PACOP
palliative aged care
outcomes program

PACOP Clinical Response Guide V2

Profile and Outcomes Collections

Acknowledgement of Country
PACOP wishes to acknowledge Aboriginal & Torres Strait Islander people as the traditional custodians of the lands we are working on. We wish to pay our respects to the Elders, past, present, emerging & future.

PCOC acknowledgement
PACOP is built upon the concepts and resources initially created by the Palliative Care Outcomes Collaboration (PCOC) and wishes to acknowledge their foundational contribution.

PACOP acknowledges the collaborative contributions from Painchek related to integration of assessment and response to Painchek items.

PACOP is an outcome and benchmarking program. PACOP creates a clinical language by embeds validated clinical assessments to systematically measure and improve resident and family/carer outcomes. For more information visit the PACOP website – pacop@uow.edu.au

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The Palliative Aged Care Outcomes Program (PACOP)

PACOP is a national palliative care program funded by the Australian Government Department of Health, Disability and Ageing.

PACOP's primary purpose is to improve care outcomes for all older Australians living in residential aged care, focusing on those approaching End-of-Life. PACOP provides a framework that supports clinical assessment for early identification of changing care needs and a protocol for timely response. It informs care and advance care planning processes, empowering individuals and carers to make informed decisions based on assessed care needs and evidence-based responses. The framework strengthens palliative care through improved access to coordinated palliative and end-of-life care and use of a common clinical language across multidisciplinary care teams[1]. and.

PACOP supports continuous quality improvement by measuring and benchmarking outcomes for individuals and their families/carers. PACOP returns a comprehensive report suite and national benchmarking results to participating aged care providers. The PACOP National Benchmarking Program guides quality improvement and demonstrates improvement of care outcomes over time (figure 1). PACOP provides education and training to participating providers, building capacity for delivery of high-quality palliative care[2]. Mentoring and support with implementation is delivered through voluntary participation in Communities of Practice.

PACOP participation helps providers demonstrate meaningful, culturally safe and inclusive palliative care aligned with the Strengthen Quality Standards[3]. PACOP's national framework for palliative aged care directly contributes to systematic improvement and strengthening of the Australian aged care system aligning with legislative and policy reform[4].

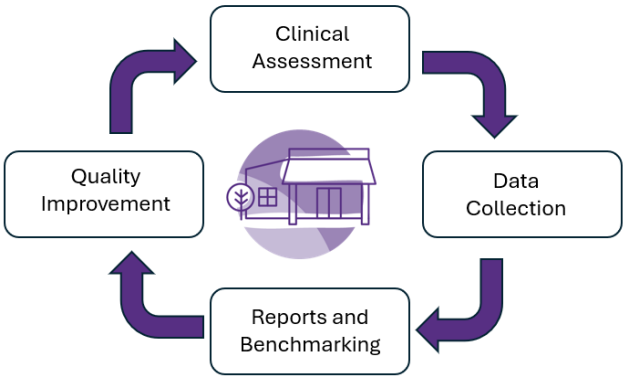


Figure 1. The PACOP cycle.

Introduction

This Clinical Guide supports the aged care workforce and service providers to understand and implement the PACOP framework and clinical response protocol.
The guide covers the two components of the program, the Profile and Outcomes Collections, and includes:

- PACOP forms and assessments
- PACOP assessment framework
- Validated assessment tool definitions and responses
- Palliative and End-of-Life Care Checklist for Aged Care Services

PACOP forms and assessments

The PACOP assessment framework is divided into two components: the **Profile Collection** and the **Outcomes Collection**.

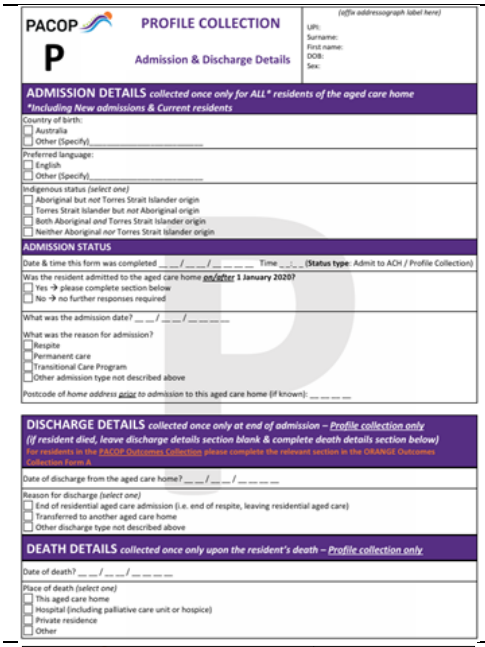
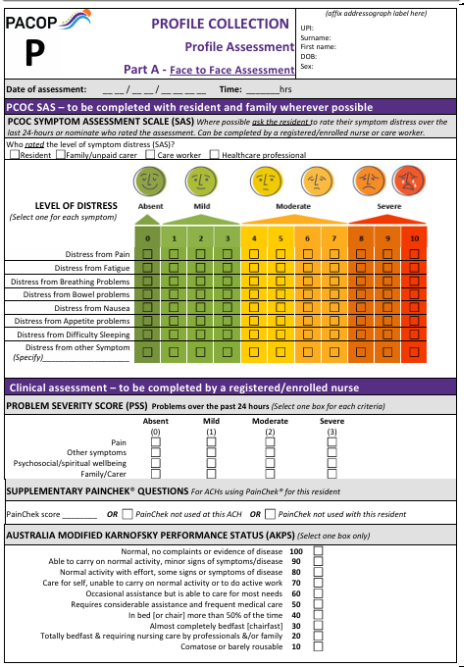
[1] Johnson, C.E., Dai, Y., Bryce, L. *et al.* The Palliative Aged Care Outcomes Program (PACOP): establishing a national framework to improve palliative care in long-term care facilities for older people. *BMC Geriatr* (2026). https://doi.org/10.1186/s12877-026-07009-5
[2] Davis EL, Mullan J, Johnson CE, et al. The experience of Australian aged care workers during a trial implementation of a palliative care outcomes programme. *Int J Health Plann Mgmt*. 2024; 39(2): 380-396. **https://doi.org/10.1002/hpm.3731**
[3] Department of Health, Disability & Aging, (2021). 2021 Strengthened Aged Care Quality Standards, Australian Government. https://www.health.gov.au/sites/default/files/2025-08/strengthened-aged-care-quality-standards-august-2025.pdf
[4] Commonwealth of Australia, Royal Commission into Aged Care Quality & Safety, Final Report: Care Dignity and Respect, Volume 1, (2021) https://www.royalcommission.gov.au/system/files/2024-03/aged-care-rc-final-report-volume-1.pdf

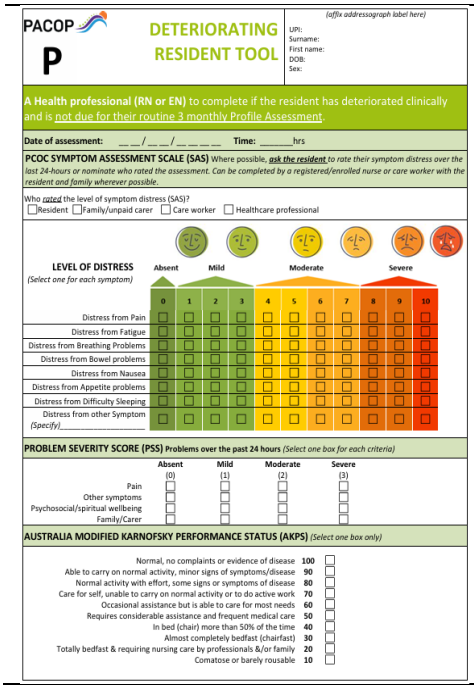
The Profile Collection

Aim: the Profile Collection involves routine screening of all residents to support early identification of palliative and End-of-Life care needs.

Assessment Frequency: There is one admission/discharge form, and two clinical assessments in the Profile Collection. See the summary of Profile Collection form and assessment summary in Table 1.

Table 1 Profile Collection form and assessment summary.

Profile Collection		
Form or Assessment	**Name and Purpose**	**Completion frequency**
	**Admission & Discharge Form** Commences the resident into routine screening in the Profile Collection and records the admission period.	Admission Section is completed upon admission into the aged care home. Discharge is documented here for residents where a death or discharge occurs in Profile Collection. Multiple admission and discharge episodes may occur where respite occurs.
	**Profile Assessment** (Part A, B & C) Routinely screens residents to identify palliative and End-of-Life care needs. Informs care planning, advance care planning, and monitors changes in condition and care needs over time.	Complete a **Profile Assessment**: Upon admission to the aged care home. A minimum of every three months. May be done more frequently. Recommended upon transfer back to the aged care service from hospital.



PACOP P

DETERIORATING RESIDENT TOOL

(affix addressograph label here)

UPI:
Surname:
First name:
DOB:
Sex:

A Health professional (RN or EN) to complete if the resident has deteriorated clinically and is not due for their routine 3 monthly Profile Assessment.

Date of assessment: __ __ / __ __ / __ __ __ __ **Time:** _____hrs

PCOC SYMPTOM ASSESSMENT SCALE (SAS) Where possible, ***ask the resident*** *to rate their symptom distress over the last 24-hours or nominate who rated the assessment. Can be completed by a registered/enrolled nurse or care worker with the resident and family wherever possible.*

Who *rated* the level of symptom distress (SAS)?
☐Resident ☐Family/unpaid carer ☐ Care worker ☐ Healthcare professional

LEVEL OF DISTRESS *(Select one for each symptom)*

Absent | Mild | Moderate | Severe

	0	1	2	3	4	5	6	7	8	9	10
Distress from Pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Fatigue	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Breathing Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Bowel problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Nausea	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Appetite problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from Difficulty Sleeping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Distress from other Symptom *(Specify)*_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PROBLEM SEVERITY SCORE (PSS) Problems over the past 24 hours *(Select one box for each criteria)*

	Absent (0)	Mild (1)	Moderate (2)	Severe (3)
Pain	☐	☐	☐	☐
Other symptoms	☐	☐	☐	☐
Psychosocial/spiritual wellbeing	☐	☐	☐	☐
Family/Carer	☐	☐	☐	☐

AUSTRALIA MODIFIED KARNOFSKY PERFORMANCE STATUS (AKPS) *(Select one box only)*

Normal, no complaints or evidence of disease	100	☐
Able to carry on normal activity, minor signs of symptoms/disease	90	☐
Normal activity with effort, some signs or symptoms of disease	80	☐
Care for self, unable to carry on normal activity or to do active work	70	☐
Occasional assistance but is able to care for most needs	60	☐
Requires considerable assistance and frequent medical care	50	☐
In bed (chair) more than 50% of the time	40	☐
Almost completely bedfast (chairfast)	30	☐
Totally bedfast & requiring nursing care by professionals &/or family	20	☐
Comatose or barely rousable	10	☐

Deteriorating Resident Tool

Completed to identify changes in a residents' condition and identify the need for palliative and End-of-Life care.

Complete a **Deteriorating Resident Tool** where there is concern for a resident or where clinical deterioration is observed.

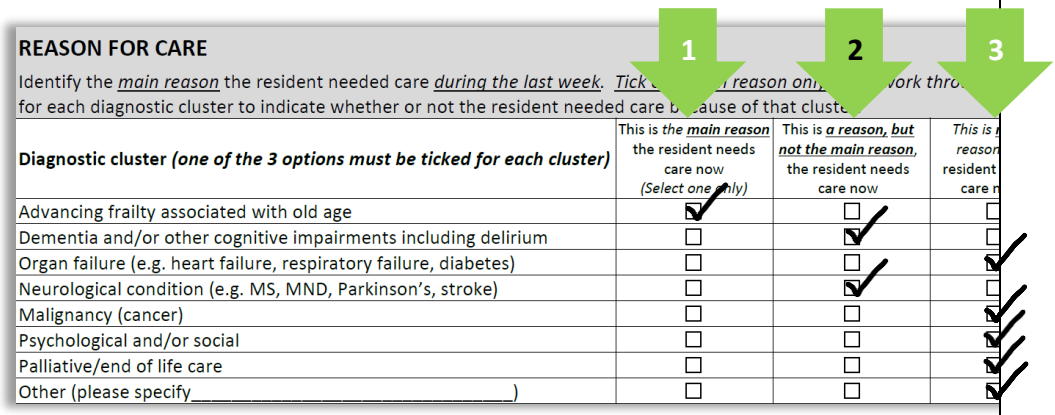
Profile Collection; Assessment completion guide.

The key components of the Profile Collection tools are described in Table 2.

Table 2 Profile Collection assessment completion guide.

Profile Assessment PART A – FACE TO FACE ASSESSMENT* ****To be completed first – with the resident and/or family.***	**Section includes:** – **Date & Time** – Records when the assessment was completed. – **Six validated assessment tools;** SAS, PSS, PainChek®, AKPS, RUG-ADL & RCFS. *Optional* PainChek® score inclusion where used by service providers. - The following codes describe who provided the scored the SAS item: Resident = **R**, Family = **F**, Care worker = **C**, or Healthcare professional = **H**. - PainChek® score, completed on the day of assessment. – **Communication** – important information regarding communication and feedback provided by the resident and their family. – **Psycho-social wellbeing** – important information relating to the resident's psychosocial wellbeing including contact with visitor frequency. – **Signature & Designation –** of the person completing the assessment. *Observed changes in self-care ability, communication, behavioural responses, and physical health relate to deterioration and changes over time reported by staff and/or family/friends who know the resident's usual function and may provide insight on disease progression[5]. Care plan reviews are informed by regular assessment of the resident's care needs.*
Profile Assessment PART B – DESK-TOP ASSESSMENT *Completed after Part A	**Section includes:** – **Date completed** – Completed within 24hrs of Part A. – **Reasons for care** – clinicians select *a reason for care* against seven diagnostic clusters. Each Diagnostic cluster must be identified as either; the '**MAIN** reason', '**A** reason' or '**NOT** a reason' for care. Please note, there should only be ONE MAIN REASON for care. - To complete this section, see the example in figure 2 below: ▪ **Column 1 Main reason** – **ONE** only selected. ▪ **Column 2 Other reasons** – all contributing reasons selected (should not include the main reason)

[5] Bourke, C., L.Chenoweth, E.Georgousopoulou, and A.Williams. 2026. "Development and Validation of the End-of-Life Assessment Tool for Advanced Dementia: A Multi Method Study." Journal of Advanced Nursing82, no. 5: 5430–5443. https://doi.org/10.1111/jan.70129.

	▪ **Column 3 NOT a reason –** those not contributing to care needs are selected (cannot be same as main ***or*** other reasons for care)  Figure 2. Diagnostic Cluster item completion. – **Advance care planning & decision making** – this section prompts conversations about documented Advance Care Planning and alternate/substitute decision making processes. *If the answer is NO to any of these items, care teams should engage with residents and their substitute decision makers to undertake Advance Care Planning. These items prompt regular discussion and review to ensure documents reflect the resident's changing needs, wants and preferences which can positively impact outcomes and experience of end-of-life care[6].* - **Recent hospital use** – this section seeks information about health service use in the past 3 months, including: recent emergency department, unplanned or planned hospital admissions. *Increasing hospital use may indicate ongoing deterioration and, in residents who experience frailty, a higher risk of death[7]. Care teams should review hospital use to identify residents with progressive deterioration and frailty who may be approaching end-of-life.* – **AN-ACC class** – this captures the current funding class based on a resident's previously assessed care needs by an external assessor. Where changes are evident in routine re-assessment, it may prompt internal discussion regarding whether a request for AN-ACC reassessment is appropriate. – **Signature & Designation –** of the person completing the assessment.
Profile Assessment **PART C – ACTION PLAN**	**Use the results from Part A & B to inform the Action Plan (Part C) for the resident. The section includes:** – **Date** – Completed within 24hrs of Parts A & B. – **^Identifying the need for Palliative Care** – this section supports early identification of changing care needs in residents who would benefit from palliative care by responding to criteria. - If **Yes to any** statements/questions **OR** yes to 2 or more of the 3 assessment items – the resident would benefit from palliative care and should commence in the **Outcomes Collection**. - If **No to all** statements/questions/assessments, or only one assessment item – continue to monitor using the Profile Collection, using the DRT where concern arises.

[6] Brinkman-Stoppelenburg A, Rietjens JA, van der Heide A. The effects of advance care planning on end-of-life care: a systematic review. Palliat Med. 2014 Sep;28(8):1000-25. doi: 10.1177/0269216314526272. Epub 2014 Mar 20. PMID: 24651708.

[7] Olga Theou, Janet K Sluggett, J Simon Bell, Samanta Lalic, Tina Cooper, Leonie Robson, John E Morley, Kenneth Rockwood, Renuka Visvanathan, Frailty, Hospitalization, and Mortality in Residential Aged Care, *The Journals of Gerontology: Series A*, Volume 73, Issue 8, August 2018, Pages 1090–1096, https://doi.org/10.1093/gerona/glx185.

	– **No action required** → If resident care plan is current and no actions are required to address needs. Reassess in 3 months unless concern arises. Document in resident record. – **Internal action required** → action/s required to comprehensively assess the identified care need, address identified care needs through review of the care plan, select all action options that apply (can select multiple). Action and document in resident record. – **External action required** → referral/s and or escalation required to address changing care needs, select all options that apply (can select multiple). Action and document in resident record. – **Signature/name & Designation–** of the person completing the assessment. *The action plan should be documented and communicated to the care team to inform care coordination. Communication and integration of internal and external partnerships support improvement of person-centered care and aligns all care providers on the goals of care and context of care delivery[8].*
DETERIORATING RESIDENT TOOL*	**Sections include:** – **Date & Time** – provides a record of when deterioration was first recognised and assessed to inform clinical escalation appropriately and inform evidence-based responses focused on assessment information. – **Five validated assessment tools** including the SAS, PSS, PainChek®, AKPS & RCFS. *Optional* PainChek® score inclusion where used by ACHs and completed on the day of assessment. - The following codes describe who provided the scored the SAS item: Resident = **R**, Family = **F**, Care worker = **C**, or Healthcare professional = **H**. – The AKPS and RCFS may indicate a change in prognosis related to deterioration. – **^Identifying the need for Palliative Care** – this section supports early identification of changing care needs in residents who would benefit from palliative care by responding to criteria. – If **Yes to any** statements/questions/assessments – the resident would benefit from palliative care and should commence in the **Outcomes Collection**. – If **No to all** statements/questions/assessments – review care plan to address deterioration & continue to monitor using the Profile Collection. – **Signature/name & Designation–** of the person completing the assessment. ***The Deteriorating Resident Tool is recommended to be completed where acute clinical assessment tools, such as the STOP & WATCH tool, are completed to assess for reasons for acute deterioration. It may also be useful where indicators of deterioration may be evident including falls, weight loss, increased hospital use etc.***

*Use of this tool is not complete until the results are actioned/discussed and clinical handover to the relevant people and the resident's care plan has been updated to meet their needs.
^One of the core components of the PACOP program is to facilitate early identification of residents who would benefit from palliative care and ensuring their needs are addressed in a timely manner. Therefore, PACOP has incorporated criteria within each clinical assessment tool in the Profile Collection (Profile Clinical Assessment Tool *Action Plan* & the Deteriorating Resident Tool) to help staff make these important decisions. Additionally, the same criteria have been incorporated into a Flowchart, this can be placed in staff areas as a visual cue to aid these important decisions when considering residents (see Appendix 2).

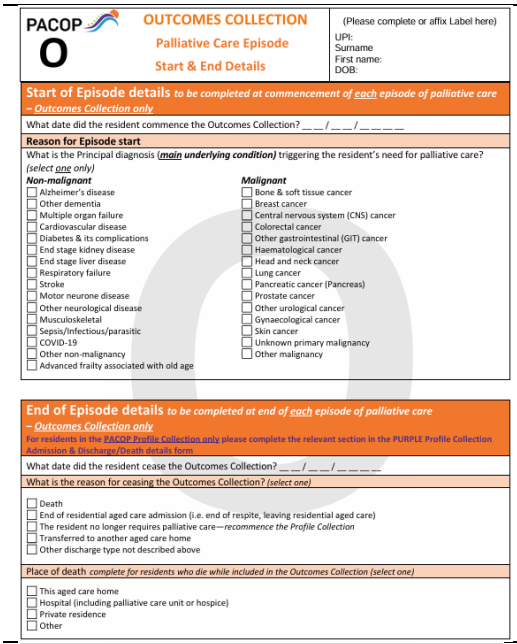
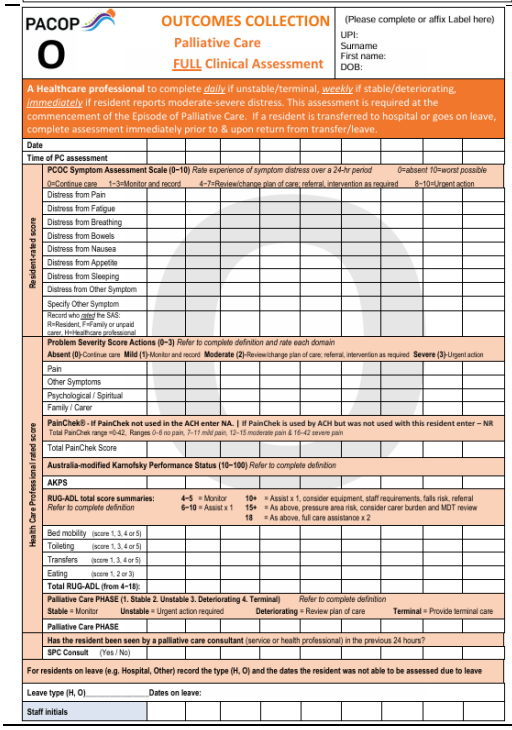
[8] Owusu-Addo, E., Gilbert, A.S., Feldman, P. *et al.* Integrated Care Models for Older People: An Umbrella Review. *Ageing Int* **50**, 35 (2025). https://doi.org/10.1007/s12126-025-09610-2

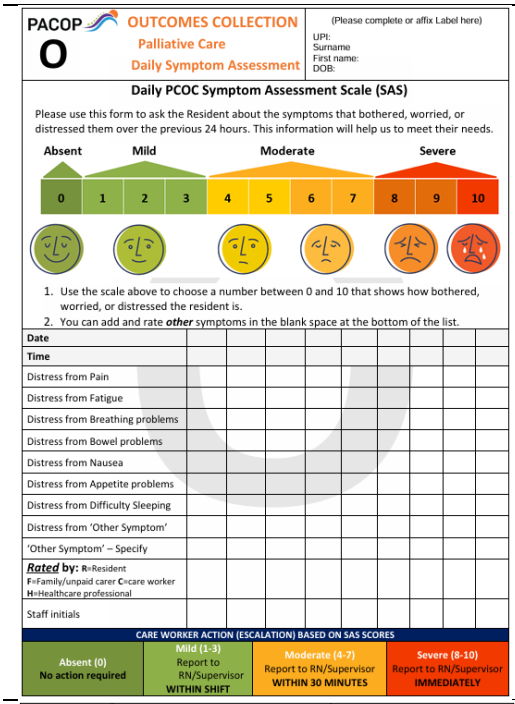
The Outcomes Collection

Aim: Residents who had palliative and End-of-Life care needs identified in the Profile Collection assessment process are transitioned into the Outcomes Collection for more frequent monitoring and clinical assessment.

Assessment Frequency: There is one Palliative Care Episode admission/discharge form, and three clinical assessments in the Outcomes Collection. See the Outcomes Collection forms and assessment summary in Table 3. The **PACOP Clinical Response Protocol** informs the clinical response to palliative and End-of-Life care needed and provides a comprehensive protocol to guide palliative care delivery.

Table 3. Outcomes Collection form and assessment summary.

Outcomes Collection		
Form or Assessment	**Name and Purpose**	**Completion Frequency**
	**Palliative Care Episode Start & End details** Documents the start and end details of the episode of palliative care	Complete Start details within 24hours of an assessment in the Profile Collection identifying the need for the resident to start palliative care. Complete end details where the episode of palliative or end-of-life care is completed following the end episode reasons on the form. ***Note:*** *A resident may have multiple palliative care episodes in the Outcomes Collection during their admission at the aged care home.*
	**Palliative Care Full Clinical Assessment** Assesses the resident and family/carers holistic palliative and end-of-life care needs. Identifies changes and prompts evidence-based responses for care planning, escalation, and coordination of palliative care.	Completed **Daily** for residents in an **Unstable** or **Terminal** Phase **OR** Completed **Weekly** for residents in a **Stable** or **Deteriorating** Phase of care. **OR** May be completed where **moderate or severe SAS score/s from the Daily SAS have been escalated** where the resident requires clinical review. Recommended to be completed on taking or returning from leave, or on discharge/transfer from the aged care home.



PACOP O

OUTCOMES COLLECTION
Palliative Care
Daily Symptom Assessment

(Please complete or affix Label here)
UPI:
Surname
First name:
DOB:

Daily PCOC Symptom Assessment Scale (SAS)

Please use this form to ask the Resident about the symptoms that bothered, worried, or distressed them over the previous 24 hours. This information will help us to meet their needs.

Absent | Mild | Moderate | Severe

0 1 2 3 4 5 6 7 8 9 10

1. Use the scale above to choose a number between 0 and 10 that shows how bothered, worried, or distressed the resident is.
2. You can add and rate ***other*** symptoms in the blank space at the bottom of the list.

Date									
Time									
Distress from Pain									
Distress from Fatigue									
Distress from Breathing problems									
Distress from Bowel problems									
Distress from Nausea									
Distress from Appetite problems									
Distress from Difficulty Sleeping									
Distress from 'Other Symptom'									
'Other Symptom' – Specify									
Rated **by:** R=Resident F=Family/unpaid carer C=care worker H=Healthcare professional									
Staff initials									

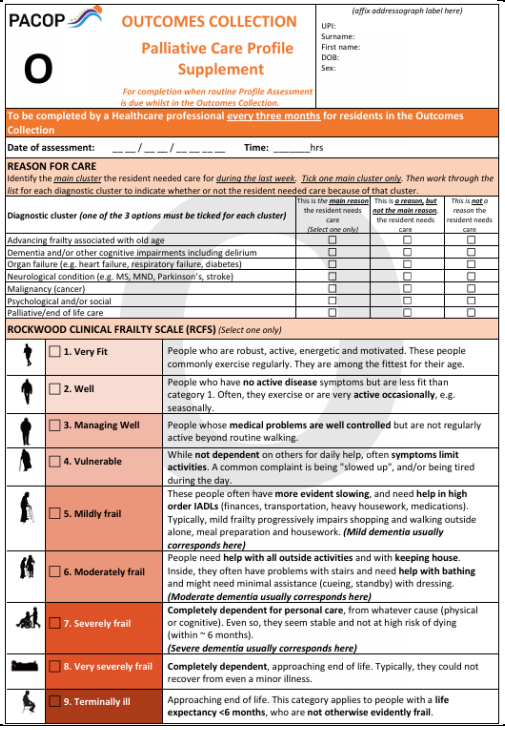
CARE WORKER ACTION (ESCALATION) BASED ON SAS SCORES

Absent (0)	Mild (1-3)	Moderate (4-7)	Severe (8-10)
No action required	Report to RN/Supervisor WITHIN SHIFT	Report to RN/Supervisor WITHIN 30 MINUTES	Report to RN/Supervisor IMMEDIATELY

Palliative Care Daily SAS assessment

Monitors the residents experience of distress related to palliative care symptoms over the past 24hrs. Evidences improved outcomes for residents through care delivered.

Completed daily for all residents in the Outcomes Collection with scores escalated to RN/Supervisor as per the Clinical Response Protocol.



PACOP O

OUTCOMES COLLECTION
Palliative Care Profile Supplement

For completion when routine Profile Assessment is due whilst in the Outcomes Collection.

(affix addressograph label here)
UPI:
Surname:
First name:
DOB:
Sex:

To be completed by a Healthcare professional every three months for residents in the Outcomes Collection

Date of assessment: __ __ / __ __ / __ __ __ __ **Time:** _____hrs

REASON FOR CARE
Identify the *main cluster* the resident needed care for *during the last week*. *Tick one main cluster only. Then work through the list* for each diagnostic cluster to indicate whether or not the resident needed care because of that cluster.

Diagnostic cluster ***(one of the 3 options must be ticked for each cluster)***	This is the ***main reason*** the resident needs care *(Select one only)*	This is ***a reason, but not the main reason*** the resident needs care	This is ***not a reason*** the resident needs care
Advancing frailty associated with old age	☐	☐	☐
Dementia and/or other cognitive impairments including delirium	☐	☐	☐
Organ failure (e.g. heart failure, respiratory failure, diabetes)	☐	☐	☐
Neurological condition (e.g. MS, MND, Parkinson's, stroke)	☐	☐	☐
Malignancy (cancer)	☐	☐	☐
Psychological and/or social	☐	☐	☐
Palliative/end of life care	☐	☐	☐

ROCKWOOD CLINICAL FRAILTY SCALE (RCFS) *(Select one only)*

☐ **1. Very Fit**	People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
☐ **2. Well**	People who have **no active disease** symptoms but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.
☐ **3. Managing Well**	People whose **medical problems are well controlled** but are not regularly active beyond routine walking.
☐ **4. Vulnerable**	While **not dependent** on others for daily help, often **symptoms limit activities**. A common complaint is being "slowed up", and/or being tired during the day.
☐ **5. Mildly frail**	These people often have **more evident slowing**, and need **help in high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework. ***(Mild dementia usually corresponds here)***
☐ **6. Moderately frail**	People need **help with all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cueing, standby) with dressing. ***(Moderate dementia usually corresponds here)***
☐ **7. Severely frail**	**Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months). ***(Severe dementia usually corresponds here)***
☐ **8. Very severely frail**	**Completely dependent**, approaching end of life. Typically, they could not recover from even a minor illness.
☐ **9. Terminally ill**	Approaching end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise evidently frail**.

Palliative Care Profile Supplement

Provides a continuation of the items in the Profile Assessment. As the clinical tools are completed in other Outcomes Collection assessments, only the supplementary items are included in this assessment.

Completed when the resident's usual Profile Assessment is due, and the resident is in the Outcomes Collection.

Note: *This is completed* ***instead*** *of the routine Profile Assessment whilst in Outcomes.*

Outcomes Collection: assessment completion guide

The key components of the Outcomes Collection tools are described in Table 4.

Table 4. Outcomes Collection assessment completion guide.

Palliative Care Episode Start & End Details	**Sections include:** – **Top section:** completed at the **START** of the episode of palliative care where monitoring in the Outcomes Collection is commenced. – Enter the date & ONE principal diagnosis as the likely cause for the need for palliative care. – **Bottom section: c**ompleted at the **END** of the episode of palliative care. – Enter the date & the reason for episode end; death/discharge or palliative care no longer required where symptoms/problems or condition has improved. Discharge or transfer from service for hospital leave may also be recorded here.
Palliative Care Full Clinical Assessment Also referred to as *Outcomes - Full Assessment*	**Completed by a health care professional *(HCP) daily or weekly* depending on allocated Phase. See information on Phase or the PACOP Clinical Response Protocol document.** **Sections include:** – Date & time of assessment. – **Six validated assessment tools** including the SAS, PSS, PainChek®, AKPS, RUG-ADL, & Phase. *Optional* PainChek® score inclusion where used by service providers. - The following codes describe who *scored* the SAS item (this is the person who *provided* the scores to be documented, not the person who documented the scores,): Resident = **R**, Family = **F**, Care worker = **C**, or Healthcare professional = **H**. – **Information** about involvement of specialist palliative care (SPC) and incidences of leave from the aged care service. – **Signature/name & Designation–** of the person completing the assessment.
Palliative Care Daily SAS Monitoring Also referred to as *Outcomes - Daily SAS*	**Sections include:** – Date & time of assessment – **The SAS visual aid**, escalation protocol, seven symptoms + 'other' – Who rated the SAS (resident, family, CW, or HCP) – **Signature/name & Designation–** of the person completing the assessment. – Proxy scoring guide available with detailed descriptors **Expanded SAS resources for residents are available on the PACOP Website including First Nations resources for Aboriginal and Torres strait Islander persons and translated versions for Culturally and Linguistically Diverse (CALD) persons to support culturally appropriate and safe palliative care.**
Palliative Care Profile Supplement Also referred to as *Outcomes - Profile Supplement*	**Sections include** *See Profile completion information on pages 6-8:* – Date & time of assessment – **Reasons for care** – **RCFS** – **Advance care planning & decision making** – **Psycho-social wellbeing** – **Recent hospital use** – **AN-ACC class** – **Signature/name & Designation**– of the person completing the assessment.

PACOP Assessment framework

See Figure 3, PACOP assessment framework, for the simplified flowchart demonstrating the identification of a resident's palliative care needs and commencement of ongoing monitoring in the Outcomes Collection based on the assessed needs of the individual using the PACOP assessment tools. The framework ensures that the resident care plan is informed by assessment, identifying changing care needs and responding with timely and supportive evidence-based interventions.

Residents with identified end-of-life care needs should have their inclusion in the National Aged Care Quality Indicator Program[9] (NACQIP) data items reviewed as exclusions may apply[10].

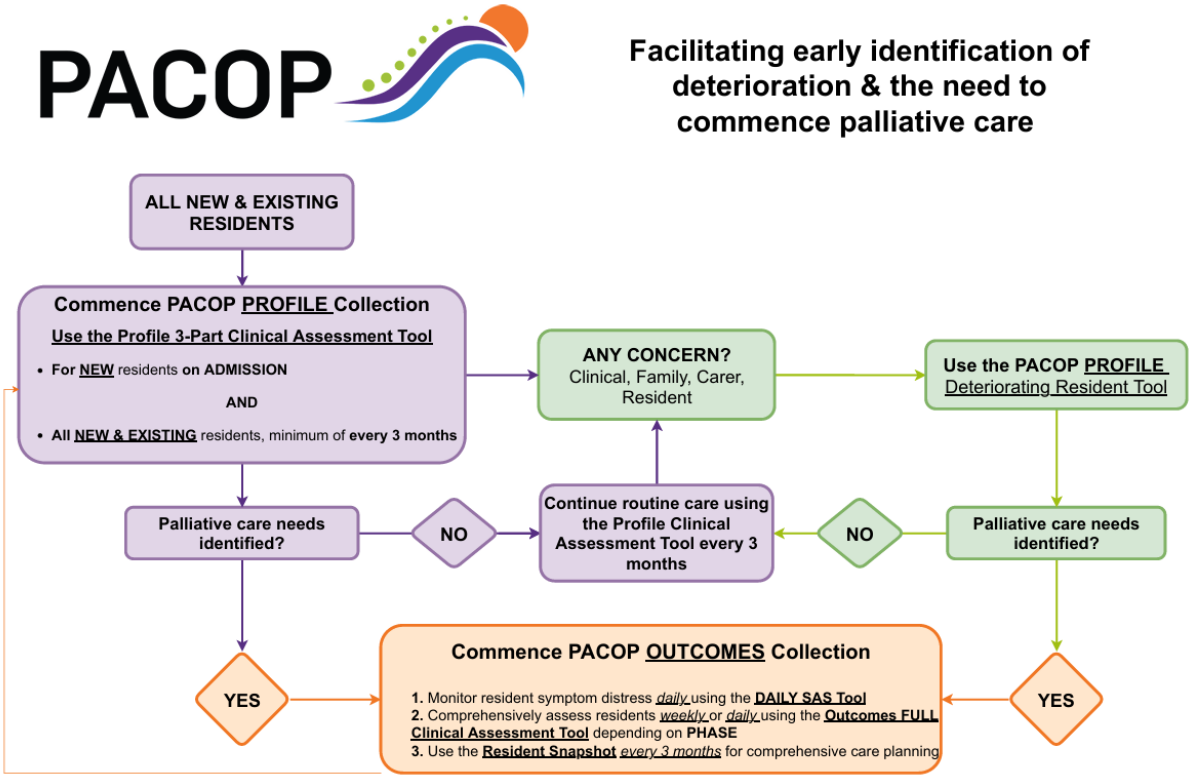


Figure 3. PACOP assessment framework flowchart.

The PACOP Clinical Response Protocol

The Clinical Response Protocol outlines the ongoing frequency of clinical assessments required, depending on the allocated Phase in the Outcomes Collection and escalation of daily SAS score monitoring.

Clinical reassessment using the Outcomes Collection Palliative Care Full Assessment may be due daily (Terminal or Unstable phases) or weekly (Stable and Deteriorating phases). For continued monitoring in between these scheduled clinical assessments, symptom distress is monitored daily using the Palliative Care Daily SAS assessment.

Where a resident experiences an increase in distress related to palliative or End-of-Life symptoms and problems, response is escalated to the Rn/Supervisor for completion of a Palliative Care Full Clinical Assessment. Clinical assessment should occur within 24hrs of Daily SAS score escalation. Further resources and education and training on the Clinical Response Protocol can be found on the PACOP Website.

[9] [9] National Aged Care Mandatory Quality Indicator Program – Manual 4.0-Part A

Validated assessment tool definitions and responses

There are seven validated clinical assessment tools included in the PACOP Profile and Outcomes Collections. Five are mandatory in the Profile Collection and an additional tool is required in the Outcomes Collection. A further too, Painchek, is optional in both the Profile and Outcomes Collections. These seven clinical assessment tools support holistic care planning as they assess physical, cognitive, psychological, and psychosocial domains. PACOP also promotes assessment and communication using standardised tools that are already familiar within the aged care and palliative care sectors. Four of the items are included in the Australian National-Aged Care Classification assessment, and four are commonly utilised in Specialist Palliative Care Services speaking to the validity and relevance of the included tools.

See table 5 for an overview of the validated assessment tools included in the PACOP assessment framework. It is helpful for care teams to consider these tools as **palliative care vital signs** to identifying when the resident's condition is deteriorating/changing and triggers the need for a clinical response and care plan review.

Table 5. Validated assessment tools included in the PACOP assessment framework.

Validated assessment tool name	Assessment tool aim	Assessment domains
Symptom Assessment Scale (SAS)[11]	The SAS is a patient (resident) reported outcomes measure, measuring distress caused by 7 common symptoms.	Seven physical symptoms defined, plus 'other'.
Problem Severity Score (PSS)[12]	The PSS is a clinician rated summary of the severity of resident/family/carer problems.	Pain, psychological/spiritual, family/carer, and other symptoms.
PainChek®[13]	PainChek is AI-driven medical device designed for pain assessment utilizing user input, facial micro-expressions and pain scores.	Assessment involves assessing 6 Domains for a Resident: the Face, Voice, Movement, Behaviour, Activity and Body
Australia Modified Karnofsky Performance Status (AKPS)[14]	The AKPS is a clinician rated assessment of performance relating to work, activity, and self-care.	Functional Status; work, activity and self-care.
Resource utilization group – Activity of Daily Living (RUG-ADL)[15]	The RUG-ADL is a clinician rated assessment of dependency.	Functional Status; bed mobility, toileting, transfers, eating.
Rockwood Clinical Frailty Scale (RCFS)[16]	The RCFS is a clinician rated prognostic tool that measures a residents physical and cognitive fitness or frailty.	Physical and cognitive frailty.
Palliative Care Phase (Phase)[17]	A clinician rated item that describes the urgency of care planning required, following holistic assessment, to address care needs of the resident and family/carers in a clinically meaningful period.	*Holistic global assessment informed by completion of the other validated assessment tools.*

[11] Sabina Clapham, Barbara A Davison, Samuel F Allingham, Darcy Morris, Pippa Blackburn, Claire E Johnson, Kathy Eagar, Patient-reported outcome measurement of symptom distress is feasible in most clinical scenarios in palliative care: an observational study involving routinely collected data, *International Journal for Quality in Health Care*, Volume 33, Issue 2, April 2021, mzab075, https://doi.org/10.1093/intqhc/mzab075

[12] Masso M, Allingham SF, Johnson CE, et al. Palliative Care Problem Severity Score: Reliability and acceptability in a national study. *Palliative Medicine*. 2015;30(5):479-485. doi:10.1177/0269216315613904

[13] Citation: Atee M, Hoti K, Chivers P and Hughes JD (2022) Faces of Pain in Dementia: Learnings from a Real-World Study Using a Technology-Enabled Pain Assessment Tool. Front. Pain Res. 3:827551. doi: 10.3389/fpain.2022.827551

[14] Abernethy, A.P., Shelby-James, T., Fazekas, B.S. *et al.* The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice [ISRCTN81117481]. *BMC Palliat Care* **4**, 7 (2005). https://link.springer.com/article/10.1186/1472-684X-4-7#citeas

[15] Jinfeng Ding, Angus Cook, Xiwen Qin, Stephen C.H. Ho, Claire E Johnson, Palliative care needs and utilization of specialist services for people imminently dying with dementia: A national population-based study, International Journal of Nursing Studies, Volume 109, 2020, 103655, ISSN 0020-7489, https://doi.org/10.1016/j.ijnurstu.2020.103655.

[16] Church S, Rogers E, Rockwood K, Theou O. A scoping review of the Clinical Frailty Scale. BMC Geriatr. 2020 Oct 7;20(1):393. doi: 10.1186/s12877-020-01801-7. PMID: 33028215; PMCID: PMC7540438. doi: 10.1186/s12877-020-01801-7

[17] Masso M, Allingham SF, Banfield M, et al. Palliative Care Phase: Inter-rater reliability and acceptability in a national study. *Palliative Medicine*. 2014;29(1):22-30. doi:10.1177/0269216314551814

Definition- The Symptom Assessment Scale (SAS)

The Symptom Assessment Scale (SAS) assesses the level of distress related to symptoms[18]. The scale includes the seven symptoms most commonly associated with palliative care needs: pain, fatigue, breathing problems, bowel problems, nausea, appetite problems, difficulty sleeping and an optional 'other'. Higher scores represent higher levels of distress. Scoring symptoms routinely screens the resident to identify immediate care needs, identifying where further assessment or investigation[19] is indicated. Scores also allow clinicians to monitor outcomes of care, where improvement or worsening of scores reflect the effectiveness of the care plan and interventions put in place. Understanding distress and palliative care needs for vulnerable populations is important as they may receive palliative care later in disease trajectory[20].

SAS Assessment Completion

The SAS is a resident rated tool. Residents may rate their distress independently or through conversation with staff or family who may assist in interpreting or allocating a score based on their understanding of the resident. This should only occur when the resident is unable to respond appropriately or communicate their distress i.e. severe dementia, or varied consciousness at end-of-life. The SAS Ruler is a useful visual aid, see figure 4.

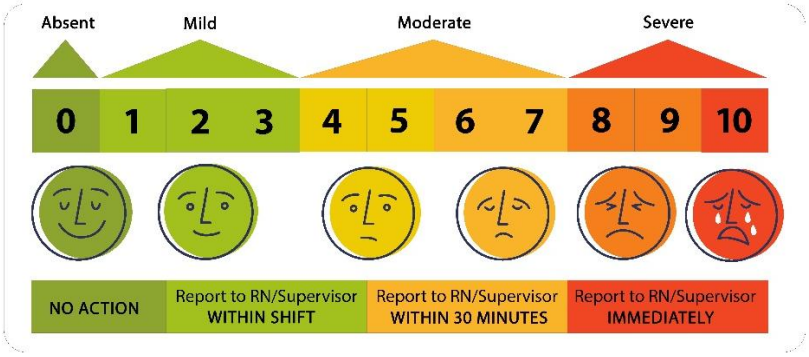


Figure 4. SAS Ruler with clinical escalation responses for care staff.

Definition- Palliative Care Problem Severity Score (PSS)

The Palliative Care Problem Severity Score (PSS) is a clinical rated assessment of problems over a 24hr period. It includes holistic assessment of four palliative care domains. If there are several problems within a domain, the score is based on the most severe and urgent care needed. The domains include Pain, Other symptoms, Psychological/Spiritual and Family/Carer. All problems or needs and their severity should be documented and addressed in the care plan.

Note: If for any reason you are unable to determine a score, N/A (not assessed) should be allocated, not "0". A score of zero (0) implies there are no problems within the domain. For e.g. score N/A for a resident with no family/carer OR if they have a family/carer that is absent or uncontactable for the scorer to assess.

Definition- PainChek®.

The PainChek® App is a mobile application that uses facial detection and analysis technology to detect facial features indicative of the presence of pain and then combines these data with non-facial pain features inputted by the User through a series of digital checklists to confirm the presence and intensity of pain.
Link to support manual here

[18] Davison BA, Allingham SF, Clapham S, Johnson CE, Currow DC, Yates P, et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

[19] Aoun SM, Monterosso L, Kristjanson LJ, McConigley R. Measuring symptom distress in palliative care: psychometric properties of the Symptom Assessment Scale (SAS). J Palliat Med. 2011 Mar;14(3):315-21. doi: 10.1089/jpm.2010.0412. Epub 2011 Jan 21. PMID: 21254812.
DOI: 10.1089/jpm.2010.0412

Clinical Responses for SAS, PSS and PainChek®.

Key Messages:

- The **moderate to severe categories** of symptom and problem scores trigger timely further investigation, and review of person-centred care plans. Consideration of appropriate interventions and actions should include internal and external escalation/referral to respond to identified care needs.
- The **absent to mild categories** of symptom and problem scores trigger ongoing monitoring and routine review of care plans or interventions.

Aged care home policy should be followed in conjunction with PACOP responses. For example, a resident with mild pain on PACOP assessment may have PRN medication administered. An in-depth pain assessment (Painchek®, Abbey etc) would be completed as per policy, with the next PACOP assessment completed as per the framework. The emergence of new behavioural symptoms in a person with previously stable dementia should prompt a comprehensive clinical assessment to determine if this is an indicator of pain[21].

Table 6 provides clinical responses for consideration following SAS, PSS[22] and PainChek® assessments to address assessed needs[23]. Table 7 outlines clinical response for PSS Family/Carer domain.

Table 6 Clinical response following SAS, PSS[24] and PainChek® assessments.

SAS, PSS, PainChek® Category & Score	Potential Actions
SEVERE SAS = 8-10 PSS = 3 PainChek® = 16-42	• Problem / symptom distress requires immediate action. • Plan of care is ineffective. • Urgent intervention, referral and escalation required. • Change of care plan indicated. • Review recommended within 24 hours. • Phase Unstable or Terminal. • ***Likely Phase in Outcomes Collection may be Unstable or Terminal***
MODERATE SAS = 4-7 PSS = 2 PainChek® = 12-15	▪ Problem/symptom distress requires change in plan of care, referral and appropriate escalation. ▪ Document review and implement any new interventions as per care plan. ▪ ***Likely Phase in Outcomes Collection may be Deteriorating or Terminal***
MILD SAS = 1-3 PSS = 1 PainChek®= 7-11	▪ Problem/symptom distress may be managed by existing care plan and routine care. ▪ Treat problem/symptom according to service protocols and available interventions in the care plan. ▪ Monitor outcome of intervention/care plan and record relevant information for review. ▪ ***Likely Phase in Outcomes Collection may be Stable/Deteriorating/Terminal***
ABSENT SAS = 0 PSS = 0 PainChek® = 0-6	▪ Problem / symptom distress absent. Continue with current care plan utilising existing interventions. ▪ Routine assessment as per PACOP framework.

[21] Macloud, R., Macfarlane, S., 2018, The Palliative Care Handbook; Guidelines for clinical management and symptom control, Ninth Edition, HammondCare, Sydney.
[22] Ding J, Johnson CE, Lee YCO, Gazey A, Cook A. Characteristics of People with Dementia vs Other Conditions on Admission to Inpatient Palliative Care. J Am Geriatr Soc. 2020 Aug;68(8):1825-1833. doi: 10.1111/jgs.16458. Epub 2020 Apr 24. PMID: 32329901.
[13] Clapham., S., Connolly, J., Hope., C., 2020, Palliative Care Outcomes Collection Assessment & Response Protocol, University of Wollongong, uow275153.pdf.
[24] Ding J, Johnson CE, Lee YCO, Gazey A, Cook A. Characteristics of People with Dementia vs Other Conditions on Admission to Inpatient Palliative Care. J Am Geriatr Soc. 2020 Aug;68(8):1825-1833. doi: 10.1111/jgs.16458. Epub 2020 Apr 24. PMID: 32329901.

	▪ ***Likely Phase in Outcomes Collection may be Stable or Terminal***

Please note PRN medication and short-term medication are NOT included in the National Aged Care Quality Indicator program polypharmacy item.

Table 7 Clinical Response for PSS Family/Carer Domain

PSS Score	Description/clinical indicator	Potential Action
3 = Severe	The family/carer are experiencing a serious problem(s) that is/are significantly impacting upon the care of the resident. This may be a new (acute) problem, or it may be an exacerbation of an existing problem. *Note: If family/carer domain of PCPSS is assessed as severe, the resident is likely to be in the unstable phase.*	An immediate response and review of care plan is required. Complete review of care plan and develop strategies for addressing problem(s). These may include: • Referral to other support services (allied health, wellbeing officer, social worker, counsellor etc.) • Advise family/carer to contact their GP or other medical practitioner • Invitation to attend multidisciplinary family meeting • Consider available community cultural or religious services and organisations • acute/outreach services, and/or helplines for advice.
2 = Moderate	The family/carer are experiencing one or more problems that are influencing the care of the resident. The problem(s) may be new or existing.	Document current problems. Complete care plan review and develop strategies for addressing problem(s). These may include: • Referral to other support services (allied health, chaplain, wellbeing officer, social worker, counsellor etc.) • Education for family/carer
1 = Mild	The family/carer are experiencing a problem(s) but these are not impacting on the care of the resident and are addressed in the current care plan.	Document current problems and follow care plan. Discuss family/carer situation and problems at team meeting. Consider need for family meeting. Monitor changes to family/carer problems through reassessment.
0 = Absent	There are no problems (or anticipated problems) identified.	Consider discussions related to advance care planning, preferred place of care, goals of care and needs, wants and preferences for care, with the resident, substitute decision maker and family/carer. Consider cultural and spiritual needs and preferences. Discuss communication plan/processes for updates on care needs and feedback and complaints processes.

Definition- Australia modified Karnofsky Performance Scale (AKPS)

The AKPS is a clinician rated tool and is used to measure the resident's current physical performance/ability at the time of assessment. Assessment using the AKPS is based on observations of the resident's ability to perform common tasks related to the domains of activity, work and self-care. It supports communication related to changes in performance and may help understand prognosis[25][26] as individuals approach End-of-Life.

Note: Where a resident is markedly mobile but unable to meaningfully participate in activity/work/self-care domains, consider if a score of <40 is appropriate referring to the full scoring definitions where a score of 20 requires extensive nursing care by professionals. In advanced stages of dementia residents often have reduced physical functioning and self-care ability and may be susceptible to infections, delirium and physical agitation[27]. Where other assessment items indicate deterioration consider if the resident would benefit from palliative care and monitoring through the Outcomes Collection and additional screening to identify causes of increased psychomotor agitation such as pain or delirium. Identification of approaching End-of-

[25] O'Connor, T., Liu, W., Samara, J., Lewis, J. and Paterson, C., 'How long do you think?' Unresponsive dying patients in a specialist Palliative care service: A consecutive cohort study, Palliative Medicine, 2024 May; 38 (5):546-554 DOI https://doi.org/10.1177/02692163241238903

[26] Morgan, DD, Tieman, JJ, Allingham, SF, Ekstrom, MP, Connolly, A, and Currow, DC, The Trajectory of Functional decline over the last 4 months of life in a palliative care population: A prospective, consecutive cohort study', Palliative Medicine. 2019;33(6):693-703. doi:10.1177/0269216319839024

[27] Bourke, C., L. Chenoweth, E. Georgousopoulou, and A. Williams. 2026. "Development and Validation of the End-of-Life Assessment Tool for Advanced Dementia: A Multi Method Study." *Journal of Advanced Nursing* 82, no. 5: 5430–5443. https://doi.org/10.1111/jan.70129.

Life is not always clearly identifiable in those with dementia[28] and multidisciplinary review may involve General Practitioners, Geriatricians, Palliative Medicine Specialists and Psychiatry to assess care needs.

Table 8 outlines recommended clinical responses for the AKPS. For score totals marked with (*) consider reviewing the National Mandatory Quality Indicator data items for resident/s.

Table 8 Clinical response for AKPS.

AKPS Scale	Description	Guide to clinical response
90 **80** **70**	**90 -** Able to carry on normal activity, minor signs or symptoms of disease **80 -** Normal activity with effort, some signs or symptoms of disease **70 -** Care for self, unable to carry on normal activity or to do active work	- Consider advance care planning (ACP)/advance care directive (ACD) with the resident and their substitute decision-maker. - Identify and discuss resident's goals of care and wishes - Identify preferred place of care - Consider providing/directing to information on Voluntary Assisted Dying[29] - Communicate and provide information to the resident, their family/carer - Identify cultural and spiritual needs/preferences
60	**60 -** Requires occasional assistance but is able to care for most needs	• Consider referral (internal/external) to allied health as appropriate, Occupational Therapist, Physiotherapist, Dietician, Social Worker - Mobility assessment review
50	**50 -** Requires considerable assistance and frequent medical care	- Review care plan - Falls assessment review - Provide appropriate equipment as required
40 **30**	**40 -** In bed (chair) more than 50% of the time **30 -** Almost completely bedfast (chairfast)	• Discussion at team meeting, multidisciplinary or palliative care meeting to review palliative care plan • Consider family meeting/case conference need • Complete pressure injury assessment • Review/request equipment (e.g., alternating air pressure mattress etc). • Consider psychological/social needs of resident and carer/family for palliative care planning • Consider spiritual support as appropriate; religious or cultural leader/Elder • Confirm communication plan with substitute decision maker/family/carer update palliative care plan • Notify GP of the need for palliative care approach for resident • Discuss anticipatory medication prescription with GP

[28] Sampson, E., Candy, B., Davis, S., Gola, A., Harrington, M., Kupeli, N., Leavey, G., Moore, K., Nazareth, I., Omar, R., Vickerstaff, V., and Jones, L., (2018), Living and Dying with Advanced dementia: A prospective cohort study of symptoms, service use and care at the end-of-life, Palliative Medicine, Vol 3, Is 2, March 18 2018, pg. 668-681. https://doi.org/10.1177/0269216317726443

[29] Sellars, M., Tacey, M., McDougall, R., Hayes, B., Pratt, B., Hempton, C., Detering, K., Aldrich, R., Benson, M., Kirwan, J., Gold, M., O'Driscoll, L. and Ko, D. (2021), Support for and willingness to be involved in voluntary assisted dying: a multisite, cross-sectional survey study of clinicians in Victoria, Australia. Intern Med J, 51: 1619-1628. https://doi.org/10.1111/imj.15434

20* **10***	**20 -** Totally bedfast (chairfast) and requiring extensive nursing care by professionals **10 -** Comatose or barely rousable	• Consider appropriate commencement of terminal/end-of-life/last-days-of-life care plan including cultural, religious and spiritual needs of the individual. • Request GP medication review, deprescribing and prescribing of terminal/End-of -Life Care medication • Request appropriate equipment; syringe driver, slide sheet etc. • Confirm resident is in the Outcomes Collection, consider allocation of Terminal Phase. • Provide education, instructions and reassurance to the resident, family/carer as appropriate. Consider diagnosis related information and information on the dying process noting care plan considerations i.e., dark coloured towels where there is a risk of bleeding[30]. • Consider after death needs of the individual and/or family/carer; return to country, disposition of remains/funeral home arrangements and liaise as appropriate[28]. • Consider bereavement needs of the family/carer.

Definition- Resource Utilisation Groups-Activities of Daily Living (RUG-ADL)

A resident's RUG-ADL is used to assess functional dependence across four domains: bed mobility, toileting, transfers and eating. The domain scores reflect the level of resources (staff/equipment/time) required to meet each of the domains, assessing the care needs of the resident[31]. The final score total indicates the level of functional dependence. The total RUG-ADL score provides a common language which is useful in clinical care to summarise a resident's functional condition and deterioration over time.

Refer to Figure 3 for the RUG-ADL scoring matrix and descriptors.

Table 9 outlines the clinical response for RUG-ADL. It should be noted that residents receiving end-of-life care are excluded from NACQIP data for Activities of Daily Living and Unplanned Weight Loss. Dietary supplements are excluded from the NACQI program polypharmacy indicator.

[30] Acquavia, K., 2023, The handbook of LGBTQIA-Inclusive Hospice and Palliative Care, Columbia University Press, New York, pg. 230.

[31] Fries *et. al., (*1994) Fries BE, Schneider DP, et al (1994) Refining a casemix measure for nursing homes. Resource Utilisation Groups (RUG-III). Medical Care, 32, 668-685 Mental Health National Outcomes and Casemix Collection: Overview of Clinician-Rated and Consumer Self-Report Measures V1.50, Mental Health & Suicide Prevention Branch, Department of Health and Ageing

Figure 3. The 4 RUG-ADL domain, full descriptors and scoring matrix.

		Bed Mobility	Toileting	Transfers
		The Resident's ability to move in bed after the transfer into bed has been completed.	*The Resident's ability to mobilise to the toilet, adjust clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes. If the level of assistance differs between voiding and bowel movement record the lower performance*	*The Resident's ability to transfer in and out of bed, bed to chair, in and out of shower/tub. Record the lowest performance of the day/night.*
1	***Independent or supervision only***	Ability to readjust position in bed and perform own pressure area relief through spontaneous movement around bed or with prompting from staff. No hands-on assistance is required. May be independent with the use of a device.	Able to mobilise to toilet, adjust clothing, cleanse self and has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from staff. No hands-on assistance is required. May be independent with the use of a device.	Able to perform all transfers independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.
3	***Limited physical assistance***	Able to readjust position in bed and perform pressure area relief with assistance of one person.	Requires hands-on assistance of one person for one or more of the tasks.	Requires hands-on assistance of one person to perform any transfer of the day/night.
4	***Other than two persons physical assist***	Requires the use of a hoist or other assistive device to readjust position and provide pressure area relief. Still requires the assistance of one person for task.	Requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/suppository. Requires assistance of one person for management of the device.	Requires the use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task.
5	***Two or more persons physical assist***	Requires two or more assistants to readjust position in bed and perform pressure area relief/care.	Requires two or more assistants to perform any step of the task.	Requires two or more assistants to perform any transfer of the day/night.

		Eating
		The Resident's ability to cut food, bring food to mouth and chew and swallow food. *Does not include preparation of the meal.*
1	***Independent or supervision only***	Once a meal has been presented in the customary fashion, able to cut, chew and swallow food independently or with supervision. No hands-on assistance required. If the resident relies on parenteral or gastrostomy feeding that they administer to themselves, then score 1.
2	***Limited physical assistance***	Requires hands-on assistance of one person to set-up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).
3	***Extensive assistance / total dependence / tube fed***	Resident needs to be fed meal by assistant, or the individual does not eat or drink full meals by mouth but relies on parenteral/gastrostomy feeding and does not administer feeds by him/himself.

Table 9 Clinical Response for RUG-ADL

Item	Description	Score	Guide to clinical response
Bed mobility, Toileting, Transfer	Independent / supervision only	**1**	• Provide equipment if required for independent use (e.g., walking stick, 4ww) • Monitor for changes
	Limited physical assistance	**3**	• Ensure care plan clearly describes the assistance required by staff • Consider a Falls Prevention/Management Plan • Consider Pressure Injury Management plan • Provide equipment if required
	Other than two-person physical assist ***(1 person + equipment/device)***	**4**	• Consider Physiotherapy or Occupational Therapist review where care needs change • Provide equipment/device as required • Ensure care plan clearly describes the assistance required by staff and instructions regarding use of device • Provide clear instructions to the Resident regarding use of the Device
	Two or more person physical Assist	**5**	• Ensure care plan accurately describes the staff, equipment, device and manual handling requirements for care provision • Provide equipment or devices as required
Eating	Independent / supervision only	**1**	• Monitor for changes
	Limited assistance	**2**	• Provide assistance required according to protocol • Ensure care plan accurately describes the staff requirements for care provision • Review Nutrition/Hydration Assessment and individuals' needs/wants preferences as required
	Extensive assistance / total dependence / tube fed	**3**	• Ensure care plan accurately describes the staff requirements for care provision • Consider review with Dietician and/or review of nutritional supplement prescriptions with General Practitioner as required • Provide modified diet/supplements as per medication chart, and local protocol. • Consider if Nutrition/Hydration Chart is required. • Complete Dignity of Risk as required based on the needs/wants/preferences of the resident and in discussion with family/carers. • Provide End-of-Life oral (mouth) care according to local protocol for residents on end-of-life/terminal care plans.

Total Score Range	Recommended Actions for Total Score
Total Score of 4-5	Independent. Monitor
Total Score of 6-13	Requires assistance. Review care plan. May be at risk of falls, pressure areas and/or choking.
Total Score of 14-17	Requires assistance of one + equipment. Review care plan. Greater risk of falls, pressure areas, choking.
Total Score of 18	Requires full assistance. Review care plan. Greatest risk of falls, pressure areas, choking.

Definition- Rockwood Clinical Frailty Scale (RCFS)

The RCFS is a validated tool for assessing increasing physical and cognitive frailty and is suitable for use in people over 65 years of age. The tool is prognostic and identifies residents who have an increased vulnerability and risk of dying. Following assessment of a resident, the RCFS can be used to summarise the resident's current level of frailty and support discussion related to care plan needs and goals.

The RFCS can be used to support communication about increasing frailty and guide discussions with residents and their family/carer/substitute decision maker to address gaps around current level of function, cognition, mobility, and social relationships, and how these have changed overtime with consideration to acute changes[32].

Palliative care is recommended to be commenced for frail individuals when they experience continued functional decline, increased health care use, and uncontrolled symptoms[33] that align with the need for palliative care criteria in the Profile Collection. Figure 4 shows the classification levels within the RCFS. Clinical Response to the RCFS is outlined in table 10.



Note: Level 9 (the person seated in a chair_ – Most residents at end of life/terminal stage will fit a RCFS score of 8 as they will be *evidently frail*. A score of 9 is for those who are terminally ill but *not otherwise evidently frail*.

Table 10 Outlines the Clinical Response Guide for RCFS

Score	Guide to Clinical Response[34]
Pre-frail; Very fit, Fit, Managing well. 1-3[35]	Consider and anticipate needs related to physical exercise, nutrition support, primary health care and Allied Health referral to maintain function, mobility, social engagement and cognition.
Vulnerable 4	Consider needs relating to psychosocial wellbeing, falls prevention, exercise regime, oral hygiene and dental health.
Living with Frailty; Mildly Frail, Moderately Frail, Severely Frail. 5-7	Review care plan and consider: • ACP, goals of care, place of care • Allied health referral; Physiotherapy (exercise, falls, mobility), dietician (food fortification or supplementation), spiritual and social wellbeing, occupational therapy (fatigue/ADLs/equipment) • Assessments may include falls, mobility, nutrition, oral health, cognition, communication • Referral to GP for medication review (polypharmacy risk and serum pathology monitoring) • Dementia support services for cognitive and behaviour review as required • Specialist review geriatrician/psychiatry as indicated

[32] Rockwood, Kenneth & Theou, Olga. (2020). Using the Clinical Frailty Scale in Allocating Scarce Health Care Resources. Canadian Geriatrics Journal. 23. 254-259. 10.5770/cgj.23.463.

[33] Russell, Andrew E., Denny, Rachel., Lee, Pearl G., Montagnini, Marcos L., 2024, Palliative care considerations in frail older adults Annals of Palliative Medicine; Vol 13, No 4 (July 31, 2024): Annals of Palliative Medicine, 2024, https://apm.amegroups.org/article/view/125224

[34] Dent E, Lien C, Lim W ... **The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty** Journal of the American Medical Directors Association, 18, 564-575 The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty - Journal of the American Medical Directors Association

[35] Toson B, Edney LC, Haji Ali Afzali H, Visvanathan R, Khadka J, Karnon J. Economic burden of frailty in older adults accessing community-based aged care services in Australia. Geriatr. Gerontol. Int. 2024; 24:939–947. **https://doi.org/10.1111/ggi.14955**

Very Severely Frail OR Terminally ill 8-9	Care planning should consider: • Palliative care plan development • Clinical escalation to GP or palliative care clinician as required • Family/carer meeting • Review at multidisciplinary and team meetings • Regular assessment and monitoring in the Outcomes Collection for response to increased risk of dying in the next 6 months and likelihood of care needs changing (physical, psychological & spiritual).

Definition Palliative Care Phase (Phase)

The Palliative Care Phase (Phase) is an assessment tool that allocates one of four phases for each Outcomes Collection Palliative Care FULL clinical assessment of a resident. The Phase relates to the care plan for the resident, whether any changes need to be made and the urgency of changes if needed. It does not relate to the phase of the underlying illness. Phase should be allocated last, after the other assessments have been completed, as those results will help inform allocation of the correct phase based on the urgency of care needs. Table 11 outlines the clinical response to Phase.

Table 11: Clinical response for Phase[36].

Start	Clinical Response	End
Stable		
Resident problems and symptoms are adequately controlled by an established care plan **and** • Interventions to maintain symptom control and quality of life have been planned **and** • Family/carer situation is relatively stable, and no new issues are apparent.	▪ Continue current care plan ▪ Reassess and monitor assessment scores using the Outcomes Collection (Daily SAS with escalation for Full assessment as indicated or when due in one week).	The needs of the resident and/or their family/carer increase, requiring changes to the existing plan of care. The urgency of care needs determines the correct Phase.
Deteriorating		
The care plan is addressing anticipated needs but requires periodic review **because** the**:** • Resident's overall functional status is declining **and/or** • Resident experiences a gradual worsening of existing problem/s **and/or** • Resident experiences a new but anticipated problem **and/or** • Family/carer experience gradual worsening distress that impacts on resident care.	▪ Review and update care plan to address current and anticipated needs ▪ Consider referral to multidisciplinary team to review and plan care (i.e., GP, allied health, palliative care clinician, spiritual care). ▪ Reassess and monitor assessment scores using the Outcomes Collection (Daily SAS with escalation for Full assessment as indicated or when due in one week).	The resident's condition plateaus (i.e. Resident is now **Stable**) ***OR*** An urgent change in the care plan and urgent intervention/escalation is required (i.e. Resident is now **Unstable**) ***OR*** Death is likely within days (i.e., Resident is now **Terminal**).
Unstable		
An urgent change in the care plan or urgent treatment is	• Urgent intervention and escalation for review is	The new plan of care is in place, it has been reviewed and no further

[36] Palliative Care Outcomes Collaboration (PCOC), (2026) Clinical Manual for Version 4 of PCOC, Document Version 1.1, Faculty of Science, Medicine and Health, University of Wollongong, Australia.

required **because** the**:** • Resident experiences a new problem that was not anticipated in the existing plan of care, **and/or** • Resident experiences a rapid increase in the severity of a current problem; **and/or** • Their family/carer needs change suddenly impacting on resident care.	required (i.e.; GP, allied health or Specialist Palliative care Clinician) • Review and update care plan • Reassess within 24hrs and monitor assessment scores using the Outcomes Collection (Full assessment and SAS daily) • Communicate changes in condition and care plan responses to the resident, family/carer and multidisciplinary health care team.	changes to the care plan are required. This does not necessarily mean that the symptom/crisis has fully resolved but there is a clear diagnosis with a plan of care (i.e. resident is **Stable** or **Deteriorating**) ***and/or*** death is likely within days (i.e. resident is now **Termina**l).
Terminal		
Death is likely within days. Resident shows signs of dying progressing towards end-of-life. Care needs may be met or unmet by current care plan.	• Provide terminal care as per end-of-life/terminal care plan. • Continue to assess resident and family/carer needs using PACOP Outcomes collection (SAS and Full clinical review daily). • Communicate updates in care plan and changes to family/carer. • Discuss care at handover, team meetings, palliative care meetings. • Liaise with health professional leading palliative care for the resident, may be GP or may be internal or external specialist palliative care clinician as required.	The resident dies ***OR*** the resident's condition changes and death is no longer likely within days (i.e. resident is now **Stable** or **Deteriorating**).

Version Control and Change History

Version	Date Effective	Approved By	Ammendment
1.0	Nov 2022	PACOP Director	N/A - Version 1
2.2	Sept 2026	PACOP Director	PACOP dataset V1.2 update, inclusion of Painchek and RCFS response.