

National Palliative Care Standards

DRAFT FOR CONSULTATION

DRAFT

Introduction

The National Palliative Care Standards represent a set of philosophical standards that clearly articulate and promote a vision for compassionate and appropriate end of life care. The Standards, currently in their fourth edition, are developed by Palliative Care Australia in collaboration with the palliative care community.

Palliative Care Australia have worked with the Standards Review Group to review and update the fourth edition of the standards. There are several things that have changed, and many things remain the same. The standards have not been updated since 2005 and much has changed for palliative care over that time, including the language we use to describe those we care for.

How to Utilise the Standards

The Standards have been developed to be utilised by Specialist Palliative Care services [*defined under the definitions section*] to support the delivery of high quality palliative care for the person receiving care (the person), their family and carers.

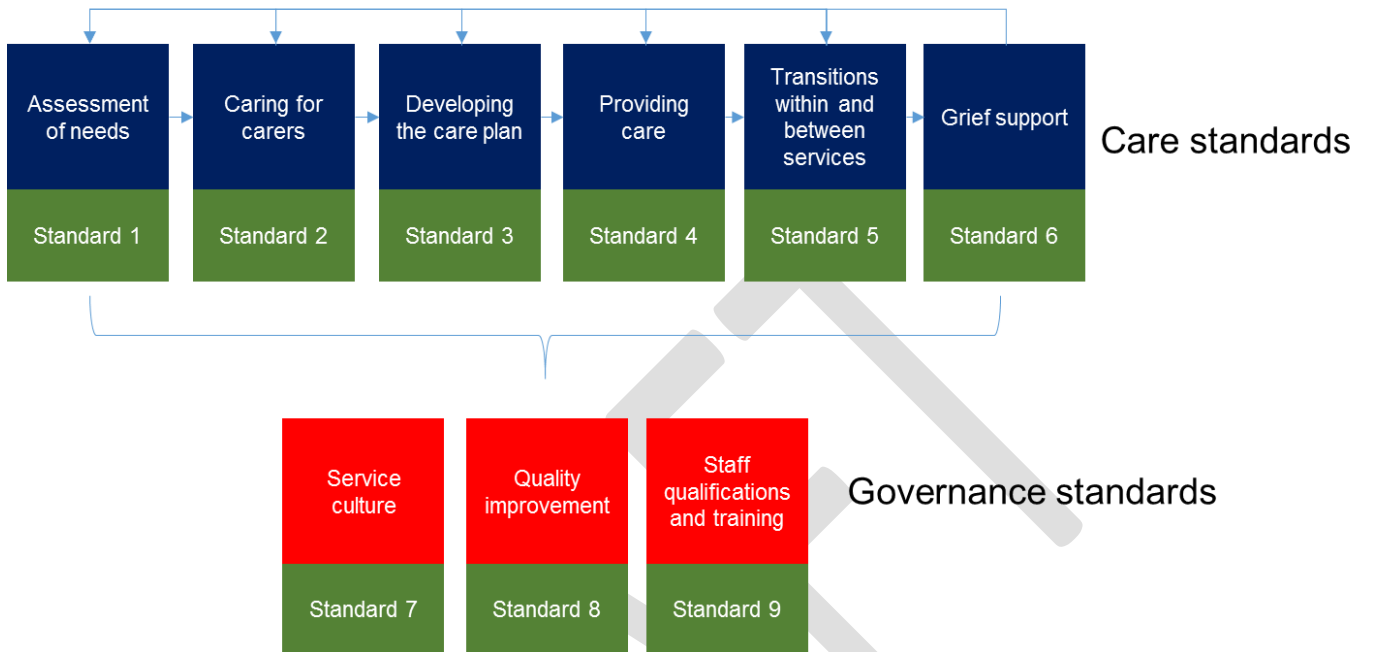
The Standards are designed to complement other Standards programmes that organisations may be required to meet. To assist in identifying these intersections with other programmes, the Standards have been mapped against the below to assist in identifying these areas:

- The Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards (Version 1).
- The ACSQHC National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care.
- The Accreditation Standards, as identified in the Quality of Care Principles 2014 and administered by the Australian Aged Care Quality Agency (AACQA).
- The previous version of Palliative Care Australia's Standards for Providing Quality Palliative Care for all Australians (2005).

The Standards are designed as service standards and not as clinical standards and therefore do not focus on patient outcomes. Instead they are divided into two categories (refer to diagram 1): Care Standards (Standard 1 to 6) and Governance Standards (Standard 7 to 9), which can assist services with their quality management, quality improvement and benchmarking. The Standards are assessed under Palliative Care Australia's National Standards Assessment Programme (NSAP).

The Standards are designed to identify minimum standards but also have components of aspirational standards that are targeted towards services that have a higher capacity, for example, to undertake complex research projects. This is a shift from the previous version of the Standards and seeks to assist in supporting organisations with a sole practitioner but also be relevant for the large services that are well resourced and have a comprehensive research and teaching role.

Diagram I: Overview of the National Palliative Care Standards



STANDARD 1.

Initial and ongoing assessment incorporates the person's physical, psychological, cultural, social and spiritual experiences and needs.

Intent of the standard

The person, their family and carers are actively involved in the initial and ongoing assessment, which focuses on their physical, psychological, cultural, social and spiritual needs.

A comprehensive and holistic assessment of the person's needs should be undertaken on presentation. Reassessment should occur regularly, particularly at changes in the phase of care. This includes identifying when the person is imminently dying and incorporating assessment of the specific needs associated with this phase.

The life experiences of the person will influence their preferences as they approach and reach the end of their life. Their life may be shaped by culture, religion, ethnicity or experience. Some people will have very deep attachments to these aspects of their life – others less so. Consideration of the physical, psychological, cultural, social and spiritual experience and needs of the person is an important part of the initial and ongoing assessment.

The person's care plan, and any changes that may occur to it, are directly informed by comprehensive and holistic assessments.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 1.1. The initial and ongoing assessments carried out by qualified interdisciplinary personnel are holistic. The assessment is coordinated to avoid duplication.
- 1.2. Clinical assessment tools are informed by the best available evidence and identify those approaching the end of life as well as those that are imminently dying.
- 1.3. The person's needs including phase changes are reassessed on a regular basis based on the person's condition and need.
- 1.4. Initial and ongoing assessments are documented in the person's clinical record and are evidenced in the care plan.

Mapping

<p>2005 Palliative Care Standards</p>	<p><i>Std. 2 The holistic needs of the patient, their caregiver/s and family, re acknowledged in the assessment and care planning processes, and strategies are developed to address those needs, in line with their wishes.</i></p> <p><i>Std. 3 Ongoing and comprehensive assessment and care planning are undertaken to meet the needs and wishes of the patient, their caregiver/s and family.</i></p>
<p>NSQHS Standards</p>	<p><i>Std. 1 Governance</i></p> <ul style="list-style-type: none"> • Patients' rights & engagement (specifically 1.17) • Clinical practice is "guided by current best practice" <p><i>Std. 2 Partnering with consumers</i></p> <ul style="list-style-type: none"> • Intention is to "Create a health service that is responsive to patient, carer and consumer input and needs." <p><i>Std. 6 – Clinical handover</i></p> <ul style="list-style-type: none"> • Patient & carer involvement in clinical handover <p><i>Std. 9 – Recognising & responding</i></p> <ul style="list-style-type: none"> • Communicating with patients & carers
<p>National Consensus Statement: Essential elements for safe high quality end of life care</p>	<p><i>EE 1</i> <i>Patient-centred communication & shared decision making</i></p> <ul style="list-style-type: none"> • Action 1.4 "individual preferences & needs of all patients [etc]" <p><i>EE 3 Components of care</i></p> <ul style="list-style-type: none"> • Action 3.1 "The psychosocial, cultural & spiritual needs of patients, families & carers should be assessed, and care should be provided in accordance with their wishes, values & needs."
<p>Aged care standards</p>	<p><i>Std. 2 Health & personal care</i></p> <ul style="list-style-type: none"> • 2.4 Clinical care "Care recipients receive appropriate clinical care." • 2.5 Specialised nursing needs "Care recipients' specialised nursing care needs are identified and met by appropriately qualified nursing staff." • 2.6 Other health and related services "Care recipients are referred to appropriate health specialists in accordance with the care recipient's needs and preferences." <p><i>Std. 3 Care recipient lifestyle</i></p> <ul style="list-style-type: none"> • 3.4 Emotional support "Each care recipient receives support in adjusting to life in the new environment and on an ongoing basis." • 3.8 Cultural & spiritual life "Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered." • 3.9 Choice & decision-making "Each care recipient (or his or her representative) participates in decisions about the services the care recipient receives" <p><i>Std. 4 Physical environment and safe systems</i></p> <ul style="list-style-type: none"> • Management of the residential care service is actively working to provide a safe and comfortable environment consistent with care recipients' care needs.

STANDARD 2.

The person's family and carers needs are assessed, including their need for information, and they are provided with appropriate support and guidance about their role according to their needs and preferences.

Intent of the standard

The person's family and carers provide an important and indispensable role providing physical, emotional, social and spiritual support and care. It is very important that services value this role, appreciate its importance and support the person's family and carers by working with them to understand the level of care that they are willing and able to provide.

The needs of the family and carers should be assessed independently from that of the patient. This will support them to better fulfil their role and aims to reduce the associated stress. Support may include facilitating access to equipment, nursing support, respite, counselling, information about financial support and any other services that are required to assist the family and carers.

It is also important that the family and carers are provided with a clear plan for the management of out-of-hours concerns or unexpected events in relation to the care of the person.

It is important to recognise that carers are often but not always family members and that a person may have more than one carer, each one requiring assessment, information and support.

Moreover a person may want specific family members or friends who are not their identified carers to be involved in and informed about their care. Clear identification of these individuals is necessary to enable effective communication and avoid distress caused by inadequate communication.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 2.1. At least one carer is identified for each person as far as possible and their specific needs are assessed and documented.
- 2.2. The service works with the family and the carers to understand their needs and desired level of involvement in care. The potential benefits and risks around assisting with care are discussed with the family and carers and there is ongoing assessment of their willingness and ability to participate in the provision of care.
- 2.3. 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).

- 2.4. The family and carers are provided with up to date information and resources that are adapted to meet their needs and that inform their participation in care planning and delivery. This may include information about accessing respite services, equipment, financial support and other services, as well as encouraging the involvement of personal support networks.
- 2.5. The family and carers are provided with a clear plan for emergency and out-of-hours events.
- 2.6. When care is provided in the home, the family and carers are educated on how to safely assist with care, including the administration of medications, lifting and bathing the person, preventing accidents, how to manage when their loved one can no longer swallow or maintain continence, and how to achieve self-care.
- 2.7. The family and carers are provided with information about the signs and symptoms of approaching death and the steps to take following the death, in a way that is appropriate for their age, culture and social situation. This may include education about administration of medications if providing care in the home.

Mapping

2005 Palliative Care Standards	<p><i>Std. 5 The primary caregiver/s is provided with information, support and guidance about their role according to their needs and wishes.</i></p> <p><i>Std. 8 Formal mechanisms are in place to ensure that the patient, their caregiver/s and family have access to bereavement care, information and support services.</i></p>
NSQHS Standards	<p><i>Std. 2 Partnering with consumers</i></p> <p><i>Std. 3 Communicating with patients and carers</i> Criteria Communicating with patients and carers: Information on healthcare associated infections is provided to patients, carers, consumers and service providers.</p> <p><i>Std. 4 Medical safety</i> Criteria Communicating with patients and carers: The clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan.</p> <p><i>Std. 7 Blood & Blood products</i> Criteria Communicating with patients and carers: Patients and carers are informed about the risks and benefits of using blood and blood products, and the available alternatives when a plan for treatment is developed.</p> <p><i>Std. 8 Preventing & managing pressure injuries</i> Criteria Communicating with patients and carers: Patients and carers are informed of the risks, prevention strategies and management of pressure injuries.</p> <p><i>Std. 9 Recognising & responding</i></p>

	<p>Criteria Communicating with patients and carers: Patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.</p> <p><i>Std. 10 Preventing falls</i></p> <p>Criteria Communicating with patients and carers: Patients and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan.</p>
<p>National Consensus Statement: Essential elements for safe high quality end of life care</p>	<p><i>EE 1 Patient-centred communication & shared decision making</i></p> <ul style="list-style-type: none"> • Action 1.3 “Culturally appropriate decision makers should be identified” • Action 1.4 “Clinicians should seek to understand ... be responsive to, the individual preferences & needs of all patients [etc]” • Action 1.6 “The patient [etc] should be provided with written information” • Action 1.7 “Clinicians should work with patients, families & carers to ensure key family members, substitute decisions-makers & carers are present during end-of-life discussions” • Action 1.11 “patients, families & carers ... provided with sufficient support to make decisions” <p><i>EE 3 Components of care</i></p> <ul style="list-style-type: none"> • Action 3.1 “The psychosocial, cultural & spiritual needs of patients, families & carers should be assessed, and care should be provided in accordance with their wishes, values & needs.” • Action 3.5 “The goals of care ... should be appropriately discussed with the patient, and their substitute decision-maker, family and carers” • Action 3.6 “The rationale for medical decisions should be clearly communicated with the patient, family and carers.” • Action 3.7 “The patient, substitute decision-maker, family and carers should be empowered to request further discussion and a review of the plan at any time.” • Action 3.9 “The patient, family and carers should not feel abandoned by the healthcare team” • Action 3.12 “Family and carers should be supported to spend time with a dying patient in accordance with their wishes” • Action 3.13 “Bereaved family and carers should be provided with written information about how to access bereavement support” <p><i>EE 5 Response to concerns</i></p> <ul style="list-style-type: none"> • Action 5.2 “The patient, substitute decision-maker, family and carers should understand the triggers and process for requesting an urgent review, and the process for responding to their request.” • Action 5.3 “Processes should be in place to enable patients, substitute decision-makers, families, carers ... to escalate concern until a satisfactory resolution is achieved.” <p><i>EE 6 Leadership & governance</i></p> <ul style="list-style-type: none"> • Action 6.1 Patients, and their families and carers should be partners in the development and governance of organisational systems for delivering end-of-life care.
<p>Aged care standards</p>	<p><i>Nil</i></p>

STANDARD 3.

The team works in partnership with the person, their family and carers to communicate, plan, set goals and make decisions about the care plan.

Intent of the standard

The person should be an active partner in their care planning as they approach and reach the end of life. Families, carers and substitute decision-makers should be included to the extent agreed upon by the person.

Comprehensive assessment provides the foundation for care planning and the care plan is re-evaluated regularly following re-assessments, particularly at changes in the person's condition. The person should be supported to consider and document their future care goals and preferences (for example in an Advance Care Plan, Goals of Care or Advance Care Directive). The person's care plan and future care goals are documented in the person's clinical record, and communicated to all those involved in the delivery of care.

Recognising that every person is unique, that their experiences as they approach the end-of-life will be different and that their goals may change over time is crucial to the delivery of care that is respectful, compassionate and that maintains dignity.

Where the person is not able to participate in care planning or decision-making it is important that a substitute decision-maker is identified in accordance with the person's goals and preferences and relevant legislation and/or policies.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 3.1. The person, their family and carers are provided with up to date information appropriate to meet their needs and to support their informed participation in care planning and decision-making.
- 3.2. Care planning is informed by the assessment process and reflects a person-centred, holistic approach that incorporates cultural, spiritual, physical, psychological and social needs.
- 3.3. The person is supported to consider, document and update their future care goals, including in an advance care plan (or other relevant state or territory future planning arrangement).
- 3.4. 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 with mental health needs, people with intellectual disabilities or people from different cultural backgrounds.
- 3.5. Initial and ongoing discussions that may inform the care plan are documented and readily available to guide care delivery.

- 3.6. The person, their family and carers expectations and preferences for the type and place of care are discussed, negotiated and an agreed plan is documented.
- 3.7. The care plan is reviewed and updated regularly, on the basis of re-assessments 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.
- 3.8. Systems are in place to identify a substitute decision maker if a person does not have the capacity to make decisions for themselves.
- 3.9. Care plans incorporate management for emergency and out of hours support, including certification of death and plans for the care and collection of the body where this is required after hours.

Mapping

2005 Palliative Care Standards	<i>Std. 1 Care, decision-making and care planning are each based on a respect for the uniqueness of the patient, their caregiver/s and family. The patient, their caregiver and family's needs and wishes are acknowledged and guide decision-making and care planning.</i>
NSQHS Standards	<p><i>Std. 1 Governance</i> Criterion: Patient rights & engagement (specifically 1.18)</p> <p><i>Std. 2 Partnering with Consumers</i></p> <p><i>Std. 4 Medical safety</i> Criterion Continuity of medication management (specifically 4.14)</p> <p><i>Std. 7 Blood and Blood Products</i> Criterion Communicating with patients and carers (specifically 7.9.2)</p> <p><i>Std. 8 Preventing and Managing Pressure Injuries</i> Criterion Communicating with patients and carers (specifically 8.10)</p> <p><i>Std. 9 Recognising and Responding to Clinical Deterioration</i> Criterion Communicating with patients and carers (specifically 9.8.1)</p> <p><i>Std. 10 Preventing Falls and Harm from Falls</i> Criterion Communicating with patients and carers (specifically 10.10)</p>
National Consensus Statement: Essential elements for safe high quality end of life care	<p><i>EE 1 Patient-centred communication & shared decision making</i></p> <ul style="list-style-type: none"> • Action 1.1 “Clinicians and patients should identify opportunities for proactive and pre-emptive end-of-life care discussions” • Action 1.2 “The clinical team should work with the patient, family and carers to identify [who] the patient wishes to be involved in discussions about their care.” • Action 1.3 “Culturally appropriate decision makers should be identified” • Action 1.4 “Clinicians should seek to understand ... be responsive to, the individual preferences & needs of all patients [etc]” • Action 1.6 “The patient [etc] should be provided with written information”

	<ul style="list-style-type: none"> • Action 1.7 “Clinicians should work with patients, families & carers to ensure key [people] are present during end-of-life discussions” • Action 1.9 “Clinicians should ... allow adequate time for those involved to absorb, process and react to the information they are being given.” • Action 1.8 “Clinicians should provide an honest and straight forward summary ... Clinicians should be compassionate and sensitive, use plain language, and avoid the use of medical jargon.” • Action 1.11 “patients, families & carers ... provided with sufficient support to make decisions” <p><i>EE 2 Teamwork & coordination of care</i></p> <ul style="list-style-type: none"> • Action 2.2 “The roles and responsibilities of different understood by all those involved in a patient’s care, including the patient themselves, and their substitute decision-maker, family and carers.” • Action 2.3 “If there is disagreement or ambiguity ... the range of views and the reasons for them should be discussed with the patient [etc].” <p><i>EE 3 Components of care</i></p> <ul style="list-style-type: none"> • Action 3.5 The goals of care ... should be appropriately discussed with the patient [etc].” • Action 3.7 “The goals of care, treatment plan and any limitations of medical treatment should be revisited with the patient [etc]” • Action 3.8 “Information about the advance care plan ... the patient’s treatment preferences should be readily available to all clinicians [etc]”
Aged care standards	Nil

STANDARD 4.

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.

Intent of the standard

Care is based on recent and comprehensive clinical assessment, delivered in accordance with the person's expressed values, goals of care and preferences as evidenced in their care plan, and informed by the best available evidence. Effective care enables the person to live as well as possible, right to the end of their life.

Distress caused by symptoms (physical, psychosocial or spiritual) is actively pre-empted, but where it occurs the response is timely and effective. This includes prompt response to needs, regularly reviewing the effectiveness of treatment, and ensuring the person, their family and carers have timely access to specialist palliative care at all times. The dignity of the person is prioritised at all times through a person-centred approach to their overall care.

It is not always possible to provide care that matches a person's preferences. Where the person's preferences cannot be met, the service is expected to explain the reasons for this to them, their family and carers and to discuss acceptable alternatives.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 4.1. Care is delivered promptly, in accordance with the changing needs of the person, their family and carers, their documented care plan and their goals and preferences.
- 4.2. The service takes practical steps to keep abreast with new and emerging evidence, and uses the best available evidence to inform clinical practice.
- 4.3. Where care cannot be delivered in accordance with the goals and preferences of the person, this is discussed with the person, their family, and carers, and an agreed alternative plan is documented and communicated.
- 4.4. There are protocols and procedures in place for the escalation of care where required based on assessed needs.
- 4.5. The service aims to actively pre-empt distress to the best of their ability but when it occurs, the response to it is timely, appropriate and effective, and actions are documented.

Mapping

<p>2005 Palliative Care Standards</p>	<p><i>Std. 2 The holistic needs of the patient, their caregiver/s and family, re acknowledged in the assessment and care planning processes, and strategies are developed to address those needs, in line with their wishes.</i></p> <p><i>Std 3. Ongoing and comprehensive assessment and care planning are undertaken to meet the needs and wishes of the patient, their caregiver/s and family.</i></p> <p><i>Std. 6 The unique needs of dying patients are considered, their comfort maximized and their dignity preserved.</i></p>
<p>NSQHS Standards</p>	<p><i>Std. 1 Governance</i> Criterion Clinical practice (specifically 1.7)</p> <p><i>Std. 2 Partnering with consumers</i></p> <p><i>Std. 8 Preventing and Managing Pressure Injuries</i> Criterion Governance (specifically 8.1) Criterion Preventing & managing (specifically 8.8)</p> <p><i>Std. 9 Recognising & responding</i> Criterion Responding (specifically 9.5)</p> <p><i>Std. 10 Preventing falls</i> Criterion Governance (specifically 10.1)</p>
<p>National Consensus Statement: Essential elements for safe high quality end of life care</p>	<p><i>EE 3 Components of care</i></p> <ul style="list-style-type: none"> • Action 3.1 “The psychosocial, cultural & spiritual needs of patients, families & carers should be assessed, and care should be provided in accordance with their wishes, values & needs.” <p><i>EE 7 Education and training</i></p> <ul style="list-style-type: none"> • Action 7.5 Clinicians should receive ongoing education about disease-specific symptom assessment and evidence-based symptom management relevant to their area of practice.
<p>Aged care standards</p>	<p><i>2.4 Clinical care:</i> Care recipients receive appropriate clinical care.</p> <p><i>2.5 Specialised nursing care needs:</i> Care recipients’ specialised nursing care needs are identified and met by appropriately qualified nursing staff.</p> <p><i>2.6 Other health and related services:</i> Care recipients are referred to appropriate health specialists in accordance with the care recipient’s needs and preferences.</p> <p><i>4.4 Living environment:</i> Management of the residential care service is actively working to provide a safe and comfortable environment consistent with care recipients’ care needs.</p>

STANDARD 5.

Care is integrated across the person's experience to ensure seamless transitions within and between services.

Intent of the standard

People may receive care from multiple services as they approach and reach the end of life. Understanding the values, goals and preferences of the person, their family and carers and communicating these effectively during movements within and between care settings will support delivery of effective, person-centred and coordinated care.

Oral communication between care providers should be supported by sufficient written information on the person's condition, their care plan and goals of care to ensure seamless care and to avoid the provision of ineffective care or care that does not align with the person's preferences.

Where appropriate, specialist palliative care services have a role to play throughout a person's end-of-life experience, working directly with the person, their family and carers and/or in partnership with other care providers to coordinate and deliver care.

All services providing palliative care should make available information to the local health, and wider communities about the populations they serve, and how their service can be accessed. This information should promote equitable access to the service. Specialist palliative care services should have clear admission criteria that are transparent and non-discriminatory in nature.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 5.1. There are policies and procedures in place that support and promote continuity of care across settings and throughout the course of the person's illness.
- 5.2. The service has in place effective communication systems to support integrated care, including processes for communicating information about the care plan, goals of care and prognosis of the person within and between services.
- 5.3. Care plans demonstrate appropriate actions to support seamless transition between care settings.
- 5.4. Specialist palliative care services' admission criteria are clear, applied consistently, and communicated to the local health and wider community, and result in equitable access to services based on clinical need.
- 5.5. Referrals from the service are made to appropriate specialists or services that are able to meet the identified physical, social and spiritual needs of the person, their family and carers (for example acute pain services, mental health services, bereavement counsellors).
- 5.6. The discharge process should allow adequate time for services to be put in place prior to discharge, and include a formal handover to ensure continuity of care and

minimise risk. Plans should be discussed with the person, their family and carers to ensure that their needs and preferences are accommodated, and that they understand that the person may enter the service again if and when their needs change.

- 5.7. Services assist local community-based service providers to build their capability to help people to be cared for in their home, where this aligns with the person's preferences.
- 5.8. Policies for prioritising and responding to referrals in a timely manner are documented.
- 5.9. The organisation has mechanisms in place to assess unmet needs including time from referral to care provision, and uses this information to develop plans for future improvement of the service.

Mapping

<p>2005 Palliative Care Standards</p>	<p><i>Std. 4 Care is coordinated to minimise the burden on patient, their caregiver/s and family.</i></p> <p><i>Std. 9 Community capacity to respond to the needs of people who have a life limiting illness, their caregiver/s and family is built through effective collaboration and partnerships</i></p> <p><i>Std. 10 Access to palliative care is available for all people based on clinical need and is independent of diagnosis, age, cultural background or geography</i></p>
<p>NSQHS Standards</p>	<p><i>Std. 1 Governance</i> Criterion Governance and quality improvement systems: There are integrated systems of governance to actively manage patient safety and quality risks. Criterion Clinical practice: Care provided by the clinical workforce is guided by current best practice (specifically 1.9)</p> <p><i>Std. 4 Medication safety</i> Criterion Continuity of medication management: The clinician provides a complete list of a patient's medicines to the receiving clinician and patient when handing over care or changing medicines (specifically 4.12)</p> <p><i>Std. 5 Patient identification</i> Intention is to correctly identify all patients whenever care is provided and correctly match patients to their intended treatment.</p>
<p>National Consensus Statement: Essential elements for safe high quality end of life care</p>	<p><i>EE 1 Patient-centred communication & shared decision making</i></p> <ul style="list-style-type: none"> • Action 1.4 "individual preferences & needs of all patients [etc]" • Action 1.13 "The content of the discussion and plan of care ... should be communicated to all teams involved in the patient's care" <p><i>EE 2 Teamwork & coordination of care</i></p> <ul style="list-style-type: none"> • Action 2.1 The clinician with overall responsibility for leading and coordinating a patient's care must be clearly identified • Action 2.2 The roles and responsibilities of different team members should be clearly defined and understood by all those involved in a patient's care <p><i>EE 3 Components of care</i></p>

	<ul style="list-style-type: none"> • Action 3.15 Clinicians should liaise with other relevant services and provide referral, as necessary <p><i>EE4 Recognising & responding</i></p> <ul style="list-style-type: none"> • Key point A patient in physical, psychosocial or spiritual distress requires rapid assistance from a suitably skilled care provider. <p><i>EE 5 Response to concerns</i></p> <ul style="list-style-type: none"> • Action 5.8 Responders should document in the health care record appropriate, detailed and structured information. • Action 5.9 If the responder is not part of the clinical team, they should communicate with the responsible medical officer ... and the plan for follow-up or further review of the patient. <p><i>EE6 Leadership & governance</i></p> <ul style="list-style-type: none"> • Action 6.3 A formal policy framework should the interface with external services, such as community and social care providers, residential aged care facilities and external hospice providers <p><i>EE 10. Systems to support high-quality care</i></p> <ul style="list-style-type: none"> • Action 10.4 Organisations should implement processes to improve communication between health services at transitions of care.
Aged care standards	Nil

DRAFT

STANDARD 6.

Families and carers have access to bereavement support services and are provided with information about loss and grief.

Intent of the standard

Personal and social circumstances may place some family members and/or carers at increased risk of experiencing problems with engagement in society in the lead up to and aftermath of a person's death. These may be emotional or psychosocial problems, or more practical issues such as financial insecurity or risk of homelessness. Grief support prior to death as well as bereavement support after a death may assist in reducing physical and psychosocial morbidity associated with loss and grief. Furthermore, early identification of potential problems and referral to the appropriate support services can assist the bereaved with preparing for and dealing with the death.

While the majority of people will integrate their loss into their life with the support of their family, friends and community, some people will experience a more complicated reaction. Evidence suggests that personal and social circumstances may place some people at increased risk of experiencing complicated grief.

Services must have mechanisms in place to identify people who are at risk of or are experiencing a complex response to their loss, and to refer them to appropriate services. Specialist palliative care services should employ staff with appropriate training and skills necessary to provide bereavement support to people experiencing loss, grief and bereavement.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 6.1. The organisation has mechanisms in place to ensure the specialist palliative care team has access to education and training to meet the needs of the family and carers when they experience loss, grief and bereavement.
- 6.2. Culturally appropriate information and resources about loss, grief and the availability of bereavement support services is routinely available to families and carers before and after the death.
- 6.3. Referrals to bereavement, specialist mental health and/or counselling professionals are made when clinically indicated.

Mapping

2005 Palliative Care Standards	<i>Std. 8 Formal mechanisms are in place to ensure that the patient, their caregiver/s and family have access to bereavement care, information and support services.</i>
NSQHS Standards	Nil
National Consensus Statement: Essential elements for safe high quality end of life care	<i>EE 3 Components of care</i> <ul style="list-style-type: none"> • Action 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.
Aged care standards	Nil

DRAFT

STANDARD 7.

The service has a philosophy, values, culture, structure and environment that supports the delivery of person-centred end-of-life and palliative care.

Intent of the standard

Specialist palliative care services are expected to be leaders in the delivery of high quality palliative care, providing services to people who may need a higher level of support than others at any time in their journey as they approach and reach the end of their life. It is important that specialist palliative care services have a clearly stated philosophy and culture that supports clinical and support staff in providing high quality palliative care.

Services should seek opportunities to influence the delivery of care at the end-of-life in other settings, through collaboration and partnerships.

Compassionate and person-centred philosophy, values and culture should underpin the provision of care, and be taken into account when planning for changes in the service delivery.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 7.1. The values and culture of the service explicitly supports the provision of person-centred palliative care.
- 7.2. The philosophy and objectives of the service are documented and incorporated into clinical practice guidelines, policies and procedures.
- 7.3. The care setting provides an appropriate environment to support people, their family and carers in their interaction and comfort, including privacy, respect for home environment, visiting hours and physical spaces for visitors.
- 7.4. Services understand the community they serve, and use this information to provide specialist palliative care services and influence wider health, aged and social care systems that meet the needs of that community.

Mapping

2005 Palliative Care Standards	<i>Std. 7 The service has an appropriate philosophy, values, culture, structure and environment for the provision of competent and compassionate palliative care.</i>
NSQHS Standards	Nil
National Consensus Statement: Essential elements for safe high quality end of life care	<p><i>Guiding principle 4. Recognising when a patient is approaching the end of their life is essential to delivering appropriate, compassionate and timely end-of-life care.</i></p> <p><i>EE 1 Patient-centred communication & shared decision making</i></p> <ul style="list-style-type: none"> • Action 1.8 “Clinicians should be compassionate and sensitive, use plain language, and avoid the use of medical jargon.” <p><i>EE 2 Teamwork & coordination of care</i></p> <ul style="list-style-type: none"> • Action 3.9 “Care, compassion, open and honest communication about what to expect, and the comfort of the dying patient remain priorities.” <p><i>EE 7</i></p> <ul style="list-style-type: none"> • Action 7.6 Education should cover ethical and medico-legal issues, including the relevant professional ethical frameworks, and the relevant legislation. • Action 7.7 Education should include specific competencies for providing culturally responsive end-of-life care to Aboriginal and Torres Strait Islander people, and to people from other culturally and linguistically diverse communities. • Action 7.8 Education should include specific training for providing end-of-life care to people with limited capacity to participate in decision-making – for example, those with mental illness, disability or cognitive impairment. • Action 7.9 Ongoing formal training in communication skills should be offered to clinicians at all levels, as these skills are critical to the delivery of end-of-life care. <p><i>EE 10. Systems to support high-quality care</i></p> <ul style="list-style-type: none"> • Action
Aged care standards	<p><i>Std. 1 Management systems ...</i></p> <ul style="list-style-type: none"> • 1.5 Planning and leadership: The organisation has documented the residential care service’s vision, values, philosophy, objectives and commitment to quality throughout the service. • 1.6 Human resource management: There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives.

STANDARD 8.

Services are engaged in quality improvement and research to improve service provision and development

Intent of the standard

In order to maintain and continuously improve the high standard of palliative care delivery in Australia, it is important for services to engage in quality improvement and lead or participate in research. The specialist palliative care service should engage in research and local quality improvement activities aimed at developing new evidence to inform practice. Where relevant, these activities should contribute to the quality improvement approach of the broader health service in which the specialist palliative care service is located.

All services are expected to embed quality improvement activities into their daily practice, working through each step of the quality improvement cycle. Services are expected to identify areas for improvement through thorough risk assessment processes, quality audits, and standards reviews, and to implement actions relevant to improving performance in identified areas. Improvement actions and outcomes should be evaluated to determine whether interventions or changes have been effective. It is expected that people using and interacting with the service are provided with opportunity to give feedback on the service received and to identify opportunities for improvement.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 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 participates in benchmarking processes to compare its service delivery over time and/or with external organisations.
- 8.6. The service supports staff to lead or participate in palliative care research wherever possible.
- 8.7. Specialist palliative care services support other services providing care to people at the end-of-life to improve the quality of that care wherever possible, including through offering support and guidance and promoting the use of advance care plans.

8.8. 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.

Mapping

2005 Palliative Care Standards	<i>Std. 11 The service is committed to quality improvement and research in clinical and management practices.</i>
NSQHS Standards	<i>Std. 1 Governance Criterion Governance & safety & quality (specifically 1.6)</i>
National Consensus Statement: Essential elements for safe high quality end of life care	<i>EE 9 Evaluation, audit & feedback</i> <ul style="list-style-type: none"> • Action 9.3 Monitoring and evaluation strategies should be developed to capture feedback about the quality of end-of-life care from multiple disciplines
Aged care standards	<i>Stds. 1-4</i> <ul style="list-style-type: none"> • Continuous improvement: The organisation actively pursues continuous improvement.

DRAFT

STANDARD 9.

Staff and volunteers are appropriately qualified, are engaged in continuing professional development and are supported in their roles

Intent of the standard

A defining feature of a specialist palliative care service is the employment of staff that have recognised qualifications or accreditation in palliative care. All services are expected to support their staff, both with respect to their ongoing professional development and also with respect to assistance in coping with the daily demands of working with people, their family and carers who require specialist palliative care.

Services are expected to ensure that volunteer services are coordinated and supervised appropriately, and volunteers receive appropriate and regular training in order to fulfil their roles safely and competently.

TO MEET THIS STANDARD, THE HEALTH SERVICE IS EXPECTED TO ENSURE:

- 9.1. The service employs an interdisciplinary team of health professionals with recognised qualifications, credentialing and experience to meet the physical, psychological, social, cultural and spiritual needs of the person, their family and carers.
- 9.2. Staff in clinical leadership and management positions have recognised qualifications and experience in relevant fields.
- 9.3. A formal assessment of palliative care education and training is undertaken for all members of the health care team to identify professional development requirements.
- 9.4. There is a framework in place, outlining the terms of staff and volunteer supervision and support. Staff and volunteers in contact with people, their family and carers receive appropriate supervision and support in accordance with the established framework.
- 9.5. The health care team should be trained in self-care strategies and be advised on how to access personal support.
- 9.6. Volunteer programs are recognised, supported and managed in accordance with the relevant volunteer standards.

Mapping

2005 Palliative Care Standards	<p><i>Std. 12 Staff and volunteers are appropriately qualified for the level of service offered and demonstrate ongoing participation in continuing professional development.</i></p> <p><i>Std. 13 Staff and volunteers reflect on practice and initiate and maintain effective selfcare strategies.</i></p>
NSQHS Standards	<p><i>Std. 1 Governance</i></p> <p>Criterion Performance & skills management: Managers and the clinical workforce have the right qualifications, skills and approach to provide safe, high-quality health care.</p>
National Consensus Statement: Essential elements for safe high quality end of life care	<p>Guiding principle 7. Safe and high-quality end-of-life care requires the availability of appropriately qualified, skilled and experienced interdisciplinary teams.</p> <p><i>EE 7 Education & training</i></p> <ul style="list-style-type: none"> • Action 7.5 Clinicians should receive ongoing education about disease-specific symptom assessment and evidence-based symptom management relevant to their area of practice.
Aged care standards	<p><i>Stds. 1-4</i></p> <ul style="list-style-type: none"> • Education and staff development: Management and staff have appropriate knowledge and skills to perform their roles effectively.