of a residents terminal illness must be reported to the Department of Health and Human Services as per the Client Incident Reporting Instruction and (enter name of relevant agency policy for incident reporting - and hyperlink).

### Specialist palliative care

4.21 Palliative care is generally provided by multidisciplinary health care teams including doctors, nurses, allied health workers, and volunteers. Palliative care can be provided in the community as well as in palliative care units (in a hospital). A resident may require an admission to an inpatient palliative care unit to stabilise symptoms and then may return home to the residence.

4.22 Palliative care offers a high level of expertise in complex symptom control, loss, grief and bereavement. Palliative care providers work in two key ways by providing:

- direct care to individuals, their families and support staff
- a consultancy service to support providers (which includes disability residential services) supporting their care of the resident, family and friends.

4.23 Contacting the specialist palliative care service can occur as soon as it has been determined that a resident has a life limiting condition and/or that curative health treatment is no longer being considered.

4.24 Palliative care services will accept referrals from anyone involved in the care of the resident, however, in most cases, the referral to a palliative care service is made by the health care provider (such as General Practitioner or Specialist).

4.25 In cases where the resident is required to be referred by (enter agency name), the referral should be made by the house supervisor’s immediate line manager.

4.26 The specialist palliative care service will have a process for receiving referrals, and this process is documented in the resource published on the WestVic Primary Health Network Website. The specialist palliative care service may also have nominated a liaison contact.

4.27 The specialist palliative care service will want to access the resident’s medical history and will make contact with the resident’s medical practitioner. Consent will need to be provided for (enter agency name) staff to share this information with the specialist palliative care service.

4.28 A list of specialist palliative care services in the Grampians Region is available at the WestVic Primary Health Network Website. This resource includes service profiles and details of referral pathways.

### Health Care and developing a Palliative Care Plan

4.29 There may be an important role for staff to access health services for symptom management, even though a cure may not be possible. This can enhance the resident’s quality of life and levels of comfort, with the most practical examples being pain relief and symptom management, including difficulties swallowing and breathing, constipation, fatigue and loss of appetite. Sometimes treatment may occur to slow the progression of the condition rather than being curative.

Palliative care services use various assessment tools and care pathways, to assist the decisions made by clinicians.

For a resident who elects to remain at the disability residential service for as long as possible, all staff at (enter agency name) should ask the health care professional to complete the *Disability Palliative End-of-Life Care Plan* (hyperlink when complete if available online). This plan can be completed in addition to tools developed by the health care provider or palliative care providers. An extended consultation may be required to allow adequate time to complete this plan.

The *Disability Palliative End-of-Life Care Plan* (hyperlink when complete) aims to capture the required information to be able to support the resident to die at the disability residential service. It is intended to guide the provision of good quality end of life (terminal) care in disability residential care. It has been modelled on the Residential aged care end of life pathway and the Ballarat Health Service Care of the Dying Management Plan.

Key residential staff should be available to step the health professional through the contents of the *Disability Palliative End-of-Life Care Plan* and answer questions.

**Partnerships**

4.30 Enter details of any Partnership Agreement between the disability residential service provider and the specialist palliative care provider.

4.31 An important role of disability residential service staff is to support palliative care staff with knowledge of the resident. The residential staff will know the care requirements of the person, their lifestyle and personal preferences. While the GP is best placed to provide background information on the resident's health condition, the residential staff can provide background information on the resident and their life.

4.32 There is an important role for residential services in facilitating palliative care and health professionals access to knowledge of the resident, including:

- how the resident communicates and makes health decisions
- background information
- what can be provided by the residential service
- available local disability services.

In addition to the above, there are a range of ways to create and support a partnership between disability residential services and palliative care services. These can include:

- regular contact
- being available
- providing a key contact person, such as an area manager in a disability community service organisation or disability managed residential service (a palliative care service provider may take the lead in the region)
- organising reciprocal learning opportunities.

**Cultural support**

4.33 Whether the resident is Aboriginal and Torres Strait Islander or from a culturally and linguistically diverse (CALD) background, each person will express their culture differently. Knowing the cultural background of a person will be important; however, getting to know the person, their family and important others will be the key to determining the best way to support the person. Both Aboriginal and Torres Strait Islander and CALD communities often have strong beliefs concerning death and dying and there is a need to be sensitive to these beliefs.

4.34 Aboriginal and Torres Strait Islander culture is not a single culture and comprises many diverse communities, each with its own customs and ceremonies. However, central to these cultures is the importance of connection and obligation to family and the wider kinship groupings.

**Additional resources for Cultural support:**

The Department of Health has published 'Providing culturally appropriate palliative care to Aboriginal and Torres Strait Islander peoples resource kit'. This publication provides strategies and training material to support staff in mainstream health services to provide culturally appropriate palliative care to Aboriginal and Torres Strait Islander peoples.

In relation to people from CALD communities, Palliative Care Australia published Multicultural palliative care guidelines. While written for the palliative care workforce, the guidelines review relevant cultural issues related to death and dying for 20 community languages. Palliative Care

Australia stresses that the summaries aren't exhaustive and that each person needs to be considered as an individual, however the guidelines provide a useful starting point in increasing cultural sensitivity.

Cross cultural training is available from a number of organisations, including **ADEC (Action on Disability in Ethnic Communities).**

**Psychosocial support**

4.35 There could be a range of areas of the resident's life that require support, such as the need for information - about the life limiting illness, treatment and care options,
and prognosis. This may include support to understand any information or decisions.

4.36 There may be increased psychosocial support needs in a residential service due to other residents and their families and the residential staff.

4.37 The specialist palliative care service will be able to provide advice and support in responding to these care issues.

**Control of pain/symptoms**

4.38 Symptoms are multidimensional and often include a sensory component (sensations), cognitive component (beliefs about the symptom), affective component (emotional responses) and behavioural component (actions in response to the symptom). Symptoms can have multiple causes and effects, and can occur concurrently. When managing symptoms it is important to focus on the experience of the resident (and family) and not just the underlying pathology of the symptoms. Remember symptoms are dynamic, requiring ongoing regular assessment, and consider multifaceted interventions and a team approach.

4.39 Pain management aims for the resident to be comfortable and contributes to their quality of life. Relief from pain may mean the resident will remain in control and be better able to make choices when required. In many cases residential staff will know the resident best and be critical to supporting specialist palliative care providers to interpret behaviour that communicates pain/comfort levels.

4.40 Pain management may involve the use and storage of opioid analgesics. The palliative care service will organise for the administration of the medication and the residence will be required to provide secure storage as outlined in (enter name of relevant policy and hyperlink).

4.41 As per (enter name of relevant medication policy and hyperlink, (enter name of agency) staff **can not** administer medication by:

- injections by a standard syringe or an injection device that has a standard length non-retractable needle. This includes intramuscular, intravenous and subcutaneous injections
- injection by any means into IV lines, or similar equipment that is sited intravenously.
- manually drawing up or loading injection devices with medication.

Where a resident requires pain relief that cannot be administered by (enter name of agency) staff, the residential service may engage the local district nursing service, a specialist palliative care provider, or a residents family member or friend (given they have been trained by the specialist palliative care provider) to administer the medication.

4.42 Four commonly experienced symptoms are:

- Pain: often the most feared symptom for people with life limiting illness and their families.
  The resident's description of pain must be believed and acknowledged. Pain can be caused by a combination of factors including the underlying disease, complications, treatments or a co-morbid condition.
- Breathlessness: is a significant problem for patients with chronic heart failure, or for patients with lung cancer or pulmonary metastases.

- Fatigue: one of the most common symptoms associated with advanced disease.
- Loss of appetite: The social meaning of food means changes in appetite can be highly significant for the resident and their caregivers.

4.43 The management of breakthrough pain needs to be a key component of the care plan and regularly reviewed. The palliative care service is best placed to determine the response. In conjunction with the palliative care service, residential services staff and managers will need to adjust medication procedures as required.

### Practical issues

4.44 Wills, funeral and estate issues may be a concern for the resident, their family or friends. Residential staff should not become involved in these issues. Further information is documented in (enter name of relevant agency policy (sometimes as referred to 'when a client dies') and hyperlink).

**Additional resources:**

Talking End of Life ...with people with intellectual disability (TEL) is designed for disability support workers but is also helpful for others including families, health professionals, and educators. This project was supported by funding from the Australian Government Department of Health under the Public Health and Chronic Disease Grant Program, and is available on the Caresearch website. The 12 modules are designed around a suite of 3 topics:

1. How do I do this? Any or all of these 5 modules will help if you're unsure about your role, how to teach about the end of life, or how to manage cultural beliefs or feelings.
2. Teaching how to understand end of life: Any or all of these 3 modules will help you to teach about dying, death and loss, grief and mourning.
3. Teaching the planning options: Any or all of these 4 modules will help if you want to teach about how to plan for dying and death.

### Death

4.45 This is often a key concern of carers and staff. The planning process should allow the opportunity for staff to increase their knowledge.

4.46 Each death is different; however, there are a range of signs that might indicate that death is approaching. Palliative Care Victoria has developed a pamphlet, *The process of dying*, to inform and assist carers to understand the end-of-life stage. The palliative care service can assist residential staff and family with interpreting the signs being noticed by staff, friends and family. The key activity for carers is to make sure the resident is comfortable.

4.47 There are established procedures to follow regarding a resident's death. These procedures can be found in (enter name of relevant agency policy and/or checklist 'when a person dies' and hyperlink).

4.48 Generally, the next-of-kin or family will be responsible for the arrangement of funerals and burials, wills and estate issues. Where there isn't anyone nominated then the matter is referred to State Trustees. Specific procedures can be found (enter name of relevant agency policy that covers 'when a person dies' and hyperlink).

4.49 In a disability residential service, once it is ascertained the person has died, the medical practitioner or any other person present must call Coronial Admissions and Enquires (CA&E) immediately on 1300 309 519. This is a requirement of the Coroners Act of Victoria 2008. The service operates 24 hours a day 7 days a week. CA&E staff will advise and support disability and medical staff as to what needs to done at this time.

4.50 Any death must be reported to the Department of Health and Human Services as per the Client Incident Management Instruction and (enter name of relevant agency policy for incident reporting and hyperlink).

4.51 The Disability Services Commissioner (DSC) is responsible for reviewing deaths that occur in Victorian disability services. In reviewing deaths in disability services, the DSC will focus on identifying the factors that may have led to the death – e.g. health and support planning, risk management, service policies, service provider actions and responses. In conducting a review, the DSC may examine relevant records. The DSC will ask service providers to provide more information through documentation, discussions, or other means. DSC will work with the Department of Health and Human Services and the Coroners Court of Victoria in conducting reviews of deaths in disability services. The Department of Health and Human Services will send all 'Major' category incident report of unusual or unexpected deaths to the DSC. The DSC will also receive referrals of deaths from the State Coroner, if the individual was a person with a disability receiving services at the time of their death.

**Additional resources for end of life**

The Palliative Approach Toolkit has been developed as part of the Implementation of a comprehensive evidence based palliative approach in Residential Aged Care project funded by the Australian Government Department of Health and Ageing under the Encouraging Best Practice in Residential Aged Care program. The Palliative Care Toolkit includes several important reference publications, including "Understanding the Dying Process" brochure.

The Southern Metropolitan Region Palliative Care Consortium have developed a factsheets that outline:
The process of dying
Investigations by the Coroner

### Aftercare

4.52 Grief is a normal response to a death and rarely results in mental health problems. Most people adapt and manage these traumatic experiences with the care and support of family, friends and community. As with the general community, residents and staff may require additional support.

4.53 Palliative care services will be the first point of support for staff and residents after a resident's death.

4.54 Staff experiencing complex grief would normally be supported through the usual workplace support mechanisms and for department staff this may include support through the workplace Employee Assistance Program.

**Additional resources for grief and loss:**

**Australian Centre for Grief and Bereavement** (ACGB) has been funded by the Department of Human Services to provide specialist bereavement services throughout Victoria. ACGB has a range of resources and information available. ACGB offers a secondary consultation service for professionals working with people who may have suffered a loss. The Practitioner Consultancy Service is free of change and house supervisors/ managers are able to contact ACGB to determine the best way to provide opportunities for other residents, staff and family members following a resident's death. ACGB can provide counselling to residents with a disability who may be having difficulties with grief. Residents with a disability should be expected to experience loss and staff should be sensitive to changes in behaviour.

**Supporting residents with grief and loss** – in 2007, Scope published Supporting people with disabilities coping with grief and loss - An easy-to-read booklet. It contains information about grief and loss, and strategies for dealing with grief, in an easy-to-read format for people with disabilities. The second section of the booklet is for people who provide support. It includes creative ideas to assist people with disabilities with grief, for example, activities that keep alive the memory of the deceased resident will be useful.

### Ritual

4.55 Ritual is a very important part of bereavement. It offers opportunities to remember the deceased, structured ways of expressing grief and provides comfort to the bereaved. Ritual may be expressed through religion or cultural activities or more simple practical activities. There should be conversations with other residents, family and staff to determine expectations and preferences. Again the palliative care service can assist in the first instance, as can the Australian Centre for Grief and Bereavement.

## 5 DEFINITIONS

### Key concepts

5.1 **Living with a life-threatening condition** – conditions or chronic illnesses that are expected to result in a significant shortening of a person's life and are not amenable to health care treatment. Includes cancer and non-cancer diagnoses, such as neurodegenerative diseases and advanced organ failure. The aim is to enhance the quality of the person's life by reducing pain, controlling symptoms and accessing required support.

5.2 **Palliative approach** - aims to improve a resident's quality of life through early identification, assessment and treatment of pain, physical, cultural, psychological, social, and spiritual needs. A palliative approach is not confined to the end stages of an illness; it provides a focus on providing comfort and actively reducing a resident's symptoms and distress and all health care providers can incorporate the palliative approach into their practice.

5.3 **Specialist palliative care** - Palliative Care Australia (PCA) defines a Specialist Palliative Care Service as a multidisciplinary health care service whose substantive work is with patients who have a life limiting illness. Specialist palliative care professionals would be expected to have recognised qualifications or accreditation in palliative care. Specialist Palliative Care Services provide consultative and ongoing care for patients with a life limiting illness and provide support for their primary carer and family during and after the patient's illness. In general, Specialist Palliative Care Services would not be directly involved in the care of people who have uncomplicated needs associated with a life limiting illness.

5.4 **Breakthough pain** can be described where there is a short burst of high intensity pain. This is common and may only last briefly. There is no single response to breakthrough pain and it varies according to:

- the type of pain
- the duration
- the condition
- whether it is related to an activity, for example, walking.

## 6 RELATED LEGISLATION AND DOCUMENTS

The Medical Treatment Planning and Decisions Act 2016

The Act provides a framework for medical treatment decision making for people who do not have the capacity to make their own decisions, and creates clear obligations for health practitioners caring for people who do not have decision making capacity.

The Coroners Act 2008

The Act sets out the Court's statutory obligations to find, where possible, identity, cause and circumstances of reportable deaths and fires.

The Disability Act 2006

The Disability Act 2006 provides a legislative scheme for people with a disability which reaffirms and strengthens their rights and responsibilities. The Act includes a set of principles that highlight disability service providers responsibilities in the provision of supports and services.

The National Disability Insurance Scheme Act 2016

The NDIS is underpinned by an 'insurance-based approach, informed by actuarial analysis, to the provision and funding of supports for people with disability.  People residing in disability residential services are generally funded by the NDIS.

The Mental Health Act 2014

Victoria's Mental Health Act 2014 places people with a mental illness at the centre of decision making about their treatment and care. The Mental Health Act establishes robust safeguards and oversights to protect the rights, dignity and autonomy of people with mental illness.

## 7 SUPPORT AND TRAINING

### Support and training

The end-of-life stage can be demanding for other residents and staff and access to support will be crucial.  There are a range of training opportunities including:

**7.1** The Talking End of Life toolkit (TEL) comprises 12 modules on topics including what death is, funeral wishes, and bequeathing. Each module contains individual stories, video examples, practical tips, resources, and links to available research that underpins the content.
The project is funded by the Commonwealth Department of Health under the Public Health and Chronic Disease Grant Program.

7.2 The Grampians Regional Palliative Care Team provides consultancy and closely with palliative care service providers and health care professionals across the region to assist in the ongoing development and delivery of effective palliative care, including education.

7.3 The Grampians Region Palliative Care Consortium undertakes work beyond the resources of individual member palliative care services.  The focus of work is optimising community access to quality palliative care through regional planning, overseeing care co-ordination and service integration.

7.4 PEPA workshops – an introduction to the palliative approach

7.5 Centre for Palliative Care Education and Research - short courses on palliative care

7.6 Australian Centre for Grief and Bereavement (ACGB) - short courses on grief and bereavement

7.7 Certificate III and Certificate IV competencies regarding end-of-life care

7.8 Most universities have post graduate qualifications from certificate level onwards.

7.9 Refer to the Palliative Care Victoria website for a list of education and training opportunities.

## 8 APPROVAL AND REVIEW DETAILS

| Approval and Review | Details |
|---|---|
| Approval Authority | [Relevant approval authority, i.e. CEO, Board or Committee |
| Administrator | [Title of position/s with overall responsibility for compliance, monitoring and review] |
| Next Review Date | |

---

## 9 APPENDIX <or APPENDICES> <delete if not required>

Enter details of all internal agency forms that were hyperlinked.

## 10 REFERENCES

- http://das.dhhs.vic.gov.au/disability-services-commissioner
- Hudon, P. (2003). Home-based support for palliative care families: challenges and recommendations. Medical Journal of Australia. 2003; 179 (6 Suppl). https://www.mja.com.au/journal/2003/179/6/home-based-support-palliative-care-families-challenges-and-recommendations
- Ballarat Health Services, Care of the Management Dying Plan (2017)
- Liverpool Care Pathway <www.endoflifecareforadults.nhs.uk/eolc/lcp.htm
- McWhinney, I R, Bass M J, and Orr V,(1995). Factors associated with location of death (home or hospital) of patients referred to a palliative care team. CMAJ, 152(3): 361–367
- Tuffrey-Winjne, I et al (2008): Palliative care provision for people with intellectual disabilities: a questionnaire survey of specialist palliative care professionals. Palliative Medicine, 22: 281-290.
- www.adec.org.au
- www.adec.org.au/
- www.caresearch.com.au/Caresearch/Portals/0/PA-Tookit/01809-CEB_DL_dying_ProcessWeb.pdf
- https://www.caresearch.com.au/tel/tabid/4660/Default.aspx
- www.caresearch.com.au/caresearch/Portals/0/Documents/WhatisPalliativeCare/PA-Toolkit/01809-CEBPARAC_module%203%20web.pdf
- www.centreforpallcare.org/
- www.dhs.vic.gov.au/disability/publications-library/residential_services_practice_manual
- www.grampianspalliativecare.com.au/home/consortium-role/
- www.grampianspalliativecare.com.au/links-and-resources/resources/
- www.grief.org.au
- www.grpct.com.au
- www.grpct.com.au/wp/wp-content/uploads/CALD-Multicultural-palliative-care-guidelines-2000.pdf
- www.health.gov.au/internet/main/publishing.nsf/content/palliativecare-pubs-indig-resource.htm
- www.legislation.gov.au/Details/C2013A00020
- www.legislation.vic.gov.au/domino/Web_Notes/LDMS/LTObject_Store/ltobjst9.nsf/DDE300B846EED9C7CA257616000A3571/7682F2C41F8FFABACA257EB300145574/%24FILE/08-77aa024%20authorised.pdf
- www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/51dea49770555ea6ca256da4001b90cd/0B82C05270E27961CA25717000216104/$FILE/06-023a.pdf
- www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/PubStatbook.nsf/f932b66241ecf1b7ca256e92000e23be/B4D3EBB66E52E98CCA25807A0014F70D/%24FILE/16-069aa%20authorised.pdf

- www.pallcarevic.asn.au/
- www.pallcarevic.asn.au/families-patients/about-palliative-care-2/pain-symptom-relief/
- www.pallcarevic.asn.au/healthcare-professionals/professional-development/education/
- www.pallcarevic.asn.au/library/for-families-patients/fp-symptoms/
- www.pallcarevic.asn.au/resources--links/uploadedFiles/1219729682543-5616.pdf
- www.pallcarevic.asn.au/uploadedFiles/1194475538825-8612.pdf
- www.pepaeducation.com/workshops/palliative-approach-workshops/
- www.providers.dhhs.vic.gov.au/cims
- www.publicadvocate.vic.gov.au/publications/124
- www.scopeaust.org.au/shop/supporting-people-grief-loss/
- www.smrpalliativecare-consortium.org.au/viewresources.asp
- www.vcat.vic.gov.au
- www.westvicphn.com.au/images/PDFs/QuickReferenceToolSPCSinGrampiansRegion.pdf
- www.who.int/cancer/palliative/en
- www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care
- www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms
- www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/palliative-care/end-of-life-and-palliative-care-framework
- www5.austlii.edu.au/au/legis/vic/consol_act/mha2014128/

## Disclaimer

**The material provided in template policy has been developed based on best-practice publications available, and the content has been endorsed by the Grampians Disability Palliative Care Steering Committee, and the Grampians Palliative Care Consortium.  Organisations who choose to adopt this material do so at their own risk.**