END OF LIFE CARE POLICY AND PROCEDURE

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Purpose and Scope

The purpose of this policy and procedure is to ensure Bilingual Care addresses the needs, goals and preferences of the consumer, and provides appropriate and meaningful end of life care. Bilingual Care is committed to supporting and promoting choices around each person's place of care and the way care is delivered, while encouraging independence and respecting dignity.

Bilingual Care will ensure seamless coordination and integration of services that are reviewed regularly and communicated, are culturally sensitive and respect the individuals' cultural, spiritual and personal preferences.

This policy and procedure also details the steps to take in managing an unexpected death in a home setting according to the *Strengthened Aged Care Quality Standards* and Serious Incident Reporting (SIRS) requirements.

Handling unexpected death requires a respectful, compassionate, sensitive and coordinated approach in response to the unexpected death of a consumer receiving supports at home.

This policy and procedure applies to all Bilingual Care staff, contractors, volunteers and health professionals delivering and coordinating services under the Support at Home End-of-Life Pathway and meets relevant legislation, regulations and Standards.

Applicable Strengthened Aged Care Quality Standards

- *Standard 1. The Person*
- *Standard 3. The Care and Services*
- *Standard 4. The Environment*
- *Standard 5. Clinical Care*

Definitions

Administering Practitioner – the practitioner who administers the substance if the person cannot self-administer e.g. doctor, nurse.

Advance Care Planning (ACP) – encompasses discussions and documentation designed to assist consumers and their family to consider what is important to them regarding future care and their preferred place of care. Their General Practitioner and wider care team would usually be involved in this process.

Advance Health Directive (AHD) – a legal document recording decisions and preferences about end of life care, including directives about specific treatment options and resuscitation. Also known as an Advance Care Directive or Living Will, depending on the State/Territory.

Coordinating Practitioner - The medical practitioner who oversees the VAD process, and

prescribes the VAD medication required for self-administration.

Enduring Power of Attorney (EPOA) – a legal document formally appointing someone to make decisions for a consumer at a future date, should they be unable to speak for themselves due to illness or capacity issues.

End of Life Care – care provided in the last weeks of a person's life. It includes the terminal phase, death and extends to bereavement care for loved ones. The needs of the consumer, their families and carers are higher at this time, and increased services and support are essential to ensure quality coordinated care.

End of Life Care at Home - support for those with a life limiting illness in a comfortable familiar environment. It includes professional, medical and personal care services as well as practical assistance from family and friends. This type of care aims to improve the person's quality of life by addressing physical, emotional and spiritual needs whilst also providing support for their loved ones.

Palliative Approach – is a person-centred philosophy that focuses on improving the quality of life for individuals and their families facing life limiting illnesses by providing relief from suffering both physical and psychosocial. It applies to older adults (aged 65 or older, or over 50 for Aboriginal or Torres Strait Islander people) with a progressive, life limiting illness or frailty, or younger people with a life limiting chronic disease that need a palliative approach in the last few years of life. They may not require a specialist palliative care team but benefit from providers regularly assessing for changes in health care needs and providing opportunities to discuss end of life preferences, as well as planning for pain management, emotional, social, psychological needs to live a full life as comfortably as possible.

Palliative Care – a quality-of-life approach to care that neither hastens death nor prolongs life for consumers with life-limiting illnesses. Care encompasses the physical, emotional, and spiritual needs of the consumer and their families, with a focus on quality of life and the consumer's wishes and preferences, symptom management, and providing care in the consumer's preferred setting (e.g. home, hospital, hospice or nursing home). It involves the early detection, assessment, and treatment of pain and other symptoms - physical, emotional, psychosocial, and spiritual. Early referral to palliative care can often prolong life and support a better quality of life for the consumer.

Palliative Care can be provided at the same time as curative life prolonging treatments for long term care, sometimes over several years.

Serious Incident Reporting Scheme (SIRS) - SIRS requires reportable incidents to be notified to the *Aged Care Quality and Safety Commission*. An Unexpected Death is a notifiable incident and must be notified within 24 hours of Bilingual Care becoming aware of it. See Bilingual Care's *Consumer Incident Management Policy and Procedure* for detailed guidance.

Terminal Care / Terminal Phase Care – care provided in the last days of life.

Unexpected Death - a death that was not anticipated on the consumer's known health status.

Voluntary Assisted Dying (VAD) - the laws across different Australian states enabling terminally ill people to seek medical assistance to end their life. This includes:

Self-Administration - where the person takes VAD medication themselves (this is sometimes called physician-assisted suicide or dying) and

Practitioner Administration - where the person is administered medication by a doctor (or in some Australian States, a Nurse Practitioner or Registered Nurse) (this is sometimes called voluntary euthanasia).

Policy

Bilingual Care acknowledges that every consumer has the right to be treated as an individual with personal needs, wishes, and goals of care, including preferences relating to where and how they receive end of life care.

Bilingual Care understands that palliative care is naturally holistic, and person centred, and while many of the physical, emotional, and spiritual needs of consumers are common, each person will require their own individualised *End of Life Plan* and process.

Bilingual Care and its staff understand that Advanced Care Plans and similar documentation is beneficial to guide consumer care and support, however the right of the consumer not to engage in these documents and conversations also needs to be respected.

Bilingual Care and its staff will support all people accessing Voluntary Assisted Dying (VAD) with dignity and respect. If Bilingual Care or its staff conscientiously object to supporting people to access or engage with VAD, they will nonetheless adhere to the legal obligations regarding conscientious objection.

In the event of an unexpected death, Bilingual Care is committed to ensuring the situation is managed appropriately with clear procedures and adherence to legal requirements, including transparency in communication with all stakeholders involved.

Procedures

Support at Home Program – End of Life Pathway

As many older people wish to remain in their own homes with their family as they near the end of their life, the End of Life Pathway under Support at Home provides additional support to help consumers remain at home if they are assessed to have 3 months or less to live.

To apply for the End of Life Pathway funding, the End of Life Pathway form must be completed by a medical practitioner or nurse practitioner (available on the My Aged Care website[1]).

If the older person/consumer is already on the Support at Home program, Bilingual Care can request a high priority Support Plan Review to access the End of Life Pathway.

An aged care assessor will review the submitted End of Life Pathway form to confirm eligibility.

Bilingual Care can continue to support the consumer if able to meet the consumer's needs under the End of Life Pathway. If Bilingual Care does not have the required resourcing or

[1] https://www.health.gov.au/our-work/support-at-home/delivering-services-for-support-at-home/end-of-life-pathway?language=en#accessing-the-pathway

supports to meet the needs of the consumer, the Clinical Advisor will assist them to connect with a suitable provider.

An End of Life consumer will receive additional funding for home care services over a 12-week period to suit their needs, including assistive technology as needed. One further extension may also be requested if the consumer is expected to require further services after the 12-week period, or unspent funds may be accessed (if available).

Supports available through the End of Life Pathway include:

- Personal and Nursing Care - hygiene assistance, medication administration and management, clinical support, pain management, wound care
- Therapeutic Services - physiotherapy, occupational therapy, counselling
- Respite and Social Support - relief for carers in home or external support
- Meal Delivery and Domestic Help - nutritional needs tailored to health needs, and household needs managed, e.g. cleaning, laundry, home hygiene.
- Home Modifications - rails, ramps, accessible bathrooms
- Transport to medical appointments
- Social Support - Companionship, community engagement
- End-of-Life Planning - Advance Care Directives, spiritual support
- 24/7 contact availability for urgent needs

Roles and Responsibilities

Bilingual Care will ensure that consumers facing serious illness and end of life care are provided with the necessary care and support for their health and welfare, that is based on their individual needs and preferences, and that is delivered with care, empathy, compassion and respect.

The goals of care include:

- comfort and symptom management
- emotional and spiritual support
- family involvement
- cultural preferences respected

Bilingual Care will ensure any environmental risks identified relevant to the services provided will be discussed with the consumer and their family/supporter/representative to safely mitigate the risk and will be documented in the consumer's *End of Life Plan*.

Bilingual Care will access required equipment and aids used or provided to consumers to ensure their care is safe and meets individual needs. Training will be provided to staff on how to use the aids and equipment, care and maintenance.

Bilingual Care will provide a dedicated care coordinator (the Clinical Advisor), a personalised *Care Plan*, 24/7 contact for urgent support and respect the consumer's cultural and spiritual needs.

To achieve the above outcomes, Bilingual Care will undertake the following actions:

1. *End of Life Plans will be* based on assessments developed in collaboration, engagement and partnership with consumers and their families, significant others, inter-disciplinary teams, social workers, doctors, nurses, hospices and other end of life services. Plans will focus on a holistic approach to care, ensuring consumer choice and input, and include emotional support and symptom management. Plans will also include how risks, incidents, and emergencies will be managed and when to refer to the Clinical Advisor or a health practitioner.

2. Where relevant, Advanced Care Directives are maintained as part of *End of Life Plans*, including enduring guardian details and documented resuscitation preferences.

3. *End of Life Plans* are up-to-date, readily available, clear, and concise, and clearly identify and describe the support needs and preferences of consumers.

4. Consumers are supported to seek regular and timely reviews of their health status and *End of Life Plan* by the Clinical Advisor in collaboration with their GP, end of life specialist, and other end of life services involved in their care.

5. Each consumer's *End of Life Plan* is communicated, where appropriate and with their consent, to their support network and other providers.

6. *End of Life Plans* are signed by the Clinical Advisor and consumer, agreeing to, and confirming, the need and consent for support. A copy of the Plan is provided to the consumer or their representative and kept readily available where end of life care is provided.

7. Staff understand the support needs outlined in *End of Life Care Plans*. Policies, procedures, and plans are in place and easily accessible to staff, including a training plan, that relates to the specific needs of each consumer receiving end of life care.

8. Skilled, trained, and experienced staff are allocated to manage consumers' end of life care needs, as support provided can be unique, complex and multi-faceted.

9. The Clinical Advisor:
   - ensures all staff undertake the necessary general and consumer specific end of life care training, including cultural safety and grief support
   - provides or coordinates training and education on death, bereavement, person-centred supports, individual values and beliefs, cultural sensitivity, independence and informed choice
   - ensures completion of communication skills training for end of life conversations relating to the complex and intensive nature of end of life care and death and dying as part of normal life
   - maintains training records and appropriate registrations and
   - monitors staff compliance and maintains a *Training and Development Register*

10. Staff allocated to care for consumers receiving end of life care receive regular supervision, and support required to provide the supports.

11. Staff communicate with consumers using their preferred communication method e.g., use of devices, interpreters, etc.

12. Families and carers are valued and receive the care and support they need.

13. The Clinical Advisor facilitates referrals as required to other health providers, in collaboration with the consumer, their representative, and end of life care team.

14. The Clinical Advisor monitors compliance with the relevant Standards through internal audits and stakeholder feedback, to gauge the quality of support being provided and to ensure an effective and appropriate service to consumers that meets their needs.

15. *End of Life Plans* are reviewed by the Clinical Advisor, evaluated, and updated regularly as changes occur, to ensure appropriate care is provided.

16. All health professionals and consulting health practitioners are to be suitably trained, accountable for their own practice and work within their scope of practice and are aware of their own legal and professional responsibilities within the Code of Practice of their professional body.

17. The Clinical Advisor will undertake regular audits of clinical care and service delivery for quality assurance and continuous improvement.

18. Bilingual Care uses feedback and complaints to understand the consumer's experience and comfort, and their families / supporters satisfaction with services, and any areas for improvement. See also Bilingual Care's *Feedback and Complaints Policy and Procedure*.

Risk Analysis

Identified Risks

Risks associated with end of life care include:

- over-medication, leading to side effects such as a lowered level of consciousness, delirium, and agitation
- under-medication, resulting in inadequate symptom or pain relief
- psychological and emotional impacts such as anxiety, depression, and existential distress
- communication challenges, such as misunderstandings or lack of communication, between consumers, families, and staff
- neglect of spiritual and cultural considerations, which can impact overall wellbeing
- cachexia, also known as 'wasting syndrome,' which is a general state of ill health involving marked weight loss, muscle loss, a lack of appetite, fatigue, and decreased strength.
- skin fragility and wounds, and
- vulnerability to social isolation

Risk Management Strategies

Strategies to reduce risks for end of life care include:

- regular medication monitoring and communication with the end of life care team and specialist to adjust medications based on individual needs

- engaging and involving mental health professionals to provide emotional support and counselling services
- maintaining and encouraging open dialogue, including around advanced care planning to align with current needs, goals and preferences and clearly documenting wishes in the consumer's *End of Life Plan*
- respecting diverse beliefs, involving spiritual advisors, and tailoring the care provided accordingly
- monitoring skin integrity and reporting skin breakdown and wounds immediately
- using pressure-relieving devices, other therapies, and nutritional supplements to assist with muscle wastage and weight loss
- promoting and encouraging time with family and friends (with the consumer's consent)

Initial Access and Care/Support Planning

During initial service access conversations with potential consumers or their representatives/supporters, the Clinical Advisor must gather information from the consumer about any end of life plans they may already have and ensure conversations and care planning incorporates this information. It is important to explore the consumer's preferences in detail. This includes not only their end of life wishes but also their physical, emotional, and spiritual wishes.

The Clinical Advisor will explain what is required to meet eligibility requirements for End of Life funding and provide the End-of-Life Pathway Form[2], if required. The Clinical Advisor will support the consumer (and their family/supporter or appointed decision maker) with arranging for an End-of-Life Pathway Form to be completed and submitted by the consumer's medical practitioner (GP, Specialist or Nurse Practitioner).

If the consumer is already funded under the Support at Home program, the Clinical Advisor will also assist with requesting an urgent Support Plan Review via the My Aged Care Service and Support Portal[3] (or the consumer may also request it via My Aged Care if they prefer).

If a consumer does not have Support at Home funding but is requesting access to the End-of-Life Pathway, there are 3 options to apply:

- Option 1: the consumer can access their GP, Specialist or Nurse Practitioner to discuss their eligibility for the End-of-Life Pathway. If eligible, the medical practitioner will need to complete the End-of-Life Pathway Form (which can be uploaded or submitted by the consumer to My Aged Care to request an assessment).
- Option 2: Apply online for an aged care assessment and the consumer can provide the completed End-of-Life Pathway Form at the assessment.
- Option 3: the consumer can contact My Aged Care on 1800 200 422 or visit a Services Australia service centre to request access to the End-of-Life Pathway. My Aged Care will register, screen and refer the consumer for an aged care assessment. The consumer will need to provide the End-of-Life Pathway Form (if they haven't already done so) to the assessor.

As part of all assessment activities including end of life planning, staff must discuss consumers' rights with them. As per Bilingual Care's *Consumer Rights Policy and Procedure*, staff must ensure each consumer, or their representative, understands their rights by providing information in ways that suit their individual communication needs.

[2] End-of-Life Pathway Form
[3] My Aged Care Service and Support Portal

Written information can be provided in different languages and Easy English or be explained verbally by staff. Staff can also help consumers access interpreters or advocates where required.

Staff must also advise consumers of their right to involve a support person in their dealings with Bilingual Care, including initial assessment meetings and conversations, and the documenting of their end of life wishes and preferences.

Where required, consumers must be provided with information and support to access a person of their choice, such as an advocate, to assist them to discuss their end of life wishes and preferences. For more information see Bilingual Care's *Decision Making, Dignity, and Choice Policy and Procedure*.

In accordance with Bilingual Care's *Privacy and Confidentiality Policy and Procedure*, respect for and protection of consumers' privacy and confidentiality must be reinforced on an ongoing basis, verbally and in literature provided by staff.

While many consumers express the desire to remain at home for end of life care, this preference may change at any time. For this reason, the Clinical Advisor should provide an opportunity for regular discussions with the consumer to capture and record any changes in their *End of Life Plan*.

End of Life Plan

Bilingual Care staff must consider the following as part of their end of life care and palliative approach for each consumer:

- the consumer's understanding of their illness, their preferences, and wishes regarding care, including where they would like to die and whether they have completed documentation such as an Advanced Health Directive and appointed an Enduring Power of Attorney
- whether spirituality is important to the consumer, and whether they would like to express or explore this further
- any cultural considerations to be factored into end of life planning
- the consumer's preference in relation to family, carers, and other significant people being involved in end of life planning
- any carer stress or strain identified and
- planning for the care of any pets owned by the consumer, when the consumer is physically unable to provide adequate care for them (for example, during periods of hospitalisation or following death).

At the time of initial assessment and care planning, the Clinical Advisor is responsible for identifying the need for an *End of Life Plan*. This may also be identified by the consumer.

Working alongside the consumer to develop their individual *End of Life Plan*, Bilingual Care's Clinical Advisor is responsible for documenting the following information (as appropriate for each person):

- medical diagnosis and the consumer's understanding about the diagnosis and any treatment
- extent of family, carer, and other representative support and involvement
- key additional contacts for the consumer and their relationship to the consumer

- whether any Advanced Care Planning has commenced or been completed (for example, Wills, Enduring Power of Attorney and Statement of Choices)
- the consumer's preferred place of care and services for end of life care, noting this may change as the consumer's health declines and care needs increase
- any other services involved (or planned to be involved) and their roles and responsibilities and contact details. The consumer's General Practitioner is often the key point-of-contact regardless of the involvement of other health professionals
- after-hours support available should the consumer require it (including whether the General Practitioner is available for home-visits, and any 24-hour advice and support services)
- any spirituality preferences and wishes of the consumer including whether they identify with a group or church and whether their spiritual or religious leader is to be contacted as part of the *End of Life Plan* implantation and
- any cultural preferences or considerations such as rituals, ceremonies, and other wishes during end of life or following death.

Steps for End of Life Planning and Care

1. The Clinical Advisor receives referral via My Aged Care or direct request and confirms eligibility for end of life care via the consumer's Notice of Decision.

2. The Clinical Advisor completes intake documentation, and confirms whether care planning and service delivery requirements can be met by Bilingual Care. If Bilingual Care and the consumer agree to proceed, the Clinical Advisor will accept the referral in the My Aged Care Service and Support Portal and notify Services Australia via the Aged Care Provider Portal.

3. The Clinical Advisor conducts holistic assessment with the consumer and their family and supporter/representatives, including their rights, end of life wishes and any physical, emotional and spiritual requests. This may include that a spiritual or religious leader is to be contacted as part of their *End of Life Plan*, and any cultural preferences or considerations such as rituals, ceremonies and other wishes during end of life or following death must be documented.
   Note: consumers have a right to decline end of life plan discussions. This needs to be documented in the consumer's notes.

4. The Clinical Advisor will provide information in ways that suits individual communication needs, e.g. different languages and Easy English, and verbally explaining information by staff. The Clinical Advisor will advise the consumer of their right to a support person of their choice, e.g. supporter or advocate, to assist them to discuss any end-of-life wishes and preferences. Bilingual Care will provide access to interpreters or advocates as required to facilitate communication.

5. The Clinical Advisor will develop an individualised *End of Life Plan* with goals, preferences and spiritual and cultural considerations for the consumer. Advanced Care Planning documents should align with current needs, goals and preferences. A multi-disciplinary team approach is taken to ensure the appropriateness of care for the consumer and clear communication between all stakeholders (with the consumer's consent).

6. As part of end of life planning, the Clinical Advisor will also determine the extent of family, carer and or other representative support and involvement, including key additional contacts and their relationship to the consumer.

7. All staff must respect and maintain strict privacy and confidentiality, in accordance with Bilingual Care's *Privacy and Confidentiality Policy and Procedure*.

8. The Clinical Advisor will undertake regular discussions with the consumer to capture and record any changes in their *End of Life Plan*.

9. The Clinical Advisor ensures after hours support is available e.g. via attending GP for home visits or any other 24-hour advice and support services.

10. All staff must check and deliver services as per the consumer's *End of Life Plan* and prioritise comfort and dignity.

11. The Clinical Advisor will continue end of life planning conversations with consumers and family, monitoring their condition and adjusting support, and obtaining other relevant services as needed.

12. The Clinical Advisor will ensure clear and detailed documentation in the progress notes and ensure clear communication with family and health professionals. Any information relating to end of life wishes and preferences including the *End of Life Plan* are to be highlighted in the consumer's records in Ezihealth.

13. As the consumer's condition progresses, the Clinical Advisor will discuss requesting or declining aspects of personal care, life prolonging treatment and responding to reversible acute conditions. Areas that require particular attention include:
    - provide the required pressure care, oral and eye care, bladder and bowel care
    - recognise and respond to any signs or symptoms of delirium
    - recognise and respond to rapidly changing needs during the last phase of life
    - provide the prescribed symptom management interventions to manage changes in pain and symptoms, e.g. pain relief medications and facilitate access to specialist equipment including other alternate comfort measures, such as aromatherapy. Ensure medications to manage pain symptoms, including anticipatory medications are prescribed, administered, reviewed and available 24/7.

14. Staff must report incidents or any changes in the consumer's condition promptly to the Clinical Advisor.

15. Minimise unnecessary transfer to hospital where this is in line with the individual's preferences.

16. Following the death of the consumer, the Clinical Advisor will support family / supporters through the bereavement and complete any final documentation.

17. All staff to always maintain confidentiality, dignity, privacy and respect for the consumer even after death, following clinical protocols and infection control practices

and standard precautions.

18. Bilingual Care will provide staff access to counselling and debriefing services.

End of Life Pathway Exhausted

Where a consumer lives longer than the approved End of Life pathway funding period, the Clinical Advisor will undertake a review of the consumer's needs and preferences and implement appropriate transition arrangements. This may include transitioning the consumer back to standard Support at Home services, updating the *Service Agreement* and funding arrangements/*Individualised Budget*, and supporting the consumer to seek reassessment where required. Bilingual Care will prioritise care continuity and the consumer's dignity, comfort, and choice at all times. See also Bilingual Care's *Care Review Policy and Procedure*.

Voluntary Assisted Dying (VAD)

Voluntary Assisted Dying (VAD) is a legal process allowing eligible individuals to voluntarily access medication to end their life. The purpose of VAD is to ensure safe, lawful and compassionate support for consumers to access VAD under the applicable state and/or territory legislation.

Staff are not authorised to administer VAD substances unless legally permitted and trained.

VAD is legal in all states including ACT. The only jurisdiction without legal VAD is the Northern Territory (NT).

All staff must comply with the VAD Act as required by NSW Law. This includes the Voluntary Assisted Dying Act 2022 No 17 (NSW)

Although each state/territory has its own legislation, common features include:

- **Eligibility** - adults with decision making capacity diagnosed with terminal illness causing intolerable suffering.
- **Process** - typically involves multiple assessments by independent medical practitioners, a written request and waiting period.
- **Safeguards** - includes oversight bodies (e.g. Voluntary Assisted Dying Oversight Board in the ACT, RACGP - GP role in Australia outlined in End-of-Life Care, creating terminal /care plans and providing support).

As part of normal service provision, Bilingual Care may have consumers that are planning for or are accessing voluntary assisted dying (VAD) services.

Eligibility

To be eligible for VAD, the consumer must:

- be an Australian citizen aged 18 or over
- be a Permanent Resident who has been a resident in the State/Territory at least 12 months when VAD is first requested
- have decision making capacity
- be diagnosed with a disease / medical condition that is:
    - advanced, progressive and will cause death
    - expected to cause death within 6 - 12 months

- cause suffering that cannot be relieved in a manner the consumer finds tolerable.

The consumer's suffering may be physical or non-physical e.g. psychological or existential.

Note: Having a disability, dementia or mental health impairment is not on its own sufficient for meeting the eligibility to access VAD. All people must meet the above criteria to access VAD. Importantly, they must be able to make and communicate their own decisions.

Accessing VAD

To access VAD, a person must go through a request and assessment process. This includes:

- making at least three requests for VAD and
- being assessed as eligible by at least two independent medical practitioners who are trained in VAD and practicing from within the State/Territory where the person is making the request.

This process could take months.

Only medical practitioners can receive a person's request for VAD and assess their eligibility.

VAD requests can be withdrawn at any time.

Enacting VAD

A medical practitioner must prescribe the VAD medication required for self-administration (called the *Coordinating Practitioner*).

Where a person has elected practitioner administration, medication must be administered by a doctor or nurse (called the *Administering Practitioner*).

To participate in VAD, nurses are required to meet registration and practice experience requirements, and complete mandatory training as required by NSW legislation.

Prior to administering VAD medication, nurses must undertake a final assessment to determine the person still has decision making capacity.

After administering VAD, the nurse must complete the relevant documentation and ensure remaining medication is disposed of appropriately.

Conscientious Objection and Supporting VAD

Bilingual Care will not obstruct access to VAD but may conscientiously object.

Although Bilingual Care may support people accessing VAD, staff employed by Bilingual Care are entitled to conscientiously object to personally being involved. Conscientious objection will be respected by Bilingual Care.

Bilingual Care will ensure conscientious objection does not prevent a person accessing lawful treatments, or negatively impact their dignity and right to choose.

The Clinical Advisor will ensure as much as possible that any staff who have raised a conscientious objection to VAD are not rostered for consumers who are accessing VAD services.

Bilingual Care will ensure any consumer considering VAD receives appropriate information and is supported to discuss this information with a medical practitioner.

Staff must not initiate VAD discussions. Where a consumer wishes to ask about VAD, staff must always respond respectfully and refer VAD enquiries to the Clinical Advisor and recommend that the consumer speak further with their attending doctor.

Support workers must not provide clinical advice, assess eligibility, or attempt to influence a consumer's decision regarding VAD.

The Clinical Advisor will undertake referral with a VAD trained practitioner or a VAD Care Service.

The Clinical Advisor will document any enquiries and referrals in the consumer's file in Ezihealth (without judgement).

Staff can offer emotional support, end of life care options and be non-discriminating when working with consumers who are considering or have chosen VAD. Staff must never pressure or coerce a consumer and their family/supporters into a decision.

Staff are expected to support family/supporters as required, maintain confidentiality, uphold the consumer's dignity and follow all legal obligations.

The Clinical Advisor will complete mandatory reporting of concerns or breaches in alignment with SIRS (Serious Incident Reporting), if applicable. See Bilingual Care's *Consumer Incident Reporting Policy and Procedure* for SIRS guidelines.

Bilingual Care will ensure that appropriate training and referral pathways are in place to support practitioners to meet their legal obligations.

Bilingual Care does not directly provide VAD services, however, its registered health practitioners may support people (within the bounds of relevant legislation) by:

- instigating conversations around VAD
- providing information on VAD
- undertaking assessments to determine eligibility for VAD
- providing routine support for people seeking VAD
- supporting people to access VAD services and
- supporting people during the administration of VAD.

Discussing and Providing Information

Bilingual Care will ensure any consumer considering VAD receives appropriate information and is supported to discuss this information with a medical practitioner.

NSW Voluntary Assisted Dying Care Navigator Service[4]
Provides statewide VAD information, practitioner pathways and support.

Phone: 1300 802 133 (Monday to Friday, 8:30am to 4:30pm, excluding public holidays)
Email: NSLHD-VADCareNavigator@health.nsw.gov.au

Ongoing Support

Any information pertaining to a consumer's end of life wishes and preferences, including any *End of Life Plan* developed, are to be highlighted and listed with priority as part of their consumer records.

Bilingual Care staff must respect each consumer's right to decline an *End of Life Plan*, and to change their wishes and preferences as their condition progresses. This must be documented on the consumer's file accordingly.

The Clinical Advisor will engage with consumers and their representatives regularly to receive feedback and document any changes to shape the way Bilingual Care respects and supports the consumer's end of life wishes and preferences. This includes the Clinical Advisor regularly reviewing and updating consumers' *End of Life Plans*.

The Clinical Advisor is responsible for the effective communication of changes to staff involved in relevant consumers' care and services.

Staff involved in consumers' care are responsible for ensuring changes in their physical, emotional, or spiritual condition, or changes in their wishes around end of life care, are communicated in a timely manner to the Clinical Advisor as per Bilingual Care's *Consumer Case Note Policy and Procedure.* This includes undertaking risk assessments as required, in accordance with Bilingual Care's *Risk Management Policy and Procedure* and reporting any concerns to the Clinical Advisor.

Bilingual Care is responsible for supporting staff in their role by providing appropriate training, resources, and opportunities for additional supervision, as per Bilingual Care's *Training and Development Policy and Procedure*.

Education and Training

As per Bilingual Care's *Training and Development Policy and Procedure*, all staff responsible for consumer's end of life planning must undergo Induction including specific training in Bilingual Care's *End of Life Care Policy and Procedure*.

Bilingual Care will ensure all staff understand what is required to make each consumer feel respected, valued, and safe, including when receiving the end of life care and services they need and prefer.

[4] New South Wales Health, 2023, *NSW Voluntary Assisted Dying Care Navigator Service,* New South Wales Government, accessed 24 March 2026, https://www.health.nsw.gov.au/voluntary-assisted-dying/Pages/navigator.aspx

Staff will be provided with education and training to ensure they understand general palliative care and end of life support, as well as communication skills and boundaries relating to the complex and intensive nature of end of life care. This includes educating staff about palliative care, death, and dying as a normal part of life. Some resources to support learning include:

- ELDAC End of Life Discussions for Aged Care – Home Care Toolkit
- Advance Care Planning Australia – Professional Resource Hub
- Palliative Care Australia – Training and Education in Palliative Care

Supporting Aboriginal and Torres Strait Islander Consumers

Supporting Aboriginal and Torres Strait Islander consumers with death involves respecting "Sorry Business" protocols, which includes avoiding the use of the deceased person's name or image, and accommodating large family gatherings. Specific resources are available to support staff to understand and provide culturally safe palliative care for Aboriginal and Torres Strait Islander people. These resources include:

- Aboriginal and Torres Strait Islander Peoples Palliative Care Resources, Palliative Care Australia
- Gwandalan National Palliative Care Project
- Indigenous Program of Experience in the Palliative Approach (IPEPA)
- Caring@home Resources for Aboriginal and Torres Strait Islander families.[5]

Bilingual Care will appoint appropriate palliative care Champions within the organisation to support and encourage other staff members.

Staff will also be educated on the individual end of life preferences of consumers before providing services for the first time, to ensure the care delivered aligns with the consumer's *End of Life Plan* or any wishes and preferences they have identified.

Death of a Consumer

Following the death of a consumer, the Clinical Advisor will ensure staff are aware of the following in relation to consumers who have identified as end of life:

- that an ambulance is unlikely needed following an expected death at home
- who is responsible for completing the Death Certificate or Life Extinct Form (usually the consumer's General Practitioner or Specialist Palliative Care Team arrange this) and
- who is responsible for contacting a funeral director (if applicable) to transport the deceased.

Following the death of a consumer, Bilingual Care will provide support to any significant family member, carer, or other representative, as well as staff involved in the consumer's life. Support may be offered via referrals to counselling and grief and loss specialist services.

Bilingual Care will also consider individual and group supervision to assist staff in processing anything they have found challenging or distressing related to the consumer's death.

[5] Department of Health and Aged Care, 2025, *Section 15.6.2 of the Support at Home program manual: A guide for registered providers*, Australian Government, accessed 24 March 2026, https://www.health.gov.au/resources/publications/support-at-home-program-manual-a-guide-for-registered-providers

Bilingual Care will consider as an organisation, ways to acknowledge and honour consumers who have died, such as sending a condolences card to the family.

Notifications

The Clinical Advisor will update the *My Aged Care Service and Support Portal* and contact *My Aged Care* to update the consumer's record with the date of death. It is essential that this is completed **as soon as possible from the date of death** to ensure there are no future communications sent to the consumer and their family/supporters.

Managing an Unexpected Death in a Home Setting

1. Attending staff to confirm the death - if uncertain call 000.

2. Staff to ensure a safe environment, preserve the scene and not unnecessarily touch or move the body.

3. Staff must notify the Clinical Advisor or senior Manager.

4. If the death was expected, notify the consumer's GP and the Clinical Advisor first.

5. All staff are responsible for notifying Emergency Services (000) and Police as required if the death was unexpected or occurred under unusual circumstances - it may involve Police investigation (e.g. suspected neglect, abuse or unexplained cause).

6. The Clinical Advisor will notify the consumer's GP and Palliative Care provider (if applicable), and next of kin with sensitivity, compassion, and offer support.

7. Staff must document all actions taken including time, date, staff involved, who was notified.

8. The Clinical Advisor, with staff, will ensure end of life wishes, if known, are respected, such as religious, spiritual and cultural practices, and considerations including mourning in death and bereavement.

9. The Clinical Advisor will offer bereavement support and co-ordinate with the deceased consumer's family / supporters / legal representative regarding guidance on the preferred undertaker and contact the funeral director for funeral arrangements.

10. SIRS Reporting - The Clinical Advisor must assess whether the death meets the criteria for a Reportable Incident (see Bilingual Care's *Consumer Incident Management Policy and Procedure* for detailed requirements). If "Yes", submit a Priority 1 Report to Commission within 24 hours, documenting the rationale for reporting.

11. Staff must ensure the necessary infection control and cleaning procedures are completed once the deceased has been transferred to the funeral parlour or hospital.

12. Staff are to follow ethical guidelines in handling any deceased person's belongings.

13. The Clinical Advisor will ensure completion of the necessary documentation - medical certification, death verification, incident report and update the consumer's file in Ezihealth. All future scheduled services should be suspended.

14. The Clinical Advisor will offer debriefing and counselling to staff and others affected to address any emotional impact and concerns.

15. The Clinical Advisor will complete an internal review to identify any contributing factors/improvements learnt as part of Quality Improvement and update the *Continuous Improvement Plan* accordingly.

Supporting Documents

Documents relevant to this policy and procedure include:

- *Assessment, Care Planning and Documentation Policy and Procedure*
- *Clinical Governance Framework*
- *Consumer Case Notes Policy and Procedure*
- *Consumer Incident Management Policy and Procedure*
- *Consumer Rights Policy and Procedure*
- *Decision Making, Dignity, and Choice Policy and Procedure*
- *Diversity and Culturally Safe Service Delivery Policy and Procedure*
- *Infection Control Policy and Procedure*
- *Palliative Care Policy and Procedure*
- *Privacy and Confidentiality Policy and Procedure*
- *Risk Management Policy and Procedure*
- *Training and Development Policy and Procedure*
- *End of Life Plan*

Monitoring and Review

This policy and procedure will be reviewed at least two yearly by the Leadership Team and incorporate staff, consumer, and other stakeholder feedback.

Bilingual Care's *Continuous Improvement Plan* will be used to record and monitor progress of any improvements identified and where relevant will be incorporated into service planning and delivery processes.

DOCUMENT CONTROL

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