H&H Care SA Pty Ltd	Form27. Palliative and End of Life Support Australian Government Support at Home Program		
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Policy and procedure 27

H&H Care SA Pty Ltd | Support at Home services

This policy guides comfort-focused, person-centred support for clients with life-limiting illness and their chosen supporters. Care must follow the client's goals, current clinical instructions and lawful decisions, with timely access to clinical help and a clear plan for deterioration or death at home.

Document control	Details
Policy number	HH SAH PALLIATIVE 027
Version and status	1.0 — Draft for Director and Clinical Lead RN approval
Prepared	24 October 2026
Policy owner	Director and Clinical Lead RN
Approved by	Director: Huy Le Clinical Lead RN: Thi Ngoc Bich Tran
Effective date	24 October 2026
Review due	12 months after approval or earlier following change or incident
Applies to	Workers, nurses, coordinators and approved personnel delivering palliative or end-of-life support

1 Purpose and scope

Support comfort, dignity, informed choice and quality of life, including practical, emotional, cultural and spiritual needs. Palliative care can begin earlier in an illness and accompany other treatment. A palliative approach does not automatically mean that a person is in the last days of life or that all treatment should stop.

H&H provides only services within agreed scope and available competence. For The Fig Trees clients, obtain written service authorisation, clinical roles, contacts and funding arrangements. Do not promise continuous nursing or emergency attendance without a confirmed service arrangement.

2 Responsibilities

The Director ensures resources, contracts, insurance, staff support and continuity. The Clinical Lead RN coordinates nursing assessment, care plans, competence, monitoring and clinical escalation. The GP or treating team provides medical assessment, prescribing and treatment decisions; specialist palliative services provide advice and care according to their arrangements.

Coordinators maintain the roster, supplies and backup contacts. Workers provide authorised care, recognise changes and report promptly. The Fig Trees and H&H agree who coordinates referrals and notifications. Each retains its own obligations; funding responsibility does not replace clinical responsibility.

3 Client partnership

Ask what matters to the person, how much information they want, who they want involved and where they prefer to receive care. Use an interpreter when needed. Avoid assumptions based on religion, culture or diagnosis. Explain that preferences and care setting can change, and review them without pressure.

Assessment advance planning and consent

4 Assessment and referral

The RN assesses comfort, symptoms, function, skin, mobility, nutrition, hydration, continence, cognition, medicine access and psychosocial needs. Identify existing clinicians, recent admissions, equipment, carer capacity and urgent risks. Refer early to the GP and specialist palliative care where indicated; a support worker must not diagnose dying or estimate prognosis.

Discuss preferred place of care and death, possible transfers, worries, cultural or spiritual practices, communication, important relationships and the support needed to remain at home. Coordinate with The Fig Trees regarding Support at Home End-of-Life Pathway eligibility and urgent access; do not guarantee approval or delay clinical care while funding is assessed.

5 Advance care planning

Offer voluntary conversations at an appropriate pace. Record wishes and locate any Advance Care Directive, appointed substitute decision maker, current clinical resuscitation plan and other relevant documents. Support access to official South Australian forms and clinical or legal advice; workers must not invent legal forms or sign as an eligible witness without checking eligibility.

An Advance Care Directive expresses the person's future directions and may appoint a substitute decision maker. A clinical resuscitation plan, including the SA 7-Step Pathway when used, documents clinical decisions about deterioration and treatment. The day-to-day H&H care plan coordinates practical care. These documents have different roles and must be reconciled by the treating clinician where instructions are unclear.

Keep current copies readily accessible to authorised workers and emergency clinicians, with version, date, location and review arrangements. Do not rely only on family recollection, a label such as palliative, or an unverified verbal instruction to withhold resuscitation or treatment.

6 Consent and treatment decisions

Support the person to make the specific decision while they can. A diagnosis or frailty does not itself remove decision-making ability. A currently capable person's decision must be heard and acted on within law. Where the person cannot decide, verify the lawful decision maker and scope of authority; next of kin status alone is insufficient.

Workers must not decide whether a refusal is legally binding or settle conflicting instructions themselves. Escalate urgently to the RN and treating clinician. A no-CPR decision does not mean no symptom relief, personal care or other appropriate treatment. Record discussion, advice and the agreed clinical response.

Planning safe care at home

7 Individual palliative care plan

Before service begins, the RN coordinates a plan with the person and relevant clinicians. Include current goals, symptom instructions, treatment limits, anticipated changes, equipment, medicines, routine supports and an escalation pathway. Identify who has accepted clinical responsibility and when each service is available.

- Name the GP, palliative service, H&H RN and after-hours clinical contact, with a tested backup route and emergency instructions.
- Specify visit frequency, support between visits, who will respond to calls, and what happens if the main carer cannot continue.
- Record medicines and equipment arrangements, anticipated supply needs, pharmacy access, power failure and urgent replacement plans.
- Record how to respond to uncontrolled symptoms, unexpected deterioration, inability to swallow and suspected death, including who will attend and arrange documentation.

An answering machine or unanswered message is not a completed clinical handover. If essential support cannot be secured, escalate and agree a safe alternative location or service. Do not leave an unsafe situation dependent on an unconfirmed referral.

8 Family and carer readiness

With consent, involve chosen supporters and assess what they are willing and able to do, including overnight support. Offer clear explanations and demonstration by an appropriate clinician. Do not assume family members can administer medicines, lift the person, manage devices or provide continuous care.

Discuss exhaustion, emotional strain, children or other dependants, respite, financial and practical concerns, and emergency backup. Arrange specialist or social support when needed. Give information in manageable steps and check understanding. A preference for death at home must not become pressure on the person or family.

9 Clinical supplies and workforce

Confirm workers have client-specific training in comfort care, observation, communication, medicine boundaries and emergency response. Nursing tasks require appropriate qualifications, competence and supervision. Complex devices, subcutaneous infusions and injections require separate orders and authorised procedures under Policies 20, 21 and 25.

Check safe storage, infection prevention, manual handling, equipment maintenance and waste arrangements. Obtain consent for access arrangements and any key safe. Maintain an approved backup roster and hand over the current plan at every transition.

Comfort care and symptom response

10 Daily comfort support

Offer gentle personal care, mouth and lip care, clean linen, comfortable positioning and pressure relief according to tolerance and the plan. Explain before touching, protect privacy and allow rest. Seek advice about safe moving and equipment rather than repeatedly repositioning through pain.

Offer desired food and drink when safe and consistent with the swallowing plan. Do not force intake. Report swallowing changes, coughing, distress or inability to take medicines for urgent clinical review. Decisions about clinically assisted nutrition or hydration require the treating team and lawful decision-making process; workers must not start, stop or alter these independently.

Provide a quiet environment, preferred music, companionship or spiritual support if wanted. Support glasses, hearing aids and familiar people. Ask how much contact or conversation the person wants. Continue respectful communication even if they respond less.

11 Symptoms requiring review

Concern	Worker action within scope
Pain or discomfort	Use the agreed self-report or observational assessment with training. Provide prescribed comfort measures, notify the RN and record response.
Breathlessness	Stay calm, assist the prescribed comfortable position and follow the plan. Do not commence oxygen or change its flow without an order. Severe or unrelieved distress requires urgent help.
Nausea vomiting constipation or urinary problems	Report promptly for assessment and treatment. Follow authorised instructions and monitor effect; do not improvise laxatives, enemas or catheter interventions.
Agitation confusion or marked drowsiness	Consider possible illness, pain or medicine effects and obtain clinical advice. Do not assume all agitation is part of dying or use restraint or sedation for convenience.
Secretions skin damage or device concerns	Follow the comfort and device plan; seek advice for new or worsening symptoms. Do not perform unapproved suction or device manipulation.

12 Escalation

Use the individual instructions for expected symptoms and contact the named clinical service promptly when relief is inadequate. Call 000 for a life-threatening emergency unless a clear applicable clinical plan directs an alternative response that can be safely followed. If instructions are absent, unclear or disputed, call 000 and explain the circumstances and available documents. Do not delay urgent help to seek funding or manager permission.

Medicines last days and treatment limits

13 Safe medicine support

Apply Policy 20. Require valid orders, the correct medicine, formulation, route and clear administration and monitoring instructions. For anticipatory and PRN medicines, confirm indication, dose, interval, maximum, escalation criteria and supply. An anticipatory prescription is not an instruction to give every medicine routinely.

Only authorised, competent personnel administer injections or operate infusion devices under a specific plan. Workers must not calculate opioid conversions, titrate doses, change pumps or substitute routes on their own. A family request does not authorise an extra dose. Record actual doses, effect, adverse effects and omitted doses; seek timely clinical advice if the route is no longer safe.

Arrange prescriber or pharmacist review when swallowing changes, medicines are ineffective or adverse effects occur. Do not crush modified-release products or independently discontinue medicines. Follow approved controlled-drug storage, checking, stock and discrepancy processes. Secure medicines from children and others without compromising authorised access.

14 Recognising the last days

Reduced intake, increased sleep, changed breathing, reduced urine and decreasing responsiveness can occur near death but may also have reversible causes. Workers report changes; the treating team assesses whether the person is dying and reviews goals, symptoms and the plan.

When the clinical team identifies the last days, update the practical plan, contacts and family information. Agree which observations remain useful and how to avoid burdensome interventions while meeting clinical instructions. Comfort, mouth care, privacy and presence remain active care. Do not stop observations or treatment merely because a person is described as dying.

15 Resuscitation and emergencies

The RN must clarify and document an accessible response before an anticipated death: whether CPR is to be attempted, the clinical basis and documents, who to call and the backup if attendance is unavailable. Workers must be briefed on the exact applicable instructions and their role.

If a person is unresponsive and not breathing normally and there is no clear applicable lawful direction to withhold CPR, call 000 and begin first aid and CPR according to training and dispatcher advice. Make relevant documents available immediately. Where a clear applicable direction exists, follow the documented pathway and seek clinical help; do not interpret a general preference to stay home as a no-CPR instruction.

16 Requests about voluntary assisted dying

Respond respectfully to questions and refer to the treating clinician or official SA Health pathway. Palliative care continues according to need. This policy does not authorise H&H staff to assess eligibility, obtain, handle, prepare or administer voluntary assisted dying medicines. Any proposed staff involvement requires separate confirmation of lawful role, competence and organisational arrangements. Escalate immediate safety concerns through the appropriate emergency response.

Death at home and care afterwards

17 Suspected expected death

Follow the agreed expected-death pathway and contact the named doctor or palliative team immediately. Notify the H&H RN and coordinator. If the death was not clearly anticipated, the plan is missing, or there is doubt whether the person has died, use the emergency pathway and call 000.

A support worker records observations and contact times but does not declare death or certify its cause. Do not record the time found as the medically established time of death. Record who attended, who verified death, the time documented by that clinician and any instructions received.

Verification or declaration of life extinct and medical certification of cause of death are different functions. An RN may undertake verification only where lawful, trained and specifically authorised under the applicable organisational procedure. An SA Health policy does not automatically credential an H&H RN. Medical certification and coronial requirements must be arranged through the appropriate practitioner or authority.

18 Unexpected or potentially reportable death

Call 000, provide first aid as indicated, and notify the RN and Director immediately. Suspected injury, neglect, medicine error, unexplained circumstances or other possible reportable death requires prompt police or medical advice about coronial notification. An anticipated death can still meet a coronial reporting criterion; do not assume that palliative status excludes reporting.

Preserve the scene, records, medicines and relevant equipment. Do not remove tubes, lines or devices, wash or move the body, dispose of medicines or release belongings except as required for immediate safety, resuscitation or authorised instructions. Document any unavoidable change and why it occurred.

Use Policy 9 and coordinate with The Fig Trees without delay. The registered provider must assess SIRS obligations promptly; an unexpected death within SIRS scope is Priority 1 and requires notification within 24 hours of awareness. Coronial or police processes do not replace aged care reporting. Record who accepts each notification task and verify completion.

19 After death and bereavement

After required verification and clearance, provide respectful care only within training and clinical instructions. Ask about cultural, spiritual and family wishes and allow time and privacy. Confirm identification and authorised arrangements before transfer by the funeral service. Keep a documented handover and property record.

Support family with clear practical information without giving legal or financial advice. Arrange safe medicine return through the pharmacist or authorised service; workers must not take medicines or dispose of controlled drugs informally. Cancel future visits sensitively after confirmation, notify relevant services with proper authority, secure records and offer bereavement support and staff debriefing.

Palliative care and escalation plan

PALLIATIVE F01 | Complete with the client and treating team. Attach current clinical orders, Advance Care Directive and resuscitation plan where available. This form does not itself create a no-CPR order.

Client name and identifiers: _____

Treating GP palliative team and named clinical lead: _____

Illness current phase baseline and review information: _____

What matters to me comfort goals preferred place of care and death: _____

Information language cultural spiritual and communication preferences: _____

Chosen supporters consent and verified decision-making authority: _____

Advance Care Directive location date and review status: _____

Clinical resuscitation plan location date clinician and applicable instructions: _____

Conflicting or unclear instructions resolved by and when: _____

Routine personal care mouth care skin mobility and comfort measures: _____

Food fluids swallowing status and clinically assisted intake decisions reference: _____

Symptom assessment instructions treatment orders and escalation thresholds: _____

Anticipatory PRN medicines route storage and authorised administrator: _____

Equipment supplies pharmacy access and backup: _____

H&H visit schedule care between visits and overnight arrangements: _____

Carer willingness capacity education respite and contingency: _____

Daytime clinical contact: _____ After hours: _____

Backup clinical contact and emergency response if unavailable: _____

Expected death instructions who to call attendance and verification arrangement: _____

Unexpected death or uncertainty response and relevant documents: _____

Family notification preferences and cultural wishes after death: _____

Referrals responsible person and completion dates: _____

Client participation and agreed information sharing: _____

Treating clinician approval role signature date: _____

H&H RN readiness approval and Fig Trees coordination reference: _____

Review date and earlier triggers: _____

Comfort record review and approval

PALLIATIVE F02 | Comfort care and clinical escalation record. Add pages as needed.

Client identifiers: _____ Worker name role: _____

Date time symptoms client report observations and change from baseline: _____

Comfort care and authorised measures provided: _____

Medicine administration record reference effect and adverse effects: _____

Food fluids mouth care skin position and care accepted or declined: _____

Client and family concerns communication and support: _____

Clinical contact time advice action and review accepted by: _____

Response outstanding needs and handover to: _____

Worker signature date: _____

PALLIATIVE F03 | Death response record. Record facts; complete required incident records separately.

Time found observations expected-death plan and emergency actions: _____

Doctor palliative team emergency service RN and family contacts with times: _____

Verifier name role documented time and certification or coronial arrangements: _____

Authorised instructions clearance and care after death: _____

Transfer identity property medicines and service handover record references: _____

Incident SIRS police or coronial tasks assigned to and confirmed completed: _____

Family follow up staff debrief and review owner date: _____

20 References and implementation

Read with Policies 1 to 26, especially rights, consent, assessment, care planning, records, SIRS, deterioration, medication, nursing governance, nutrition and complex care. Official guidance checked 24 October 2026. Apply current South Australian law and approved client-specific clinical instructions.

- Commission — Outcome 5.7 Palliative care and end-of-life care. https://www.agedcarequality.gov.au/strengthened-quality-standards/clinical-care/palliative-care-and-end-life-care
- SA Government — Advance care directives. https://www.sa.gov.au/topics/family-and-community/planning-ahead/advance-care-directives
- Healthdirect — Preparing for a death at home. https://www.healthdirect.gov.au/healthcare-and-services/end-of-life-care/preparing-for-a-death-at-home
- ELDAC — Palliative and advance care planning resources. https://www.eldac.com.au/
- SA Courts — Coroners Court reporting a death. https://www.courts.sa.gov.au/online-services/coroners-court-reporting-a-death/
- Commission — Unexpected death and SIRS. https://www.agedcarequality.gov.au/providers/serious-incident-response-scheme/reportable-incidents/unexpected-death

Before implementation approve local clinical procedures, verify resuscitation and death response pathways, enter contacts, brief workers and confirm competence and after-hours backup. Review after significant change and each death; quarterly audit plans, symptoms, missed care and follow-up actions under Policy 18.

Director: _____ Clinical Lead RN: _____ Effective date: _____

Next review: _____