Essential Component 8: Quality care during the last days of life – standards comparison

National Palliative Care Standards, 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 8
1. Assessment of needs Initial and ongoing assessment incorporates the person's physical, psychological, cultural, social and spiritual experiences and needs	**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.
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	**2.1** Care planning is informed by the assessment process and reflects a person-centred, holistic approach that incorporates cultural, spiritual, physical, psychological and social needs. **2.2** The person, their family and carers are provided with up-to-date information appropriate to meet their needs and support informed participation in care planning and decision-making. **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. **2.6** Specific attention is paid to the needs of people who may be vulnerable or at risk, to support communication, goal setting and care planning. This includes but is not limited to Aboriginal and Torres Strait Islanders, asylum seekers, people who have experienced torture and trauma, people who are experiencing homelessness, people living with mental illness, intellectual disabilities or dementia, paediatric populations or people from ethnically and culturally diverse backgrounds. **2.8** The expectations and preferences of the person, their family and carers for the type and place of care are discussed, negotiated and an agreed plan is documented. **2.9** The care plan is reviewed and updated regularly, on the basis of reassessments of the person's condition, needs, and preferences, and in consultation with the person, their family and carers. Changes to the care plan are documented. **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.

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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	**3.1** At least one carer is identified for each person as far as possible and their specific needs, including their need for information, are assessed and documented. **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). **3.5** The family and carers are provided with a clear plan for emergency and after-hours events. **3.6** Depending on the location of care and the person's needs and preferences, the family and carers are educated on how to safely assist with care, including managing risk, manual handling and activities of daily living. **3.7** The family and carers are provided with information about the signs and symptoms of approaching death and the steps to take following death, in a way that is appropriate for their age, culture and social situation.
4. Providing care The provision of care is based on the assessed needs of the person, informed by evidence, and is consistent with the values, goals and preferences of the person as documented in their care plan	**4.1** 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. **4.3** 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.

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

Relevant standard	Relevant action (where available) against Essential Component 8
1. Clinical governance • Patient safety and quality systems	**1.15** The health service organisation: a. identifies the diversity of the consumers using its services b. identifies groups of patients using its services who are at higher risk of harm c. incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care. **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	**1.21** 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 **1.26** 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.
• Safe environment for the delivery of care	**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.
2. Partnering with consumers • Partnering with patients in their own care	**2.4** The health service organisation ensures that its informed consent processes comply with legislation and best practice. **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.

Relevant standard	Relevant action (where available) against Essential Component 8

• Health literacy	**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.
	
	2.8 The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community.
	
	2.9 Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review.
	
	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.

• Partnering with consumers in organisational design and governance	**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
	3.6 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	**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.

Relevant standard	Relevant action (where available) against Essential Component 8

• Continuity of medication management	**4.6** Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan. They 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.
	
	4.11 The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks.

5. Comprehensive care
• Clinical governance and quality improvement to support comprehensive care
 	
• Developing the comprehensive care plan
	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. identify, at all times, the clinician with overall accountability for a patient's care.
	
	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.

Relevant standard	Relevant action (where available) against Essential Component 8

• Delivering comprehensive care	**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.
	
	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.
	
	5.15 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.*
	
	5.20 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.*

Relevant standard	Relevant action (where available) against Essential Component 8

• Minimising patient harm	**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 Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency.
	
	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.
	
	5.24 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.
	
	5.25 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.
	
	5.27 The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice.
	
	5.28 The workforce uses the systems for preparation and distribution of food and fluids to:
	   a. meet patients' nutritional needs and requirements
	   b. monitor the nutritional care of patients at risk
	   c. identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone
	   d. support patients who require assistance with eating and drinking.

Relevant standard	Relevant action (where available) against Essential Component 8
	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. **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. **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. **5.35** Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. minimise and, where possible, eliminate the use of restraint b. govern the use of restraint in accordance with legislation c. report use of restraint to the governing body.

Relevant standard	Relevant action (where available) against Essential Component 8

	5.36 Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that:
	   a. minimise and, where possible, eliminate the use of seclusion
	   b. govern the use of seclusion in accordance with legislation
	   c. report use of seclusion to the governing body.

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.

• 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.

• 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.
	
	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 8

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.
	
	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.
	
	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.
	
	8.8 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

• Responding to acute deterioration	**8.10** The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration.

Relevant standard	Relevant action (where available) against Essential Component 8
	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 8
1. Patient/family centred care Patients/children and families are part of decision making about end-of-life care	**Adult** **1.5** Whenever possible, clinicians should prepare for having conversations about end-of-life care. Necessary preparation may include: • reaching consensus among all of the clinical teams involved in the patient's care about the patient's prognosis and what treatment options are appropriate to recommend • ensuring familiarity with the patient's history and current condition (this may include discussion with key community care providers), their family structure, and cultural needs and preferences • arranging adequate time for uninterrupted discussion • ensuring that patients have access to their regular communication aids • arranging for the appropriate people to be in attendance – ideally, this will include the patient, their substitute decision-maker, carers and family members, the most senior doctor available, the nurse responsible for the patient's care, and other members of the interdisciplinary team such as interpreters, aboriginal support workers, chaplains or social workers • ensuring that discussions can be held in an appropriately quiet and private environment. **1.9** Clinicians should express empathy for the patient's situation. They should allow adequate time for those involved to absorb, process and react to the information they are being given. Multiple discussions may be required.

Relevant standard	Relevant action (where available) against Essential Component 8
	1.10 End-of-life discussions should routinely include the provision of information about organ and tissue donation for transplantation, in circumstances where donation is possible. These discussions should be conducted with advice from the state or territory DonateLife agency and should preferably be led by clinicians who have attended the core *Family Donation Conversation* workshop. **Paediatric** **1.6** Whenever possible, clinicians should prepare for having conversations about end-of-life care. Necessary preparation may include: • reaching consensus among all of the teams involved in the child's care about the prognosis and what treatment options are appropriate to recommend. • ensuring familiarity with the child's history and current condition (this may include discussion with key community care providers), their family structure, and cultural needs and preferences arranging adequate time for uninterrupted discussion. • arranging adequate time and an appropriate physical environment for uninterrupted discussion. • ensuring that the child and their parents have access to their regular communication aids. • arranging for the appropriate people to be in attendance – depending on the child and parents' individual preferences. this may include the child, their parents and family, the most senior doctor available, the nurse responsible for the child's care, and other members of the interdisciplinary team such as interpreters, aboriginal support workers, child life therapists, chaplains or social workers • ensuring that discussions can be held in an appropriately quiet and private environment. **1.12** Clinicians should express empathy for the child and parents' situation. Allow adequate time for those involved to absorb, process and react to the information they are being given. Multiple opportunities for discussion may be required.
3. Goals of care Clear goals improve quality of end-of-life care	**Adult** **3.2** Patients who are likely to die within the short or medium term should be informed about the process and purpose of advance care planning and asked if they would like to instigate or revisit their advance care plan. **3.3** As part of the advance care planning process, clinicians should ask about, and document, a patient's wishes in regard to donation of

Relevant standard	Relevant action (where available) against Essential Component 8
	their organs and tissues for clinical use or research purposes after death, where this is clinically appropriate. **3.4** Unnecessary burdens associated with medical treatment should be avoided for dying patients. For example, non-beneficial or unwanted observations, surgical interventions, investigations, medications and treatments should not be prescribed or administered. Where a clinician feels pressured – by the patient, family, carer or another health professional – to provide such interventions, they should seek advice and support from an experienced colleague who is able to assist with a second opinion and sensitive discussion. **3.7** The goals of care, treatment plan and any limitations of medical treatment should be revisited with the patient, substitute decision-maker, family and carers when significant changes in the patient's condition or circumstances occur – for example, when the patient is in transition to the terminal phase. The patient, substitute decision-maker, family and carers should be empowered to request further discussion and a review of the plan at any time. **3.10** All patients, including people with chronic or severe mental illness, intellectual disability or cognitive impairment, have the right to adequate pain relief and symptom control, and to the prevention and relief of suffering. Physical symptoms should be managed in alignment with the patient's wishes, and treatment reviewed regularly. If communication problems make it difficult to ascertain the patient's wishes or needs, it is important to seek advice from, and consult with, families and carers. **3.11** Dying patients should be supported to receive oral food and fluids for as long as they wish. **3.12** Family and carers should be supported to spend time with a dying patient in accordance with their wishes, including in the period immediately after death. **Paediatric** **3.3** Clinicians should avoid unnecessary burdens associated with medical treatment for dying children. For example, non-beneficial observations, surgical interventions, investigations, medications and treatments should not be prescribed or administered. Where a clinician feels pressured – by the family or another health professional – to provide such interventions, they should seek advice and support from an experienced colleague who is able to assist with a second opinion and sensitive discussion or seek legal or clinical ethics advice where appropriate.

Relevant standard	Relevant action (where available) against Essential Component 8
	3.5 Clinicians should revisit the goals of care, treatment plan and any limitations of medical treatment when significant changes in the child's condition, preferences, or circumstances occur – for example, when the child is in transition to the terminal phase. **3.7** Clinicians should enable the child and their parents to request further discussion and a review of the goals of care, treatment plan and any limitations of medical treatment at any time. **3.10** Clinicians should support dying children to receive oral food and fluids for as long as they wish. **3.11** Clinicians should manage physical symptoms in alignment with the child and their parents' wishes, and review treatment regularly **3.15** Clinicians should support parents and families to care for their dying child and provide information about what to expect during the dying process. **3.17** Clinicians should support parents, siblings and other family members to spend time with a dying child, including in the period immediately after death.
5. Responding to concerns Clinicians get help to rapidly respond to patient suffering	**Adult** **5.4** Concern or worry that a patient is dying or approaching the end of their life and has unmet end-of-life care needs should prompt interdisciplinary review of the goals of care and the treatment plan, leading to appropriate recommendations for follow-up and ongoing communication. This applies regardless of whether the concern is raised by the patient; their substitute decision-maker, family or carers; or a clinician. **Paediatric** **5.3** Clinicians should conduct an interdisciplinary review of the goals of care and the treatment plan when concerns are raised that a child has unmet end-of-life care needs including physical, psychosocial or spiritual distress. Plan and document required follow-up and ongoing communication with the child, parents, and other clinicians. **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.

Relevant standard	Relevant action (where available) against Essential Component 8
10. Supporting systems Systems align with NSQHS Standards to improve outcomes	**Adult** **10.1** Systems should be in place to support clinicians to work with patients, families and carers to receive, prepare, review or update advance care plans and directives, according to the wishes of the patient. These systems should align with NSQHS *Standard 1 (Governance for safety and quality in health service organisations)* and *Standard 9 (Recognising and responding to clinical deterioration in acute health care).* **10.2** Systems should be in place to provide clinicians with access to essential palliative medications 24 hours a day, 7 days a week. These systems should align with NSQHS *Standard 4 (Medication safety).* **Paediatric** **10.1** The health service organisation should ensure that systems are in place to support clinicians to work with children and their families to receive, prepare, review or update age-appropriate advance care plans, according to the wishes of the child and their family. These systems should align with NSQHS *Standard 1 (Governance for safety and quality in health service organisations)* and *Standard 9 (Recognising and responding to clinical deterioration in acute health care).* **10.2** The health service organisation should ensure that systems are in place to provide clinicians with access to essential palliative medications 24 hours a day, seven days a week. These systems should align with NSQHS *Standard 4 (Medication safety).*

Standards for general practice (RACGP), 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 8
GP Standard 2.1: Continuous and comprehensive care	**GP2.1 b.** Our practice provides continuity of care and comprehensive care.

Aged Care Quality Standards (Australia)

Relevant standard	Relevant action (where available) against EC 8
3. Personal care and clinical care	
4. Services and supports for daily living	

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

Relevant standard	Relevant action (where available) against Essential Component 8
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 on the basis of 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 8
Key action 6: Symptom management	Timely and effective best practice symptom management is fundamental in the provision of quality end-of-life and palliative care (EoLPC) and must include engagement between primary health care and 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. **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.

Relevant standard	Relevant action (where available) against Essential Component 8
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.