End of Life and Palliative Care Clinical Principles

Self-assessment tool

Service or entity being assessed

This tool is not just for specialist end of life and palliative care services. This may be completed by a team, service, department, ward, division, stream, facility, network, local health district or specialty health network. For example, renal service, oncology ward, department of geriatric medicine, palliative care team.

Team members completing the self assessment (name and position)

Part A: Patient-centred care

The patient and the multidisciplinary team are both essential participants in discussions and decision-making at the end of life. Substitute decision-makers, families and carers should be included, according to the patient's expressed wishes.

Health services should ensure that clinical governance processes are embedded to support the delivery of end-of-life and palliative care, as it aligns with NSQHS Standard 5 (Comprehensive Care) and Standard 2 (Partnering with Consumers).

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.

NSW GOVERNMENT | AGENCY FOR CLINICAL INNOVATION

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Key action 1: Screening and identification

Key action 1 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
1.1 People who are approaching and reaching the end of their life are identified in a timely manner through the use of a recognised clinical assessment tool	☐	☐	☐	☐
Comments				

Key action 2: Triage

Key action 2 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
2.1 Processes are in place to facilitate timely referral for end of life and/or palliative care needs assessment, through the use of recognised clinical tools	☐	☐	☐	☐
2.2 Patients are provided access to multidisciplinary support and specialist palliative care based on assessed need via their preferred modality (face to face or virtual care)	☐	☐	☐	☐
Comments				

Key action 3: Comprehensive assessment

Key action 3 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
3.1 A holistic and comprehensive assessment is undertaken for all people (including priority populations) with end of life and/or palliative care needs	☐	☐	☐	☐
Comments				

Key action 4: Care planning

Key action 4 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
4.1 Shared decision-making principles are applied to discussions and decisions regarding immediate care needs and advance care planning	☐	☐	☐	☐
4.2 Goals of care are clearly documented	☐	☐	☐	☐
4.3 Goals of care are always accessible to team members	☐	☐	☐	☐
Comments				

Key action 5: Open and respectful communication

Key action 5 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
5.1 The person, their carer or person responsible and family are provided with clear information regarding available care and how it will be provided, that matches their level of health literacy	☐	☐	☐	☐
5.2 Health professionals are provided with training and support to hold end of life conversations with patients, their carer or person responsible and family	☐	☐	☐	☐
5.3 Health care interpreters are used where the person, or their carer or person responsible do not speak English fluently	☐	☐	☐	☐
Comments				

Key action 6: Symptom management

Key action 6 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
6.1 Optimal management of physical and non-physical symptoms is provided	☐	☐	☐	☐
6.2 Processes are in place to review, respond and escalate care if required, including through case conferencing modalities	☐	☐	☐	☐
Comments				

Key action 7: 24/7 access to support

Key action 7 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
7.1 Processes are in place to ensure all people receiving EoLPC, as well as their family and carers, have access to appropriate advice and support 24/7 (including via virtual care where appropriate)	☐	☐	☐	☐
7.2 People receiving EoLPC, as well as their family and carers, are informed of how to access appropriate advice and support 24/7	☐	☐	☐	☐
Comments				

Key action 8: Place of death

Key action 8 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
8.1 Processes are in place to identify preferred place of death for persons recognised as nearing the end of life	☐	☐	☐	☐
8.2 The preferred place of death setting is reviewed regularly by the service	☐	☐	☐	☐
8.3 The preferred place of death is reflected in goals of care plans for persons recognised as nearing the end of life	☐	☐	☐	☐
Comments				

Key action 9: Grief and bereavement support

Key action 9 tools and resources

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	Unsure
9.1 The person, their carer or person responsible and family are offered grief and bereavement support based on assessed need	☐	☐	☐	☐
9.2 Processes are in place to provide bereavement information and support in response to the needs of carers or persons responsible and family, at the time and after a death	☐	☐	☐	☐
9.3 Where risks or higher unmet needs are identified, access to additional support and services are provided	☐	☐	☐	☐
Comments				

Part B: Leadership and governance

Health services should ensure that the governance of systems for the delivery of end-of-life and palliative care aligns with NSQHS Standard 1 (Clinical Governance) and Standard 2 (Partnering with Consumers). Executive and clinical leaders at all levels of the organisation's clinical and corporate governance structures should provide proactive and practical support to the multidisciplinary teams and managers who are responsible for delivering end-of-life and palliative care.

Respond to the following questions as they apply to your service or entity	**Yes**	**No**	**In progress**	**N/A**	**Unsure**
1. The local health district or specialty health network has an end of life committee* or equivalent to support governance	☐	☐	☐	☐	☐
Comments					
2. The Guideline key actions embedded into local health district or specialty health network models of care, clinical procedures and protocols	☐	☐	☐	☐	☐
Comments					
3. Feedback on the implementation and ongoing application of the Guideline is included in standing executive, management and multidisciplinary team meeting agendas	☐	☐	☐	☐	☐
Comments					
4. The Guideline and associated tools and resources are readily available and accessible to clinicians	☐	☐	☐	☐	☐
Comments					

* These committees are to take responsibility for the development of a clear approach for end of life and palliative care governance and quality improvement for their organisation. This will ensure consistent and equitable provision of end of life and palliative care across the district or network, as well as facilitate ongoing monitoring, evaluation and quality improvement processes.

Respond to the following questions as they apply to your service or entity	Yes	No	In progress	N/A	Unsure
5. Local end of life and palliative care education programs for clinical staff incorporate reference to the Guideline key actions	☐	☐	☐	☐	☐
Comments					
6. The Guideline key actions are used to improve, monitor and evaluate the quality of patient care	☐	☐	☐	☐	☐
Comments					
7. Data collection processes are in place to review and monitor end of life and palliative care service delivery (including virtual care modalities)	☐	☐	☐	☐	☐
Comments					

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