

Implementing the actions in the National Consensus Statement: Essential elements for safe and high-quality end-of-life care (the Consensus Statement) will support the delivery of safe and high-quality end-of-life care within your organisation. This fact sheet can help your organisation to provide evidence to meet some requirements in the National Safety and Quality Health Service (NSQHS) Standards.

The essential elements and actions in the Consensus Statement align with the NSQHS Standards. This fact sheet outlines the links between the Consensus Statement and the NSQHS Standards. These links can be divided into three main areas:

- advance care planning
- clinicians and patients as partners in care
- communication.

A detailed list of the links between actions in the Consensus Statement and the NSQHS Standards can be found at Table 1.

To systematically and comprehensively improve the safety and quality of end-of-life care you will need to implement systems to address all elements and actions in the Consensus Statement. However, not all of the essential elements or actions link directly to the NSQHS Standards or are discussed in this fact sheet.

Version two of the NSQHS Standards is being developed for release in 2017/18. This version will include more specific actions about end-of-life care, linking more closely with the Consensus Statement.

background to the consensus statement

The health care that people receive in the last years, months and weeks of their lives can help to minimise the distress and grief associated with death and dying for the individual, and for their family, friends and carers.

The Australian Commission on Safety and Quality in Health Care (the Commission) developed the National Consensus Statement: essential elements for safe and high-quality end-of-life care (the Consensus Statement). Endorsed by Health Ministers in May 2015, the Consensus Statement sets out suggested practice for the provision of end-of-life care in settings where acute care is provided.

Clinicians, health service executives and managers, policy-makers, educators and training providers can use the principles and ten essential elements of the Consensus Statement as a guide to improving the safety and quality of end-of-life care.

advance care planning

NSQHS Standards – Actions 1.18.4, 9.8.1, 9.8.2

Advance care planning is an important part of providing safe and high-quality end-of-life care. The Consensus Statement Components of Care essential element highlights the importance of advance care planning in providing opportunities for patients to communicate their values, goals and wishes for their care at the end of life.



The NSQHS Standards contain three specific actions relating to advance care planning and treatment-limiting orders in Standard 1: Governance for Safety and Quality in Health Service and Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care. Health services are required to have systems in place to support the preparation and documentation of advance care plans, directives and/or treatment limiting orders.

Having systems in place for documenting advance care plans helps to ensure that the patient's treatment preferences are readily available at the point of care, including for emergency services and community-based services where relevant.

Part of the advance care planning process can be the creation of advance care directives. These are legal documents describing a person's future preferences for their care and can include the appointment of a substitute decision-maker (**box 1**). There are variations in state and territory legislation and policy governing the development and documentation of advance care directives.

More information is available from:
<http://advancecareplanning.org.au>

box 1 - substitute decision-makers

'Substitute decision-maker' is a general term for a person who is either appointed or identified to make health care decisions on behalf of a person whose decision-making capability is impaired.

Substitute decision-makers should make decisions according to three key ethical principles:

- respect for autonomy, or the requirement to respect a person's right to self-determination
- beneficence, or the requirement to do good
- non-maleficence, or the requirement to do no harm.¹

Each state and territory has its own legislation relating to substitute decision-makers. In most jurisdictions a person can appoint a substitute decision-maker through an advance care directive or power of attorney/guardianship.

For more information visit the Advance Care Planning Australia website:
<http://advancecareplanning.org.au/advance-care-planning/for-professionals/the-law-of-advance-care-planning>

¹ The Australia Health Ministers' Advisory Council, *A National Framework for Advance Care Directives*, September 2011 (p.17)

partners in care

NSQHS Standards – Actions 1.18.1, 1.18.2

When clinicians work to understand a patient's preferences and goals, unnecessary distress and suffering for patients and their families can be avoided. With clinicians and patients working together to make decisions about care, it is more likely the patient will receive appropriate treatment that is in line with their goals of care.

The Consensus Statement highlights the importance of patient-centred communication and shared-decision making in end-of-life care. The Patient-Centred Communication and Components of Care essential elements link strongly to actions in the NSQHS Standards.

Action 1.18.1 in the NSQHS Standards requires health services to work with patients as partners in planning for their care.

Shared decision-making is a critical part of making sure that patients approaching the end of their lives are partners in their own care. Patients, substitute decision-makers, families and interdisciplinary teams should work together to make decisions in the patient's best interests.



The shared decision-making process should include obtaining and documenting the patient's informed consent.

Action 1.18.2 in the NSQHS Standards requires health services to have mechanisms in place to monitor and improve documentation of informed consent.

Organisations should have mechanisms in place to support patients, families and carers to make informed decisions about their end-of-life care. This includes support for patients, substitute decision-makers, 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.

Informed consent at the end of life may relate to withholding non-beneficial treatment or transitioning to a palliative approach, without necessarily excluding active medical treatment.

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.

communication

NSQHS Standards – Actions 1.18.3

Conversations about uncertain prognosis, death and dying require compassion, knowledge, experience, sensitivity and skill on the part of clinicians.

The Patient-Centred Communication essential element recommends clinicians prepare for end-of-life conversations, use plain language and allow adequate time for those involved to process the information they are being given. Multiple discussions may be required for clinicians and patients, families and carers to reach agreement about the goals of care.

Action 1.18.3 in the NSQHS Standards requires organisations to have mechanisms in place to align the information provided to patients with their capacity to understand.

Suggested implementation strategies for this action include utilising open communication, accessible formats for information and providing education and training in effective communication.

The Education and Training essential element recommends ongoing formal training in communication skills be offered to clinicians at all levels. Training should include specific competencies for providing culturally responsive end-of-life care to Aboriginal and Torres Strait Islander people, and to people from culturally and linguistically diverse communities.



table 1 : links between actions in the consensus statement and the NSQHS standards

NSQHS Standards Item	NSQHS Standards Action	Consensus Statement Actions
1.1	1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	6.3, 6.4, 6.7
1.18	1.18.1 Patients and carers are partners in the planning for their treatment	1.7, 2.3, 3.5, 3.7
	1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent	1.11, 2.3, 2.4
	1.18.3 Mechanisms are in place to align the information provided to patients with their capacity to understand	1.8, 1.11, 7.7, 7.9
	1.18.4 Patients and carers are supported to document clear advance care directives and/or treatment limiting orders	3.2, 3.5, 3.8, 6.6
1.20	1.20.1 Data collected from patient feedback systems are used to measure and improve health services in the organisation	7.3, 9.1, 9.3, 9.4, 9.6
4.10	4.10.2 Action is taken to reduce the risks associated with storage and distribution of medicines	6.8, 10.2
	4.11.2 Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines	6.8, 10.2
6.2	6.2.1 The workforce has access to documented structured processes for clinical handover	10.4, 10.5
9.8	9.8.1 A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	3.2, 6.6, 10.1
	9.8.2 Advance care plans and other treatment-limiting orders are documented in the patient clinical record	3.8, 5.6, 10.5, 10.6

Commission resources:

End-of-life Care:

www.safetyandquality.gov.au/our-work/recognising-and-responding-to-clinical-deterioration/end-of-life-care-in-acute-hospitals/

NSQHS Standards:

www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/resources-to-implement-the-nsqhs-standards/

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