Essential Component 10: Quality care is supported through access to reliable – standards comparison

National Palliative Care Standards, 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 10
1. Assessment of needs Initial and ongoing assessment incorporates the person's physical, psychological, cultural, social and spiritual experiences and needs	**1.5** Initial and ongoing assessments are documented in the person's clinical record.
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	**2.4** The person is supported to consider, document and update their future care goals including in an advance care plan. **2.5** A system is in place for receiving, storing, accessing and sharing existing advance care plans. **2.7** Initial and ongoing discussions informing the care plan are documented and readily available to guide care delivery.
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. **4.4** There are protocols and procedures in place for the escalation of care where required, based on assessed needs. **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	**5.9** The organisation has mechanisms in place to assess unmet needs and uses this information to develop plans for future improvement of the service.

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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	**7.2** The philosophy and objectives of the service are documented and incorporated into clinical practice guidelines, policies and procedures.
8. Quality improvement Services are engaged in quality improvement and research to improve service provision and development	**8.1** An ongoing quality improvement process is implemented to review clinical performance and outcomes, and to identify, implement and evaluate improvement activities. **8.2** Data about the effectiveness of palliative care delivery is collected, reviewed and reported locally. **8.3** System failures are systematically identified and investigated, and there are opportunities to learn from error. **8.4** The service engages in robust and rigorous clinical audit review. **8.5** The service is accredited to ensure achievement of governance and safety requirements. **8.6** The service participates in benchmarking processes to compare its service delivery over time and/or with external organisations. **8.7** The service supports staff to lead or participate in palliative care research wherever possible. **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. **8.9** The person, their family and carers and the community are provided with opportunities to provide input into the evaluation of the service via formal and informal feedback mechanisms.

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

Relevant standard	Relevant action (where available) against Essential Component 10

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.

• Patient safety and quality systems	**1.8** The health service organisation uses organisation-wide quality improvement systems that:
	  a. identify safety and quality measures and 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.

Relevant standard	Relevant action (where available) against Essential Component 10

	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.
	
	1.12 The health service organisation:
	   a. uses an open disclosure program that is consistent with the *Australian open disclosure framework*
	   b. monitors and acts to improve the effectiveness of open disclosure processes.
	
	1.13 The health service organisation:
	   a. has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care
	   b. has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems
	   c. uses this information to improve safety and quality systems.
	
	1.14 The health service organisation has an organisation-wide complaints management system, and:
	   a. encourages and supports patients, carers and families, and the workforce to report complaints
	   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.

Relevant standard	Relevant action (where available) against Essential Component 10
	1.16 The health service organisation has healthcare record systems that: a. make the healthcare record available to clinicians at the point of care b. support the workforce to maintain accurate and complete healthcare records c. comply with security and privacy regulations d. support systematic audit of clinical information e. integrate multiple information systems, where they are used. **1.17** The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. are designed to optimise the safety and quality of health care for patients b. use national patient and provider identifiers c. use standard national terminologies. **1.18** The health service organisation providing clinical information into the My Health Record system has processes that: a. describe access to the system by the workforce, to comply with legislative requirements b. maintain the accuracy and completeness of the clinical information the organisation uploads into the system.
• Clinical performance and effectiveness	**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. **1.27** 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. **1.28** 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

Relevant standard	Relevant action (where available) against Essential Component 10
	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.
2. Partnering with consumers • Clinical governance and quality improvement systems to support partnering with consumers	**2.1** Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. implementing policies and procedures for partnering with consumers b. managing risks associated with partnering with consumers c. identifying training requirements for partnering with consumers. **2.2** The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. monitoring processes for partnering with consumers b. implementing strategies to improve processes for partnering with consumers c. reporting on partnering with consumers.
• Partnering with patients in their own care	**2.6** 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.
• Partnering with consumers in organisational design and governance	**2.11** The health service organisation: a. involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community. **2.12** The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation. **2.13** The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs.
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 10

• 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, reconciling 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.

5. Comprehensive care
• Clinical governance and quality improvement to support comprehensive care
 	
• Developing the comprehensive care plan
	5.3 Clinicians use organisational processes from the *Partnering with Consumers Standard* when providing comprehensive care to:
	  a. actively involve patients in their own care
	  b. meet the patient's information needs
	  c. share decision-making.
	
	5.4 The health service organisation has systems for comprehensive care that:
	  a. support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment
	  b. provide care to patients in the setting that best meets their clinical needs
	  c. ensure timely referral of patients with specialist healthcare needs to relevant services
	  d. always identify the clinician with overall accountability for a patient's care
	
	5.8 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.
	
	5.9 Patients are supported to document clear advance care plans.

Relevant standard	Relevant action (where available) against Essential Component 10

• Delivering comprehensive care	**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.
	
	5.16 The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice.
	
	5.17 The health service organisation has processes to ensure that current advance care plans:
	  a. can be received from patients
	  b. are documented in the patient's healthcare record.
	
	5.19 The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care.
	
	5.20 Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care.*

Relevant standard	Relevant action (where available) against Essential Component 10

6. Communicating for safety
 	
• Clinical governance and quality improvement to support effective communication
	6.1 Clinicians use the safety and quality systems from the *Clinical Governance Standard* when:
	  a. implementing policies and procedures to support effective clinical communication
	  b. managing risks associated with clinical communication
	  c. identifying training requirements for effective and coordinated clinical communication.
	
	6.4 The health service organisation has clinical communications processes to support effective communication when:
	  a. identification and procedure matching should occur
	  b. all or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations and on discharge
	  c. critical information about a patient's care, including information on risks, emerges or changes.

• 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
	8.4 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.

Relevant standard	Relevant action (where available) against Essential Component 10
• Responding to acute deterioration	**8.6** The health service organisation has protocols that specify criteria for escalating care, including: a. agreed vital sign parameters and other indicators of physiological deterioration b. agreed indicators of deterioration in mental state c. agreed parameters and other indicators for calling emergency assistance d. patient pain or distress that is not able to be managed using available treatment e. worry or concern in members of the workforce, patients, carers and families about acute deterioration. **8.7** The health service organisation has processes for patients, carers or families to directly escalate care. **8.8** 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 10
1. Patient/family centred care Patients, children and families are part of decision making about end-of-life care	**Adult** **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. **1.11** Clinicians should check that patients, families and carers have been provided with sufficient support to make decisions. This includes support for patients, substitute decisionmakers, families and carers who have communication difficulties associated with cultural and linguistic diversity, or decision-making difficulties associated with disability, mental illness or cognitive impairment. **1.12** Clinicians should clearly document the content of the discussion and any agreed plan of care in the patient clinical record. Any unresolved issues that require further follow-up should also be documented, along with a plan for follow-up. **1.13** The content of the discussion and plan of care, including any limitations of medical treatment, should be communicated to all teams involved in the patient's care, including relevant community care providers. **Paediatric** **1.12** 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. **1.13** Clinicians should check that the child and their parents have been provided with sufficient support to make decisions. This includes support for children and parents who have communication difficulties, cultural, spiritual or linguistic needs, or decision-making difficulties associated with disability, mental illness or cognitive impairment. **1.14** Clinicians should clearly document the content of discussions and any agreed plan of care in the patient clinical record. Any unresolved issues that require further follow-up should be documented, along with a plan for follow-up. **1.15** Clinicians should communicate the content of the discussion and plan of care, including any limitations of medical treatment, to all teams involved in the child's care, including relevant community care providers.

Relevant standard	Relevant action (where available) against Essential Component 10
3. Goals of care Clear goals improve quality of end-of-life care	**Adult** **3.1** The psychosocial, cultural and spiritual needs of patients, families and carers should be assessed, and care should be provided in accordance with their wishes, values and needs. Support should be offered for patients, carers and families who wish to include cultural or religious practices in their care, such as particular foods, singing, ceremonies or healing. **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 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. **3.5** The goals of care, the treatment plan and any limitations of medical treatment for the current admission should be appropriately discussed with the patient, and their substitute decision-maker, family and carers, and clearly documented in the patient clinical record by the treating medical officer or team. This should occur as early as possible in the patient's admission to the health service, and the information should be routinely reviewed and updated throughout the admission. **3.6** The rationale for medical decisions to discontinue or withhold non-beneficial observations, investigations or treatments should be clearly communicated with the patient, family and carers. **3.8** Information about the advance care plan, clinical treatment plan, goals of care, any limitations of medical treatment and the patient's treatment preferences should be readily available to all clinicians involved in the patient's care, including those involved in caring for the patient in emergencies, after hours and, where relevant, in the community. **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

Relevant standard	Relevant action (where available) against Essential Component 10
	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. **Paediatric** **3.2** Clinicians should inform families about the process and purpose of advance care planning. This process should be undertaken using age-appropriate advance care planning documents where available. **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. **3.4** Clinicians should document the outcomes of the decision-making process in the child's clinical record. These outcomes include the goals of care, the agreed treatment plan, including prevention and relief of suffering, and any limitations of medical treatment. **3.6** Clinicians should clearly communicate the rationale for medical decisions to discontinue or withhold nonbeneficial observations, investigations or treatments to the parents and, where appropriate, the child. **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. **3.8** Information about the advance care plan, clinical treatment plan, goals of care, any limitations of medical treatment, and the child and parents' treatment preferences should be readily available to all clinicians involved in the child's care, including those involved in caring for the child in emergencies, after hours, through ambulance services and, where relevant, in the community. **3.11** Clinicians should manage physical symptoms in alignment with the child and their parents' wishes, and review treatment regularly. **3.19** Clinicians should consider whether the death of a child may need to be reported to the coroner. Clinicians should discuss this with the parents and other relevant health care providers prior to the death of the child.

Relevant standard	Relevant action (where available) against Essential Component 10
5. Responding to concerns Clinicians get help to rapidly respond to patient or child 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. **5.6** To avoid after-hours decisions to limit medical treatment or stop non-beneficial treatments, pre-emptive planning should be undertaken by the team with overall responsibility for the patient's care. When after-hours decision-making is required as a result of sudden or unexpected deterioration in the patient's condition, the patient should be followed up by the responsible team as soon as possible. **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. **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. **5.6** Clinicians providing assistance in emergency situations should: • have access to support from a clinician of sufficient authority to make decisions about stopping nonbeneficial treatments and providing palliative care • document appropriate, detailed and structured information about the outcomes of the call for assistance, discussions with the child and their parents, and the plan for follow-up or further review of the child in the healthcare record • communicate with the responsible medical officer in an appropriate, detailed and structured way about the outcomes of the call for assistance, and the plan for follow-up or further review of the child • use calls for assistance as a teaching and mentoring opportunity for other clinicians and students whenever possible, although resolving the concerns of the child and their parents should be the first priority.

Relevant standard	Relevant action (where available) against Essential Component 10
6. Leadership and governance Policies and systems for end-of-life care	**Adult** **6.2** The health service executive should consider how best to allocate resources within the context of the organisation's strategic plan to support the delivery and effective functioning of systems for providing end-of-life care. **6.4** The policy framework for end-of-life care should apply across the acute health service. It should identify potential variations in its application that might exist in different circumstances (such as at different times of day or in satellite locations). **6.6** Policies and processes should be in place regarding advance care directives, organ and tissue donation, limitations of medical treatment and end-of-life decision-making to ensure that the care delivered in response to deterioration is consistent with appropriate clinical practice and the patient's expressed wishes. **6.7** A formal governance process should be in place to oversee the development, implementation and ongoing review of systems for end-of-life care. If a committee has this role, it should: • have appropriate responsibilities delegated to it and be accountable for its decisions and actions to the executive • monitor the effectiveness of interventions and education. • have a role in reviewing performance data • provide advice about the allocation of resources • include consumers, interdisciplinary team members, managers and executives. **Paediatric** **6.2** The health service executive should consider how best to allocate resources within the context of the organisation's strategic plan to support the delivery and effective functioning of systems for providing paediatric end-of-life care. **6.4** The health service organisation should identify potential variations in the application of the policy framework that might exist in different circumstances (such as at different times of day or in satellite locations). **6.6** The health service organisation should establish a formal governance process to oversee the development, implementation and ongoing review of systems for end-of-life care. If a committee has this role, it should: • have appropriate responsibilities delegated to it and be accountable for its decisions and actions to the executive • monitor the effectiveness of interventions and education • have a role in reviewing performance data

Relevant standard	Relevant action (where available) against Essential Component 10
	• provide advice about the allocation of resources • include consumers, interdisciplinary team members, managers and executives.
7. Education and training Clinicians have the skills and knowledge to provide end-of-life care	**Adult** **7.1** All members of the interdisciplinary team should receive education about their roles and responsibilities in relation to local systems and processes for recognising and managing end-of-life care. **7.4** Junior and student clinicians should be encouraged and enabled to take up the learning opportunities offered by participating in family meetings, multidisciplinary case review meetings, mortality and morbidity conferences, and adverse event reviews. **7.5** Clinicians should receive ongoing education about disease-specific symptom assessment and evidence-based symptom management relevant to their area of practice. **7.6** Education should cover ethical and medico-legal issues, including the relevant professional ethical frameworks, and the relevant legislation in the state or territory of clinical practice. **Paediatric** **7.1** The health service organisation should provide education for all members of the interdisciplinary team about their roles and responsibilities in relation to local systems and processes for recognising and managing end-of-life care. **7.4** The health service organisation should encourage and enable junior and student clinicians to take up the learning opportunities offered by participating in family meetings, multidisciplinary case review meetings, mortality and morbidity conferences, and adverse event reviews. **7.5** The health service organisation should ensure that clinicians receive ongoing education about disease-specific symptom assessment and evidence-based symptom management relevant to their area of practice. **7.6** Education should cover ethical and medico-legal issues, including the relevant professional ethical frameworks, and the relevant legislation in the state or territory of clinical practice.
9. Evaluation and feedback The quality of end-of-life care is measured and improved	**Adult** **9.1** Data about the effectiveness of processes and systems for delivering end-of-life care should be collected, reviewed and reported locally (including over time).

Relevant standard	Relevant action (where available) against Essential Component 10
	9.2 Clinicians must lead evaluation and audit and feedback aggregate, de-identified data to their peers and colleagues.
	9.3 Monitoring and evaluation strategies should be developed to capture feedback about the quality of end-of-life care from multiple disciplines (for example, medicine, nursing, social work), as well as from patients, substitute decision-makers, families and carers.
	9.4 Evaluation and monitoring should be simple, inexpensive and feasible. The processes should use routinely collected data and data linkage, where possible.
	9.5 Measures of the safety and quality of end-of-life care could include: • whether triggers to identify patients approaching the end-of-life were correctly used and applied • effectiveness of treatment of symptoms • documentation of the patient's wishes and alignment of the patient's expressed wishes with actual care • real-time feedback on patient experiences of care • feedback on their experiences from families and carers of patients who received end-of life care • whether any existing advance care directive or plan was enacted • the category of death (expected, unexpected or diagnosis) • the time lapse between deciding to palliate or referring to specialist palliative care, and death • transfers of care in the last week of life (for example, transfers to or from intensive care).
	9.6 Methods for collecting data could include: • retrospective audit of case notes (for example, documentation of discussions, patient preferences, anticipatory plan of care and plan of care in the terminal phase; appropriateness and frequency of clinical observations) • medication chart safety review (to determine whether inappropriate medications were stopped, and palliative medications were prescribed and administered appropriately) • follow-up with families, carers, clinicians and other staff involved in the patient's end-of-life care • use of tools developed for specific settings (for example, the Family Satisfaction section in the Intensive Care Unit survey) • multidisciplinary mortality and morbidity review.
	9.7 All deaths should be routinely reviewed to determine whether the safety and quality of the patient's end-of-life care were acceptable, and how they could have been improved.

Relevant standard	Relevant action (where available) against Essential Component 10
	Paediatric **9.1** The health service organisation should collect, review and report locally (including over time) data about the effectiveness of processes and systems for delivering paediatric end-of-life care. **9.2** The health service organisation should ensure that clinicians lead evaluation and audit, and feedback aggregate, de-identified data to their peers and colleagues. **9.3** The health service organisation should develop monitoring and evaluation strategies to capture feedback about the quality of paediatric end-of-life care from multiple disciplines (for example, medicine, nursing, social work), as well as from children and their families. **9.4** Evaluation and monitoring should be simple, inexpensive and feasible. The health service organisation should develop processes that use routinely collected data and data linkage, where possible. **9.5** Measures of the safety and quality of end-of-life care could include: • effectiveness of treatment of symptoms • recognition of the child's disease trajectory • documentation of the child and their parents' wishes, and alignment of these wishes with actual care • real-time feedback on child and family experiences of care • feedback on their experiences from families of children who received end-of-life care • whether any existing advance care plan was enacted • the category of death (expected, unexpected or diagnosis) • the time lapse between deciding to palliate or referring to specialist palliative care, and death • transfers of care in the last week of life (for example, transfers to or from intensive care). **9.6** Methods for collecting data could include: • retrospective audit of case notes (for example, documentation of discussions, the child and their parents' preferences, anticipatory plan of care and plan of care in the terminal phase; appropriateness and frequency of clinical observations) • medication chart safety review (to determine whether inappropriate medications were stopped, and palliative medications were prescribed and administered appropriately). • follow-up with families, clinicians and other staff involved in the child's end-of-life care • use of tools developed for specific settings (for example, the Family Satisfaction section in Intensive Care Survey) • multidisciplinary mortality and morbidity review.

Relevant standard	Relevant action (where available) against Essential Component 10
	9.7 The health service organisation should implement processes to routinely review the safety and quality of all deaths and determine if end-of-life care could have been improved.
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)*. **10.4** Organisations should implement processes to improve communication between health services at transitions of care. This should include processes for communicating the content of discussions about prognosis and advance care planning. These processes should align with NSQHS *Standard 6 (Clinical handover)*. **10.5** Health services should work with community care providers to ensure that systems are in place for communicating and accessing advance care directives or plans developed in community care settings. **10.6** Systems should be in place to facilitate appropriate documentation about end-of-life care, and to reduce the burden of documentation and data collection when possible. **10.7** Technological systems and solutions should be implemented where they will support safe and high-quality end-of-life care, in accordance with the essential elements in this Consensus Statement. **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)*. **10.4** The health service organisation should implement processes to improve communication between health services at transitions of care. This should include processes for communicating the content of discussions about prognosis and advance care planning. These processes should align with NSQHS *Standard 6 (Clinical handover)*.

Relevant standard	Relevant action (where available) against Essential Component 10
	10.5 The health service organisation should work with community care providers to ensure that systems are in place for communicating and accessing advance care plans developed in community care settings. **10.6** The health service organisation should ensure that systems are in place to facilitate appropriate documentation about end-of-life care, and to reduce the burden of documentation and data collection when possible. **10.7** The health service organisation should implement technological systems and solutions where they will support safe and high-quality paediatric end-of-life care, in accordance with the essential elements in this Consensus Statement.

Standard for general practice (RACGP), 5th Edition

Relevant standard	Relevant action (where available) against Essential Component 10
Core Standard 6: Information management	**C6.** Information management
Core Standard 7: Content of patient health records	**C7.** Content of patient health records

Aged Quality Care Standards (Australia)

Relevant standard	Relevant action (where available) against Essential Component 10
8. Organisational governance	

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

Relevant standard	Relevant action (where available) against Essential Component 10
3. There is access to care providers across all settings who are skilled and competent in end-of-life and palliative care	End-of-life and palliative care can be delivered in multiple settings. It must be supported by a skilled and competent workforce.
4. Care is well-coordinated and integrated	People needing end-of-life and palliative care may receive care from multiple services across a number of settings. Care should be delivered in an integrated and well-coordinated manner with seamless transitions between services and settings.

Relevant standard	Relevant action (where available) against Essential Component 10
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

Relevant Standard	Relevant action (where available) against Essential Component 10