Essential Component 7: Access to specialist care when needs are complex – standards comparison

National Palliative Care Standards, 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 7
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	**4.1.** Care is delivered promptly, in accordance with the changing needs of the person, their family and carers, their documented care plan and their goals and preferences. **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. **4.3** Where care cannot be delivered in accordance with the goals and preferences of the person, this is discussed with the person, their family, and carers, and an agreed alternative plan is documented and communicated. **4.4** There are protocols and procedures in place for the escalation of care where required, based on assessed needs. **4.5** The service aims to actively pre-empt distress to the best of their ability but when it occurs, the response to it is timely, appropriate and effective, and actions are documented. **4.6** The effectiveness of care is measured according to established indicators and outcomes.
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.

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Relevant standard	Relevant action (where available) against Essential Component 7
	5.5 Referrals from the specialist palliative care service are made to appropriate specialists or services that are able to 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 and include 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 and that they 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	**6.3** The service employs a structured assessment of bereavement that addresses the emotional, behavioural, spiritual and physical domains. **6.7** Referrals to bereavement, specialist mental health or counselling professionals are made when clinically indicated. **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	**7.3** The care setting provides an appropriate environment to support people reaching the end of their lives, their family and carers. **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.
8. Quality improvement	**8.8** Specialist palliative care services support other services providing care to people at the end-of-life to improve the quality of that care.

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Relevant standard	Relevant action (where available) against Essential Component 7
9. Staff qualifications 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.

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

Relevant standard	Relevant action (where available) against Essential Component 7
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 system	**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.

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Relevant standard	Relevant action (where available) against Essential Component 7
	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. **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

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Relevant standard	Relevant action (where available) against Essential Component 7
	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 **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.
• 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.

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

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Relevant standard	Relevant action (where available) against Essential Component 7
• Safe environment for the delivery of 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. **1.29** The health service organisation maximises safety and quality of care: **a.** through the design of the environment **b.** by maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose. **1.30** The health service organisation: **a.** identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce **b.** provides access to a calm and quiet environment when it is clinically required. **1.32** The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so. **1.33** The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people.
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.

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Relevant standard	Relevant action (where available) against Essential Component 7
• Partnering with patients in their own care • Health literacy • Partnering with consumers in organisational design and governance	**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. **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.
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.
4. Medication 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 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:

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Relevant standard	Relevant action (where available) against Essential Component 7
	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 **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. **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. **5.16** 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.

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Relevant standard	Relevant action (where available) against Essential Component 7
• Minimising patient harm	**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.* **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. **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. **5.32** The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts. **5.33** The health service organisation has processes to identify and mitigate situations that may precipitate aggression.
6. Communicating for safety • Clinical governance and quality improvement to support effective communication	**6.3** Clinicians use organisational processes from the *Partnering with Consumers Standard* to effectively communicate with patients, carers and families during high-risk situations to: **a.** actively involve patients in their own care **b.** meet the patient's information needs **c.** share decision-making. **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.

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Relevant standard	Relevant action (where available) against Essential Component 7
• 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 at 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. **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
8. Recognising and responding to acute deterioration • Detecting and recognising acute deterioration, and escalating care	**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.

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Relevant standard	Relevant action (where available) against Essential Component 7
• Responding to acute deterioration	**8.7** The health service organisation has processes for patients, carers or families to directly escalate care. **8.8** The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance. **8.9** The workforce uses the recognition and response systems to 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. **8.11** The health service organisation has processes to ensure rapid access at all times 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 7
3. Goals of care Clear goals improve the quality of end-of-life care	**Adult** **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** **3.13** 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.
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.

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Relevant standard	Relevant action (where available) against Essential Component 7
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 that end-of-life care needs are not being adequately recognised or addressed by the clinical team. **5.5** Clinicians should have rapid access to specialist palliative care advice 24 hours a day and 7 days a week. This may include access by telephone or videoconference. **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. **5.8** Responders should document in the health care record appropriate, detailed and structured information about the outcomes of the call for assistance, discussions with the patient or substitute decision-maker and the plan for follow-up or further review of the patient. **5.9** If the 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. **5.4** Clinicians should know how to get rapid access to specialist paediatric palliative care advice 24 hours a day, seven days a week. This may include access by telephone or videoconference.

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Relevant standard	Relevant action (where available) against Essential Component 7
6. Leadership and governance Policies and systems for end-of-life care	**Adult** **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** **6.7** 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.
10. Supporting systems Systems align with NSQHS Standards to improve outcomes	**Adult** **10.3** Systems should be in place to provide timely access to input from specialist palliative care clinicians, when required for patients with complex palliative care needs. or as a supportive resource for other clinicians. This may include off-site access via videoconferencing or teleconferencing. **Paediatric** **10.3** The health service organisation should ensure that systems are in place to provide timely access to input from specialist paediatric palliative care clinicians when required for children with complex palliative care needs, or as a supportive resource for other clinicians. This may include off-site access via videoconferencing or teleconferencing.

Standard for general practice (RACGP), 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 7
GP Standard 2.3: Engaging with other services	**GP2.3 a.** Our practice collaborates with other health services to deliver comprehensive care.

Aged Care Quality Standards (Australia)

Relevant standard	Relevant action (where available) against Essential Component 7
1. Consumer dignity and choice	
2. Ongoing assessment and planning with consumers	
3. Personal care and clinical care	

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

Relevant standard	Relevant action (where available) against Essential Component 7
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 (EoLPC) 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 7
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.
Key action 6: Symptom management	Timely and effective best practice symptom management is fundamental in the provision of quality EoLPC and must include engagement between primary health care/general practitioners, EoLPC 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, 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.

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Relevant standard	Relevant action (where available) against Essential Component 7
	Action: Processes are in place to ensure all people receiving EoLPC, as well as their family and carers, have access 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.

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