Essential Component 3: Access to care providers across all settings who are skilled and competent in caring for people requiring palliative and end-of-life care – standards comparison

National Palliative Care Standards, 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 3
2. Developing the care plan The person, their family and carers work in partnership with the team to communicate, plan, set goals of care and support informed decisions about the care plan	**2.10** Care plans incorporate management for emergency and after-hours support, including certification of death and plans for the care and collection of the body where this is required after hours.
3. Caring for carers The needs and preferences of the person's family and carers are assessed, and directly inform provision of appropriate support and guidance about their role	**3.6** Depending on the location of care and the person's needs and preferences, the family and carers are educated on how to safely assist with care, including managing risk, manual handling and activities of daily living. **3.7** The family and carers are provided with information about the signs and symptoms of approaching death and the steps to take following death, in a way that is appropriate for their age, culture and social situation.
4. Providing care The provision of care is based on the assessed needs of the person, informed by evidence, and is consistent with the values, goals and preferences of the person as documented in their care plan	**4.2** The service takes practical steps to keep abreast with new and emerging evidence and uses the best available evidence to inform clinical practice.
5. Transitions within and between services Care is integrated across the person's experience to ensure seamless transitions within and between services	**5.5** Referrals from the specialist palliative care service are made to appropriate specialists or services that can meet the identified physical, social and spiritual needs of the person, their family and carers (for example, acute pain services, mental health services, bereavement counsellors). **5.7** Services assist local community-based service providers in building their capability to assist people to be cared for in their home, where this aligns with the person's preferences.

Relevant standard	Relevant action (where available) against Essential Component 3
6. Grief support Families and carers have access to bereavement support services and are provided with information about loss and grief	**6.8** The organisation has mechanisms in place for the specialist palliative care team to access education, training and supervision to meet the loss, grief and bereavement needs of the family and carers.
7. Service culture The service has a philosophy, values, culture, structure and environment that supports the delivery of person-centred palliative care and end-of-life care	**7.1** The values and culture of the service explicitly support the provision of person-centred palliative care. **7.4** Services understand the community they serve and use this information to both provide optimal specialist palliative care services and influence wider health, aged and social care systems that meet the needs of that community.
9. Staff qualification and training Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles	**9.1** The service employs a multidisciplinary team of health professionals with recognised qualifications, credentialing and experience to meet the physical, psychological, social, cultural and spiritual needs of the person, their family and carers. **9.2** Staff in clinical leadership and management positions have recognised qualifications and experience in relevant fields. **9.3** A formal assessment of palliative care education and training is undertaken for all members of the health service to identify professional development requirements. **9.4** Staff and volunteers receive appropriate supervision and support in accordance with an established professional development framework. **9.5** Staff undergo training to ensure delivery of culturally safe care. **9.6** Staff are trained in self-care strategies and advised on how to access personal support. **9.7** Volunteer programs are recognised, supported and managed in accordance with the relevant volunteer standards.

National Safety and Quality Service Standards, 2nd Edition

Relevant standard	Relevant action (where available) against Essential Component 3

1. Clinical governance
 	
• Governance leadership and culture
	1.1 The governing body:
	  a. provides leadership to develop a culture of safety and quality improvement and satisfies itself that this culture exists within the organisation
	  b. provides leadership to ensure partnering with patients, carers and consumers
	  c. sets priorities and strategic directions for safe and high-quality clinical care and ensures that these are communicated effectively to the workforce and the community
	  d. endorses the organisation's clinical governance framework
	  e. ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce
	  f. monitors the action taken as a result of analyses of clinical incidents
	  g. reviews reports and monitors the organisation's progress on safety and quality performance.
	
	1.2 The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people.
	
	1.4 The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people.

• Patient safety and quality systems	**1.15** The health service organisation:
	  a. identifies the diversity of the consumers using its services
	  b. identifies groups of patients using its services who are at higher risk of harm
	  c. incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care.

• Clinical performance and effectiveness	**1.20** The health service organisation uses its training systems to:
	  a. assess the competency and training needs of its workforce
	  b. implement a mandatory training program to meet its requirements arising from these standards
	  c. provide access to training to meet its safety and quality training needs
	  d. monitor the workforce's participation in training.
	
	1.21 The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients.

1.22 The health service organisation has valid and reliable performance review processes that:
    a. require members of the workforce to regularly take part in a review of their performance
    b. identify needs for training and development in safety and quality
    c. incorporate information on training requirements into the organisation's training system.

1.23 The health service organisation has processes to:
    a. define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan
    b. monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice
    c. review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered.

1.24 The health service organisation:
    a. conducts processes to ensure that clinicians are credentialed, where relevant
    b. monitors and improves the effectiveness of the credentialing process.

1.25 The health service organisation has processes to:
    a. support the workforce to understand and perform their roles and responsibilities for safety and quality
    b. assign safety and quality roles and responsibilities to the workforce, including locums and agency staff.

1.26 The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate.

1.27 The health service organisation has processes that:
    a. provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice
    b. support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care.

1.28 The health service organisation has systems to:
    a. monitor variation in practice against expected health outcomes
    b. provide feedback to clinicians on variation in practice and health outcomes

	c. review performance against external measures
	d. support clinicians to take part in clinical review of their practice
	e. use information on unwarranted clinical variation to inform improvements in safety and quality systems.
	f. Record the risks identified from unwarranted clinical variation in the risk management system.
2. Partnering with consumers • Clinical governance and quality improvement systems to support partnering with consumers	**2.1** Clinicians use the safety and quality systems from the *Clinical Governance Standard* when: a. implementing policies and procedures for partnering with consumers b. managing risks associated with partnering with consumers c. identifying training requirements for partnering with consumers. **2.2** The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. monitoring processes for partnering with consumers b. implementing strategies to improve processes for partnering with consumers c. reporting on partnering with consumers.
• Partnering with patients in their own care	**2.6** The health service organisation has processes for clinicians to partner with patients or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care. **2.7** The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care.
• Health literacy	**2.8** The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community. **2.9** Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review.
• Partnering with consumers in organisational design and governance	**2.10** The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. information is provided in a way that meets the needs of patients, carers, families and consumers b. information provided is easy to understand and use c. the clinical needs of patients are addressed while they are in the health service organisation. d. Information needs for ongoing care are provided on discharge.

	2.11 The health service organisation:
	   a. involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care
	   b. has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community.
	
	2.13 The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs.

4. Medication and safety • Clinical governance and quality improvement to support medication management	**4.4** The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians.

5. Comprehensive care
  • Clinical governance and quality improvement to support comprehensive
 	
  • Developing the comprehensive care plan
	5.3 Clinicians use organisational processes from the *Partnering with Consumers Standard* when providing comprehensive care to:
	   a. actively involve patients in their own care
	   b. meet the patient's information needs
	   c. share decision-making.
	
	5.4 The health service organisation has systems for comprehensive care that:
	   a. support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment
	   b. provide care to patients in the setting that best meets their clinical needs
	   c. ensure timely referral of patients with specialist healthcare needs to relevant services
	   d. always identify the clinician with overall accountability for a patient's care.
	
	5.5 The health service organisation has processes to:
	   a. support multidisciplinary collaboration and teamwork
	   b. define the roles and responsibilities of each clinician working in a team.
	
	5.13 Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:
	   a. addresses the significance and complexity of the patient's health issues and risks of harm
	   b. identifies agreed goals and actions for the patient's treatment and care.
	   c. identifies the support people a patient wants involved in communications and decision-making about their care

	d. starts discharge planning at the beginning of the episode of care e. includes a plan for referral to follow-up services, if appropriate and available f. is consistent with best practice and evidence.
• Delivering comprehensive care	**5.16** The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice. **5.18** The health service organisation provides access to supervision and support for the workforce providing end-of-life care. **5.20** Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care.*

6. Communicating for safety
• Clinical governance and quality improvement to support effective communication
 	
• Communication of critical information
	6.4 The health service organisation has clinical communications processes to support effective communication when:
	   a. identification and procedure matching should occur
	   b. all or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations and on discharge
	   c. critical information about a patient's care, including information on risks, emerges or changes.
	
	6.9 Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:
	   a. clinicians who can make decisions about care
	   b. patients, carers and families, in accordance with the wishes of the patient.

8. Recognising and responding to acute deterioration • Responding to acute deterioration	**8.10** The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration. **8.11** The health service organisation has processes to always ensure rapid access to at least one clinician, either on site or in close proximity, who can deliver advanced life support. **8.12** The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated. **8.13** The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration.

National Consensus Statement (Adult and Paediatric)

Relevant standard	Relevant action (where available) against Essential Component 3
1. Patient and family centred care Patients/children and families are part of decision making about end-of-life care	**Adult** **1.5** Whenever possible, clinicians should prepare for having conversations about end-of-life care. Necessary preparation may include: • reaching consensus among all of the clinical teams involved in the patient's care about the patient's prognosis and what treatment options are appropriate to recommend • ensuring familiarity with the patient's history and current condition (this may include discussion with key community care providers), their family structure, and cultural needs and preferences • arranging adequate time for uninterrupted discussion • ensuring that patients have access to their regular communication aids • arranging for the appropriate people to be in attendance – ideally, this will include the patient, their substitute decision-maker, carers and family members, the most senior doctor available, the nurse responsible for the patient's care and other members of the interdisciplinary team such as interpreters, Aboriginal support workers, chaplains or social workers • ensuring that discussions can be held in an appropriately quiet and private environment. **1.6** The patient, substitute decision-maker, family and carers should be provided with written information about which clinician is responsible for leading and coordinating their care. Whenever possible, this clinician should be directly involved in discussions about the patient's end-of-life care. **1.8** Clinicians should provide an honest and straightforward summary of their clinical assessment of the situation, what they consider to be appropriate and feasible options for treatment, any risks and potential side effects, and the likelihood of the patient's condition improving in response to such treatment. Clinicians should be compassionate and sensitive, use plain language, and avoid medical jargon. **Paediatric** **1.6** Whenever possible, clinicians should prepare for having conversations about end-of-life care. Necessary preparation may include: • reaching consensus among all teams involved in the child's care about the prognosis and what treatment options are appropriate to recommend

Relevant standard	Relevant action (where available) against Essential Component 3
	• ensuring familiarity with the child's history and current condition (this may include discussion with key community care providers), their family structure, and cultural needs and preferences arranging adequate time for uninterrupted discussion • arranging adequate time and an appropriate physical environment for uninterrupted discussion ensuring that the child and their parents have access to their regular communication aids • arranging for the appropriate people to be in attendance – depending on the child and parents' individual preferences, this may include the child, their parents and family, the most senior doctor available, the nurse responsible for the child's care and other members of the interdisciplinary team such as interpreters, Aboriginal support workers, child life therapists, chaplains and social workers. • ensuring that discussions can be held in an appropriately quiet and private environment. **1.7** Clinicians should provide parents with written information about which clinician is responsible for leading and coordinating their child's care. Whenever possible, this clinician should be directly involved in discussions about the child's end-of-life care. **1.11** Clinicians should provide an honest and straightforward summary of the clinical assessment findings, appropriate and feasible options for treatment, any risks and potential side effects, and the likelihood of the child's condition improving in response to such treatment. Be compassionate and sensitive, use plain language, and avoid medical jargon.
2. Teamwork Clinicians work together to provide end-of-life care	**Adult** **2.1** The clinician with overall responsibility for leading and coordinating a patient's care must be clearly identified. If the patient is unable to speak for themselves, their substitute decision-maker must also be clearly identified. **2.2** The roles and responsibilities of different team members should be clearly defined and understood by all those involved in a patient's care, including the patient themselves, their substitute decision-maker, family and carers. **2.4** Appropriate processes should be in place to enable all team members, including junior clinicians, to engage with the broader team, voice concerns and act on the expressed preferences and consent of the patient

Relevant standard	Relevant action (where available) against Essential Component 3
	2.5 Experienced team members are responsible for providing supervision, leadership, support, mentorship and teaching to develop the skills and capacity of junior team members in relation to end-of-life care. **Paediatric** **2.1** The clinician with overall responsibility for leading and coordinating the child's care should be clearly identified. **2.2** The roles and responsibilities of different interdisciplinary team members should be clearly defined and understood by all those involved in the child's care, including the child (as appropriate) and their parents. **2.4** Appropriate processes should be in place to enable all interdisciplinary team members, including junior clinicians, to engage with the broader healthcare team, voice concerns and act on the expressed preferences and consent of the child and their parents. **2.5** Experienced interdisciplinary team members should provide supervision, leadership, support, mentorship and teaching to develop the skills and capacity of junior team members in relation to end-of-life care.
4. Using triggers Triggers identify when patients need end-of-life care	**Adult** **4.1** The 'surprise' question should be used by clinicians as a simple screening mechanism to recognise patients who could benefit from end-of-life care interventions. Clinicians should ask themselves: • Would you be surprised if this patient died in the next 12 months? • Would you be surprised if this patient died during this admission, or in the next days or weeks? **4.2** A critically important trigger for assessment, discussion and consideration of referral to specialist palliative care is when the patient, family members, carers or other members of the interdisciplinary team request palliative care, or express concern or worry that the patient is dying or has unmet end-of-life care needs. **4.3** Clinicians should consider other useful triggers for recognition and review of patients who may benefit from end-of-life care interventions. Such triggers might be derived from condition-specific mortality risk prediction tools or from critical events, such as: • diagnosis of life-limiting conditions • poor or incomplete response to medical treatment, continued deterioration despite medical treatment, or development of new clinical problems during inpatient admission.

Relevant standard	Relevant action (where available) against Essential Component 3
	Paediatric **4.1** Clinicians should use the 'surprise' question as a simple screening mechanism to recognise children who may benefit from end-of-life care interventions. Clinicians should ask themselves: • Would you be surprised if this child died as a result of this condition or problem? • Would you be surprised if this child died in the next 12 months? • Would you be surprised if this child died during this admission or in the next days or weeks? **4.2** Clinicians should consider other useful triggers for recognition and review of children who may benefit from end-of-life care interventions. Such triggers might be derived from condition-specific mortality risk prediction tools or from critical events, such as: • presentation with life-threatening trauma or disease • diagnosis of life-limiting conditions. • poor or incomplete response to medical treatment, continued deterioration despite medical treatment, and/or development of new clinical problems during inpatient admission • repeated calls to the rapid response team, particularly if the child has been admitted for more than one week • multi-system comorbidities (cardiovascular, pulmonary, endocrine, etc.) • maximal medical therapies already in place • decline in the child's condition, or a clinical determination that they will not benefit from interventions such as surgery, dialysis or treatment in intensive care • unexpected or prolonged recent admissions to hospital for exacerbation of a life-limiting chronic condition • the child, parents and family members, or other members of the interdisciplinary team requesting palliative care, or expressing concern or worry that the child is dying or has unmet end-of-life care needs.
5. Responding to concerns Clinicians get help to rapidly respond to patient/child suffering	**Adult** **5.3** Processes should be in place to enable patients, substitute decision-makers, families, carers and members of the interdisciplinary team to escalate concern until a satisfactory resolution is achieved. This should include access to a second opinion if there are concerns that end-of-life care needs are not being adequately recognised or addressed by the clinical team. **5.10** Although resolving the concerns of the patient, carers or family should be the first priority, whenever possible, responders providing assistance should also use calls for assistance as a teaching and mentoring opportunity for other clinicians and students.

Relevant standard	Relevant action (where available) against Essential Component 3
	Paediatric **5.1** Members of the interdisciplinary team should escalate concerns as required and in line with relevant policies and procedures until a satisfactory resolution is achieved. This may include accessing a second opinion if there are concerns that end-of-life care needs are not being adequately recognised or addressed. **5.6** Clinicians providing assistance in emergency situations should: • have access to support from a clinician of sufficient authority to make decisions about stopping nonbeneficial treatments and providing palliative care • document appropriate, detailed and structured information about the outcomes of the call for assistance, discussions with the child and their parents, and the plan for follow-up or further review of the child in the healthcare record • communicate with the responsible medical officer in an appropriate, detailed and structured way about the outcomes of the call for assistance, and the plan for follow-up or further review of the child • use calls for assistance as a teaching and mentoring opportunity for other clinicians and students whenever possible, although resolving the concerns of the child and their parents should be the first priority.
6. **Leadership and governance** Policies and systems for end-of-life care	**Adult** **6.2** The health service executive should consider how best to allocate resources within the context of the organisation's strategic plan to support the delivery and effective functioning of systems for providing end-of-life care. **6.3** A formal policy framework should exist, outlining the organisational approach to end-of-life care. It should include: • governance arrangements • roles and responsibilities • communication and documentation processes • processes for advance care planning and limiting medical treatment • alignment with systems for recognising and responding to clinical deterioration • access to specialist palliative care advice and services • the interface with external services, such as community and social care providers, residential aged care facilities and external hospice providers clear dispute resolution processes, including access to mediation, bioethics and legal support in situations of complex end-of-life decision-making or conflict • training and education requirements • access to professional clinical supervision, and formal and informal debriefing, to suit the varied needs of clinicians

Relevant standard	Relevant action (where available) against Essential Component 3
	• access to support and debriefing for nonclinical staff • evaluation, audit and feedback processes, and reporting requirements. **6.4** The policy framework for end-of-life care should apply across the acute health service. It should identify potential variations in its application that might exist in different circumstances (such as at different times of day or in satellite locations). **6.8** Organisations should have systems in place to ensure that essential resources required for the provision of safe and high-quality end-of-life care (for example, private space for family meetings, equipment and medications) are always operational and available. **Paediatric** **6.2** The health service executive should consider how best to allocate resources within the context of the organisation's strategic plan to support the delivery and effective functioning of systems for providing paediatric end-of-life care. **6.3** The health service organisation should create a formal organisational policy framework for paediatric end-of-life care which applies across the acute health service, including: • governance arrangements • roles and responsibilities • communication and documentation processes • processes for advance care planning and limiting medical treatment • alignment with systems for recognising and responding to acute deterioration • criteria and processes for accessing help for end-of-life issues that are causing concern (for example, ethical or legal advice) • access to specialist paediatric palliative care advice and services • the interfaces with external services, such as community and social care providers, and external hospice providers • clear dispute resolution processes, including access to mediation, bioethics and legal support in situations of complex end-of-life decision-making or conflict • training and education requirements • access to professional clinical supervision, and formal and informal debriefing, to suit the varied needs of clinicians • access to support and debriefing for nonclinical staff • evaluation, audit and feedback processes, and reporting requirements.

Relevant standard	Relevant action (where available) against Essential Component 3
	6.4 The health service organisation should identify potential variations in the application of the policy framework that might exist in different circumstances (such as at different times of day or in satellite locations).
	6.7 The health service organisation should develop systems to ensure that essential resources required for the provision of safe and high-quality paediatric end-of-life care (for example, private space for family meetings, equipment and medications, memory making materials, access to toys and education resources) are always operational and available.
7. Education and training Clinicians have the skills and knowledge to provide end-of-life care	**Adult** **7.1** All members of the interdisciplinary team should receive education about their roles and responsibilities in relation to local systems and processes for recognising and managing end-of-life care. **7.2** All clinicians should be familiar with the Guiding principles of this Consensus Statement and able to apply the Processes of Care elements (elements 1-5). **7.4** Junior and student clinicians should be encouraged and enabled to take up the learning opportunities offered by participating in family meetings, multidisciplinary case review meetings, mortality and morbidity conferences, and adverse event reviews. **7.5** Clinicians should receive ongoing education about disease-specific symptom assessment and evidence-based symptom management relevant to their area of practice. **7.6** Education should cover ethical and medico-legal issues, including the relevant professional ethical frameworks, and the relevant legislation in the state or territory of clinical practice. **7.7** Education should include specific competencies for providing culturally responsive end-of-life care to Aboriginal and Torres Strait Islander people, and to people from other culturally and linguistically diverse communities. **7.8** Education should include specific training for providing end-of-life care to people with limited capacity to participate in decision-making (for example, those with mental illness, disability or cognitive impairment). This should include education about the role and legal status of families, carers and substitute decision-makers.

Relevant standard	Relevant action (where available) against Essential Component 3
	7.9 Ongoing formal training in communication skills should be offered to clinicians at all levels, as these skills are critical to the delivery of end-of-life care. **7.10** All members of the interdisciplinary team should receive education about how to recognise and resolve feelings of moral distress and burnout in themselves and their colleagues. They should also receive information about how to seek help, if required. **Paediatric** **7.1** The health service organisation should provide education for all members of the interdisciplinary team about their roles and responsibilities in relation to local systems and processes for recognising and managing end-of-life care. **7.2** The health service organisation should ensure that all clinicians are familiar with the Guiding principles of this Consensus Statement and able to apply the Processes of Care elements (elements 1-5) in their practice. **7.4** The health service organisation should encourage and enable junior and student clinicians to take up the learning opportunities offered by participating in family meetings, multidisciplinary case review meetings, mortality and morbidity conferences, and adverse event reviews. **7.5** The health service organisation should ensure that clinicians receive ongoing education about disease-specific symptom assessment and evidence-based symptom management relevant to their area of practice. **7.6** Education should cover ethical and medico-legal issues, including the relevant professional ethical frameworks, and the relevant legislation in the state or territory of clinical practice. **7.7** Education should include specific competencies for providing culturally responsive end-of-life care to Aboriginal and Torres Strait Islander people, and to people from other culturally and linguistically diverse communities. **7.8** Education should include specific training for providing end-of-life care to children of different ages and developmental stages. This should include those with limited capacity to participate in decision-making – for example, those with mental illness, disability or cognitive impairment. This should include education about parental responsibility and making decisions in the best interests of the child.

Relevant standard	Relevant action (where available) against Essential Component 3
	7.9 Ongoing formal training in communication skills should be offered to clinicians at all levels, as these skills are critical to the delivery of end-of-life care. **7.10** All members of the interdisciplinary team should receive education about how to recognise and resolve feelings of moral distress and burnout in themselves and their colleagues. They should also receive information about how to seek help, if required.
8. Supervision and support Clinicians providing end-of-life care are supported	**Adult** **8.1** A policy framework should exist outlining how supervision and support are provided to clinicians and other staff members who are in contact with patients and their families. **8.2** Clinicians and other staff members who are in contact with patients and their families should know when and how to access peer support, mentoring and clinical supervision. This information should be provided at the start of employment and as part of regular refresher training. **8.3** Clinicians should know how to access support after particularly distressing or problematic episodes of care. This may involve accessing external services for formal clinical supervision, counselling or debriefing. **8.4** Clinicians should be supported to develop skills in self-care, reflective learning and providing peer support to colleagues. **Paediatric** **8.1** The health service organisation should have a policy framework outlining how supervision and support are provided to clinicians and other staff members who are in contact with the child and their parents. **8.2** The health service organisation should ensure that clinicians and other staff members who are in contact with the child and their parents know when and how to access peer support, mentoring and clinical supervision. This information should be provided at the start of employment and as part of regular refresher training. **8.3** The health service organisation should ensure that clinicians know how to access support after particularly distressing or problematic episodes of care. This may involve accessing external services for formal clinical supervision, counselling or debriefing. **8.4** The health service organisation should support clinicians to develop skills in self-care, reflective learning and providing peer support to colleagues.

Standards for General Practice (RACGP), 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 3
GP Standard 2.1: Continuous and comprehensive care	**GP2.1 a.** Our patients can request their preferred practitioner. **GP2.1 b.** Our practice provides continuity of care and comprehensive care.
GP Standard 3.1: Qualifications, education and training of healthcare practitioners	**GP3.1** Qualifications, education and training of healthcare practitioners

Aged Care Quality Standards (Australia)

Relevant standard	Relevant action (where available) against Essential Component 3
7. Human resources	

End-of-life and Palliative Care Framework (NSW Health)

Relevant standard	Relevant action (where available) against Essential Component 3
3. There is access to care providers across all settings who are skilled and competent in end-of-life and palliative care	End-of-life and palliative care can be delivered in multiple settings. It must be supported by a skilled and competent workforce.
4. Care is well-coordinated and integrated	People needing end-of-life and palliative care may receive care from multiple services across several settings. Care should be delivered in an integrated and well-coordinated manner with seamless transitions between services and settings.
5. Access to quality care is equitable	There can be significant variation in access to end-of-life and palliative care services across NSW. There are groups across NSW who need greater support to access end-of-life and palliative care services.

Clinical Principles for End-of-life and Palliative Care (NSW Health)

Relevant standard	Relevant action (where available) against Essential Component 3
Key action 2: Triage	Triage improves timely and appropriate access to multidisciplinary care for the person, their family and carers. **Action:** Processes are in place to facilitate timely referral and access for further and thorough end-of-life or palliative care needs assessment, including by specialist palliative care services, when indicated.

Relevant standard	Relevant action (where available) against Essential Component 3
Key action 3: Comprehensive assessment	Comprehensive assessment enables the evaluation of physical, environmental, social, cultural, emotional, psychosocial and spiritual needs. Comprehensive assessment can also determine the need for inclusion of an Aboriginal liaison officer or palliative care Aboriginal health worker, as required, or the use of the Health Care Interpreter Service. **Action:** Processes are in place to ensure comprehensive, culturally appropriate and holistic assessment is undertaken for all people identified as having end-of-life or palliative care needs.
Key action 4: Care planning	Care planning establishes the care goals and needs of the person, their family and carers. Individuals should be involved as much as possible in their care planning, to ensure their preferences and needs are reflected. Recognising variation in community and cultural preferences and expectations of care will help to support a person-centred approach for all. Multicultural health and Aboriginal health professionals can provide cultural guidance and support and, where applicable, be part of the multidisciplinary team. **Action:** Processes are in place to ensure that following comprehensive assessment of people with life-limiting illnesses, the person and their family/carers are actively involved in discussions and decisions regarding immediate care needs and advance care planning. Appropriate documentation must reflect these decisions.
Key action 6: Symptom management	Timely and effective best practice symptom management is fundamental in the provision of quality end of life and palliative care and must include engagement between primary health care/general practitioners, end of life and palliative care specialists and multidisciplinary team members. **Action:** Clear processes are in place to ensure there is provision of optimal, best practice physical, spiritual and psychological symptom management, as agreed by care providers, the person with the life-limiting illness, their family and carers. Processes are in place to review, respond and escalate if required, including case conferencing modalities.
Key action 7: 24/7 access to support	Access to support 24 hours a day, seven days a week (24/7) delivers timely appropriate care interventions and builds partnerships in decision-making with the person, their family and carers. Providing access to urgent clinical advice, medications (prescribing and supply) and support in the after-hours period will support people to be cared for in their preferred place and provide a point of contact for individuals, their family and carers. **Action:** Processes are in place to ensure all people receiving end of life and palliative care, as well as their family and carers, have access

Relevant standard	Relevant action (where available) against Essential Component 3
	to appropriate support 24/7, and are informed of how to access this support. In the after-hours period, mechanisms are in place to provide urgent clinical advice and support for people receiving care at home. People have clear information and instructions about how to access this advice.
Key action 9: Grief and bereavement support	Grief and bereavement support assists with the multifaceted aspects of loss that are associated with death, such as emotional, financial and practical challenges. Support includes responding to needs around 'sorry business' practices for Aboriginal families and carers, and specific cultural needs. **Action:** • Processes are in place to ensure the person and their family and carers are provided with grief and bereavement support throughout the care continuum, and processes are in place for the screening of all carers for bereavement risk. • Processes are in place to provide bereavement information and support in response to the needs of families and carers, at the time and after a death. Where risks or higher needs are identified, access to additional care planning, support and referrals are provided, including where the person was cared for outside of specialist palliative care.