Australian Government

CHCPAL002 Plan for and provide care services using a palliative approach

Release: 2

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Modification History

Release	Comments
Release 2	This version was released in *CHC Community Services Training Package release 2.0* and meets the requirements of the 2012 Standards for Training Packages. "advanced care directives" corrected to "advance care directives"
Release 1	This version was released in *CHC Community Services Training Package release 2.0* and meets the requirements of the 2012 Standards for Training Packages. Significant change to the elements and performance criteria. New evidence requirements for assessment including volume and frequency requirements. Significant changes to knowledge evidence.

Application

This unit describes the skills and knowledge required to contribute to the development, implementation, evaluation and communication of a care plan for individuals with life-threatening or life-limiting illness and/or normal ageing process in a team environment using a palliative approach.

This unit applies to workers in a residential or community context. Work performed requires some discretion and judgement and is carried out under regular direct or indirect supervision.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian/New Zealand standards and industry codes of practice.

Elements and Performance Criteria

ELEMENT	PERFORMANCE CRITERIA
Elements define the essential outcomes	*Performance criteria describe the performance needed to demonstrate achievement of the element.*
1. Plan a palliative approach to	1.1 Assist with care planning using a palliative approach

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Elements define the essential outcomes	*Performance criteria describe the performance needed to demonstrate achievement of the element.*
individual care	to maximise the person's quality of life and comfort
	1.2 Identify immediate and potential future care requirements based on the condition or illness of the person
	1.3 Identify current specialist palliative care requirements if relevant
	1.4 Ensure planning includes involving and supporting the person, family members, carers and/or significant others
	1.5 Ensure care plan holistically addresses the person's needs that extend over time not just end-of-life
2. Support individuals to identify their preferences for quality of life choices	2.1 Consult the person, family members, carers and/or significant others to identify and share information regarding current and changing needs and preferences
	2.2 Respect and account for the person's lifestyle, social, cultural and spiritual choices and needs in developing the care plan
	2.3 Ensure the planning process supports the freedom of the person, family, carer and/or significant others to discuss spiritual and cultural issues in an open and non-judgemental way
	2.4 Demonstrate respect for the roles of the person and carer in planning, delivering care and decision making
	2.5 Address any issues that are outside scope of own role by referring them to the appropriate member of the care team in line with organisation requirements
	2.6 Model communication with the person, families, carers and/or significant others that shows empathy and provides emotional support
3. Assist with advanced care planning	3.1 Assist with the determining of advance care directives in line with role, organisation, legal and ethical guidelines
	3.2 Assist with the documentation of advance care directives in line with the person's preferences and organisation procedures

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Elements define the essential outcomes	*Performance criteria describe the performance needed to demonstrate achievement of the element.*
	3.3 Ensure all advance care directives are communicated and understood by relevant parties in accordance with confidentiality requirements
	3.4 Actively support the ethical end-of-life decisions agreed by the person and carer, in line with organisation policy and care plan directives
	3.5 Assist with identifying the person's ongoing decisions, preferences, needs and issues in relation to end-of-life and document in the care plan in consultation with supervisor or appropriate team member
	3.6 Observe the impact on the family and carers of the person's end-of-life decisions, needs and issues and provide support as needed
4. Take action to alleviate pain and other end-of-life symptoms	4.1 Plan and document in care plan strategies to maximise comfort in collaboration with supervisor and/or health professional
	4.2 Assess the person's need for pain and symptom relief in line with care plan and report to supervisor and/or health professional
	4.3 Provide pain and symptom relief in line with role, care plan, legislation and organisation policy
	4.4 Provide appropriate information about the use of pain relieving medication and other treatments to staff, individuals, their family and carers, in consultation with supervisor and/or other health professional,
	4.5 Observe, report and document effectiveness of interventions for pain and symptom relief
	4.6 Communicate ineffectiveness of interventions to supervisor and/or other health professional and document
5. Contribute to the development and implementation of end-of-life care strategies	5.1 Respect and incorporate the person's preferences including cultural and spiritual wishes when contributing to an end-of-life care plan
	5.2 Maintain the dignity of the person when planning end-of-life care and immediately following death

ELEMENT	PERFORMANCE CRITERIA
Elements define the essential outcomes	*Performance criteria describe the performance needed to demonstrate achievement of the element.*
	5.3 Observe any signs of a person's imminent death and/or deterioration and report to appropriate members of the care team in line with organisation requirements
	5.4 Provide a supportive environment for the person, families, carers and/or significant others and those involved in their care at end-of-life
	5.5 Ensure that decisions made by the person, family, carers and/or significant others are reviewed regularly, communicated to staff and updated on the care plan
	5.6 Identify the emotional needs of other individuals and their families, carers and/or significant others affected when a death occurs and provide the necessary support or referrals in line with organisation requirements
	5.7 Prepare the person, family, other staff and self for any distressing end-of-life events within own responsibilities
6. Identify and manage emotional responses in self and others	6.1 Identify and reflect upon own emotional responses to death and dying and raise and discuss any issues with supervisor and/or other appropriate person
	6.2 Identify and reflect upon potential impact of personal responses on self and others and action appropriately
	6.3 Inform others about support systems and bereavement care available
	6.4 Follow organisation policies and procedures in relation to emotional welfare of self, team members, individuals and family
	6.5 Assist colleagues to debrief and discuss bereavement care
	6.6 Identify other strategies and resources available for debriefing
	6.7 Evaluate effectiveness of emotional response strategies

Foundation Skills

The Foundation Skills describe those required skills (such as language, literacy, numeracy and employment skills) that are essential to performance.

Foundation skills essential to performance are explicit in the performance criteria of this unit of competency.

Unit Mapping Information

No equivalent unit.

Links

Companion Volume implementation guides are found in VETNet - https://vetnet.gov.au/Pages/TrainingDocs.aspx?q=5e0c25cc-3d9d-4b43-80d3-bd22cc4f1e53