Building Nurse Capacity Program
Healthy North Coast PHN

FACILITATOR GUIDE

eLearning Modules

Supporting the delivery of in-person learning sessions alongside the BNC online modules

Topic	Modules covered	Level(s)
Deteriorating Resident	DR Modules 1-4	Foundational · Intermediate
Advance Care Planning	ACP Modules 1-4	Foundational · Intermediate · Advanced
Palliative Care	PC Modules 1-2	Foundational · Intermediate
My Health Record	MHR Module	Intermediate
Using Health Pathways	Health Pathways	Foundational · Intermediate · Advanced
Telehealth	Telehealth	Foundational · Intermediate · Advanced

Co-designed with RACH staff across Ballina, Tweed, Port Macquarie & Coffs Harbour | 2026

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How to Use This Guide

This guide supports designated RACH trainers and nurse educators to deliver in-person learning sessions that complement the BNC eLearning modules available at agedcare.practicecoach.com.au. It does not replace the eLearning modules - it enhances them by providing the structured group discussion, case study practice, and facilitation support that online learning alone cannot offer.

The Three Learning Levels

Each module section in this guide is coded to one of three learning levels. These levels describe both the complexity of the content and who it is most suited for:

Level	Who it's for	Content focus
🟢 FOUNDATIONAL	Personal Care Attendants (PCAs), lifestyle staff, non-clinical team members, new starters. No clinical background required.	Awareness, observation, reporting - what to notice, who to tell, how to explain.
🔵 INTERMEDIATE	Enrolled Nurses, Registered Nurses, Clinical Care Managers. Requires clinical knowledge and practice context.	Clinical assessment, tool application, legal compliance, structured communication.
🟣 ADVANCED	Designated Trainers, Nurse Educators, senior RNs, Clinical Managers. Requires confidence in facilitation and clinical communication.	Conversation skills, facilitation, coaching others, ethical decision-making.

> These levels are not rigid - a Foundational module may be valuable for an RN new to aged care, and an Advanced module is suitable for any experienced clinician interested in developing facilitation skills. Use the audience descriptions as a guide.

Module Map - What to Deliver to Whom

Use this table to plan your sessions across your team:

Module	Level	Best for	Works as tack-on to meeting?
DR Module 1 - Recognising deterioration	Foundational	All staff, new starters	Yes - 15 min
DR Module 2 - ISBAR for non-nursing	Foundational	PCAs, lifestyle staff	Yes - 15-20 min

Module	Level	Best for	Works as tack-on to meeting?
DR Module 3 - DRTT for nurses	Intermediate	RNs, senior ENs	15 min (familiarity); 30 min (full practice)
DR Module 4 - ISBAR for nursing	Intermediate	RNs, ENs	Yes - 15-20 min
ACP Module 1 - What is ACP?	Foundational	All staff	Yes - 15 min
ACP Module 2 - Addressing worries	Foundational	All staff	Yes - 15 min
ACP Module 3 - Legal steps / ACD	Intermediate	RNs, Clinical Managers	Yes - 20-25 min
ACP Module 4 - Having the conversation	All levels	Trainers, Educators, senior RNs	30 min recommended
PC Module 1 - When & how to help	Foundational	All staff	Yes - 15-20 min
PC Module 2 - End of life support	Intermediate	All nursing + care team	20-30 min recommended
MHR Module - Using My Health Record	Intermediate	RNs, Managers	Yes - 15-20 min

Each Module Section Contains

- Level badge and audience description
- Module summary - what the eLearning covers
- Learning objectives - what participants should be able to do after the session
- Trainer preparation notes
- Session delivery guide - step-by-step for both 15-minute and 30-minute formats
- Discussion questions - 4 questions mapped to learning objectives
- Case study - with debrief prompts
- Knowledge check Q&A - key questions and answers from module content
- Common learner questions and suggested responses
- Post-session activity (the 'What Next?' from each module)
- Additional resources with links

General Facilitation Tips

⭐ Best delivery approach: add 15-30 minutes to an existing staff meeting. Don't schedule separate training sessions - attach to where your team already gathers.

Tip	Detail
Watch the module first	Review the eLearning before the session. The module notes contain the full script - use them to prepare your examples and discussion.
Use the case studies	Each module uses recurring characters (Lesley, Bill, Terry, Agnes). Use these consistently - familiarity with the cases builds engagement.
Choose one format	Pick either 15-min or 30-min for each session. Mixing formats mid-session is harder to manage than sticking to one pace.
Start with a hook, not content	Every guide starts with a question. Open with it - let the group respond before you present anything. This generates engagement you can't create by presenting first.
ACP Module 4 deserves a 30-min slot	The ACP conversation skills module is most effective when participants can practice and debrief. Don't compress it to 15 minutes.
Document attendance	Use the sign-in sheet from the Participant Workbook for participants to track completion and sign off.

TOPIC 1
Deteriorating Resident

Four modules cover deteriorating residents - two at Foundational level (all staff) and two at Intermediate level (nursing staff). They build sequentially: Module 1 teaches recognition, Module 2 teaches non-nursing escalation, Module 3 introduces the DRTT for nurses, and Module 4 deepens nursing ISBAR. All modules use the same case study character - Lesley - which makes cross-module facilitation coherent.

⚠️ Clinical note: The DRTT (DR Module 3) is a nursing tool and should not be taught in sessions with mixed clinical and non-clinical staff. Run DR Modules 1-2 separately from DR Modules 3-4.

DR Module 1 - Is This Resident Unwell? Recognising Deterioration

🟢 **FOUNDATIONAL** All RACH staff - PCAs, lifestyle coordinators, non-clinical team, new starters. No clinical background required.

Topic	Deteriorating Resident	**Module**	DR Module 1	**15-min format**	Yes	**30-min format**	Yes

Module Summary

This module introduces the concept of resident deterioration to all staff. It explains why RACH residents are particularly vulnerable to decline, emphasises that everyone has a role in recognition regardless of their clinical role, and introduces two practical tools: STOP AND WATCH for rapid identification and SPICT-4ALL for identifying slower deterioration. It uses the case of 'Lesley' - a resident who becomes unwell and behaves out of character - as a relatable anchor for learning.

Learning Objectives

By the end of this session, participants will be able to:

- Describe why RACH residents are at increased risk of deterioration
- Explain that every staff member - regardless of role - has a responsibility to notice and escalate change
- Identify the signs of a deteriorating resident using the STOP AND WATCH tool
- Use the SPICT-4ALL tool to recognise residents deteriorating more gradually
- Know what to do when they notice a change - call for help, report to nurse on duty

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'Think of a resident you know well - how would you know if something was different about them?' Let 2-3 people respond.	**Welcome & hook (3 min)** Ask: 'What changes have you noticed in a resident that turned out to matter?' Invite 2-3 stories.
Key concept (5 min) Play or summarise DR Module 1. Emphasise: deterioration can be subtle in older people. A change from their usual self is the signal.	**Module overview (5 min)** Summarise or play module. Cover: why RACH residents are vulnerable; who notices; the importance of noticing change before vital signs change.
STOP AND WATCH (5 min) Walk through the STOP AND WATCH acronym. Ask staff to call out what they would look for in 'Lesley's' case.	**STOP AND WATCH activity (8 min)** Show or describe Lesley's scenario. In pairs or small groups: which STOP AND WATCH signs does Lesley show? Report back.
Takeaway (2 min) One message: 'If something feels off, say something. You don't need to know what's wrong - you just need to report it.'	**SPICT-4ALL (5 min)** Introduce gradual deterioration concept. Who in your current resident group might benefit from a palliative care conversation? (Do not name residents - keep general.)
Close (1 min) Prompt: Ask manager where to report concerns at this facility. Date for next session.	**Discussion (6 min)** Discussion questions (see below).
	Takeaway + What Next (3 min) Each person to ask their manager: 'Where and how do I report a concern about a resident?' Record the answer and bring to next session.

Discussion Questions

💬 **Discussion Questions**

Q1. Think of a resident you care for regularly. What does their 'normal' look like? How would you know if they were off?

Q2. What has stopped you (or might stop you) from reporting a concern to a nurse? What could make it easier?

Q3. The module says 'you may know this resident better than their doctor.' What do you think about that responsibility?

Q4. What does your workplace currently do when a PCA or carer raises a concern about a resident's condition?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: Why are RACH residents at higher risk of deterioration than younger people?
A: They often have multiple health conditions, may have dementia (limiting self-reporting), have frailty/muscle weakness, and may be approaching end of life. Signs of decline can be subtle and mimic their usual baseline.

Q: What does STOP AND WATCH stand for?
A: Seems different / Talks or communicates less / Overall needs more help / Pain (new or worsening) / Ate less / No bowel movement in 3 days / Drank less / Weight change / Agitated / Tired, weak, confused, drowsy / Change in skin / Harder to walk or transfer.

Q: What is the SPICT-4ALL tool used for?
A: Identifying residents who may be deteriorating more gradually - over weeks or months - and may need palliative care planning. It covers conditions like cancer, dementia, heart/lung/kidney disease.

Q: If you notice a change and the nurse is busy, what should you do. What does your policy say and expect?
A: Interrupt politely and say: 'I need to tell you about a resident who doesn't seem right.' Deterioration can move quickly - do not wait.

Common Questions from Learners

Question	Suggested response
'It's not my job - I'm just a carer'	'Actually everyone has a role, and the module says this too - because you often know residents better than their nurses or doctors do. Your observation matters.'
'What if I'm wrong and I bother someone?'	'It's always better to raise a concern that turns out to be nothing than to miss something serious. A nurse would far rather be asked than not told.'
'What if I don't know the medical words to describe what I see?'	'You don't need medical words. Say what you see: "She just doesn't seem herself. She didn't wake up properly and her tummy looks bigger." That's enough to get help.'

Post-Session Activity

What Next (from the module): Ask your manager - 'Where do I record or report a concern about a resident?' Make a note of this and bring it to the next session.

Additional Resources

🔗 **Additional Resources**

STOP AND WATCH Tool:
https://hunterprimarycare.com.au/health-professionals/ace-education-resources-2/ *- ~5 min - printable tool from Hunter Primary Care*

SPICT-4ALL Tool: https://www.spict.org.uk/spict-4all/ *- ~10 min - plain language guide for identifying need for palliative care planning*

DR Module 2 - Taking Action: ISBAR for Non-Nursing Staff

🟢 **FOUNDATIONAL** Non-nursing RACH staff (PCAs, lifestyle coordinators, allied health assistants) who need to escalate concerns to a nurse. Bridges into Intermediate for ENs building confidence.

Topic	Deteriorating Resident	**Module**	DR Module 2	**15-min format**	Yes	**30-min format**	Yes

Module Summary

Builds directly on DR Module 1. Once a non-nursing staff member has identified that a resident may be unwell, this module teaches them how to escalate that concern clearly and effectively to a nurse using ISBAR (Identify, Situation, Background, Assessment, Recommendation). Uses the AVPU alertness scale for initial observation, provides worked examples with Lesley's case, and models ISBAR as a communication confidence tool, not a clinical assessment tool.

Learning Objectives

By the end of this session, participants will be able to:

- Identify and gather the key information needed before escalating a concern
- Use the AVPU scale to describe how alert a resident appears
- Explain the five components of ISBAR and what to include in each
- Practise an ISBAR handover using a real or simulated resident scenario
- Know to always document changes in a resident's notes

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'Has anyone ever had to tell a nurse that a resident wasn't well? What did you say?' Share 1-2 responses.	**Welcome & hook (3 min)** Ask: 'What makes it hard to tell someone you're worried about a resident?' Discuss briefly.
AVPU (3 min) Introduce AVPU - Awake / Verbal / Pain / Unresponsive. Apply to Lesley: 'She responds to voice but is groaning, not talking.'	**AVPU + observation (5 min)** Teach AVPU. Walk through what to observe and note before calling: alertness, vital signs if able, symptoms, what's changed.
ISBAR walkthrough (7 min) Walk through the ISBAR acronym using the worked example from the module. Emphasise: write it down first, you don't need to know what's wrong - just what you observed.	**ISBAR theory (7 min)** Go through each ISBAR component with worked examples. Play the module video if possible.
Practise (2 min) Ask one person to try an ISBAR for Lesley out loud. Others can prompt.	**Role play (10 min)** In pairs: one person plays the PCA raising the concern, one plays the nurse. Use Lesley's scenario or a real de-identified case from their facility. Swap roles. Debrief.
Close (1 min) Takeaway: 'ISBAR gives you a script when you're worried. Use it.'	**Debrief + common Qs (5 min)** What felt hard? What would make it easier? Address common worries (see common Q&A below).

Discussion Questions

💬 **Discussion Questions**

Q1. What information would you try to gather before calling a nurse about a resident who seems unwell?

Q2. In Lesley's ISBAR example from the module, what did the carer do well? Is there anything you would add?

Q3. What situations make it harder to speak up about a concern? (e.g. busy shift, unsure if it's serious, not knowing the nurse well) How could those barriers be reduced?

Q4. Why do you think ISBAR is used by clinicians all over the world? What problem does it solve?

Case Study

📋 **Case Study / Scenario**

Using the Lesley scenario from DR Module 1: Lesley is drowsy, not communicating clearly, abdomen is more swollen than usual, temperature 37.9°C. Lesley hasn't opened their bowels in 3 days (from the shift notes). You are a PCA and need to call the nurse on duty.

Debrief prompts:

1. Before you call - what would you write down? Walk through each ISBAR letter and fill it in for Lesley.
2. Role-play: call the nurse using ISBAR. What do you say for the 'Assessment' part when you're not clinically trained?

3. 'R' is Recommendation - as a PCA, what can you recommend? (e.g. 'Could you please come and assess Lesley?')
4. After the call - what do you need to document?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What does AVPU stand for?

A: Awake - resident is awake; Verbal - responds to voice; Pain - responds to pain stimulus; Unresponsive - no response to stimulus.

Q: What does ISBAR stand for?

A: Identify (who you are, who you're calling about); Situation (why you're calling, what's happening); Background (usual health, history); Assessment (what you've observed including vital signs); Recommendation/Request (what you need).

Q: In the 'Assessment' part of ISBAR, what should a non-nursing carer include?

A: Your observations: how alert the resident is (AVPU), any vital signs you were able to take, what has changed from normal, and your overall impression - e.g. 'They're just not themselves and I'm worried.'

Q: Why is it important to write down ISBAR information before calling?

A: Being on a busy shift and suddenly needing to hand over a concern is stressful. Writing it down ensures you don't miss key information, particularly under pressure.

Common Questions from Learners

Question	Suggested response
'I'm not trained - what if I get the assessment wrong?'	'You're not being asked to diagnose anything. You're asked to report what you see. What you observe is valuable even if you don't know what it means.'
'The nurse always seems too busy'	'If a resident's condition is a concern, you must interrupt - politely but firmly. Patient safety comes first. ISBAR helps you do that quickly and clearly.'
'What if it turns out to be nothing?'	'Raising a false alarm is far better than missing a genuine deterioration. Nurses would rather know.'

Post-Session Activity

What Next (from the module): Practise aloud communicating your concerns about Lesley to a nursing colleague using the ISBAR format. Ask for their feedback on how you went.

Additional Resources

🔗 **Additional Resources**

How to use AVPU:
https://www.ems1.com/ems-training/articles/use-avpu-scale-to-determine-a-patients-level-of-consciousness-FVpjgzNGwSJAGoeQ/ *- ~5 min quick read*

ISBAR Clinical Handover Form (HNC):
https://hneccphn.imgix.net/assets/src/uploads/resources/Aged-Care/form-isbar-4ac-v11.pdf *- Printable ISBAR form with explanations (~5 min)*

ISBAR Module on ALIS: https://learning.agedcarequality.gov.au/user_login *- 15-min module (requires ALIS access)*

DR Module 3 - The DRTT: Clinical Assessment for Nursing Staff

Please note: The Deteriorating Resident Triage Tool (DRTT) is a clinical decision support tool developed by Healthy North Coast PHN in partnership with Aged Care Nurse Practitioners and specialist clinicians. Its use in your facility may be subject to local clinical governance approval processes. Before introducing the DRTT as part of your training program, confirm with your facility manager, Director of Nursing, or clinical governance lead that the tool has been reviewed and approved for use at your site. Where approval is pending or has not yet been sought, this toolkit supports you to begin training on other BNC program topics - including HealthPathways, Advance Care Planning, Palliative Care, and MyHealthRecord - while that process is underway.

🔵 **INTERMEDIATE**	Registered Nurses and experienced Enrolled Nurses working in RACH clinical roles. Requires clinical assessment knowledge. Not suitable for non-nursing staff.

Topic	Deteriorating Resident	**Module**	DR Module 3	**15-min format**	Yes	**30-min format**	Yes

Module Summary

The clinical core of the Deteriorating Resident series. Designed exclusively for nursing staff, this module walks RNs through the Deteriorating Resident Triage Tool (DRTT) - a clinical tool developed by HNC PHN, Aged Care Nurse Practitioners and specialists. Covers the full DRTT workflow: A-G assessment, vital signs, checking Advance Care Directives, using the symptom deterioration pages, following the response pathway, knowing when to escalate and to whom, and post-event documentation. Demonstrated with Lesley's abdominal deterioration scenario.

Learning Objectives

By the end of this session, participants will be able to:

- Perform an initial A-G nursing assessment of a deteriorating resident
- Locate and navigate the DRTT on the HNC website
- Use the DRTT deterioration symptom pages to determine severity and response category
- Apply the DRTT response pathway to determine interventions and escalation steps
- Incorporate Advance Care Directive review into clinical decision-making
- Know when and how to use the RACH after-hours fast-track number (1800 867 221)

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'Has anyone used the DRTT? What was helpful?' If not: 'Have you ever been unsure whether to call the GP or wait? What made it hard?'	**Welcome & clinical review (3 min)** Brief recap of A-G assessment. Ask who has recently used it - what prompts did they find useful?
DRTT overview (7 min) Walk through the DRTT steps using the flowchart. Don't demonstrate the full tool - focus on the structure: detect → A-G assess → check ACD → symptom page → response pathway → escalate → document.	**DRTT full walkthrough (10 min)** Step through the DRTT using Lesley's case. Show or describe each page. If screen available, navigate live.
Live demo (4 min) Open the DRTT on a device if available. Show where to find it, how to navigate to a symptom page. Use Lesley's scenario.	**ACD/Goals of Care integration (5 min)** Discuss how the DRTT prompts checking the ACD at each stage. What happens when a resident's ACD says 'stay in RACH'? How does that affect the red-zone response?
Close (2 min) Key message: 'Bookmark this now. It's designed to be used at the bedside.' Share fast-track number.	**Practice scenario (8 min)** Small groups: use a de-identified recent case or a modified Lesley variant (change the symptom - e.g. respiratory deterioration instead of abdominal). Work through DRTT together. What level of urgency? What response?
	Debrief + resources (4 min) Discussion questions. Share the fast-track number and bookmarking the DRTT.

Discussion Questions

💬 **Discussion Questions**

Q1. Which steps in the DRTT workflow do you feel most confident with? Which steps would you want more practice or support with?

Q2. When a resident's ACD says they wish to remain in RACH for all care - how does that change your DRTT response, particularly if they fall in a red-zone category?

Q3. How does your facility currently store and access ACDs at the point of care? Is this working well?

Q4. The DRTT includes an after-hours fast-track number (1800 867 221). How many people in this room knew about this? When would you use it?

Case Study

📋 **Case Study / Scenario**

Following on from DR Module 2: You are the RN on duty. A PCA reports Lesley is drowsy, not communicating, and has an apparently bloated abdomen. You do an A-G assessment. Vital signs: temperature 37.9°C (yellow range), other obs normal. Bowel chart shows no bowel movement for 3 days. Lesley reports nausea when asked. Lesley's ACD states: 'I want to be comfortable and treated at the RACH if possible - not transferred to hospital.' On reviewing the DRTT abdominal symptoms page, Lesley appears to meet red-zone criteria.

Debrief prompts:

5. Step through the DRTT workflow for Lesley. What does each step tell you to do?
6. Lesley is in the red zone but her ACD says to remain in RACH. How do you resolve this in your clinical plan?
7. What nursing interventions would you initiate before calling the GP?
8. You call the GP using ISBAR. What are the key clinical details to communicate?
9. What do you document, and when do you notify family?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What does the A-G assessment in the DRTT stand for?
A: Airway, Breathing, Circulation, Disability (conscious state), Exposure (skin/wounds), Fluids, Glucose, Goals of Care (ACD check).

Q: Where is the DRTT found?
A: Online at hnc.org.au/deteriorating-resident-triage-tool-nnsw-mnc-nsw - bookmark it on your clinical device for bedside access.

Q: What is the RACH after-hours fast-track number?
A: 1800 867 221 - available 24/7 to all MNC and NNSW RACHs. Use this when GP is unavailable after hours.

Q: After using the DRTT and contacting the GP, what are the final steps?
A: Implement GP recommendations; notify family; document in resident notes; update care plan. If GP was not involved in management, notify them by next working day.

Common Questions from Learners

Question	Suggested response
'The DRTT takes too long in an emergency'	'It's designed to be used in parallel with assessment - not after. The symptom pages are navigable quickly once you're familiar. Familiarity comes with practice, not just in emergencies.'
'What if the GP disagrees with what the DRTT is telling me?'	'The DRTT is a clinical decision support tool, not a mandate. Document your assessment, document the GP advice, and escalate to your clinical manager if you have concerns about the plan.'
'Our facility doesn't have ACDs for most residents'	'That's important information - raise it with your manager and discuss how to prioritise ACP conversations. The ACD affects every DRTT decision.'

Post-Session Activity

What Next: Bookmark the DRTT now at hnc.org.au. Save the after-hours fast-track number: 1800 867 221. Use the DRTT at least once on the next unwell resident you assess - even if straightforward - to build familiarity.

Additional Resources

🔗 **Additional Resources**

Deteriorating Resident Triage Tool (DRTT):
https://hnc.org.au/deteriorating-resident-triage-tool-nnsw-mnc-nsw *- Bookmark this on your clinical device - use at bedside*

ISBAR Clinical Handover Form:
https://hneccphn.imgix.net/assets/src/uploads/resources/Aged-Care/form-isbar-4ac-v11.pdf *- Printable ISBAR with guidance*

RACH After-Hours Fast-Track (24/7):
https://hnc.org.au/deteriorating-resident-triage-tool-nnsw-mnc-nsw *- Phone: 1800 867 221 - available to all MNC & NNSW RACHs*

DR Module 4 - Clinical ISBAR for Nursing Staff

🔵 **INTERMEDIATE** Registered Nurses and Enrolled Nurses in clinical roles. Builds on DR Module 3. Suitable for ENs under RN supervision for some components.

Topic	Deteriorating Resident	**Module**	DR Module 4	**15-min format**	Yes	**30-min format**	Yes

Module Summary

The nursing-specific companion to DR Module 2, this module teaches nurses how to construct and deliver a clinical-grade ISBAR handover after completing an assessment. Where DR Module 2 helps non-nursing staff escalate observations, this module focuses on what nurses communicate: A-G findings, vital signs, clinical impressions, Goals of Care status, and nursing diagnosis. Includes clinical handover form reference and worked examples.

Learning Objectives

By the end of this session, participants will be able to:

- Identify the key clinical information required for a nursing ISBAR handover
- Construct a structured ISBAR incorporating A-G findings, vital signs, Goals of Care and clinical impression
- State a nursing diagnosis and clinical request in the Recommendation/Request component
- Know where to locate and how to use the HNC ISBAR clinical handover form

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Recap (2 min) Quick ISBAR acronym check: I-S-B-A-R. What goes in each section?	**Warm-up (3 min)** Ask: 'What's the most challenging ISBAR you've had to do? What made it hard?'
Clinical ISBAR components (7 min) Walk through nursing-specific additions: A-G abnormalities, vital signs (with ranges), ACD/Goals of Care inclusion in the S and A sections, nursing diagnosis in R.	**Clinical ISBAR theory (8 min)** Cover all components with nursing-specific examples. Use the handover form structure as a template.
Worked example (4 min) Work through a nursing ISBAR for Lesley with clinical detail. Demonstrate the difference between a PCA handover (DR2) and a nursing handover (DR4).	**Scenario practice (12 min)** Pairs or threes: one acts as nurse doing the ISBAR to a GP; one plays the GP (asking clarifying questions); one observes and gives feedback. Use Lesley or a provided scenario. Rotate roles.
Close (2 min) Takeaway: 'The R section is where your clinical judgement goes. Own it.' Hand out ISBAR form if available.	**Debrief (7 min)** What clinical information did the 'GP' need that wasn't provided? What made the handover easier or harder to follow?

Discussion Questions

💬 **Discussion Questions**

Q1. What is the difference between what a PCA would say in an ISBAR and what a nurse would say? Walk through a specific scenario.

Q2. In the Recommendation component, the module gives three examples: 'requires hospital intervention', 'requires medical review', 'requires treatment to palliate'. How do you decide which applies?

Q3. How do you incorporate Goals of Care / ACD information into your ISBAR without making it too long?

Q4. What happens when you're not sure what nursing diagnosis to give? How do you handle uncertainty in your recommendation?

Case Study

📋 **Case Study / Scenario**

You are the RN on duty. Following your DRTT assessment of Lesley (from DR Module 3), you need to call Lesley's GP. Lesley has: temperature 37.9°C, drowsy state (responds to verbal), abdominal distension, no bowel movement for 3 days, nausea. ACD states preference to remain at RACH. You have commenced nil-by-mouth per the DRTT intervention guidance.

Debrief prompts:

10. Write out a full clinical ISBAR for this call. Include vital signs, A-G findings, ACD status, and your nursing diagnosis.
11. For the Recommendation: does Lesley require hospital intervention, medical review, or palliation? Justify your answer given the ACD.
12. The GP asks: 'What's her current medication list for constipation?' You don't have it in front of you. What do you say?
13. After the call - what do you document and when?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What clinical information must be included in the 'Assessment' component for a nursing ISBAR?

A: Clinical observations (BP, HR, O2 saturations, RR and effort, pain, temperature, consciousness level), A-G clinical findings, and Goals of Care considerations.

Q: What are three examples of a nursing 'Recommendation' to a GP?

A: 1. 'Acute event requiring hospital intervention'; 2. 'Resident requires medical review - anticipatory orders do not cover current needs'; 3. 'Resident requires treatment in place to palliate.'

Q: Where do you mention the resident's ACD in an ISBAR?

A: It should appear in both Situation (noting its existence and key preferences) and Assessment/Recommendation (factoring it into clinical decision-making and escalation plan).

Common Questions from Learners

Question	Suggested response
'I feel embarrassed when the GP corrects my assessment'	'ISBAR gives you a professional framework to stand in. Document your clinical findings. Your observation is valid even if the clinical interpretation differs.'
'The GP never follows up - what do I do?'	'Document your call and the advice given. If concerned the plan is insufficient, escalate to your clinical manager or NUM. Use the DRTT after-hours fast-track if needed: 1800 867 221.'

Post-Session Activity

What Next: Download and print the ISBAR Clinical Handover Form from the resources below and use it during your next clinical handover. Bring any questions to the Coaching Circle.

Additional Resources

🔗 **Additional Resources**

ISBAR Clinical Handover Form (HNC):
https://hneccphn.imgix.net/assets/src/uploads/resources/Aged-Care/form-isbar-4ac-v11.pdf *- Printable form with guidance (~5 min)*

ISBAR Module on ALIS: https://learning.agedcarequality.gov.au/user_login *- 15-min module (requires ALIS login)*

TOPIC 2
Advance Care Planning

The ACP series spans all three learning levels across four modules. Modules 1 and 2 are foundational - accessible to all staff with a focus on awareness, readiness cues and referral. Module 3 is intermediate - legal and clinical mechanics for nurses. Module 4 is advanced - the skill of facilitating the conversation itself, best suited to trained educators and designated trainers. The series uses consistent characters (Agnes and Margaret as case study residents) and builds toward the Serious Illness Conversation Guide as a practical framework.

💡 Facilitation note: ACP Module 4 is specifically identified in the BNC program as a module better delivered through Train the Trainer than online-only. Staff benefit from being able to ask questions, practise language and debrief. Always run this as a 30-min session.

ACP Module 1 - What is Advance Care Planning? Where to Start

🟢 **FOUNDATIONAL**	All RACH staff - including PCAs, lifestyle staff, food services, and non-clinical team members. No clinical background required. Also suitable as an introduction for nursing staff new to ACP.

Topic	Advance Care Planning	**Module**	ACP Module 1	**15-min format**	Yes	**30-min format**	Yes

Module Summary

Introduces Advance Care Planning (ACP) to all staff. Explains the difference between ACP (the ongoing process of discussing and planning future care) and an Advance Care Directive (the legal document recording those wishes). Uses plain language throughout. Covers why ACP matters specifically for RACH residents - most of whom will pass away within two years of entry - and the risk of not having a plan. Does not cover how to have ACP conversations (that is ACP Module 4).

Learning Objectives

By the end of this session, participants will be able to:

- Explain what Advance Care Planning is in plain language to a resident or family member
- Describe the difference between Advance Care Planning and an Advance Care Directive
- Explain why ACP is especially important for people living in residential aged care
- Identify the risks for residents who do not have an Advance Care Plan
- Know where completed ACDs are stored at their facility

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'Have you ever had to make a decision for a loved one who couldn't speak for themselves? What made it hard?'	**Welcome & hook (3 min)** Ask: 'Has a resident or family member ever asked you about future care wishes? What happened?'
Key concepts (7 min) Summarise ACP vs ACD. Emphasise: ACP is the conversation; ACD is the document. Why RACH - 95% will pass away within 2 years; dementia can limit later participation.	**Module content (8 min)** Summarise or play the module. Cover all key concepts including ACP, ACD, Goals of Care, and the 'voice' metaphor.
Discussion (4 min) Ask: 'If a resident asked you today what ACP was, what would you say?' Share responses.	**ACP vs ACD - clarifying questions (5 min)** Common confusion: 'Are these the same thing?' Walk through the distinction with examples. Show what an ACD document looks like if possible.
What Next (2 min) Each person to ask manager: 'Where are completed ACDs stored for our residents?'	**Discussion (8 min)** Use discussion questions below.
	What Next + debrief (6 min) Ask manager activity. Debrief: what surprised you? What do you want to know more about?

Discussion Questions

💬 **Discussion Questions**

Q1. If a resident's family member asked you, 'What's the point of doing an advance care plan?', what would you say?

Q2. The module says 95% of people entering RACH will pass away within 2 years. How does that change your view of when to start ACP conversations?

Q3. Why do you think ACP is not done more routinely? What gets in the way?

Q4. Have you ever been in a situation where you wished a resident had an ACD? What happened?

Case Study

📋 **Case Study / Scenario**

Margaret, 84, moved into your RACH three months ago following a stroke. She has mild cognitive impairment and lives with her daughter. Her daughter says: 'We've never talked about this stuff - it feels morbid.' Margaret, on a good day, says to you: 'I just don't want to end up on machines.' There is no ACD in her file.

Debrief prompts:

14. What might you say to Margaret when she says she doesn't want to end up on machines?
15. How would you explain ACP to Margaret's daughter without it feeling 'morbid'?
16. Who in your facility would you refer Margaret and her daughter to for the next steps?
17. Why is now a better time than later to have this conversation with Margaret?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What is the difference between Advance Care Planning and an Advance Care Directive?
A: ACP is the process - the conversations, thinking and planning about future care. An ACD is the legal document that records the person's preferences and comes into effect when they can no longer make decisions for themselves.

Q: Why is ACP particularly important for RACH residents?
A: Approximately 95% of people who enter permanent RACH will die within two years. Many also have dementia or cognitive decline, which may limit their ability to participate in planning over time. Early conversations ensure their wishes are captured while they have capacity.

Q: What are the risks of not having an Advance Care Plan?
A: Residents may receive care or treatments they would not have wanted (e.g. hospital transfers). Families face greater distress when they don't know the person's wishes. The resident's voice is absent from decisions about their own life.

Common Questions from Learners

Question	Suggested response
'Isn't ACP the doctor's job?'	'Everyone can play a role. Doctors formally document directives, but carers, nurses and lifestyle staff can introduce the concept, listen for readiness cues, and refer on. You're often the first person a resident talks to about these things.'
'Won't it upset the resident to talk about this?'	'Research shows that ACP conversations do not cause distress - they actually reduce it for residents and their families. The key is bringing it up with warmth and without pressure.'

Post-Session Activity

What Next (from the module): Ask your manager - 'How does our workplace help residents complete ACP? Where are completed ACDs stored? Are they uploaded to My Health Record?' Make a note and bring this to your next session.

Additional Resources

🔗 **Additional Resources**

Advance Care Planning Australia: https://www.advancecareplanning.org.au/ *- National ACP information hub - resources for consumers and providers*

NSW ACD Information and Form: https://www.health.nsw.gov.au/patients/acp/Publications/acd-info-form-book.pdf *- Official NSW ACD form and guidance booklet*

ACP Module 2 - Addressing Worries About ACP

🟢 **FOUNDATIONAL** All RACH staff - same audience as ACP Module 1. Particularly valuable for staff who will have early, informal ACP conversations with residents and families. A natural extension of Module 1.

Topic	Advance Care Planning	**Module**	ACP Module 2	**15-min format**	Yes	**30-min format**	Yes

Module Summary

Builds on ACP Module 1 by focusing on the common concerns staff, residents and families raise about ACP - and how to address them with skill and compassion. Covers how every team member can play a role, how to notice 'signs of readiness' for ACP conversations, how to respond to emotions, and how to identify who to refer residents to for formal ACP completion. Includes practical communication frameworks (naming, empathy, explore) and worked examples including the Agnes scenario.

Learning Objectives

By the end of this session, participants will be able to:

- Describe the role each team member can play in supporting ACP at their facility
- Identify and respond to 'signs of readiness' for ACP conversations in residents and families
- Address common staff concerns about initiating ACP discussions
- Respond to resident/family worries about ACP (anxiety, denial, protectiveness) with empathy
- Know where to refer residents and families for formal ACP support at their facility

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Read the Agnes scenario from the module: 'Mireilla, a PCA, notices Agnes is thoughtful after returning from hospital...' Ask: 'Has someone ever opened up to you like this during care?'	**Hook (3 min)** Read or play the Agnes scenario. Ask: 'What did Mireilla do well? What would you have done differently?'
Signs of readiness (5 min) Go through the five 'signs of readiness' phrases from the module. Ask staff: 'Have you heard any of these from residents?'	**Signs of readiness - practice (8 min)** Show the five 'readiness' phrases. In pairs: one person says a readiness phrase; the other responds using language from the module. Swap.
Responding to worries (5 min) Cover the NURSS framework (Name, Understand, Respect, Support, Silence/Empathy). Model one response aloud.	**Common staff worries (7 min)** Read out the worries from the module one by one. Ask: 'Which of these do you relate to?' Discuss solutions as a group.
Referral + Close (3 min) Who at this facility can residents be referred to for formal ACP discussions? Make sure everyone knows.	**Responding to resident/family emotions (7 min)** Role play a resident expressing denial ('I don't want to think about this'). Practice an empathetic response. Debrief.
	Wrap-up (5 min) Discussion questions. Who is the ACP referral contact at this facility?

Discussion Questions

💬 **Discussion Questions**

Q1. The module lists five signs that a resident may be ready for an ACP conversation. Which of those signs have you noticed in residents you care for?

Q2. In the Agnes scenario, Agnes opens up about her fears unprompted. How would you continue that conversation? What would you say next?

Q3. What are your own concerns about raising ACP with residents? Which worry from the module resonates most with you?

Q4. Who at this facility is the 'right person' to refer a resident to once you notice a readiness cue? Do all staff know who this is?

Case Study

📋 **Case Study / Scenario**

Agnes has just returned from two nights in hospital. During her morning care, she tells you: 'I saw the woman in the next bed - she didn't make it. It got me thinking. I don't want to go like that. And my family just tells me to stop being negative.' (Adapted from ACP Module 2 - the Mireilla and Agnes scenario.)

Debrief prompts:

18. Agnes is showing a 'sign of readiness.' What are the signs in her words? What would you say to her?
19. Using the NURSS framework: how would you respond to Agnes's comment 'I don't want to go like that'?
20. Agnes says her family 'shushes her.' How might you address this with Agnes and potentially with her family?
21. What would your next step be - who would you tell, and what would you say to them?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What are three 'signs of readiness' a resident might show for an ACP conversation?
A: Awareness of their illness and talking about its progression; open to discussing the future; bringing up experiences from the past (their own or others'); expressing fear of dying like someone they saw; saying they have been thinking about death lately.

Q: If a resident says 'I don't want to think about this right now', what should you do?
A: Respect their preference, acknowledge it ('It sounds like this isn't a good time - that's okay'), leave the door open ('If you change your mind, I'm always happy to listen'), and document that the conversation was attempted.

Q: Who can formally complete an ACP discussion and document an ACD?
A: Any health professional can support the conversation; formally witnessing and completing an ACD requires a competent adult (the resident) and two witnesses, ideally including a health professional.

Common Questions from Learners

Question	Suggested response
'I don't have time to have ACP conversations during care'	'You don't need to have the whole conversation at once. Your role is to notice the cue, respond warmly, and refer on. That can take 2 minutes. The referral is the main action.'
'What if the family tells me not to discuss it?'	'The ACP process belongs to the resident, not the family. You can acknowledge the family's concern while still creating space for the resident. This is a clinical and ethical issue - raise it with your manager or NUM if pressure from family is preventing ACP.'

Post-Session Activity

What Next (from the module): Ask your manager - 'Who in our workplace has the role of supporting ACP discussions with residents? Who should I refer a resident to?' Make a note.

Additional Resources

🔗 **Additional Resources**

Advance Care Planning Australia - Consumer Resources:
https://www.advancecareplanning.org.au/ *- Resources residents can read or family members can take home*

NSW ACD Form and Guide:
https://www.health.nsw.gov.au/patients/acp/Publications/acd-info-form-book.pdf *- Official NSW ACD document - useful to have on hand when a referral is made*

ACP Module 3 - Completing an Advance Care Directive: Legal and Practical Steps

🔵 **INTERMEDIATE**	Registered Nurses, Enrolled Nurses in clinical roles, and Clinical Care Managers. Requires understanding of clinical handover and care planning. Particularly relevant for nurses who witness or locate ACDs.

Topic	Advance Care Planning	**Module**	ACP Module 3	**15-min format**	Yes	**30-min format**	Yes

Module Summary

The clinical and legal mechanics of ACDs. Covers what makes an ACD valid under NSW law (competent adult, correct witnessing, clear preferences), what nurses need to know about witnessing ACDs, how to explain the document to residents and families in plain language, and - critically - when and how to include ACD information in clinical handover (ISBAR). Also covers where ACDs are stored and how to locate them. This module directly supports the DRTT use in DR Module 3 (checking Goals of Care).

Learning Objectives

By the end of this session, participants will be able to:

- Describe the legal status of a valid Advance Care Directive in NSW
- Identify the features of a correctly completed ACD (signing, witnessing, content)
- Explain the ACD to residents and families in accessible language
- Incorporate ACD status into clinical handover (ISBAR) at key care moments
- Locate completed ACDs in their organisation's system
- Understand when they can and cannot witness an ACD

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'If a resident had a valid ACD saying they don't want to go to hospital - and they deteriorated - what would you do?' Discuss briefly.	**Warm up (3 min)** Poll: 'How many residents in your ward have a completed ACD?' Discuss what that tells us.
What makes an ACD valid (7 min) Cover the five validity criteria: competent adult; full name/DOB/address; signed; two witnesses (one health professional preferred); clear preferences not someone else's wishes.	**ACD validity in depth (10 min)** Cover all validity criteria with examples of what 'clear and specific' preferences look like and what invalidates a document. Discuss NSW-specific rules.
ISBAR integration (4 min) Walk through the two example handovers from the module (Mrs Ng and Mr Liotta). When and how do you mention an ACD in handover?	**Can I witness an ACD? (5 min)** Walk through the witnessing requirements. Who can witness? What do you need to confirm? When should a nurse decline to witness?
Close (2 min) Ask: 'Where are ACDs stored in this facility? Is it easy to find at the point of care?'	**Handover integration practice (8 min)** Show the Mrs Ng and Mr Liotta examples. Ask participants to write their own ISBAR snippet that includes ACD status for a resident in their ward (de-identified).
	Debrief (4 min) Discussion questions. What is the most common gap you see in ACD practice at this facility?

Discussion Questions

💬 **Discussion Questions**

Q1. If a resident has an ACD that says they want 'all treatment possible' but later, when more unwell, they tell a staff member they don't want to go to hospital - which takes precedence? What should you do?

Q2. The module says an ACD is 'legally binding if correctly completed.' What would you do if you had reason to believe an ACD might not be valid (e.g. witnessed by a family member, not a health professional)?

Q3. Think about your facility's system for storing and accessing ACDs. Would you be able to locate a resident's ACD at 3am in an emergency? What improvements could be made?

Q4. Why is including ACD information in clinical handover (ISBAR) important - even when the resident is not currently unwell?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What are the key features of a valid ACD in NSW?

A: Completed and signed by a competent adult; includes full name, DOB and address; signed by two witnesses (ideally one health professional); neither witness is an appointed Enduring Guardian; contains clear, specific preferences that are the person's own; applies to current situation.

Q: When does an ACD come into effect?

A: Only when the person has lost decision-making capacity - they continue to make their own decisions until then.

Q: When should you include ACD information in a clinical handover?

A: At any change in condition or change in location (hospital transfer, new illness, GP review), and as standard in an ISBAR when the resident is deteriorating or a new care decision is needed.

Q: Can a nurse witness an ACD?

A: Yes, if they can confirm the person has decision-making capacity and is acting freely and voluntarily. A nurse cannot witness if they are appointed as an Enduring Guardian for that resident.

Common Questions from Learners

Question	Suggested response
'The family wants to override the ACD'	'A valid ACD is legally binding and cannot be overridden by family wishes. Your role is to explain this with compassion and escalate to your manager or medical team if the family is applying pressure inconsistent with the resident's legal document.'
'Our facility keeps ACDs in the paper file and it's hard to find'	'Raise this as a patient safety issue with your manager. The DRTT explicitly requires checking the ACD. If it can't be found quickly, it cannot protect the resident's wishes at the critical moment.'

Post-Session Activity

What Next (from the module): Ask your manager - 'Where are ACDs stored in our workplace - electronic, paper, or both? How do I locate one quickly at 3am?' Make a note. Ensure it is accessible at the point of care.

Additional Resources

🔗 **Additional Resources**

NSW ACP Laws:
https://www.advancecareplanning.org.au/law-and-ethics/state-and-territory-laws/advance-care-planning-laws-in-nsw *- NSW-specific legal framework for ACDs*

NSW ACD Form and Guidance Booklet:
https://www.health.nsw.gov.au/patients/acp/Publications/acd-info-form-book.pdf *- Official ACD form for NSW*

Advance Care Planning Australia: https://www.advancecareplanning.org.au/ *- Resources for residents on choosing a substitute decision-maker*

ACP Module 4 - Having Supportive ACP Conversations

🟣 **ADVANCED**	Designated Trainers, Clinical Nurse Educators, senior RNs, and Clinical Managers who will facilitate ACP conversations or coach others in doing so. This module requires clinical communication confidence and is most effective when participants already have basic ACP knowledge from Modules 1-3.

Topic	Advance Care Planning	**Module**	ACP Module 4	**15-min format**	Yes	**30-min format**	Yes

Module Summary

The most clinically and emotionally sophisticated module in the ACP series. Focuses on the actual skill of initiating, sustaining and concluding ACP conversations with residents who may be resistant, uncertain, or emotionally reactive. Introduces the Serious Illness Conversation Guide (SICG) as a structured framework. Covers recognising readiness versus non-readiness, working with signs and cues, leaving doors open, and who can and should lead these conversations. Particularly suited to Train the Trainer facilitation - learners need to debrief and ask questions, not just watch online.

Learning Objectives

By the end of this session, participants will be able to:

- Identify key moments when ACP conversations are most appropriate and timely
- Recognise verbal and behavioural cues that a resident may be ready to discuss their future care
- Use conversation starters and the Serious Illness Conversation Guide (SICG) to initiate a supported ACP discussion
- Respond with empathy and skill to residents or families who are not yet ready to engage
- Know who can facilitate ACP conversations at each level (any staff for listening; trained clinician for guiding and documenting)

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'Has anyone ever tried to start an ACP conversation and it felt awkward or difficult? What made it hard?'	**Warm up (3 min)** Read conversation starters from the module aloud. Ask: 'Which of these feels most natural to you? Which feels hardest?'
Key moments + cues (5 min) Recap the five key moments (moving into RACH, GP review, serious illness, resident asks, post-hospital). Review 'signs of readiness' cues.	**Agnes scenario debrief (7 min)** Play or reread the Agnes/Mireilla scenario from ACP Module 2. Discuss: what readiness signs did Mireilla pick up? What did she do well?
SICG intro (5 min) Introduce the Serious Illness Conversation Guide steps: setup → healthcare knowledge → reason for planning → values and concerns → plan and close. Share one example phrase from each step.	**SICG in depth (8 min)** Walk through the five SICG steps with example phrases. Focus on: how to share the reason for planning ahead, and how to explore values and concerns.
Close (3 min) Key message: 'You don't need a perfect script. You need curiosity and a willingness to hear the answer.' Direct to SICG video resource.	**Role play (8 min)** Pairs: one plays a recently admitted resident who brings up end-of-life concerns obliquely; one plays the nurse using SICG steps. Debrief: what felt natural? What felt awkward?
	Debrief + summary (4 min) Key messages: ACP is iterative; leave the door open; document even a declined conversation.

Discussion Questions

💬 **Discussion Questions**

Q1. The module says 'the earlier the better' for ACP conversations. Is that reflected in your facility's practice? What prevents early conversations?

Q2. What do you say to a resident who is clearly showing readiness cues but the family has said 'don't bring it up'? How do you navigate that?

Q3. The Serious Illness Conversation Guide is designed for structured conversations. When might a more informal, unscripted approach be more appropriate?

Q4. After facilitating an ACP conversation, what do you document - even if the resident declined to go further? Why does this matter?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What are the five key moments when ACP conversations are most appropriate?

A: 1. Moving into RACH; 2. GP is asked to review; 3. Serious illness is present; 4. Resident asks to discuss future care; 5. Before/after an unplanned hospital stay.

Q: What are the five steps of the Serious Illness Conversation Guide (SICG)?

A: 1. Set up the conversation; 2. Assess healthcare knowledge; 3. Share reason for planning ahead; 4. Explore values and concerns (hopes, fears, goals as health declines); 5. Plan and close.

Q: If a resident is not ready to discuss ACP, what should you do?

A: Acknowledge their choice without pressure ('That's okay - if you ever want to talk about it, I'm here'), leave the door open, document that the conversation was attempted and the resident's response, and consider a follow-up at a future key moment.

Q: Can someone with dementia participate in ACP?
A: People living with dementia may still express preferences even if they lack full capacity for a legally binding ACD. These expressed preferences should be documented in the care plan and can inform a substitute decision-maker's choices.

Common Questions from Learners

Question	Suggested response
'I'm not a social worker or palliative care specialist - is it really my role to have these conversations?'	'Anyone can listen and provide basic support. This module is about knowing how to start the conversation and when to refer. Formal ACD completion requires a trained clinician, but noticing readiness and creating the opening is everyone's role.'
'What if I start the conversation and the resident becomes very upset?'	'That is not a sign you did the wrong thing - it often means the topic genuinely matters. Use the NURSS framework: name the emotion, understand, respect, support. Offer to come back. Document. Refer to your palliative care or ACP lead if needed.'

Post-Session Activity

What Next (from the module): Watch the Serious Illness Conversation Guide video (see resources). Ask your manager - 'If a resident wants to discuss their future care wishes with someone, who do I refer them to at this facility?'

Additional Resources

🔗 **Additional Resources**

Serious Illness Conversation Guide (SICG) Video:
https://www.youtube.com/watch?v=nz0doKMC6Hk *- Example of SICG in practice - NZ context, approx 10 min*

SICG Framework PDF: https://www.ariadnelabs.org/serious-illness-care/ *- Ariadne Labs - original SICG developers*

NSW ACD Form for residents:
https://www.health.nsw.gov.au/patients/acp/Publications/acd-info-form-book.pdf *- For residents ready to complete formal documentation*

ACP Research: ACP does not cause distress:
https://pmc.ncbi.nlm.nih.gov/articles/PMC8062377/pdf/520_2020_Article_5799.pdf *- Evidence base referenced in the module*

TOPIC 3
Palliative Care

Two modules cover palliative care. Module 1 is accessible to all staff and focuses on recognising when palliative care might help and how to advocate for residents - it uses Bill's story as a central anchor. Module 2 focuses on the end-of-life period itself, including creating a peaceful environment, saying goodbye, and supporting staff and other residents after a death. Both modules work well as a paired 30-minute session for the whole care team.

💡 Consider running PC Modules 1 and 2 together as a 30-45 minute palliative care in-service. The combined session covers the full arc from 'when to introduce palliative care' to 'what happens at end of life and after.'

PC Module 1 - Knowing When and How to Help Residents Access Palliative Care

🟢 **FOUNDATIONAL**	All RACH staff, including PCAs, lifestyle and non-clinical roles. Suitable as an introduction for nursing staff. Accessible and practical - no prior palliative care knowledge required.

Topic	Palliative Care	**Module**	PC Module 1	**15-min format**	Yes	**30-min format**	Yes

Module Summary

Introduces palliative care as a broad, holistic approach that goes well beyond end-of-life care. Uses the case of 'Bill' - a resident with advanced heart failure - to explore what palliative care looks like in practice, how to recognise when a resident might benefit, and how any staff member can be an advocate for their residents. Covers the 'Surprise Question', the SPICT-4ALL tool, common symptoms that palliative care can address, and who to contact at a local level for specialist support. Strongly emphasises early initiation and the importance of not waiting until a crisis.

Learning Objectives

By the end of this session, participants will be able to:

- Explain what palliative care is - and what it is not - in plain language accessible to residents and families
- Identify situations when a palliative care approach could benefit a resident
- Use the 'Surprise Question' and SPICT-4ALL tool to recognise when palliative care might be appropriate
- Know how to advocate for a resident who may need palliative care (who to ask, what to say)
- Identify the local palliative care supports available in their region

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'What comes to mind when you hear the words palliative care? What do you think it is?' Take a few responses - expect 'dying', 'giving up', 'hospice'.	**Hook + myth-busting (5 min)** Quick poll: 'What is palliative care?' Take responses, address myths. Common myths: 'It means giving up', 'It's only for cancer', 'It's only for the last days'.
Reframe (5 min) Summarise: palliative care is not just for dying - it's for anyone with a life-limiting illness who has uncomfortable symptoms. Introduce Bill and how palliative care helped his breathlessness.	**Bill's story (7 min)** Walk through Bill's full case from the module. What was wrong? What was tried? How did palliative care help? What did his daughter think at first?
When to think about it (5 min) Introduce the Surprise Question: 'Would I be surprised if this resident died in the next 12 months?' If no - it may be time to plan. Briefly introduce SPICT-4ALL.	**The Surprise Question + SPICT-4ALL (5 min)** Apply both tools to residents in the group's care (no names). Who would you be surprised to lose in the next year? Are any SPICT-4ALL criteria present?
Who to ask + Close (3 min) Script: 'I have a resident with advanced [condition] who seems really uncomfortable with [symptom]. Do you think they could benefit from a palliative care approach?' Who would they say this to at this facility?	**Common symptoms + advocacy (8 min)** Briefly cover the symptom list from the module: breathlessness, pain, constipation, nausea, fatigue, delirium, anxiety, spiritual needs. Walk through how to advocate using the script.
	Local supports + debrief (5 min) What are the local palliative care services? Does everyone know where to find them? Debrief: what shifted for anyone about what palliative care is?

Discussion Questions

💬 **Discussion Questions**

Q1. Bill's daughter says: 'I suppose there's nothing that can be done now.' What does that tell you about how families understand palliative care? How would you respond?

Q2. Think of a current or recent resident. Would you be surprised if they died in the next 12 months? What does that tell you about their palliative care needs?

Q3. What is the most common barrier to early palliative care at your facility - staff knowledge, GP engagement, family resistance, or something else?

Q4. The module says palliative care is most effective when introduced early. Is that reflected in practice at your facility? What would need to change?

Case Study

📋 **Case Study / Scenario**

Bill, 79, has lived in your RACH for 8 months. He has advanced heart failure. Lately he has been sleeping poorly, waking short of breath, and his joints ache. The doctor has reviewed him and says all his medications are optimised. His daughter says 'I suppose there's nothing that can be done.' Bill says he 'would give anything to sleep better and with less pain.' (From PC Module 1.)

Debrief prompts:

22. Does Bill meet the Surprise Question threshold? Does he meet any SPICT-4ALL criteria?
23. Using the script from the module, how would you raise palliative care support with Bill's GP?
24. What simple comfort strategies (from the module) could be tried now while waiting for a specialist?
25. How would you explain palliative care to Bill's daughter in a way that addresses her belief that 'nothing can be done'?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What is the 'Surprise Question' and how is it used?
A: 'Would I be surprised if this resident died in the next 12 months?' If no - it may be an indicator that palliative care planning is appropriate now. It is a quick clinical prompt, not a formal assessment.

Q: Can palliative care be offered at the same time as treatment for an acute illness?
A: Yes - palliative care can be given alongside curative or life-prolonging treatment at any stage of a life-limiting illness. It focuses on symptom relief and quality of life regardless of what other treatments are in place.

Q: What are some symptoms that a palliative care approach can help with?
A: Pain, breathlessness, nausea, constipation, fatigue, delirium, anxiety, spiritual/existential distress, and support for family and carers.

Common Questions from Learners

Question	Suggested response
'Doesn't suggesting palliative care mean we're giving up on the resident?'	'No - it means we're adding support. Palliative care is not instead of treatment. It's alongside treatment to relieve symptoms and improve quality of life. The WHO says early palliative care actually reduces unnecessary hospitalisations.'
'Families often refuse palliative care - they think it means death is imminent'	'This is a common misunderstanding. Gently explain that palliative care can begin much earlier. It might help to say: "We're not talking about what happens at the end - we're talking about making your [loved one] more comfortable now."'

Post-Session Activity

What Next (from the module): Ask your manager - 'What are the local sources of specialist palliative care advice for our facility? Who do we call first?' Make a note. Bring to next session.

Additional Resources

🔗 **Additional Resources**

SPICT-4ALL Tool: https://www.spict.org.uk/spict-4all/ *- Plain language palliative care indicators - ~10 min*

Palliative Care Continuum (Palliative Care Victoria): https://www.pallcarevic.asn.au/dard/end-of-life/palliative-care *- Visual overview of when palliative care applies*

WHO Palliative Care Fact Sheet: https://www.who.int/news-room/fact-sheets/detail/palliative-care *- Evidence base for early palliative care*

PC Module 2 - Supporting Residents at End of Life

🔵 **INTERMEDIATE**

All nursing staff and care leaders. Also suitable for PCAs and lifestyle staff as a compassionate care module - the content is accessible and emotionally important for the whole team. Pair with PC Module 1 for a complete palliative care session.

Topic	Palliative Care	**Module**	PC Module 2	**15-min format**	Yes	**30-min format**	Yes

Module Summary

Focuses on providing high-quality care during the final stages of a resident's life. Covers how to identify and honour a resident's values and preferences (through documentation, knowledge of the person, communication and revisiting), how to sensitively explore spiritual and religious needs, how to create a calm and dignified environment, how to support staff and residents after a death, and how to build an ongoing culture of compassionate remembrance. Presented with warm, practical detail by Dr Jesse Zanker.

Learning Objectives

By the end of this session, participants will be able to:

- Use documentation, personal knowledge, communication and regular review to identify a resident's end-of-life wishes
- Start sensitive conversations about spiritual, religious and cultural needs using open-ended questions

- Create a calm, comfortable environment for a resident approaching death
- Support other residents and staff after a resident's death
- Contribute to a culture of respect and remembrance in their facility

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'What does a good death look like to you? What would make it worse?' Take 2-3 responses.	**Hook (4 min)** Invite people to share: 'Tell me about a resident death that felt handled well. What made the difference?'
Identifying values (5 min) Cover the four strategies from the module: documentation (ACD), knowledge of the person, communication, revisiting. Emphasise: knowing the resident's favourite music, food, sleep position matters.	**Values and preferences deep-dive (8 min)** Walk through the four strategies. Focus especially on 'communicating' - role play: how do you ask a resident about spiritual or religious needs if they haven't brought it up? Use example phrases from the module.
Environment + goodbye (5 min) Walk through practical environment strategies from the module: lighting, sound, smell, family presence. Cover: saying goodbye before death; respectful care of the body; notifying staff and other residents.	**Environment activity (5 min)** Using the senses framework: in small groups, create a brief end-of-life environment plan for a fictional resident who loves nature sounds and gardens. What would you do for touch, sight, smell, sound?
Close (3 min) Ask: 'What does your facility currently do well when a resident dies? What would you change?'	**Grief and culture (8 min)** Cover staff grief support, other resident support, memorials and remembrance. Discuss: 'What does our facility currently do? What's missing?'
	Debrief (5 min) What was most useful? What will you take back to your ward or team?

Discussion Questions

💬 **Discussion Questions**

Q1. The module says residents' values are unlikely to change but their preferences might. Can you give an example of a preference that might change as a resident's health declines?

Q2. Think of a resident you know well. If they were approaching the end of life, what would make their environment right for them? (Sounds, smells, who should be present, etc.)

Q3. What does your facility currently do to support staff after a resident's death? What would help staff most?

Q4. The module mentions symbolic acts of remembrance - a photo display, planting a tree, a hall of remembrance. Which of these do you think your residents and staff would value most?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What are the four strategies for identifying a resident's end-of-life values and preferences?

A: 1. Documentation (review ACD and care plans); 2. Knowledge and learning (what you know from caring for them - likes, dislikes, personality); 3. Communicating (creating safe space to ask); 4. Revisiting (checking in regularly as health changes).

Q: What are some ways to support staff after a resident's death?

A: Debriefing sessions; normalising grief; acknowledging emotions openly; access to counselling or peer support; remembrance activities; creating a culture where grief is accepted and expressed.

Q: What does 'gentle and respectful care immediately following death' involve?

A: Dignified care of the body (closing eyes, straightening the body, respecting cultural traditions such as family washing); respectful notification of staff and other residents; offering family time and privacy; creating space for farewells.

Common Questions from Learners

Question	Suggested response
'I find it hard when a resident I'm close to dies'	'That's entirely normal - it reflects the real relationships you build in this work. Your facility should have debriefing available. If it doesn't, that's worth raising. Grief is not a weakness - it's evidence of good care.'
'Families sometimes say or do things at end of life that I don't know how to handle'	'The module recommends ensuring families have a private space to step out to; gently checking in; and reminding them that hearing is often the last sense to go - their voice is comforting to the resident. For complex situations, involve your manager or the palliative care team.'

Post-Session Activity

What Next (from the module): Discuss with your manager - 'What is our workplace culture around support for staff and residents when someone is receiving end-of-life care? What could be improved?'

Additional Resources

🔗 **Additional Resources**

Palliative Care End of Life Practical Guide:
https://www.pallcarevic.asn.au/dard/end-of-life/palliative-care *- Palliative Care Victoria - practical guidance*

CareSearch - Evidence for Aged Care Palliative Practice: https://www.caresearch.com.au/ - *Australia's leading palliative care evidence and practice hub*

TOPIC 4
My Health Record

One module covers My Health Record. It is targeted at nursing staff and RACH managers and focuses on practical application at admission and for complex care coordination. The module is highly practical - its value is greatest when participants can check their own facility's MHR connectivity status during or after the session and identify next steps.

MHR Module - Using My Health Record in RACH

🔵 **INTERMEDIATE**	Registered Nurses, Enrolled Nurses in clinical roles, and RACH Managers. This module is specifically targeted at nursing staff and managers, as per the eLearning module itself. Not suitable as an all-staff module.

Topic	My Health Record	**Module**	MHR Module	**15-min format**	Yes	**30-min format**	Yes

Module Summary

Introduces My Health Record (MHR) in the context of RACH nursing practice. Explains what MHR is, what information it contains (medications, allergies, discharge summaries, pathology, imaging, ACDs), how to access it, and how it can improve care - particularly at admission. Uses 'Terry' as a case study of a newly admitted resident whose transfer paperwork was lost. Also covers how to upload an ACD with consent, and what clinical questions nurses should ask their managers about MHR access at their facility.

Learning Objectives

By the end of this session, participants will be able to:

- Explain what My Health Record is and who controls it
- Describe the types of health information that may be found in a resident's MHR
- Explain how MHR can improve care for newly admitted or acutely unwell residents
- Know how to access MHR at their facility - or the questions to ask their manager
- Understand the consent and policy requirements before accessing or uploading to MHR

Trainer Preparation

Before facilitating: watch or review the eLearning module, note the 'What Next?' activity, and read through the discussion questions and case study below.

Session Delivery Guide

Choose the format that fits your available time. Both formats work as add-ons to an existing staff meeting.

⏱ 15-Minute Session	⏱ 30-Minute Session
Hook (2 min) Ask: 'Has a resident ever arrived at your facility without their full medication history or transfer paperwork? What happened?'	**Hook (4 min)** Ask: 'Have you used MHR? What was helpful? What was confusing or unavailable?'
What is MHR (5 min) Cover the key points: secure national record; resident-controlled; accessible by authorised providers. Walk through the types of information available.	**MHR content deep-dive (8 min)** Walk through each information type: immunisations, allergies, medications, discharge summaries, pathology, imaging, ACD. When would each be most useful to you as a nurse?
Terry's case (5 min) Summarise Terry's scenario: admission after hip surgery, paperwork lost, GP new to Terry. How did MHR help? What would have happened without it?	**Terry's scenario applied (7 min)** Work through Terry's admission: what did the nurse find in MHR? How did it change the care plan? What would have been delayed without it?
What next (3 min) Three questions for managers: Is our RACH connected to MHR? Are you authorised to access it? What training do you need?	**ACD upload + consent (5 min)** Cover the requirements: resident or representative instruction; consent tickbox in software; must be specifically instructed to upload - not assumed.
	Facility-specific discussion (6 min) Is your RACH connected to MHR? Who can access it? What is the MHR policy at this facility? Where would you go for training?

Discussion Questions

💬 **Discussion Questions**

Q1. If a resident arrives with no transfer documentation and you have MHR access - what are the first three things you would look for and why?

Q2. About 55% of RACHs in the HNC region are currently registered and 18% are actively using MHR (April 2026)[1]. What do you think are the main barriers? What would help adoption?

Q3. The module says 'MHR does not contain a complete health record.' What does that mean for how you use it clinically? What would you still need to check elsewhere?

Q4. If a resident's family member wants to upload an ACD to MHR - what questions do you need to ask first?

Knowledge Check

✅ **Knowledge Check - Q&A**

Q: What types of health information might be found in a resident's MHR?

A: Past immunisations; recorded allergies; current and past medications; hospital discharge summaries; pathology results (blood, urine, swabs); imaging reports (X-rays, CT scans); specialist letters; shared health summaries; and potentially uploaded Advance Care Planning documents.

Q: Who controls a resident's My Health Record?

[1] https://www.digitalhealth.gov.au/initiatives-and-programs/my-health-record/statistics

A: The resident (or their nominated representative - family member, power of attorney, or legal guardian). They decide what is uploaded, who can see it, and what stays in the record.

Q: What should a nurse do before uploading an ACD to MHR?

A: Ensure they are specifically instructed by the resident or their authorised representative to do so. Confirm consent using the software tickbox. Check your facility's MHR policy. Confirm your facility's software can do this.

Q: What are the three questions a nurse should ask their manager about MHR?

A: 1. Is our RACH connected to My Health Record? 2. Am I authorised to access residents' MHR? 3. What training do I need to complete before accessing MHR?

Common Questions from Learners

Question	Suggested response
'MHR is empty for most of our residents'	'That's changing over time - MHR is increasingly likely to contain useful information as more providers upload. It's always worth checking, especially at admission or for complex cases. And it takes 30 seconds.'
'We're not connected to MHR yet'	'Raise this with your manager as a clinical priority. Connection can be pursued through your clinical software vendor or via the Digital Health Agency. In the meantime, know the NPP access pathway (see resources) for authorised alternative access.'
'I'm worried about privacy if I access a resident's MHR'	'Access is only lawful when directly related to the resident's care at your facility. Your facility will have a written policy - read it before accessing. Unauthorised access is a serious breach with legal consequences.'

Post-Session Activity

What Next (from the module): Ask your manager - 'Is our RACH connected to My Health Record? Am I authorised to access it? What training is required?' Review the Digital Health MHR training linked below.

Additional Resources

🔗 **Additional Resources**

My Health Record Provider Training: https://training.digitalhealth.gov.au/enrol/index.php?id=60 - *Free online training for healthcare providers - recommended for all clinical staff*

My Health Record System Provider Portal: https://www.myhealthrecord.gov.au/for-healthcare-professionals/ - *Information on connecting your RACH to MHR*

National Provider Portal (NPP) access: https://www.myhealthrecord.gov.au/for-healthcare-professionals/ - *Alternative access pathway if not connected via clinical software*

Appendix - Quick Reference

Resources at a Glance

Resource	URL / Contact
Deteriorating Resident Triage Tool (DRTT)	hnc.org.au/deteriorating-resident-triage-tool-nnsw-mnc-nsw
RACH After-Hours Fast-Track (24/7)	1800 867 221
STOP AND WATCH Tool	hunterprimarycare.com.au/health-professionals/ace-education-resources-2/
SPICT-4ALL Tool	spict.org.uk/spict-4all/
ISBAR Clinical Handover Form (HNC)	hneccphn.imgix.net/assets/src/uploads/resources/Aged-Care/form-isbar-4ac-v11.pdf
ISBAR Module on ALIS	learning.agedcarequality.gov.au/user_login
NSW ACD Form and Guidance	health.nsw.gov.au/patients/acp/Publications/acd-info-form-book.pdf
Advance Care Planning Australia	advancecareplanning.org.au
Serious Illness Conversation Guide	ariadnelabs.org/serious-illness-care/
My Health Record Provider Training	training.digitalhealth.gov.au/enrol/index.php?id=60
CareSearch - Palliative Care Evidence	caresearch.com.au
WHO Palliative Care Fact Sheet	who.int/news-room/fact-sheets/detail/palliative-care
BNC eLearning Modules	agedcare.practicecoach.com.au
1:1 Coaching Support	team@primarycareinnovation.com.au

Session Planning Template

Module	Date	Audience	Format	Trainer	Done?
DR Module 1					☐
DR Module 2					☐
DR Module 3					☐
DR Module 4					☐
ACP Module 1					☐
ACP Module 2					☐
ACP Module 3					☐
ACP Module 4					☐
PC Module 1					☐

Module	Date	Audience	Format	Trainer	Done?
PC Module 2					☐
MHR Module					☐
Telehealth Module 1					☐
Telehealth Module 2					☐