Essential Component 4: There is early recognition that a person may be approaching the end-of-life – standards comparison

National Palliative Care Standards, 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 4
1. Assessment of needs Initial and ongoing assessment incorporates the person's physical, psychological, cultural, social and spiritual experiences and needs	**1.1** The initial and ongoing assessments are carried out by qualified interdisciplinary personnel. **1.3** Clinical assessment tools are informed by the best available evidence and identify those approaching the end-of-life as well as those that are imminently dying. **1.4** The person's needs are reassessed on a regular basis. **1.5** Initial and ongoing assessments are documented in the person's clinical record. **1.6** Ongoing assessments are used to inform the care plan and any subsequent changes to it.

National Safety and Quality Health Service (NSQHS) Standards, 2nd Edition

Relevant standard	Relevant action (where available) against Essential Component 4
1. Clinical governance • Patient safety and quality systems	**1.16** The health service organisation has healthcare record systems that: a. make the healthcare record available to clinicians at the point of care b. support the workforce to maintain accurate and complete healthcare records c. comply with security and privacy regulations d. support systematic audit of clinical information e. integrate multiple information systems, where they are used.
• 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.

Relevant standard	Relevant action (where available) against Essential Component 4

	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.
	
	1.27 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.

2. 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	**2.10** 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.

Relevant standard	Relevant action (where available) against Essential Component 4

3. Preventing and controlling healthcare-associated infection
• Infection prevention and control systems
	3.6 Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider:
	  a. patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care
	  b. whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance
	  c. accommodation needs to manage infection risks
	  d. the need to control the environment
	  e. precautions required when the patient is moved within the facility or to external services
	  f. the need for additional environmental cleaning or disinfection
	  g. equipment requirements.

4. Medication safety
• Documentation of patient information
 	
• Continuity of medication management
	4.5 Clinicians take a best possible medication history, which is documented in the healthcare record, on presentation or as early as possible in the episode of care.
	
	4.6 Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan and reconcile any discrepancies on presentation and at transitions of care.
	
	4.7 The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation.
	
	4.8 The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system.
	
	4.10 The health service organisation has processes:
	  a. to perform medication reviews for patients, in line with evidence and best practice
	  b. to prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems
	  c. that specify the requirements for documentation of medication reviews, including actions taken as a result.

5. Comprehensive care
• Clinical governance and quality improvement to support comprehensive 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.
	
	5.6 Clinicians work collaboratively to plan and deliver comprehensive care.

Relevant standard	Relevant action (where available) against Essential Component 4

• Developing the comprehensive care plan	**5.7** The health service organisation has processes relevant to the patients using the service and the services provided:
	   a. for integrated and timely screening and assessment
	   b. that identify the risks of harm in the *Minimising patient harm* criterion.
	
	5.8 The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal or Torres Strait Islander origin, and to record this information in administrative and clinical information systems.
	
	5.10 Clinicians use relevant screening processes:
	   a. on presentation, during clinical examination and history taking, and when required during care
	   b. to identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm
	   c. to identify social and other circumstances that may compound these risks.
	
	5.11 Clinicians comprehensively assess the conditions and risks identified through the screening process
	
	5.12 Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record.
	
	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	**5.14** The workforce, patients, carers and families work in partnership to:
	   a. use the comprehensive care plan to deliver care
	   b. monitor the effectiveness of the comprehensive care plan in meeting the goals of care

Relevant standard	Relevant action (where available) against Essential Component 4
• Minimising patient harm	c. review and update the comprehensive care plan if it is not effective d. reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur. **5.15** The health service organisation has processes to identify patients who are at the end-of-life that are consistent with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care.* **5.21** The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines. **5.22** The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines. **5.24** The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. falls prevention b. minimising harm from falls c. post-fall management. **5.29** The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the *delirium clinical care standard*, where relevant b. manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation. **5.30** Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. recognise, prevent, treat and manage cognitive impairment b. collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care.

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	5.31 The health service organisation has systems to support collaboration with patients, carers and families to:
	    a. identify when a patient is at risk of self-harm
	    b. identify when a patient is at risk of suicide
	    c. safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed.
	
	5.33 The health service organisation has processes to identify and mitigate situations that may precipitate aggression.
	
	5.34 The health service organisation has processes to support collaboration with patients, carers and families to:
	    a. identify patients at risk of becoming aggressive or violent
	    b. implement de-escalation strategies
	    c. safely manage aggression, and minimise harm to patients, carers, families and the workforce.

6. Communicating for safety
  • Clinical governance and quality improvement to support effective communication
	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.

• Communication of critical information	**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.

• Documentation of information	**6.11** The health service organisation has processes to contemporaneously document information in the healthcare record, including:
	    a. critical information, alerts and risks
	    b. reassessment processes and outcomes
	    c. changes to the care plan.

8. Recognising and responding to acute deterioration
  • Detecting and recognising acute deterioration and escalating care
	8.4 The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:
	    a. document individualised vital sign monitoring plans
	    b. monitor patients as required by their individualised monitoring plan
	    c. graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient.

Relevant standard	Relevant action (where available) against Essential Component 4

	8.5 The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to:
	
	    a. monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium
	    b. include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan
	    c. assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported
	    d. determine the required level of observation
	    e. document and communicate observed or reported changes in mental state.

National Consensus Statement (Adult and Paediatric)

Relevant standard	Relevant action (where available) against Essential Component 4
1. Patient and family-centred care Patients/children and families are part of decision making about end-of-life care	**Adult** **1.1** Clinicians and patients should identify opportunities for proactive and pre-emptive end-of-life care discussions, to increase the likelihood of delivering high-quality end-of-life care aligned with the patient's values and preferences, and to reduce the need for urgent, after-hours discussions in emergency situations. **1.2** The clinical team should work with the patient, family and carers to identify the substitute decision-maker, family spokesperson or other key contacts that the patient wishes to be involved in discussions about their care. **1.3** In some cultures, mainstream assumptions about death and dying, and about patients and families as decision-makers may not be correct. Culturally appropriate decision-makers should be identified as early as possible so that strategies can be put in place for obtaining their input into discussions about end-of-life care. **1.4** Clinicians should seek to understand, and be respectful, sensitive and responsive to, the individual preferences and needs of all patients, substitute decision-makers, families and carers, regardless of aspects of identity such as culture, religious belief, gender or sexual preference. **1.5** Whenever possible, clinicians should prepare for having conversations about end-of-life care. Necessary preparation may include:

Relevant standard	Relevant action (where available) against Essential Component 4
	- 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. **Paediatric** **1.1** The interdisciplinary team should identify who has with parental responsibility. **1.2** Clinicians should assess the capacity of the child to be involved in discussions and decision-making about their care. This capacity may change across the illness trajectory and as the child develops. **1.4** Clinicians should be respectful, sensitive and responsive to the preferences and needs of individual children and their families, regardless of aspects of identity such as culture, religious belief, gender or sexual preference. **1.5** Clinicians, the child and their parents should identify opportunities for proactive and pre-emptive end-of-life care discussions to increase the likelihood of delivering high quality end-of-life care aligned with the child and their parents' values and preferences, and to reduce the need for urgent, after-hours discussions in emergency situations.
3. Goals of care Clear goals improve quality of end-of-life care	**Adult** **3.1** The psychosocial, cultural and spiritual needs of patients, families and carers should be assessed, and care should be provided in accordance with their wishes, values and needs. Support should be offered for patients, carers and families who wish to include cultural or religious practices in their care, such as particular foods, singing, ceremonies or healing.

Relevant standard	Relevant action (where available) against Essential Component 4
	Paediatric **3.1** Clinicians should assess the psychosocial, cultural and spiritual needs of the child. Support should be offered for families who wish to include cultural or religious practices in the care of the child, such as particular foods, singing, ceremonies or healing.
4. Using triggers Triggers identify when patients/children 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, and/or development of new clinical problems during inpatient admission. **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

Relevant standard	Relevant action (where available) against Essential Component 4
	- 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.

Standards for general practice (RACGP), 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 4
Core Standard 5: Clinical management of health issues	**C5.1** Diagnosis and management of health issues
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 4
2. Ongoing assessment and planning with consumers	
3. Personal care and clinical care	

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

Relevant standard	Relevant action (where available) against Essential Component 4
1. Care is person centred	Care should be based on the unique, holistic needs and preferences of the person receiving care. It should respect their preferences and their dignity. The individual, their families and carers are equal partners in the decisions relating to their care and treatment. Provision of care should be based on assessed need and be flexible in response to the person's changing needs and preferences.
2. There is recognition and support for families and carers	Families and carers play a pivotal role in the end-of-life and palliative care service system. It is essential their role is recognised, valued, and supported. Health services should support families and carers to be involved in planning and providing care, and to access the services they need to carry out this role.

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

Relevant standard	Relevant action (where available) against Essential Component 4
Key action 1: Screening and identification	Undertaking screening and identification with recognised tools ensures identification of people who have potentially unmet end-of-life and/or palliative care needs. This process also recognises and identifies underserved populations. **Action:** Processes are in place to identify those people who are approaching and reaching the end of their life.
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 and/or palliative care needs assessment, including by specialist palliative care services, when indicated.