Essential Component 9: Supporting people through loss and grief – standards comparison

National Palliative Care Standards, 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 9
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	**2.6** 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. **2.10** 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	**3.1** At least one carer is identified for each person as far as possible and their specific needs including need for information are assessed and documented. **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	**4.5** 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.
5. Transitions within and between services Care is integrated across the person's experience to ensure seamless transitions within and between services	**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. **5.5** 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).

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Relevant standard	Relevant action (where available) against Essential Component 9
6. Grief support Families and carers have access to bereavement support services and are provided with information about loss and grief.	**6.1** Culturally appropriate information and resources about loss, grief and bereavement support services is routinely provided to families and carers before and after the death. **6.2** The service provides education about loss, grief and bereavement to staff, volunteers and other community providers. **6.3** The service employs a structured assessment of bereavement that addresses emotional, behavioural, social, spiritual and physical domains. **6.4** The risk assessment process begins on intake to the palliative care service and continues throughout the service's involvement with the person and beyond. **6.5** The service uses validated tools to assess for signs and symptoms of persistent and intense distress in bereaved persons. **6.6** The service develops strategies and referral pathways, in partnerships with other providers in the community, to assist families and carers in feeling more prepared for the death and to accommodate grief into their lives after bereavement. **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.

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

Relevant standard	Relevant action (where available) against Essential Component 9
1. Clinical governance • Governance, leadership and culture	**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	**1.15** 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. **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.

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Relevant standard	Relevant action (where available) against Essential Component 9
• Safe environment for the delivery of care	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. **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 • Partnering with patients in their own care	**2.6** The health service organisation has processes for clinicians to partner with patients or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care.

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Relevant standard	Relevant action (where available) against Essential Component 9
• Health literacy • Partnering with consumers in organisational design and governance	**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. **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	**5.4** 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.

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Relevant standard	Relevant action (where available) against Essential Component 9
• Developing the comprehensive care plan • Delivering comprehensive care	**5.5** The health service organisation has processes to: **a.** support multidisciplinary collaboration and teamwork **b.** define the roles and responsibilities of each clinician working in a team. **5.6** Clinicians work collaboratively to plan and deliver comprehensive care **5.7** The health service organisation has processes relevant to the patients using the service and the services provided: **a.** for integrated and timely screening and assessment **b.** that identify the risks of harm in the *Minimising patient harm* criterion. **5.8** The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal or Torres Strait Islander origin, and to record this information in administrative and clinical information systems. **5.10** Clinicians use relevant screening processes: **a.** on presentation, during clinical examination and history taking, and when required during care **b.** to identify cognitive, behavioural, mental and physical conditions, issues and risks of harm **c.** to identify social and other circumstances that may compound these risks. **5.11** Clinicians comprehensively assess the conditions and risks identified through the screening process. **5.13** 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:

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Relevant standard	Relevant action (where available) against Essential Component 9
	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. **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	**5.21** 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.

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Relevant standard	Relevant action (where available) against Essential Component 9
	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. **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.

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Relevant standard	Relevant action (where available) against Essential Component 9
	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. **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 • Communication at clinical handover	**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. **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

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Relevant standard	Relevant action (where available) against Essential Component 9
• Communication of critical information • Documentation of information	**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. **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. **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	**8.5** 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.

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Relevant standard	Relevant action (where available) against Essential Component 9
• 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. **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 9
1. Patient and family-centred care Patients, children and families are part of decision making about end-of-life care	**Adult** **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.
3. Goals of care Clear goals improve quality of end-of-life care	**Adult** **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. **3.13** Bereaved family and carers should be provided with written information about how to access bereavement support when they have left the health service. **Paediatric** **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. **3.16** Clinicians should provide information about organ and tissue donation for transplantation, in circumstances where donation is possible. Discussions should be conducted with advice from the state or territory DonateLife agency. Such discussions should preferably be led by clinicians who have attended the core *Family Donation Conversation* workshop. If families have previously expressed a wish for the child to die at home, they should be informed that choosing organ donation may influence options for the place of death. The process of organ donation should not interfere with the family's wishes to be with their child for some time after death.

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Relevant standard	Relevant action (where available) against Essential Component 9
	3.17 Clinicians should support parents, siblings and other family members to spend time with a dying child, including in the time immediately after death. **3.18** Clinicians should provide bereaved parents, siblings and other family members with written information about how to access bereavement support from the time the child receives a life-limiting diagnosis. This may include providing support to the child's friends or, for an adolescent, boyfriend or girlfriend.

Standards for general practice (RACGP), 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 9
GP Standard 2.2: Follow up systems	**GP2.2 e.** High-risk (seriously abnormal and life-threatening) results identified outside normal opening hours are managed by our practice.

Aged Care Quality Standards (Australia)

Relevant standard	Relevant action (where available) against EC 9

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

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

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

Relevant standard	Relevant action (where available) against Essential Component 9
Key action 9: Grief and bereavement support	Grief and bereavement support assists with the multifaceted aspects of loss that are associated with death, such as emotional, financial and practical challenges. Support includes responding to needs around 'sorry business' practices for Aboriginal families and carers and specific cultural needs. **Action:** • Processes are in place to ensure the person and their family/carers are provided with grief and bereavement support throughout the care continuum, and processes are in place for the screening of all carers for bereavement risk. • Processes are in place to provide bereavement information and support in response to the needs of families and carers, at the time and after a death. Where risks or higher needs are identified, access to additional care planning, support and referrals are provided, including where the person was cared for outside of specialist palliative care.

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