Palliative Care Australia

Submission to the Australian Health Ministers' Advisory Council on a National Code of Conduct For health care workers

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Palliative Care Australia

Palliative Care Australia (PCA) is the peak national organisation representing the interests and aspirations of all who share the ideal of quality care at the end of life. Our mission is to influence, foster and promote the delivery of quality care at the end of life through ongoing policy and advocacy, education, and developing collaborative relationships in Australia and internationally.

We believe that palliative care must be available regardless of location, age, income, diagnosis or prognosis, social and cultural background, to support Australians to live well at the end of life.

But we remain a very long way from achieving our goals. In 2011, nearly 147,000 Australians died. Of these, 107,000 would have benefitted from access to palliative care services, yet only one third to one half did.

PCA has an interest in the proposed National Code of Conduct as a number of the occupational groups expected to be subject to the National Code are those who provide services to people receiving palliative care, including in hospices and in their homes. PCA supports the development of the National Code as it is essential that people at the end of life, at a time when they and the families can be very vulnerable, know that health professionals providing them with care have professional integrity and that there are appropriate checks in place.

While PCA understands that it is the intent of the National Code to apply to a range of settings, including services provided in people's homes, the inclusion of home care should be made clearer and more explicit than it currently is in the consultation document.

A number of the clauses in the National Code relate to priority areas that have been identified by PCA[1]. These include:

Workforce – Care for the dying must be a standard education provision for every health professional across their career. Without supporting the specialist and generalist workforce to provide palliative care across all settings, the needs of dying Australians will continue to be unmet.

Awareness – There is a need for increased awareness of palliative care and end of life care across the community and amongst health professionals. Not discussing or planning for end of life makes it difficult to provide care for a person according to their wishes, particularly where they lose capacity to make decisions, and causes anxiety and stress for families.

Quality – The *Standards for Providing Quality Palliative Care for all Australians*[2] should inform palliative care practice wherever it is delivered, be included within the broader accreditation programs and be promoted as one way in which the community can be sure they will receive high quality services.

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[1] Palliative Care Australia 2014-15 Pre-Budget Submission, January 2014

[2] Palliative Care Australia (2005), Standards for Providing Quality Palliative Care for all Australians.

Advance Care Planning – PCA has called for action on implementing nationally consistent advance care planning across the states and territories in Australia, as inconsistent processes and legislation creates confusion for patients and health professionals.

The need for consistent advance care planning is relevant to a number of points in the National Code around informed consent, and respecting and adhering to the wishes of patients.

This submission addresses the questions listed in the Quick Response Form.

Section 2.2 – Proposed terms of National Code

Definitions

How should the class or classes of person that are to be subject to this National Code be identified?

Is the term 'health care worker' an acceptable term to use to describe to whom the National Code applies, or is another term such as 'unregistered health practitioner' or 'health practitioner' preferable, as in NSW and South Australia?

PCA supports the current identification of the class or classes of person that are subject to the National Code.

The use of the term 'health care worker' is acceptable and appropriate as it is broad enough to encompass a wide range of health care professionals. The use of the term 'unregistered health practitioner' might be interpreted as being restrictive in terms of the occupational groups that would be perceived as being included, such as people who provide alternative therapies.

Application of this Code

Is the proposed scope of application of the National Code acceptable?

Is it preferable that the National Code apply to all health care workers whether registered or not? If so, what are the potential advantages and disadvantages of this approach?

The proposed scope of the National Code is acceptable. The current approach described in the National Code consultation paper appears to be the best to adopt. The final approach adopted needs to be one which is clear and simple in terms of time frames for making decisions, and aims to reduce duplication or cross-over with other jurisdictional processes.

1. Health care workers to provide services in a safe and ethical manner

Should the National Code include a minimum enforceable standard that addresses the provision of services in a safe and ethical manner?

If so, do these subclauses cover all the principal professional obligations that should apply to any health care worker, regardless of the type of treatment or care they provide?

If the National Code is to be effective, then a minimum enforceable standard should be included.

In terms of the professional obligations covered in the subclauses, there should be a statement included on having an awareness of advance care plans and the legal obligations surrounding them, as this goes directly to health care workers being aware of the types of services or treatments a person does and does not want to receive, and therefore providing services in a safe and ethical manner. This is particularly important when a person does not have the capacity to make an informed decision.

With regards to subclause 2(g) the emphasis should not only be on the patient to inform their treating medical practitioner. There should be an inclusion in this subclause of the responsibility of the health care worker to communicate with the treating medical practitioner on the treatments they are providing, rather than only suggesting this as the responsibility of the patient.

2. Health care workers to obtain informed consent

Should the National Code include a minimum enforceable standard that addresses informed consent? If so, then how should it be framed and how should the complexities of informed consent in emergencies and with respect to minors be dealt with?

Is this clause expressed in a way that will best capture the conduct of concern?

PCA supports including a clause on informed consent. It relates to a priority area for PCA, as mentioned previously, of having nationally consistent advance care planning across the states and territories in Australia, as inconsistent processes and legislation creates confusion for patients and health professionals.

The consultation paper notes that the issue of informed consent in health care is complex. PCA believes that introducing nationally consistent legislation on advance care planning would address some of these complexities, particularly in situations where an individual is no longer able to make informed decisions. Informed consent also relates to the issue of patient centred care, which should be recognised in any document such as the National Code regarding what sort of care a person receives.

3. Appropriate conduct in relation to treatment advice

Should the National Code include a minimum enforceable standard that addresses the provision of treatment advice?

If so, is this clause expressed in a way that will best capture the conduct of concern?

This clause further relates to the issue of respecting the patient's choice about what services or care they do and do not want to receive and is very relevant for palliative

care. PCA supports the clause as it is currently expressed and believes it is an important one to include.

As is noted above in the response to section 1 regarding subclause 2(g), communication between health care workers is important and this responsibility needs to be emphasised, so that it is not only seen as the responsibility of the patient.

4. Health care workers to report concerns about treatment or care provided by other health care workers

Should the National Code include as a minimum enforceable standard a mandatory reporting obligation for all health care workers to report other health care workers who in the course of providing treatment or care place clients at serious risk of harm?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Should the wording more closely reflect the mandatory reporting provisions imposed on registered health practitioners under the National Law?

PCA supports including a clause in the National Code about health care workers referring matters where they believe another worker is placing a client/patient at risk of harm. Along with this, there should be a subclause prohibiting health care workers from making frivolous or vexatious complaints. This is also an issue of public safety and confidence, so that this sort of behaviour is discouraged and reputable health care workers don't have false claims made against them.

The wording for mandatory reporting provisions for registered health practitioners under the National Law is a good basis to use, in terms of supporting health care workers to report concerns when they have them or observe them.

5. Health care workers to take appropriate action in response to adverse events

Should the National Code include a minimum enforceable standard that addresses appropriate conduct in dealing with emergencies and adverse events?

If so, is this clause expressed in a way that will best capture the conduct of concern?

PCA supports this clause and has no specific comments.

6. Health care workers to adopt standard precautions for infection control

Should the National Code include a minimum enforceable standard that addresses the adoption of infection control procedures?

If so, is this clause expressed in a way that will best capture the conduct of concern?

This is an issue important for palliative care and PCA supports its inclusion.

7. Health care workers diagnosed with infectious medical conditions

Should the National Code include a minimum enforceable standard that addresses health care workers diagnosed with infectious medical conditions?

If so, is this clause expressed in a way that will best capture the conduct of concern?

PCA supports this clause and has no specific comments.

8. Health care workers not to make claims to cure certain serious illnesses

Should the National Code include a minimum enforceable standard that addresses claims to cure or treat life threatening and terminal illnesses?

If so, is this clause expressed in a way that will best capture the conduct of concern?

PCA supports this clause because, as the clause notes, people with a life threatening condition or illness and people at the end of life are vulnerable to exploitation. With the move towards patient centred and directed care and funding, there must be processes in place to provide people with redress where false claims are made about treatments.

9. Health care workers not to misinform their clients

Should the National Code include a minimum enforceable standard that addresses misinformation and misrepresentation in the provision of health products and services?

If so, is this clause expressed in a way that will best capture the conduct of concern?

PCA supports this clause and has no specific comments.

10. Health care workers not to practise under the influence of alcohol or drugs

Should the National Code include a minimum enforceable standard that addresses the provision of treatment or care to clients while under the influence of alcohol or drugs?

If so, is this clause expressed in a way that will best capture the conduct of concern?

PCA supports this clause and has no specific comments.

11. Health care workers with certain mental or physical impairment

Should the National Code include a minimum enforceable standard that addresses health care workers who suffer from physical or mental impairments that may impact their provision of treatment or care to their clients?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Is subclause 2 necessary, or does subclause 1 sufficiently capture the behaviour of concern?

Expertise from mental health and alcohol and other drugs groups should be sought on this clause.

12. Health care workers not to financially exploit clients
Should the National Code include a minimum enforceable standard that addresses financial exploitation of clients?

If so, is this clause expressed in a way that will best capture the conduct of concern, particularly in relation to the treatment or care of elderly, disabled and seriously or terminally ill clients?

PCA supports the inclusion of this clause. PCA would note that nationally consistent advance care planning and guardianship legislation would assist in achieving the intent of this clause.

13. Health care workers not to engage in sexual misconduct
Should the National Code include a minimum enforceable standard that prohibits sexual misconduct by health care workers?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Should the draft National Code be strengthened to specifically address sexual or physical assault in the health care setting, or is the preferred approach to expand the definition of 'prescribed offences' and rely on clauses 3 and 4?

PCA supports this clause and has no specific comments.

14. Health care workers to comply with relevant privacy laws
Should the National Code include a minimum enforceable standard in relation to breaches of client privacy by health care workers?

If so, is this clause expressed in a way that will best capture the conduct of concern?

PCA supports this clause and has no specific comments.

15. Health care workers to keep appropriate records
Should the National Code include a minimum enforceable standard in relation to clinical record keeping by health care workers and client access to and transfer of their health records?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Are subclauses 2 and 3 necessary, or does subclause 1 sufficiently capture the conduct of concern?

This clause does not address the use of electronic health records. The National Code will need to consider how unregistered health professionals/health care workers will access or be permitted access to e-health records, with the permission of the patient, and if this is currently being addressed by the relevant body developing electronic health records.

16. Health care workers to be covered by appropriate insurance

Should the National Code include a minimum enforceable standard in relation to the professional indemnity insurance obligations of health care workers?

If so, is this clause expressed in a way that will best capture the conduct of concern?

Is this clause likely to impose unreasonable compliance costs on health care workers?

PCA supports this clause and has no specific comments.

17. Health care workers to display code and other information

Should the National Code include a minimum enforceable standard in relation to display of the National Code, their qualifications and avenues for complaint? If so, is this clause expressed in a way that will achieve this intent?

Should there be a requirement, as in the SA Code, for health care workers to display their qualifications?

Are the exemptions to the requirement to display the National Code and qualifications appropriate?

This clause is an example of the point made in the introduction of this submission that it needs to be clear that the National Code applies to people receiving services in their home. The clause currently notes that a health care worker must display documents in a manner which is visible and lists premises where the clause won't apply.

One way to address this would be to display the code electronically on a web site, where a health care worker has a website. However, where a health care worker is providing services in a person's home, there must be a requirement that they display the relevant documents directly to the person receiving the treatment or service.

Items not included in the draft National Code of Conduct

1. Sale and supply of optical appliances

Is this an acceptable approach to dealing with regulation of the sale and supply of optical appliances?

2. Health care workers required to have a clinical basis for treatments

Is the proposed approach adopted in this draft National Code appropriate given the complexities of determining what treatments do and do not have 'an adequate clinical basis'?

Should the National Code include an additional clause along the following lines 'A health care worker must take special care when a treatment they are offering to a client is experimental or unproven, to inform the client of any risks associated with the treatment'? If so, how should complexities with identifying which treatments are 'unproven' be dealt with?

The National Code should address the issue of experimental or unproven treatments. This relates to people who are diagnosed with a terminal or life threatening condition or illness or at the end of life, being vulnerable to exploitation. An alternative to an additional clause for this specific issue could be to incorporate a sub-clause in clause 8. Therefore along with addressing claims made to cure an illness, there could also be a provision whereby health care workers must disclose if the treatment is experimental or unproven.

Section 3.2 - Scope of application of the National Code

Definition of a health care worker

What terminology is preferred to identify and define the class or classes of person who are to be subject to the National Code?

Is the term 'health care worker' acceptable, or is another term preferable?

The use of the term 'health care worker' is acceptable and appropriate as it is broad enough to encompass a wide range of health care professionals. The use of the term 'unregistered health practitioner' might be interpreted as being restrictive in terms of the occupational groups that would be perceived as being included, such as people who provide alternative therapies.

Definition of a health service

How important is national consistency in the scope of application of the National Code, particularly with respect to the definition of what constitutes a 'health service'?

If consistency is considered necessary, how should 'health service' and 'health care worker' be defined?

Is there a need to include a reference to 'volunteer' in the definition of provider/health service provider?

National consistency in the scope of the application of the National Code is important. Option 3, where a consistent definition is applied for the purposes of the National Code, appears to be the more achievable and pragmatic approach. The option of allowing each jurisdiction to determine the scope of application of the National Code and definition of health service is likely to not lead to uniformity and as a consequence, cause problems where health workers operate across jurisdictions or leave one jurisdiction to practice in another. Where a health care worker has been deemed unfit to deliver a service in one jurisdiction, there must be certainty for people that this will transfer to other jurisdictions.

The proposed definition for a 'health service' and 'health care worker' is appropriate.

With regards to including a reference to 'volunteer' in the definition, this would be a useful inclusion as many volunteers deliver similar services to a professional health care worker and health service providers have volunteers who work under their auspice. For example, there are substantive numbers of volunteers who work under

the auspices of palliative care organisations. There would need to be some clarification or inclusion of further details around the qualifications of volunteers, the duties they undertake or services they provide, and what levels of training they receive, if they are specifically included in the National Code.

In PCA's submission to the Senate Standing Committee on Community Affairs Inquiry into Palliative Care in Australia[3], the role of volunteers in palliative care and supporting these volunteers was discussed. Following extensive training, volunteers increase and enhance the range of supports palliative care services can offer to their clients. Appropriately trained volunteers can perform tasks that otherwise may need to be undertaken by professional staff, allowing professional staff to focus on their areas of specific expertise and possibly enabling the service to take on more clients. Further detail on this is provided at Appendix 1.

Section 3.3 Application of a 'fit and proper person' test

Should there be power to issue a prohibition order on the grounds that a person is not fit and proper to provide health services where they present a serious risk to public health and safety?

Is there a preferred option for enabling the application of a fit and proper person test?

Is consistency across jurisdictions considered important in the approach adopted?

There should be a consideration of including power to issue a prohibition notice if a person poses a risk to public safety. As per the previous question, the best option is likely to be one where national consistency is achieved. However, the second option outlined in the consultation paper, where each jurisdiction's legislation contains a provision to apply a 'fit and proper person' test, would also be suitable.

Section 3.4 Who can make a complaint?

How important is national consistency in who may make a complaint?

If consistency is considered important, is there a preferred approach for specifying in legislation who may make a complaint?

Nationally consistent processes with the National Code, where processes are being set in place that deal with health care workers working across different jurisdictions, are likely to make the National Code easier to implement. In terms of identifying who can make a complaint, consistency is preferable. The definition listed in the consultation paper from New South Wales and Queensland seems an appropriate one to use.

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[3] Palliative Care Australia, Submission to the Australian Senate Standing Committee on Community Affairs Inquiry into Palliative Care in Australia, April 2012

Section 3.5 Commissioner's 'own motion' powers

How important is national consistency with respect to the power for a Commissioner to initiate an investigation of a matter on his or her own motion, without a complaint?

If consistency is considered important, should all state and territory Commissioners have such 'own motion' powers?

Nationally consistent processes with the National Code, where processes are being set in place that deal with health care workers working across different jurisdictions, are likely to make the National Code easier to implement. It is recognised that every state and territory has different complaints bodies, legislation and processes which may need to be a part of the National Code's implementation, particularly with Own Motions. Therefore this may be one provision where existing state and territory processes apply, where they are consistent with the National Code, but states and territories that don't have similar Own Motion powers should have them created to be consistent with those that do.

Section 3.6 Grounds for making a complaint

How important is national consistency in the grounds for making a complaint?

If consistency is considered important, is there a preferred approach for defining the grounds for making a complaint and what terminology is preferred?

As per response for *3.4 Who can make a complaint*.

Section 3.7 Timeframe for lodging a complaint

How important is national consistency in the timeframe within which a complaint must be lodged?

If consistency is considered important, is there a preferred approach, that is, should a timeframe be specified, and if so, what should it be and should there be discretion to extend it an in what circumstances?

As per question *3.4 Who can make a complaint*, consistency with the National Code, where national processes are being set in place that deal with health care workers working across different jurisdictions, are likely to make the National Code easier to implement. If a time limit or timeframe is set, noting there are currently different time limits in some jurisdictions of 12 months or 2 years and in others none, there must be discretion to extend time limits for a complaint to be made. Particularly in cases where people are bereaved, it may be a considerable time before people are able to organise themselves and emotionally deal with making a complaint. There must therefore be flexibility and discretion applied to any timeframes established.

Section 3.8 Interim prohibition orders

How important is national consistency with respect to the issuing of interim prohibition orders?

If consistency is considered important, what is the preferred approach with respect to the grounds for issuing an interim order, the process and the maximum time period?

The aim should be to achieve national consistency. The preferable basis of the interim prohibition orders would be the process applied in New South Wales and also include offences under criminal law. The process should be time limited with steps in place to allow a process of natural justice for the health care worker, such as giving notice to the health care worker when the notice is issued.

Section 3.9 Who is empowered to issue prohibition orders

How important is national consistency with respect to the body that is conferred with powers to issue prohibition orders?

If consistency is considered important, which body should have the power to issue ongoing prohibition orders, the Commissioner or a tribunal?

As with the other sections, national consistency is preferable. This is to ensure as far as practicable that matters under the National Code, complainants and health care workers are dealt with in a similar way in each jurisdiction. However, as also noted in response to *3.5 Commissioner's 'own motion' powers,* it is recognised that every jurisdiction has different bodies and entities that deal with complaints and issue orders, for example. The bodies empowered to issue prohibition orders may have to be dealt with on a jurisdiction by jurisdiction basis, in order for this part of the National Code to be implemented within the most appropriate body or entity.

Section 3.10 Grounds for issuing prohibition orders

How important is national consistency in the grounds for issuing a prohibition order?

If consistency is considered important, is there a preferred approach?

As per previous responses, national consistency is preferable. As noted in *Section 3.8 Interim prohibition orders*, a broad set of powers which synthesises elements of existing examples in the consultation paper would be the best approach. The processes in place in New South Wales and South Australia seem appropriate.

Section 3.11 Publication of prohibition orders and public statements

How important is national consistency in the publication of public statements that include the details of prohibition orders issued?

If consistency is considered important, is there a preferred approach?

As the number of significant complaints that lead to prohibition are likely to not be large in number, then publication of the final order is important. The interim order could be more discretionary if an investigation is ongoing, and to give a health care

worker natural justice. Again, national consistency is preferable. While current jurisdictions use different means to make public prohibition orders, the key issue is that the orders or statements are readily accessible by the public.

Section 3.12 Application of interstate prohibition orders

How important is national consistency in achieving application across Australia of prohibition orders and interim prohibition orders issued in each state and territory?

If consistency is considered important, is there a preferred approach for achieving mutual recognition of prohibition orders?

The streamlined and mutual recognition approach of the Health Practitioner Registration National Law seems sensible for the National Code, where if a practitioner's registration is cancelled or suspended in one jurisdiction or had conditions attached, the cancellation, suspension or conditions applied automatically in all other states and territories without the need for additional administrative or regulatory action. Such an approach for the National Code would be appropriate.

Section 3.13 Right of review of a prohibition order

How important is national consistency with respect to review rights for practitioners who are subject to a prohibition order?

If consistency is considered important, is there a preferred approach?

A consistent process based on New South Wales and South Australia seems the best approach.

Section 3.14 Penalties for breach of a prohibition order

How important is national consistency with respect to the offences and penalties that apply for breach of a prohibition order?

If consistency is considered important, what is the preferred approach?

Consistency may not be as important with penalties, so long as those applied in each jurisdiction reasonably correspond. Other cases where laws or codes have been harmonised would be useful to examine here in terms of what penalties have resulted.

Section 3.15 Powers to monitor compliance with prohibition orders

How important is national consistency with respect to powers to monitor practitioner compliance with prohibition orders issued?

If consistency is considered important, is there a preferred approach?

It would be preferable for prohibition orders to attach conditions to a health care workers practice to regularly report compliance to better enable monitoring, as is suggested in the consultation paper. While this would require resourcing, it seems

achievable and reasonable that the processes established to manage the National Code could incorporate reporting mechanisms.

Section 3.16 Information sharing powers

How important is national consistency with respect to the sharing of confidential information between HCEs and with other regulators?

If consistency is considered important, what is the preferred approach?

With information sharing powers, the most important issue will be ensuring that there are legislative provisions in all jurisdictions that ensure sharing occurs. If these provisions already exist and are reasonably consistent, then change may not be required.

Section 4.1 Mutual recognition

What is the preferred option for making publicly accessible information about prohibition orders that are issued in each state and territory?

Are there any issues that need to be considered when designing and implementing such arrangements?

Option 1 is likely to be the best option as it is low cost and the easiest to implement, as it does not place the responsibility on one jurisdiction. Presumably, the costs of providing information can be incorporated into existing websites in each jurisdiction. While there won't be one national list, each jurisdiction should have the prohibition list for that state or territory and they should be readily accessible by anyone in other jurisdictions. This would rely on each jurisdiction making this information accessible, such as through a website.

Any other comments?

Do you have any other comments to make about the draft National Code, policy parameters or administrative arrangements?

PCA has no other specific comments.

Would you like to be informed of the outcome of the consultation? **Yes**

Appendix 1 – Supporting Volunteers in Palliative Care

The integral role that volunteers play in palliative care is an exception, rather than the norm in health care delivery. They have shaped palliative care and have been called a 'national treasure'. They are vital core members of interdisciplinary palliative care teams. A 2005 Victorian palliative care workforce study showed that palliative care volunteers made up 60% of the combined palliative care labour workforce.

Currently in Australia the essential role of the volunteer in the palliative care team is acknowledged through such policies as the *National Palliative Care Strategy*, the *Standards for Providing Quality Palliative Care for all Australians* (Standards 12 and 13) and the *Health System Reform and Care at the End of life Guidance Document.* The important role of volunteers is also recognised in the PC report *Caring for Older Australians*.

Palliative care volunteers work across all palliative care domains - physical, spiritual, social and emotional. Following extensive training they increase and enhance the range of supports palliative care services can offer to their clients. Their presence makes services more consumer responsive, and the involvement of volunteers in all aspects of service planning and delivery can be an effective means of consumer empowerment. They can liaise between health care professionals and the community by showing the former the particular needs of their community. Palliative care volunteers increase the social, emotional and practical supports available. Most importantly, volunteers bring normality into the lives of the terminally ill and their carers during a time that may otherwise be dominated by medical treatments. They are often the one constant for patients and families and as a result get to know them much better than the doctors and nurses. Appropriately trained volunteers can perform tasks that otherwise may need to be undertaken by professional staff, allowing professional staff to focus on their areas of specific expertise and reducing their stress, and possibly enabling the service to take on more clients.

Managers of Volunteers are essential to the designing of volunteer services and the recruiting, induction and training, supervision and support of volunteers. They provide a diverse human resource management role often supporting a large numbers of volunteers. Currently many of these Managers work in isolation. Some are unfunded. To do their job appropriately these positions must be filled by qualified people with human resource and education skills, salaried appropriately and their programs resourced well. Opportunities for networking with other Managers of Palliative Care Volunteers are essential to support retention and best practice.

Very little palliative care volunteer workforce development has been undertaken in Australia. The United Kingdom is currently investing heavily in research and development in this area. Canada has undertaken a national survey of palliative care volunteer services and has developed guiding principles to assist in developing standards for palliative care volunteers. These have now been included in accreditation processes.

Over the past 4 years the state of Victoria has been very innovative in specialist palliative care volunteerism. The Department of Human Services has undertaken a palliative care volunteer survey, and, together with Volunteering Victoria, developed the *Victorian Palliative Care Volunteer Standards and Templates* (the only ones of their kind in Australia). Palliative Care Victoria (PCV) has developed

and recently evaluated a state-wide *Palliative Care Volunteer Training Resource Kit* that is now also being used ad hoc in other states and territories and in some other countries. PCV works with the Managers of Palliative Care Volunteer Network on issues relevant to the sector. Some other states have, or are starting to develop, state Managers of Volunteer Networks.

Currently Australian palliative care volunteer programs are guided by a myriad of broad standards and guidelines; the overarching *National Palliative Care Standards* (Standards 12 and 13), the *Volunteering Australia Standards*[4] and the *Working with Volunteers and Managing Volunteer Programs in Health Care Settings*[5]. Understanding their specific application for the palliative care volunteer sector can be confusing and very time consuming.

There is currently no national consistency around palliative care volunteer training and any specific training requirements or volunteer competencies. The majority of palliative care volunteer induction and on-going training programs are developed locally.

Victoria has already developed state-wide guiding standards and training competencies specifically for palliative care volunteer services and these could be used as a base line for adaption and adoption nationally.

The changing demographics of prospective volunteers and the growing need for palliative care means it is imperative that Australia has a national strategy for palliative care volunteering, if it is to retain and grow the valuable contributions of volunteers involved in palliative care and end of life care. There is also the opportunity to extend the involvement of volunteers to related areas, such as aged care, where volunteers are involved mainly in lifestyle activities and administration, rather than supportive care for residents and their families at the end of life.

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[4] Volunteering Australia Standards
http://www.volunteeringaustralia.org/html/s09_search/default.asp?s=Volunteering%20Australia%20Standards%20&dsa=14368

[5] Working with Volunteers and Managing Volunteer Programs in Health Care Settings
http://www.ozvpm.com/resourcebank/documents/nh48.pdf