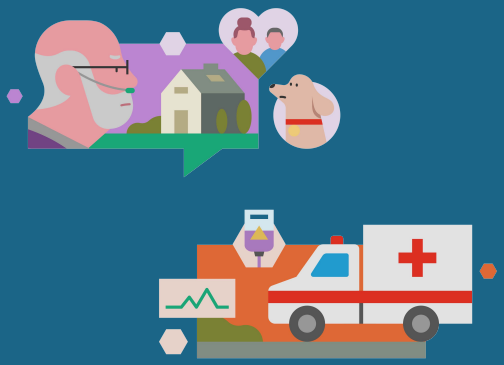
end-of-life ESSENTIALS®
education for acute hospitals

Comprehensive Care Standard Action 5.17

The Comprehensive Care at the End of Life actions form part of the National Safety and Quality Health Care Standards (2021).

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 record.



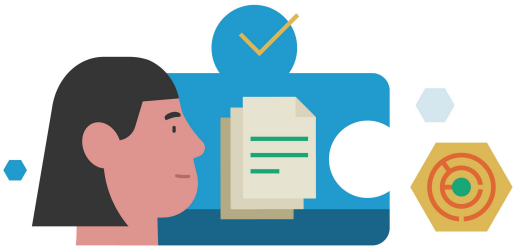
Consider accessing the **End-of-Life Essentials Goals of Care at the End of Life Module** and **Toolkit.** The Toolkit includes a checklist to support formalising discussions with the patient and family about death and dying, their wishes and preferences, and ensuring these are accessible to the treating team. The **Emergency Department End-of-Life Care Module** and **Toolkit** also appraise the opportunities for compassionately discussing advance care planning in fast-paced clinical environments.

Advance Care Planning Australia has information on **Advance Care Planning**, which they describe as "the process of planning for your future health care. It relates to health care you would or would not like to receive if you were to become seriously ill or injured and are unable to communicate your preferences or make decisions. This often relates to the care you receive at the end of your life". One way to achieve this is for clinicians to discuss the patient's values and preferences with them to determine shared goals of care.

advancecareplanning.org.au

Also explore the **End-of-Life Essentials Communication and Decision-Making Module** and **Toolkit**. The module highlights that establishing goals of care via shared decision-making is the basis of person-centred care and, along with communication, is a very important concept in end-of-life care. These processes can be enabled via a family meeting, with choices and wishes formally documented via an Advance Care Plan noted in the healthcare record.

The End-of-Life Essentials **Communication Training Resources** support educators in delivering training around communication in the context of: an individual's response to understanding that life is limited, and discussion of changing goals of care. Consider the following seminar question: "Do you think of yourself as a good communicator with patients and families when it comes to negotiating goals of care? Why?"



The End-of-Life Essentials **Coordinating Patient Care Module** and **Toolkit** explores patient coordination in the context of providing care at the end of life, including supporting quality patient assessment and advance care planning.

Access the End-of-Life Essentials **Meeting the Standards Module** and **Toolkit** to learn more about what you can do to deliver high quality end-of-life care and prepare the organisation for accreditation, including:

- Leadership - ensures clear policies and strategic direction (aligning with jurisdiction) that drives ACP quality.
- Workforce capability - ensuring that the knowledge, skills and competence to enable staff to partner with patients and/or their subsitute decision makers to implement ACP.
- Communication - enable timely and appropriate communication. Do staff know how to compassionately ask a patient about ACP and where to document plans or directives?
- Evaluation and audit - to monitor quality and safety and to identify areas of need within the organisation. Audit of compliance and noncompliance of advanced care plans is valuable, along with policies, actions, and documentation of advance care plans. How will you know whether certain changes lead to an improvement in end-of-life care? What changes about managing advance care plans will drive improvement?

EOLE insight

Staff require a level of comfort and confidence regarding asking a patient or person responsible about an advance care plan. Consider how staff training happens regarding asking about and reviewing advance care plans.