Essential Component 6: [Seamless transitions across all care settings](#) – standards comparison

National Palliative Care Standards, 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 6
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	**2.3** Systems are in place to identify a substitute decision maker if a person does not have the capacity to make decisions for themselves. **2.5** A system is in place for receiving, storing, accessing and sharing existing advance care plans. **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	**3.3** There are systems in place to ensure that the person's nominated family and carers are supported to participate in the provision of health care in accordance with the preferences of the person, their family and carers (taking into account privacy requirements). **3.4** The family and carers are provided with up-to-date information and resources that are adapted to meet their needs and that inform their participation in care planning and delivery. This may include information about accessing respite services, equipment, financial support and other services, as well as encouraging the involvement of personal support networks and self-care. **3.5** The family and carers are provided with a clear plan for emergency and after-hours events.
5. Transitions within and between services Care is integrated across the person's experience to ensure seamless transitions within and between services	**5.1** There are policies and procedures in place that support and promote continuity of care across settings and throughout the course of the person's illness. **5.2** The service has in place effective communication systems to support integrated care, including processes for communicating information about the care plan, goals of care, prognosis and death of the person within and between services. **5.3** Care plans demonstrate appropriate actions to support seamless transition between care settings. **5.4** Specialist palliative care services' admission criteria are clear, applied consistently, communicated to the local health and wider community and result in equitable access to services based on clinical need.

Relevant standard	Relevant action (where available) against Essential Component 6
	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). **5.6** Discharging a person from a specialist palliative care service should allow adequate time for services to be put in place prior to discharge, including a formal handover to ensure continuity of care and minimise risk. Plans should be discussed with the person, their family and carers to ensure that their needs and preferences are accommodated. They should understand that the person may enter the service again if their needs change. **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. **5.8** Policies for prioritising and responding to referrals in a timely manner are documented and audited regularly to identify improvement opportunities. **5.9** The organisation has mechanisms in place to assess unmet needs and uses this information to develop plans for future improvement of the service.
6. Grief support Families and carers have access to bereavement support services and are provided with information about loss and grief	**6.6** The service develops strategies and referral pathways, in partnerships with other community providers, to assist families and carers in preparing for the death and dealing with grief after bereavement. **6.7** Referrals to bereavement, specialist mental health or counselling professionals are made when clinically indicated.
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.

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

Relevant standard	Relevant action (where available) against Essential Component 6

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	**1.7** The health service organisation uses a risk management approach to:
	  a. set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols
	  b. monitor and take action to improve adherence to policies, procedures and protocols
	  c. review compliance with legislation, regulation and jurisdictional requirements.
	
	1.8 The health service organisation uses organisation-wide quality improvement systems that:
	  a. identify safety and quality measures, monitor and report performance and outcomes
	  b. identify areas for improvement in safety and quality
	  c. implement and monitor safety and quality improvement strategies
	  d. involve consumers and the workforce in the review of safety and quality performance and systems.

Relevant standard	Relevant action (where available) against Essential Component 6

	1.9 The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:
	   a. the governing body
	   b. the workforce
	   c. consumers and the local community
	   d. other relevant health service organisations.
	
	1.10 The health service organisation:
	   a. identifies and documents organisational risks
	   b. uses clinical and other data collections to support risk assessments
	   c. acts to reduce risks
	   d. regularly reviews and acts to improve the effectiveness of the risk management system
	   e. reports on risks to the workforce and consumers
	   f. plans for, and manages, internal and external emergencies and disasters.
	
	1.11 The health service organisation has organisation-wide incident management and investigation systems, and:
	   a. supports the workforce to recognise and report incidents
	   b. supports patients, carers and families to communicate concerns or incidents
	   c. involves the workforce and consumers in the review of incidents
	   d. provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers
	   e. uses the information from the analysis of incidents to improve safety and quality
	   f. incorporates risks identified in the analysis of incidents into the risk management system
	   g. regularly reviews and acts to improve the effectiveness of the incident management and investigation systems.
	
	1.13 The health service organisation:
	   a. has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care
	   b. has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems
	   c. uses this information to improve safety and quality systems.
	
	1.14 The health service organisation has an organisation-wide complaints management system, and:
	   a. encourages and supports patients, carers and families, and the workforce to report complaints

Relevant standard	Relevant action (where available) against Essential Component 6
	b. involves the workforce and consumers in the review of complaints c. resolves complaints in a timely way d. provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. uses information from the analysis of complaints to inform improvements in safety and quality systems f. records the risks identified from the analysis of complaints in the risk management system g. regularly reviews and acts to improve the effectiveness of the complaints management system. **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. **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. **1.17** The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. are designed to optimise the safety and quality of health care for patients b. use national patient and provider identifiers c. use standard national terminologies. **1.18** The health service organisation providing clinical information into the My Health Record system has processes that: a. describe access to the system by the workforce, to comply with legislative requirements b. maintain the accuracy and completeness of the clinical information the organisation uploads into the system.

Relevant standard	Relevant action (where available) against Essential Component 6
• Clinical performance and effectiveness	**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.

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	**2.5** The health service organisation has processes to identify:
	  a. the capacity of a patient to make decisions about their own care
	  b. a substitute decision-maker if a patient does not have the capacity to make decisions for themselves.
	
	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.
	
	2.10 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 6

• partnering with consumers in organisational design and governance	**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.

3. Preventing and controlling healthcare-associated infection • Infection prevention and control systems	**3.7** The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations.

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

• Developing the comprehensive care plan	**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

Relevant standard	Relevant action (where available) against Essential Component 6
	c. identifies the support people a patient wants involved in communications and decision-making about their care d. commences 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 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. **5.17** The health service organisation has processes to ensure that current advance care plans: a. can be received from patients b. are documented in the patient's healthcare record. **5.19** The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of 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.*
• Minimising patient harm	**5.23** The health service organisation providing services to patients at risk of pressure injuries ensures that: a. patients, carers and families are provided with information about preventing pressure injuries b. equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries. **5.25** The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls. **5.26** Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies.

Relevant standard	Relevant action (where available) against Essential Component 6

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 at clinical handover	**6.7** The health service organisation, in collaboration with clinicians, defines the:
	  a. minimum information content to be communicated at clinical handover, based on best-practice guidelines
	  b. risks relevant to the service context and the particular needs of patients, carers and families
	  c. clinicians who are involved in the clinical handover.
	
	6.8 Clinicians use structured clinical handover processes that include:
	  a. preparing and scheduling clinical handover
	  b. having the relevant information at clinical handover
	  c. organising relevant clinicians and others to participate in clinical handover
	  d. being aware of the patient's goals and preferences
	  e. supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient
	  f. ensuring that clinical handover results in the transfer of responsibility and accountability for care.

• 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 to:
	  a. clinicians who can make decisions about care
	  b. patients, carers and families, in accordance with the wishes of the patient.
	
	6.10 The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians.

• 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.

Relevant standard	Relevant action (where available) against Essential Component 6

8. Recognising and responding to acute deterioration
 	
• Detecting and recognising acute deterioration, and escalating care
 	
• Responding to acute deterioration
	8.6 The health service organisation has protocols that specify criteria for escalating care, including:
	    a. agreed vital sign parameters and other indicators of physiological deterioration
	    b. agreed indicators of deterioration in mental state
	    c. agreed parameters and other indicators for calling emergency assistance
	    d. patient pain or distress that is not able to be managed using available treatment
	    e. worry or concern in members of the workforce, patients, carers and families about acute deterioration.
	
	8.7 The health service organisation has processes for patients, carers or families to directly escalate care.
	
	8.10 The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration.
	
	8.12 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 6
1. Patient/family centred care Patients/children and families are part of decision making about end-of-life care	**Adult** **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. **1.7** Whenever possible, clinicians should work with patients, families and carers to ensure that key family members, substitute decision-makers and carers are present during end-of-life discussions. This will ensure that consistent messages are given about treatment options, their likelihood of success, risks and prognosis. This is particularly important when patients are in the process of transition to the terminal phase, as conflict and uncertainty among family and carers can result in avoidable suffering.

Relevant standard	Relevant action (where available) against Essential Component 6
	1.12 Clinicians should clearly document the content of the discussion and any agreed plan of care in the patient clinical record. Any unresolved issues that require further follow-up should also be documented, along with a plan for follow-up.
	1.13 The content of the discussion and plan of care, including any limitations of medical treatment, should be communicated to all teams involved in the patient's care, including relevant community care providers.
	Paediatric **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.
	1.9 Clinicians should work with parents to ensure that key family members are present during end-of-life discussions or that appropriate follow-up meetings are offered. This will ensure that consistent messages are given about treatment options, their likelihood of success, risks and prognosis.
	1.14 Clinicians should clearly document the content of discussions and any agreed plan of care in the patient clinical record. Any unresolved issues that require further follow-up should be documented, along with a plan for follow-up.
2. Teamwork Clinicians work together to provide end-of-life care	**Adult** **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, and 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.
	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 **2.2** The roles and responsibilities of different interdisciplinary team members should be clearly defined and understood by all those

Relevant standard	Relevant action (where available) against Essential Component 6
	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.
3. Goals of care Clear goals improve the quality of end-of-life care	**Adult** **3.9** The patient, family and carers should not feel abandoned by the healthcare team, or fear that care will be stopped or reduced, when the goals of care shift from cure to comfort because the patient is dying. Care, compassion, open and honest communication about what to expect, and the comfort of the dying patient remain priorities. **3.14** Clinicians should explore and discuss alternatives to hospital-based care, when possible and appropriate, and as preferred by the patient. If feasible, this could include the patient's usual residence, a local hospital, a community or residential aged care facility, or a hospice or other palliative care facility. **3.15** Clinicians should liaise with other relevant services and provide referral**,** as necessary – for example, to specialist inpatient or community palliative care services **Paediatric** **3.9** The child and their parents should not feel abandoned by the healthcare team, or fear that care will be stopped or reduced, when the goals of care shift from cure to comfort. Clinicians should communicate openly about comfort care and what to expect in the terminal phase. **3.12** Clinicians should explore and discuss alternatives to hospital-based care, when possible and appropriate, and as preferred by the child and their parents. This could include providing appropriate referrals, equipment and support to deliver care in the family home, the child's local hospital, a hospice or other palliative care facility. **3.13** Clinicians should liaise with, and provide referral to, other relevant services as necessary – for example, to children's hospice, specialist inpatient or community palliative care services.

Relevant standard	Relevant action (where available) against Essential Component 6
4. Using triggers Triggers identify when patients/children need end-of-life care	**Adult** **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. **Paediatric** **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 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

Relevant standard	Relevant action (where available) against Essential Component 6
	that end-of-life care needs are not being adequately recognised or addressed by the clinical team. **5.7** Responders providing assistance in emergency situations should have access to support from a clinician of sufficient authority to make decisions about stopping non-beneficial treatments and providing palliative care. **5.9** If a responder is not part of the clinical team, they should 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 patient. **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. **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. **5.5** When sudden or unexpected deterioration in the child's condition occurs, clinicians should inform the parents and the interdisciplinary team with primary responsibility for the child's care as soon as possible. **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.

Relevant standard	Relevant action (where available) against Essential Component 6
6. Leadership and governance Policies and systems for end-of-life care	**Adult** **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 • 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). **6.5** The policy framework for end-of-life care should operate in synergy with recognition and response systems for patients who are clinically deteriorating. **6.6** Policies and processes should be in place regarding advance care directives, organ and tissue donation, limitations of medical treatment and end-of-life decision-making to ensure that the care delivered in response to deterioration is consistent with appropriate clinical practice and the patient's expressed wishes. **6.7** A formal governance process should be in place to oversee the development, implementation and ongoing review of systems for end-of-life care. If a committee has this role, it should: • have appropriate responsibilities delegated to it and be accountable for its decisions and actions to the executive • monitor the effectiveness of interventions and education • have a role in reviewing performance data

Relevant standard	Relevant action (where available) against Essential Component 6
	• provide advice about the allocation of resources • include consumers, interdisciplinary team members, managers and executives. **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. **6.9** Organisations should work with local community-based service providers to build capacity for people to be cared for in their preferred place of death (for example, at home). **Paediatric** **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 (e.g. ethical or legal advice) • access to specialist paediatric palliative care advice and services • the interface 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. **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). **6.5** The health service organisation should establish policies and processes for advance care planning, organ and tissue donation, limitations of medical treatment, symptom management and end-of-life decision-making to ensure that the care delivered in response to deterioration is consistent with appropriate clinical practice, the child and their parents' expressed wishes, and the best interests of the child.

Relevant standard	Relevant action (where available) against Essential Component 6
	6.6 The health service organisation should establish a formal governance process to oversee the development, implementation and ongoing review of systems for end-of-life care. If a committee has this role, it should: • have appropriate responsibilities delegated to it, and be accountable for its decisions and actions to the executive • monitor the effectiveness of interventions and education • have a role in reviewing performance data • provide advice about the allocation of resources • include consumers, interdisciplinary team members, managers and executives. **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. **6.8** The health service organisation should work with local community-based service providers and families to build capacity for children to be cared for in the preferred place of care (for example, at home).
7. Education and training Clinicians have the skills and knowledge to provide end-of-life care	**Adult and paediatric** **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.
10. Supporting systems Systems align with NSQHS Standards to improve outcomes	**Adult and paediatric** **10.4** Organisations should implement processes to improve communication between health services at transitions of care. This should include processes for communicating the content of discussions about prognosis and advance care planning. These processes should align with NSQHS *Standard 6 (Clinical handover).*

Standards for General Practice (RACGP), 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 6
Core Standard 5: Clinical management of health issues	**C5.3** Clinical handover
GP Standard 2.3: Engaging with other services	**GP2.3 a.** Our practice collaborates with other health services to deliver comprehensive care. **GP2.3 b.** Our practice's referral letters are legible and contain all required information.

Aged Care Quality Standards (Australia)

Relevant standard	Relevant action (where available) against Essential Component 6
1. Consumer dignity and choice	
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 6
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 a number of 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 6
Key action 8: Place of death	Supporting people to receive care and die in their preferred place requires consistent open communication, health literate information, and access to relevant services and equipment. Consideration of the care setting and whether the clinical needs of the person can be met should interface with systems to prevent or minimise unnecessary hospital admissions. If home is the preferred care setting, consideration of availability of community health and support services to meet the person and their family or carer's needs is important.
	Action: Processes are in place for identified and embedded local pathways which support people to:
	- identify their preferred place of death - be cared for in the place of their choosing (where it is safe and feasible to do so) - die as close to home as possible, if this is the preference.
	Regular assessment of the appropriateness of the preferred setting is also encouraged.