# Advanced Palliative Care for Older Adults Training Course

22 – 26 November 2026
Cape town

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**Ref:** 1526_212731 **Date:** 22 – 26 November 2026 **Location:** Cape town **Fees:** 4500 Euro

## Overview

Advanced Palliative Care for Older Adults Training Course is a one-week course for palliative and geriatric care leaders, nurses, allied health and social care professionals, quality teams, care coordinators, and healthcare managers, who leave with an Older Adult Palliative Care Coordination Pack. The course integrates palliative needs assessment, symptom burden, frailty, cognition, function, communication, shared decision making, advance care planning, family caregiver support, ethics, interdisciplinary care, transitions, documentation, quality, and improvement. Agile Leaders Training Center presents palliative care for older adults as coordinated support for comfort, goals, dignity, and continuity.

## Who Should Attend

- Functions responsible for palliative and older-adult care planning
- Teams responsible for nursing, allied health, and social care
- Personnel responsible for symptom support and treatment review
- Care coordinators responsible for transitions and continuity
- Functions responsible for family and caregiver support
- Quality leaders responsible for assurance and service improvement

The course assumes participants coordinate older-adult care, quality, communication, or support and leaves out prescribing qualification, hospice credentialing, clinical diagnosis, and general elderly-care operations.

## Departments and Industries

The course supports departments and organizations that plan, coordinate, or improve palliative care for older adults.

- Hospitals and ambulatory healthcare services
- Primary care and community health organizations
- Residential, nursing, and long-term care services
- Home care and social support organizations
- Palliative, geriatric, rehabilitation, and allied health teams
- Quality, ethics, patient experience, and care coordination functions

## Learning Objectives

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

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- Analyze palliative needs, symptoms, function, frailty, and context
- Apply communication and shared decision-making methods
- Build goals-of-care and advance care planning processes
- Use family, caregiver, and interdisciplinary support structures
- Evaluate transitions, treatment burden, documentation, and safety
- Prioritize quality evidence and service improvements

## Course Agenda

### Day 1: Palliative Needs and Priorities

- Palliative Need Identification and Referral Checklist
- Physical, Emotional, Social, and Spiritual Assessment Map
- Symptom Burden, Function, and Frailty Profile
- Multimorbidity and Treatment Burden Review
- Person Values, Priorities, and Dignity Record

### Day 2: Communication and Care Decisions

- Communication Preference and Capacity Assessment
- Serious Illness Conversation Structure
- Shared Decision-Making and Option Discussion Grid
- Goals-of-Care Agreement and Review Template
- Advance Care Planning Documentation Pathway

### Day 3: Comfort and Family Support

- Pain and Distressing Symptom Review Framework
- Cognitive Impairment and Delirium Support Plan
- Comfort, Function, and Daily Living Goal Matrix
- Family Caregiver Needs and Readiness Assessment
- Psychosocial, Cultural, and Spiritual Support Map

### Day 4: Coordination, Transitions, and Quality

- Interdisciplinary Roles and Named Lead Charter
- Care Transition and Information Handover Checklist
- Treatment Review and Medication Burden Record
- Palliative Care Documentation and Quality Dashboard
- Service Access, Continuity, and Improvement Tracker

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## Day 5: Older Adult Palliative Care Practice

- Suggested Exercise: Needs and Symptom Assessment Review
- Suggested Exercise: Goals and Shared Decision Conversation
- Suggested Exercise: Family Support and Comfort Planning
- Suggested Exercise: Transition and Quality Evidence Review
- Capstone Exercise: Older Adult Palliative Care Coordination Pack

## Practical Exercises

The course uses suggested activities based on fictional hospital, primary care, residential care, community, and home-care situations.

- Suggested activity: combine palliative needs, symptoms, function, frailty, values, and family context in one assessment.
- Suggested activity: structure a goals-of-care conversation and document preferences, capacity, options, and review points.
- Suggested activity: build an interdisciplinary comfort and family-support plan with clear responsibilities.
- Suggested activity: review a transition, treatment burden, documentation, dashboard, and improvement action set.

## FAQs

### Who suits advanced palliative care for older adults training, and what does it assume?

Palliative, geriatric, nursing, allied health, social care, coordination, quality, and management functions suit the training; it assumes responsibility for care or support and excludes prescribing authority and hospice credentialing.

### How does palliative care for older adults differ from general elderly care training?

Palliative care for older adults concentrates on serious illness needs, symptom burden, goals, values, communication, advance care planning, family support, ethics, interdisciplinary coordination, transitions, and quality rather than broader older-adult service operations.

### How are goals of care established in palliative care for older adults?

Goals are established by assessing the person's priorities, decision-making capacity, communication preferences, symptoms, function, treatment burden, cultural and spiritual context, available options, family involvement, and agreed points for review.

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## How should family caregivers be supported in older-adult palliative care?

Family caregivers should be identified with the person's agreement, assessed for information and support needs, included in decisions as appropriate, prepared for transitions and changing symptoms, linked with resources, and offered regular opportunities to review concerns.

## Conclusion

Participants leave with an Older Adult Palliative Care Coordination Pack containing needs, symptom, function, frailty, communication, decision, goals, advance planning, family, transition, treatment review, dashboard, and improvement tools. The pack links personal priorities with coordinated action. It helps teams document choices, support caregivers, manage transitions, and review continuity and quality across care settings.