

*National Guidelines
for Palliative Care
And
Interpretation Guide*

First Edition

December 2015

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This Guide is also available on the Singapore Hospice Council website:

<http://www.singaporehospice.org.sg>

Statement of Intent

The first edition of the National Guidelines for Palliative Care was drafted after widespread consultation in 2014. The Guidelines and the Interpretation Guide are not intended to serve as standards or requirements for meeting the Ministry of Health's licensing requirements. They were developed based on inputs from subject matter experts and an experienced multidisciplinary group of palliative care providers. The guidelines and templates are based on the best available knowledge at the time of development and should not be construed as the only methods of care to achieve the desired outcomes.

The measures stated in the Interpretation Guide serve as a tool for measuring quality of palliative care provision in Class C Providers. For Class A and B providers, these measures serve as recommended palliative care approaches for palliative care patients seen within their practice.

Foreword

In his speech at the Singapore Palliative Care Conference on 28 June 2014, Mr Gan Kim Yong, Minister of Health said

“Palliative care has become even more important today, in the context of our rapidly ageing population. We need to invest in developing palliative care services, as this is a critical piece in our overall efforts to provide good and affordable care.”

Minister Gan announced the National Guidelines for Palliative Care and the Ministry’s plans for improving the standards of palliative care locally. The National Guidelines for Palliative Care was developed in fulfilment of one of the goals in the National Strategy for Palliative Care, which had recommended the development of local standards for palliative care.

The Ministry of Health subsequently provided funding to the Singapore Hospice Council (SHC) to develop the Interpretation Guide for the National Guidelines for Palliative Care. The Interpretation Guide was formulated to help service providers better understand the requirements and desired outcomes of the National Guidelines for Palliative Care. They were derived from extensive literature review and stakeholder consultation. It is hoped that organizations and services will embrace the National Guidelines for Palliative Care and make use of the Interpretation Guide to reflect on their practice, identify areas for quality improvement and make changes to improve them.

SHC is committed to implementation of the National Guidelines for Palliative Care in all institutions. SHC strongly encourages institutions to approach SHC if they require advice on implementing the National Guidelines for Palliative Care.

The Steering Committee is grateful to the team of committed doctors, nurses and medical social workers in the Guidelines Implementation Workgroup, who have worked tirelessly to put this together. In addition, many other professionals have contributed significantly to the materials used in this Guide and shared their wealth of experience with the team. Without their selfless contribution, this would not have come to pass.

We believe that this will contribute towards our vision of quality palliative care for patients with life-limiting illnesses and look forward to working with everyone towards this end.

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How to Use the Guide

The National Guidelines for Palliative Care aims to articulate a vision for high quality palliative care. The guidelines cover four domains, namely patient care, family and caregiver support, staff and volunteer management, and safe care. It is envisioned that the guidelines will promote a whole-of-sector approach for continuous quality improvement in palliative care, so that all who suffer from life-limiting illnesses may live their last days in peace, comfort and dignity.

The aim of this Interpretation Guide is to help service providers better understand the requirements and desired outcomes of the National Guidelines for Palliative Care so that they can put in place appropriate processes and practices to achieve these outcomes.

Each guideline consists of:

- ❖ **Rationale:** This section outlines the rationale behind adopting the guideline.
- ❖ **Explanatory notes:** This section provides explanation of terms used in the guideline.
- ❖ **Good Practices:** This section provides suggestions on good practices that providers can adopt to achieve the outcome.
- ❖ **Suggested measures** (where applicable): This section contains quality measures which service providers can use to evaluate their services and benchmark against other local service providers.
- ❖ **Assessment tools** (where applicable): This section provides international and local assessment tools to guide service providers in evaluating the suggested measures.
- ❖ **Resources for service providers** (where applicable): This section provides guidelines, forms and webpage links on resources relevant to the guideline. Additional resources can also be found in the annex.

Provider Class Descriptions

It is recognised that the different groups of providers across the healthcare spectrum have differing roles in the provision of palliative care. Three groups of providers have been identified, and specific indicators have been described for each of these groups.

Class A Providers are those whose substantive work is not in caring for patients with life-limiting illnesses, but who will encounter them in the course of work. These include general practitioners in the community, and doctors, nurses and allied health staff in restructured and community hospitals.

Class B Providers are those who routinely care for a substantive number of patients with life-limiting illness. These include staff of chronic disease management programs, intensive care units, specialist cancer units, geriatric units, home care providers and nursing homes.

Class C Providers are those who care solely for patients with life-limiting illness. These include palliative care teams in private, restructured and community hospitals, inpatient hospices and hospice home care and hospice day care providers.

All classes of providers should utilize the palliative care approach in managing patients with life-limiting illness who are under their care. Notwithstanding this, it is recognized that the three groups have different roles in the provision of palliative care. For example, Class C Providers manage patients whose needs exceed the capabilities of Class A and Class B Providers, and also provide consultative support to other providers. Class A and Class B Providers manage patients within their capabilities, but are responsible for referring patients and their families to Class C Providers where appropriate. Therefore, different quality indicators and recommendations for good practices have been outlined for each group, reflecting these differences in roles.

Glossary of Terms

Access to Opioids is defined as the availability of opioids and the ability to administer them to patients.

Advance Care Planning (ACP) is a voluntary process of discussion between an individual and their care providers and persons close to them, with the purpose of clarifying a person's wishes and care preferences for future care should they become seriously ill in the future and are unable to make decisions and/or communicate their wishes to others.

Advance Medical Directive (AMD) is a legal document signed in advance that allows patients to indicate that they do not wish to have extraordinary life-sustaining treatment in the event that they are unconscious and suffering from terminal illness. The term "terminal illness" is defined in the AMD Act as an "incurable condition caused by injury or disease from which there is no reasonable prospect of a temporary or permanent recovery where death would, within reasonable medical judgment, be imminent regardless of the application of extraordinary life-sustaining treatment; and the application of extraordinary life-sustaining treatment would only serve to postpone the moment of death of the patient."

Approaching the end of life¹ is defined as when a person is likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

Caregiver refers to a person, often but not necessarily a family member, who undertakes to provide for the needs of the patient and who may take on additional technical tasks in the process, e.g. administration of medicines. The *primary caregiver* is the primary support person for the patient and does not include members of the healthcare team.

Complex needs may derive from the patient, carer or healthcare team and the help required may be intermittent or continuous, depending on the level of need and rate of disease progression. Examples of complex needs include:²

¹ National Gold Standards Framework. The GSF Prognostic Indicator Guidance, 4th Ed. 2011; <http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf> . Accessed 10 July 2015.

² North Yorkshire and York Palliative Care Group. Eligibility criteria for Specialist Palliative Care Services. 2005.

- Physical symptoms – uncontrolled or complicated symptoms, specialized nursing requirements, complex mobility or functioning issues.
- Psychological – uncontrolled anxiety or depression, cognitive or behavioural issues.
- Social – complex situations involving children, family or carers, finance issues, communication difficulties and patients with special needs.
- Spiritual – unresolved issues around self-worth, loss of meaning and hope, requests for euthanasia, unresolved religious or cultural issues.
- Ethical – conflicting interests involving ethical principles that impinge on decision-making by patient, family or care team.

Critical Incidents are critical or traumatic incidents that can be defined as ‘any sudden event or situation that involves actual, threatened, witnessed or perceived death, serious injury, or threat to the physical and psychological integrity of an individual or group.’

Culture is shaped by historical, economic, social, political, and geographical events and guides an individual’s values, beliefs, and behaviour. It defines who an individual is within the context of society, and influences the interpretation of suffering, illness, and death. Culture affects how a patient navigates within the healthcare system during illness and at the end of life.

Ethical Dilemma: An ethical dilemma involves the need to choose from among two or more morally acceptable options or between equally unacceptable courses of action, when one choice prevents selection of the other. Examples of ethical dilemmas include the following:

- Conflict of ethical principles (e.g. patient’s wish to die at home but without adequate support – autonomy vs non-maleficence)
- Requests for palliative sedation
- Withdrawing or not providing life-sustaining treatment

Lasting Power of Attorney (LPA) is a legal document which allows a person who is at least 21 years of age (donor) to voluntarily appoint one or more persons (donee) to make decisions and act on his behalf if he should lose mental capacity. A donee can be appointed to act in two broad areas – personal welfare as well as property and affairs matters.

Life-limiting illness refers to illnesses where there is little or no hope of cure, and it is expected that death will be a direct consequence of the illness. This includes cancer and non-cancer conditions.

Palliative care emergencies are unexpected changes to a patient’s condition which include the following:

- Pain crisis
- Stridor

- Massive bleed
- Intractable seizures
- New spinal cord compression
- Superior vena cava obstruction
- High suicide risk

Quality Improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of patients.

Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.³ This was further defined by the EAPC (European Association for Palliative Care) taskforce on Spiritual Care in Palliative Care in 2010 as:

Spirituality is the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seeks meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred.

The spiritual field is multidimensional:

1. Existential challenges (e.g. questions concerning identity, meaning, suffering and death, guilt and shame, reconciliation and forgiveness, freedom and responsibility, hope and despair, love and joy).
2. Value based considerations and attitudes (what is most important for each person, such as relations to oneself, family, friends, work, things nature, art and culture, ethics and morals, and life itself).
3. Religious considerations and foundations (faith, beliefs and practices, the relationship with God or the ultimate).⁴

Symptoms at the end of life are common symptoms at the end of life which include the following:

- Pain
- Dyspnoea
- Respiratory secretions/death rattle
- Terminal delirium

³ Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus. *Journal of Palliative Medicine*. Jun 2014;17(6):642-56.

⁴ European Association for Palliative Care. EAPC taskforce on Spiritual Care in Palliative Care Summary. <http://www.eapcnet.eu/Themes/Clinicalcare/Spiritualcareinpalliativecare.aspx> .Accessed 15 July 2015

- Nausea/vomiting

Overview of Guidelines

Domain 1: Patient Care

Guideline 1 – Timely Identification: People approaching the end of life are identified in a timely manner.

Guideline 2 – Reducing Barriers to Care: Palliative care is available for all people based on clinical need, regardless of diagnosis, age, gender, financial means, ethnic and cultural background, and care setting.

Guideline 3 – Coordinated Care: Care is delivered in a coordinated manner that ensures continuity of care across settings and over time.

Guideline 4 – Holistic Assessment and On-going Care Planning: Holistic assessment and on-going care planning are implemented in an interdisciplinary manner to meet the changing needs and wishes of patients, caregivers and families.

Guideline 5: Advance Care Planning: All patients at the end of life have access to Advance Care Planning (ACP).

Guideline 6: Patient-Centred Care: Patients receive care that is customized to their unique needs and preferences as informed by holistic assessments.

Guideline 7 – Care in the Last Days of Life: Care is taken to fulfil the needs of patients in the last days of life, as well as those of their caregivers and families.

Domain 2: Family and Caregiver Support

Guideline 8 – Caregiver Support: Caregivers of patients with life-limiting illness face significant stress in their roles, and their own practical and emotional needs need to be supported.

Guideline 9 – Bereavement Care: Family members affected by a death are offered timely bereavement support appropriate to their needs and preferences.

Domain 3: Staff and Volunteer Management

Guideline 10 – Qualified Staff and Volunteers: Care for those approaching the end of life is delivered by staff and volunteers (where applicable) with the appropriate qualifications and skill mix for the level of service offered, and who demonstrate ongoing participation in training and development.

Guideline 11 – Staff and Volunteer Self-Care: Staff and volunteers reflect on practice, maintain effective self-care strategies and have access to support in dealing with the psychological stress associated with working among the terminally ill and bereaved.

Domain 4: Safe Care

Guideline 12 – Access to and Use of Opioids: Patients at the end of life should have access to opioids for symptom control, with guidelines and processes in place to ensure safe and effective use.

Guideline 13 – Clinical Quality Improvement: The service is committed to improvement in clinical and management practices.

Guideline 1: Timely Identification

People approaching the end of life are identified in a timely manner.

Rationale: Failure to identify patients with life-limiting illnesses may lead to inappropriate care. Timely identification with appropriate needs assessment helps service providers to meet patients’ needs and preferences in a more meaningful way.¹⁻¹²

1.1 There is evidence of a system in place to identify people approaching the end of life (i.e. likely to die within the next 12 months).

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>“System”: Process in place to identify patients approaching the end of life.</p> <p>“Approaching the end of life”¹³: When a person is likely to die within the next 12 months.</p> <p>This includes people whose death is imminent (expected within a few hours or days) and those with:</p> <ul style="list-style-type: none"> ▪ Advanced, progressive, incurable conditions ▪ General frailty and co-existing conditions that mean they are expected to die within 12 months ▪ Existing conditions if they are at risk of dying from a sudden acute crisis in their condition ▪ Life-threatening acute conditions caused by sudden catastrophic events. <p>The timeframe of 12 months provides a guide as to when people might be identified as approaching the end of life. For some conditions, the trajectory may require identification and subsequent planning to happen earlier. For other conditions, it may not be possible to identify people until nearer the time of death. Identification should take place with sufficient time to enable provision of high-quality end of life planning, care and support in accordance with the person’s needs and</p>	<p>Good Practice: Class A & B Providers</p> <ul style="list-style-type: none"> ▪ Class A & B Providers shall, at consultation with patients, identify those who are approaching the end of life. ▪ This can be done using assessment tools (see below for examples) or the Surprise Question– “Would you be surprised if this patient dies within the next 12 months?” <p>Assessment Tools:</p> <ul style="list-style-type: none"> ▪ Gold Standards Framework (GSF) Prognostic Indicator Guidance¹³ (http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf) ▪ Center to Advance Palliative Care (CAPC) – Table 3 Criteria for Palliative Care Assessment at the time of admission:¹⁴ ▪ Quick guide to identifying patients for supportive and palliative care from Macmillan Cancer Support¹⁵ (http://webarchive.nationalarchives.gov.uk/20130718121128/http://endoflifecare.nhs.uk/search-resources/resources-search/publications/imported-publications/quick-guide-to-identifying-patients-for-supportive-and-palliative-care.aspx)

preferences. Identification will need to be considered on an individual basis.

Identification of people approaching the end of life may be initiated by either health or social care professionals in any setting.

- AIC Home Programme Referral Criteria, available on Page 1 of referral form¹⁶ (http://aic.sg/uploadedFiles/Resources/Forms_and_Guidelines/AIC%20HOME%20Programme%20Referral%20Form%20%28May%202012%29.pdf)
- Project Dignity Criteria
 - ✓ Progressive cognitive decline, manifested by increasing word finding difficulty (FAST 7A- 6 words and less)And one of the following:
 - ✓ pneumonia in the past 1 year
 - ✓ serum albumin <35g/L
 - ✓ feeding tube
- Supportive and Palliative Care Indicators Tool (SPICCTM)¹⁷ (<http://www.spict.org.uk/>)

Resources for Service Providers:

Disease-specific indicators of prognosis:

Heart Failure:

- CAPC Fast Facts #143¹⁸ – Prognostication in Heart Failure (<https://www.capc.org/fast-facts/143-prognostication-heart-failure/>)
- Seattle Heart Failure Model¹⁹ (http://depts.washington.edu/shfm/non_health.php)

Renal Failure

- CAPC Fast Facts #191²⁰ – Prognostication in Patients Receiving Dialysis (<https://www.capc.org/fast-facts/191-prognostication-patients-receiving-dialysis/>)

Liver Failure

- CAPC Fast Facts #189²¹ – Prognosis in Decompensated Chronic Liver Failure (<https://www.capc.org/fast-facts/189-prognosis-decompensated-chronic-liver-failure/>)

Dementia

- CAPC Fast Facts #150²² – Prognostication in Dementia (<https://www.capc.org/fast-facts/150-prognostication-dementia/>)

COPD

- CAPC Fast Facts #141 – Prognosis In End-Stage COPD²³
(<https://www.capc.org/fast-facts/141-prognosis-end-stage-copd/>)
- BODE Index for COPD survival prediction²⁴

HIV and AIDS

- CAPC Fast Fact #213 – Prognosis In HIV And AIDS²⁵
(<https://www.capc.org/fast-facts/213-prognosis-hiv-and-aids/>)

Anoxic-Ischemic Encephalopathy

- CAPC Fast Fact #234 – Prognosis Of Anoxic-Ischemic Encephalopathy²⁶
(<https://www.capc.org/fast-facts/234-prognosis-anoxic-ischemic-encephalopathy/>)

Guideline 2: Reducing Barriers to Care

Palliative care is available for all people based on clinical need, regardless of diagnosis, age, gender, financial means, ethnic and cultural background, and care setting.

Rationale: All patients with life-limiting illnesses should be cared for by healthcare professionals using a palliative care approach. Patients with needs that exceed the resourced capabilities of the service provider should have access to palliative care services. Similarly, where patients require expertise or care outside the scope of the palliative care service, the ability to call upon other services or providers will enhance the care of the patient.^{9,27-36}

2.1 Patients are referred to palliative care services or providers in other fields (e.g. counselling support), should their needs exceed the resourced capabilities of the service provider.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A & B Providers: Patients with life-limiting illnesses (cancer and non-cancer) with needs that exceed the resourced capabilities of the service provider should be referred to palliative care services or providers in other fields.</p> <p>These patients include those with:</p> <ul style="list-style-type: none"> ▪ Poorly controlled pain and/or other symptoms not responding to optimal medical treatment ▪ Complex psychosocial and/or spiritual issues requiring a multi-disciplinary approach. <p>Examples of providers in other fields include:</p> <ul style="list-style-type: none"> ▪ Pain specialists ▪ Psychiatrists ▪ Radiation oncologists 	<p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Service Providers should have access to Referral Guidelines and a list of resources available to guide them in referring patients and families, for example AIC website³⁷ (aic.sg/default.aspx) or individual hospital referral criteria. <p>Specific Referral Guidelines</p> <ul style="list-style-type: none"> ▪ AIC Home Programme Referral Criteria¹⁶ <ul style="list-style-type: none"> ✓ End-Stage Heart Failure NYHA Class 3 or 4 despite maximal medical or surgical treatment AND <p style="margin-left: 40px;">Any 1 of the following</p> <ol style="list-style-type: none"> a) Severe Pulmonary Hypertension b) Deteriorating clinical and functional status as assessed by Cardiologist c) 2 or more hospitalisations for decompensated heart failure within the past 12 months <ul style="list-style-type: none"> ✓ End-Stage Lung Disease Any 2 from a) – c) + d) <ol style="list-style-type: none"> a) Dyspnea at rest despite maximal treatment with bronchodilators b) Repeated ED visits or hospitalisations for exacerbations or pulmonary infections c) Hypoxaemia on Room Air (PaO₂ < 55mm Hg or SaO₂ < 88%) or

	<p>Hypercapnia (PaCO₂ > 50mm Hg) in between exacerbations</p> <p>d) FEV1 < 30% or fulfils criteria for LTOT (for COPD patients)</p> <ul style="list-style-type: none"> ✓ End-Stage Renal Failure <ul style="list-style-type: none"> a) GFR < 10ml/min per 1.73m² AND b) Patients refuse Renal Replacement Therapy or Decision made to stop dialysis due to medical reasons ▪ Project Dignity Criteria Advanced Dementia <ul style="list-style-type: none"> ✓ Progressive cognitive decline manifested by increasing word-finding difficulty (FAST 7A – Speaks 6 words or less) ✓ AND 1 of the following: <ul style="list-style-type: none"> a) Pneumonia in the past 1 year b) Serum Albumin < 35g/L c) Feeding Tube ▪ Singapore Hospice Council – Who needs it?³⁸ (http://www.singaporehospice.org.sg/who-needs-it.html) ▪ Example of local Palliative Care Services Referral Guidelines (See examples in Annex)
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2.2 There is evidence of arrangements to ensure that people approaching the end of life, as well as their families and caregivers, know whom to contact for advice.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A & B Providers: All patients and their families and caregivers should have resources that advise on available palliative care services.</p>	<p>Good Practice:</p> <ul style="list-style-type: none"> ▪ All Class A and B Providers should know how to access online palliative care resources from SHC and AIC websites. ▪ Downloadable brochures should be made available on SHC and AIC websites. <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Information for patients and families on scope of services provided by palliative care or hospice services and referral procedures³⁹

	<p>(http://www.singaporehospice.org.sg/providers.html)</p> <ul style="list-style-type: none"> ▪ Agency for Integrated Care Silver Pages ⁴⁰ (www.silverpages.sg) ▪ Example of brochure from individual palliative care service providers (See examples in Annex)
<p>2.3 The service provider triages and assigns priorities to all initial consult requests and ensures that care is delivered in a timely manner.</p>	
<p>National Palliative Care Guidelines <i>Explanatory Notes</i></p>	<p>Good Practices <i>Suggested Measures to Achieve Better Care</i></p>
<p>Class C Providers: Palliative care providers should be responsive to referrals from other providers/specialists and institutions.</p> <ul style="list-style-type: none"> ▪ Non-urgent referrals should be seen within an acceptable time frame (See Numerical Indicators) 	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of new referrals seen/contacted/acknowledged within the time-frames stated below. <p>Numerator: Number of new referrals seen/contacted/acknowledged within stated time-frame. Denominator: Total number of new referrals.</p> <ul style="list-style-type: none"> ✓ New inpatient hospital referrals: patients or families should be seen within 1 working day. ✓ New home-care/day care referrals: patients or families should be contacted by a member of the clinical team within 2 working days of receiving the referral. It refers to the time period between admission date and first contact by service provider. ✓ New inpatient hospice referrals: referrals should be acknowledged within 2 working days. It refers to the time period between the date of referral received and acknowledgement of the referral, be it accepted, rejected or pending further information.

2.4 The patient and family have access to palliative care services 24 hours a day, seven days a week.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class C Providers: Services must have a 24/7 on-call palliative care coverage available to patients and families.</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of on-call system (register/roster) in place for palliative care.
2.5 The service provider has protocols for responding to palliative care emergencies or urgent needs.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class C Providers: Service providers must have written response protocols for staff to respond to palliative care emergencies or urgent needs.</p> <p>Such protocols must be available to all clinical staff providing services and could come in the form of a department guide for managing the conditions listed below.</p> <p><i>Palliative care emergencies</i> are unexpected changes to a patient’s condition which include the following:</p> <ul style="list-style-type: none"> ▪ Pain crisis ▪ Stridor ▪ Massive bleed ▪ Intractable seizures ▪ New spinal cord compression ▪ Superior vena cava obstruction ▪ High suicide risk 	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of a response guideline in palliative care emergencies, including pain crisis, stridor, massive bleed, intractable seizures, new spinal cord compression, superior vena cava obstruction, high suicide risk. <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Protocols for responding to palliative care emergencies or urgent needs (See examples in Annex)

2.6 The service provider has formal links with specialists or providers in other fields to ensure access to expert advice and management of patients with specific needs in these areas.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class C Providers: <i>(Inpatient hospice/Home care/Day care providers)</i></p> <p>List of relevant visiting specialists for contact when needed. For example:</p> <ul style="list-style-type: none"> ▪ Primary Referring Specialist ▪ Medical Oncologist ▪ Radiation Oncologist ▪ Pain Specialist ▪ Psychiatrist ▪ Others (as deemed necessary by individual organisations) 	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of list of visiting specialists in other fields or partner institutions who can be called upon when needed. The list should minimally include: <ul style="list-style-type: none"> ✓ Primary Referring Specialist ✓ Medical Oncologist ✓ Radiation Oncologist ✓ Pain Specialist ✓ Psychiatrist ✓ Others (as deemed necessary by individual organisations) <p>This measure is not applicable to hospital settings.</p>

Guideline 3: Coordinated Care

Care is delivered in a coordinated manner that ensures continuity of care across settings and over time.

Rationale: Patients may require care from various service providers at different stages of the illness. Poor coordination includes ineffective communication between services, inflexible responses to changes in need over time and fragmented care across different disciplines. The lack of coordination of care and services may increase the stress experienced by patients and their families, and lead to unnecessary resource utilisation (e.g. laboratory investigations, emergency department visits, admissions). Better coordination of care increases quality of life.⁴¹⁻⁴⁷

3.1 There should be a primary provider coordinating the patient’s care.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A & B Providers: All patients should have a primary provider identified to coordinate their care. For example, a GP or primary specialist or case manager.</p> <p>Class C Providers: Primary Provider is defined as:</p> <p><i>Acute care setting</i> – Primary specialist team or palliative care team</p> <p><i>Inpatient hospice</i> – Palliative care physician or nurse</p> <p><i>Home care facility</i> – Patient’s home care physician or nurse</p> <p>The primary provider can change in accordance with a change in care setting.</p>	<p>Good Practice: All Providers</p> <ul style="list-style-type: none"> ▪ All patients should have a designated primary provider to coordinate their care. ▪ For patients who are transferred across care settings, there must be proper handover of patients from one primary provider to another.

3.2 Networks are established between different service providers, to facilitate the provision of seamless and holistic care for patients.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: Patients with palliative care needs are often transferred from one health care setting to another (eg. from hospital to home hospice) in the course of their illness. Informal or formal networks between service providers will facilitate provision of seamless and holistic care.</p>	<p>Good Practice: Class B & C Providers All Class B & C Providers should establish linkages with service providers in various settings such as restructured hospitals or community hospice services (e.g. community hospitals, inpatient hospice, or home hospice care) to ensure seamless care for patient.</p>
3.3 The patient, caregivers and family are provided with clear written instructions on how to seek help if needed at any time, including after office hours.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: Clear written instructions on what patient, caregivers and family can do if they require help, including after office hours. This applies to certain settings, for example:</p> <ul style="list-style-type: none"> ▪ Patients who are discharged or on home leave from hospitals or inpatient hospices ▪ Home care patients ▪ Day care patients 	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of contact instructions available for patients, caregivers and family to seek help if needed, including after office hours. For examples: <ul style="list-style-type: none"> ✓ Patients who are discharged or on home leave from hospitals or inpatient hospices ✓ Home care patients ✓ Day care patients <p>(This measure is not applicable to hospital consult services)</p>

3.4 During transfers between different care settings, necessary patient information is provided to the receiving service provider.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>All Providers: Memos or verbal handovers should be made during transfers between different care settings. These handovers should include:</p> <ul style="list-style-type: none"> ✓ Summary of active symptoms issues during the admission ✓ Latest blood and/or imaging results (where applicable) ✓ Information regarding medications such as rationale for drugs used; response to medications; side effects and tolerability; date of dose adjustments ✓ Latest discussion/decisions on goals and extent of care ✓ Advance care planning discussions (where applicable) ✓ Possible red flags on a case-by-case basis such as complicated family issues, collusion, delay in diagnosis or treatment, etc <p>Class C Providers: For unplanned emergency admissions to restructured hospitals, inpatient hospice and home care teams should inform hospital palliative care teams to follow-up. Conversely, discharges known to hospital palliative care teams should be handed over to community palliative care teams to ensure continuity of care.</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of memo/verbal handovers performed for expected/planned transfers. (Case Notes Audit) <p>Numerator: Number of memos/verbal handovers completed. Denominator: Total number of patients within service transferred to other settings (for expected/planned transfers).</p>

3.5 Where the patient’s needs fall beyond the usual scope of service, for example personal care needs, referrals are made to other appropriate service providers to meet these needs.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>All Providers: The needs of patients and family may include personal needs that are beyond the scope of service of the provider. It is important to obtain the necessary resources to meet these personal needs as part of holistic care.</p>	<p>Good Practice: All Providers There must be documentation of referrals that are made to appropriate services to meet the identified needs of the patient and family. These may include access to services that provide for example:</p> <ul style="list-style-type: none"> ▪ help in the home ▪ help at school or work ▪ assistance with transportation ▪ rehabilitation ▪ counselling, and/or ▪ equipment <p>This may be coordinated by the MSW in the team or in the organization that a patient is referred to.</p>

3.6 A plan is in place for the certification of death during and after office hours.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>All Providers: There must be a protocol or patient information sheets/pamphlets in place for certification of death during and after office hours.</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of a protocol or patient information sheets/pamphlets available to guide certification of death during and after office hours.

3.7 There is evidence of audits to ensure coordination of care.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class C Providers: There is evidence of audits on continuity of care across all settings.</p>	<p>Suggested Measures:</p> <ul style="list-style-type: none"> ▪ See Measures in 3.3 and 3.4

Guideline 4: Holistic Assessment and On-going Care Planning

Holistic assessment and on-going care planning are implemented in an interdisciplinary manner to meet the changing needs and wishes of patients, caregivers and families.

Rationale: Patients approaching the end of life should receive an initial holistic assessment that covers their physical, psychological, social, spiritual and cultural needs and preferences. Identified needs and preferences can then be supported by members of the interdisciplinary team.^{34,48-51} Subsequent on-going assessment and care planning should be proactive and responsive to patients' changing needs.

4.1 All patients identified as approaching the end of life undergo documented holistic assessments that cover the patient and family's physical, psychological, social, spiritual and cultural needs and preferences.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A Providers: There should be documentation of screening and management of common symptoms like pain, dyspnoea, other relevant symptoms and assessment of psychosocial needs where relevant.</p> <p>Class B & C Providers: All patients must have documentation of the following initial assessments:</p> <ul style="list-style-type: none"> ▪ Pain, dyspnoea and other relevant symptoms ▪ Psychological Assessment: Mood/coping/ anxiety/ depression ▪ Social History: Genogram or case notes documentation of immediate family members and living arrangements ▪ Spiritual: Religious beliefs and any relevant healthcare preferences ▪ Cultural: Race, preferred language and any other relevant healthcare preferences. 	<p>Suggested Measures:</p> <p>Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients screened for pain during first clinical encounter/initial assessment. (Case Notes Audit) <p>Numerator: Number of patients screened for pain during first clinical encounter/initial assessment.</p> <p>Denominator: Total number of patients seen for first clinical encounter/initial assessment.</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients screened for dyspnoea, nausea, vomiting, confusion and bowel problems during first clinical encounter/initial assessment. (Case Notes Audit) <p>Numerator: Number of patients screened for dyspnoea, nausea, vomiting, confusion and bowel problems during first clinical encounter/initial assessment.</p> <p>Denominator: Total number of patients seen for first clinical encounter/initial assessment.</p>

- Percentage (%) of patients with documented psychological, social, spiritual and cultural screening by third clinical encounter. Screening should minimally include:
 - ✓ Psychological: mood/ coping/ anxiety/ depression
 - ✓ Social: genogram or case notes documentation of immediate family members and living arrangements
 - ✓ Spiritual: religion
 - ✓ Cultural: race and language
 (Case Notes Audit)

Numerator: Number of patients with documented psychological, social, spiritual and cultural screening by third encounter.

Denominator: Total number of patients seen by third clinical encounter.

Assessment Tools:

- Edmonton Symptom Assessment System (ESAS)⁵²⁻⁵⁴
(<http://www.palliative.org/newpc/professionals/tools/esas.html>)
- Palliative Care Outcomes Collaboration (PCOC) Dataset forms⁵⁵⁻⁵⁷
(<http://ahsri.uow.edu.au/pcoc/forms/index.html>)
- FICA Spiritual Assessment Tool⁵⁸⁻⁶²
(<https://smhs.gwu.edu/gwish/clinical/fica>)
- HOPE Spiritual Assessment Tool⁶³
(http://www.rcpsych.ac.uk/pdf/A_guide_to_the_assessment_of_spiritual_concerns_in_mental_healthcare.pdf)
- “Are you at peace?” One item to probe spiritual concerns at the End of Life⁶⁴
- iPOS – Integrated Palliative Care Outcomes Scale⁶⁵ (<http://pos-pal.org/>)

Resources for Service Providers:

- Forms and other resources from US providers, assembled by the Center to Advance Palliative Care⁶⁶
(https://media.capc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf)

4.2 There is evidence of individualised care plans made after the holistic assessment of the needs of patients, caregivers and families.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A Providers: An individualized management care plan (including pain and symptom management) should be documented after the initial assessment.</p> <p>Class B & C Providers: All patients must have an individualized management care plan (including pain, symptom management and relevant psychosocial issues) documented.</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients with individualized documented care plans at the end of first clinical encounter/initial assessment. (Case Notes Audit) <p>Numerator: Number of patients with individualized documented care plans at the end of first clinical encounter/initial assessment.</p> <p>Denominator: Total number of patients seen for first clinical encounter/initial assessment.</p>
4.3 Assessment and care-planning reflect an interdisciplinary approach.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: There must be documentation of timely involvement of the multi-disciplinary team in the care of the patient (where relevant members of the team are called in when required). The multi-disciplinary team should include doctors, nurses, MSWs/Counsellors. The involvement of therapists, pharmacists, dieticians, pastoral staff, and other specialists is encouraged (if available and necessary).</p> <p>Multi-disciplinary inputs could be provided at various settings and take place over a few or multiple meetings.</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of multi-disciplinary team meetings held at least fortnightly to discuss patient care.

4.4 There is evidence of on-going assessment and care planning at appropriate intervals that documents changes in the patient and family's needs, and response to treatment over time.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: There must be documentation that the patient assessment and management plans are updated on a regular basis based on the patient and family's evolving needs.</p> <p>Class C Providers: There should be regular assessment and monitoring for improvement of physical symptoms like pain and dyspnoea.</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of moderate or severe pain episodes improved within 72 hours or by next visit. Moderate or severe pain is defined by a pain score of 4 and above. Improvement is defined by any reduction in pain. (Case Notes Audit) <p>Numerator: Number of moderate or severe pain episodes improved within 72 hours or by next visit. Denominator: Total number of moderate or severe pain episodes.</p> <p>Assessment Tools:</p> <ul style="list-style-type: none"> ▪ See Assessment Tools in 4.1
4.5 Regular assessment of physical symptoms, and psychological and spiritual needs is conducted with the use of assessment tools where appropriate.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: There must be documentation of regular review of pain and symptom assessment during each episode of care or at least every 3 days.</p> <p>Class C Providers: In addition to above, there must be documentation of regular psychological/spiritual assessment for both patients and families. These assessments can be performed by any member of the palliative care team.</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients assessed for pain every visit or at least every three days. (Case Notes Audit) <p>Numerator: Number of patients assessed for pain every visit or at least every three days. Denominator: Total number of patients with more than 1 clinical encounter.</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients assessed for dyspnoea, nausea, vomiting, confusion and bowel problems every visit or at least every three days. (Case Notes Audit) <p>Numerator: Number of patients assessed for dyspnoea, nausea, vomiting, confusion and bowel problems every visit or at least</p>

	<p>every three days.</p> <p>Denominator: Total number of patients with more than 1 clinical encounter.</p> <ul style="list-style-type: none"> Percentage (%) of patients and/or families assessed for psychosocial/spiritual needs every visit or at least once a week. <p>Assessment tools used may include:</p> <ul style="list-style-type: none"> ✓ ESAS (anxiety/depression/well-being) ✓ PCOC (overall problem severity score for psychological/spiritual/social) ✓ IPOS (anxiety/depression/feeling at peace) ✓ Other tools eg. Distress Thermometer (Case Notes Audit) <p>Numerator: Number of patients and/or families assessed for psychosocial/spiritual needs every visit or at least once a week.</p> <p>Denominator: Total number of patients and/or families with more than 1 clinical encounter.</p> <p>Assessment Tools:</p> <ul style="list-style-type: none"> See Assessment Tools in 4.1 <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> Local Class C Provider Patient Assessment Forms (See examples in Annex)
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4.6 There are mechanisms in place to identify and assess risks of self-harm.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: There must be documentation of screening/assessment for suicide in patients assessed to be depressed or at risk of self-harm.</p> <p>The screening/assessment can be done by asking the patient the following - “Have you thought about ending your life?”</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> Percentage (%) of patients assessed for suicide in patients who are assessed to be depressed. (Case Notes Audit). <p>The screening/assessment can be done by asking the patient the following - “Have you thought about ending your life?”</p> <p>Numerator: Number of patients assessed for suicide who are deemed to be depressed.</p> <p>Denominator: Total number of patients</p>

<p>Class C Providers: Patients assessed to be at risk of suicide or self-harm should be referred to other relevant professionals within an acceptable time-frame (i.e., MSWs or Psychiatrists).</p>	<p>deemed to be depressed.</p> <ul style="list-style-type: none">▪ Evidence of a system in place to ensure that patients at high risk of suicide are referred to MSW or Psychiatrist within 24 hours.
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Guideline 5: Advance Care Planning

All patients at the end of life have access to Advance Care Planning (ACP).

Rationale: ACP helps to ensure that patients' wishes are respected in the event that they become incapable of participating in treatment decisions, and allows for treatment at the end-of-life to be consistent with the patients' preferences.⁶⁷⁻⁷³

5.1 There are systems in place to provide patients with life-limiting illness with information about, and access to, Advance Care Planning.

National Palliative Care Guidelines *Explanatory Notes*

“Systems”:

System refers to infrastructure in support of Advance Care Planning. This consists of mechanisms that can include:

- Patient ownership of their ACP forms
- Patient understanding of their access to legal documentation (e.g. AMD and LPA)
- Visible and accessible documentation in healthcare notes/electronic system
- Mechanisms that ensure patients' care preferences are well documented, communicated and honoured as care transits through different healthcare settings
- Develop a recommended practice in the ACP process that includes substitute healthcare decision-maker with the consent of patient and ensure he/she is aware that in the event the patient is deemed mentally incompetent, he/she may have to make decision on behalf of the patient

“Advance Medical Directive (AMD)”/“Lasting Power of Attorney (LPA)”:

Refer to glossary of terms for definition of AMD and LPA

Good Practices

Suggested Measures to Achieve Better Care

Good Practice:

All Providers

Staff are aware of the retrieval and storage of ACP documents in healthcare records/ electronic system.

Class A Providers

Awareness of available resources for ACP discussion.

Class B Providers

Class B providers shall have a system in place to identify those who are approaching the end of life and provide access to ACP discussion.

Resources for Service Providers:

- AIC Website – ACP brochures, ACP workbook, ACP forms³⁷
(Disease-specific ACP discussion worksheets, Preferred Plan of Care discussion worksheets)
- National Guidelines for Palliative Care
- Living Matters ACP website⁷⁴
(www.livingmatters.sg)
- Institution-specific ACP referral resources
(See examples in Annex)
- Singapore Silver Pages Caregivers' Resources for Advance Care Planning⁷⁵
(<https://www.silverpages.sg/caregiving/active-caregivers/Advance%20Care%20Planning>)

	<ul style="list-style-type: none"> ▪ Lasting Power of Attorney⁷⁶ (http://www.publicguardian.gov.sg/The-LPA/The-Lasting-Power-of-Attorney) ▪ MOH, Advance Medical Directive Act (2010) Adapted from MOH website at⁷⁷ (http://www.moh.gov.sg/content/moh_web/home/legislation/legislation_and_guidelines/advance_medical_directiveact.html) ▪ National Medical Ethics Committee, Guide for Healthcare Professionals on the Ethical Handling of Communication in Advance Care Planning (2010)⁷⁸ (http://www.moh.gov.sg/content/dam/moh_web/Publications/Guidelines/National%20Medical%20Ethics%20Committee%20Guidelines/2010/NMEC%20Guide%20for%20Comms%20in%20ACP.pdf)
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5.2 The service provider routinely conducts Advance Care Planning to ascertain and document patients' and families' preferences about treatment at the end-of-life, and fulfils these preferences as far as possible.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers:</p> <ul style="list-style-type: none"> ▪ ACP should be routinely conducted and documented in healthcare notes/electronic notes <ul style="list-style-type: none"> ✓ ACP is routinely reviewed in the following situations: <ul style="list-style-type: none"> i. Changes in medical condition ii. Changes in preferences ▪ Efforts are made to include substitute healthcare decision-makers with the consent of patients, where applicable. ▪ Patients' care preferences are fulfilled as far as possible. ▪ Patients' care preferences are communicated to other service providers as care transits through different healthcare settings. (using PPC form, online ACP form or other written documents) <p>Class C Providers: All doctors, nurses and MSWs should be certified as ACP facilitators.</p>	<p>Suggested Measures:</p> <p>Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients with ACP discussion documented in case notes/electronic notes. The ACP discussion should minimally include resuscitation status, preferred place of care and preferred place of death. (Case Notes Audit) <p>Numerator: Number of patients with ACP discussion documented in case notes/electronic notes.</p> <p>Denominator: Total number of patients with life-limiting illness. (Excluding patients who are unable to complete the ACP discussion and those who do not wish to discuss)</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients with ACP discussion communicated to main spokesperson/family/next of kin. (Case Notes Audit)

	<p>Numerator: Number of patients with ACP discussion communicated to main spokesperson/family/next of kin.</p> <p>Denominator: Total number of patients with documented ACP discussion.</p> <ul style="list-style-type: none"> ▪ Percentage (%) of staff who are certified ACP facilitators. <p>Numerator: Number of doctors/ nurses/ MSWs who are certified ACP facilitators.</p> <p>Denominator: Total number of doctors/ nurses/ MSWs.</p>
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5.3 There are systems in place to monitor if patients' Advance Care Plans are honoured.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: There should be a system in place to monitor if a patients' Advance Care Plans are honoured (multidisciplinary meetings, mortality/ morbidity reviews, ward rounds, etc.).</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence that upon death, a review is done to assess if a patient's ACP is honoured.

Guideline 6: Patient-Centred Care

Patients receive care that is customized to their unique needs and preferences as informed by holistic assessments.

Rationale: Patients have unique needs and preferences, which may differ depending on their cultural background. The patient’s quality of life is improved by care that is customized to their unique physical, emotional, cultural and spiritual needs.⁷⁹⁻⁸²

6.1 Each patient’s unique cultural and spiritual needs are taken into consideration in the provision of care services.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A & B Providers: All providers should screen for spiritual/psychosocial/cultural needs and concerns at initial consultation and intervals, particularly with changes in disease status.⁸³</p> <p>Class C Providers: Refer to Guideline 4.1 & 4.5</p>	<p>Suggested Measures:</p> <p>Class C Providers</p> <ul style="list-style-type: none"> ▪ As per measure in 4.1: Percentage (%) of patients with documented psychological, social, spiritual and cultural screening by third clinical encounter. Screening should minimally include: <ul style="list-style-type: none"> ✓ Psychological: mood/ coping/ anxiety/ depression ✓ Social: genogram or case notes documentation of immediate family members and living arrangements ✓ Spiritual: religion ✓ Cultural: race and language (Case Notes Audit) <p>Numerator: Number of patients with documented psychological, social, spiritual and cultural screening by third encounter.</p> <p>Denominator: Total number of patients seen by third clinical encounter.</p> <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ FICA (Faith, Importance, Community, Address)⁵⁸⁻⁶² ▪ Forms and other resources from US providers, assembled by the Center to Advance Palliative Care⁶⁶ (https://media.capc.org/filer_public/88/06/8806cedd-f78a-4d14-a90e-aca688147a18/nqfcrosswalk.pdf)

6.2 Information on the patient’s condition is openly and sensitively communicated to the patient and family (if permissible by patient) on a regular basis.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>All Providers: All providers should provide update of patient’s condition to both patient and family on a regular basis: at initial consult and whenever there are changes in the clinical condition of the patient.</p> <p><i>Note:</i> Providers should respect the patient’s autonomy and right to know about his/her condition and approach issues of collusion sensitively, understanding the cultural influences and the role of family in decision making.</p>	<p>Good Practice: All Providers Communication to the patient and family should be performed and documented whenever there are changes in the patient’s clinical condition.</p>
6.3 Spiritual support and therapy services (e.g. occupational, physical and speech therapy) are made available to patients when needed. Where these competencies do not exist within the service provider, there should be defined links to access these services.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class C Providers: Every Class C Provider should have a list of or have access to therapy support services whenever necessary.</p>	<p>Suggested Measures: Class C Providers Evidence of access to spiritual support, physical, occupational, and speech therapy services. Spiritual support includes support from religious leaders, counsellors, or MSWs.</p> <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Agency for Integrated Care. Singapore Silver Pages.⁴⁰ (https://www.silverpages.sg/)

6.4 In the presence of complex ethical dilemmas beyond the resourced ability of service provider, there are policies and procedures to ensure access to ethics committees (or equivalent).

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>“Ethical Dilemma”: An ethical dilemma involves the need to choose from among two or more morally acceptable options or between equally unacceptable courses of action, when one choice prevents selection of the other.⁸⁴</p> <p>Examples of Ethical Dilemmas include:</p> <ul style="list-style-type: none"> ▪ Conflict of ethical principles (e.g. patient’s wish to die at home but without adequate support – autonomy vs non-maleficence) ▪ Requests for palliative sedation ▪ Withdrawing or not providing life-sustaining treatment <p>Class C Providers: Protocols for referring difficult ethical cases to involve documented consultation with palliative care specialist(s), and/or ethics committee.</p> <p>Providers should have access to experts or ethics committee that can be consulted when needed.</p>	<p>Suggested Measures:</p> <p>Class C Providers Evidence of a referral system to an Ethics Consultant or Committee for complex ethical cases. For example, a medical and professional audit committee (MPAC) or equivalent, with terms of reference to cover for difficult ethical cases.</p> <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Online casebook on “Making Difficult Decisions with Patients and Families”, developed by the NUS Centre for Biomedical Ethics⁸⁵ (http://www.bioethicscasebook.sg/) ▪ Jonsen’s 4 boxes approach⁸⁶ https://depts.washington.edu/bioethx/tools/4boxes.html (See examples in Annex)

Guideline 7: Care in the Last Days of Life

Care is taken to fulfil the needs of patients in the last days of life, as well as those of their caregivers and families.

Rationale: During the last hours and days of life, the unique needs of patients and families should be taken into consideration, the comfort of patients maximised and their dignity respected.⁸⁷⁻⁹³

7.1 There is recognition and documentation of the patient’s transition to the active dying phase, and communication to the patient, family and staff on the patient’s imminent death.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>All Providers: Healthcare staff recognises and documents the patient’s transition to the active dying phase in a timely manner, and conveys this information to the patient (where appropriate), family and staff.</p>	<p>Good Practice: All Providers</p> <ul style="list-style-type: none"> ▪ All healthcare staff should be trained in identifying signs and symptoms of dying. ▪ All healthcare staff should be trained in end-of-life communication skills. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients whose transition to the active dying phase is documented. Examples of documentation of transition: <ul style="list-style-type: none"> ✓ Transition to phase 4 in PCOC ✓ Initiation of a care plan for the dying (Case Notes Audit) <p>Numerator: Number of patients whose transition to the active dying phase is documented. Denominator: Total number of expected deaths.</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients whose transition to the active dying phase and imminent death is communicated to the patient (where applicable) & family as documented in case notes. (Case Notes Audit) <p>Numerator: Number of patients whose transition to the active dying phase is communicated to the patient (where applicable) & family as documented in case</p>

	<p>notes.</p> <p>Denominator: Total number of expected deaths.</p> <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Watson M, Lucas C, Hoy A, Wells J. Oxford Handbook of Palliative Care, 2nd Edition. Chapter 16: The terminal phase⁹⁴ ▪ CAPC Fast Facts #3 – Syndrome of Imminent Death⁹⁵ (https://www.capc.org/fast-facts/3-syndrome-imminent-death/) ▪ Care plans from local institutions (See examples in Annex)
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7.2 The family is educated on a timely basis on the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate and culturally appropriate manner.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A Providers: Family members are given information or directed to resources regarding the signs and symptoms of imminent death on a timely basis and in a way that is appropriate for their age, culture and social situation.</p> <p>Class B & C Providers: Family members are given information or directed to resources regarding the signs and symptoms of imminent death on a timely basis, and prepared on the recognition and management of potential symptoms and concerns in a way that is appropriate for their age, culture and social situation.</p>	<p>Good Practice: All Providers</p> <ul style="list-style-type: none"> ▪ Family members should be given information or directed to resources regarding the signs and symptoms of imminent death on a timely basis. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of a system in place to provide families with information or resources regarding the signs and symptoms of imminent death. <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ See resources for 7.1 ▪ NQF Bereaved Family Survey⁹⁶ (www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=67383) ▪ Singapore Hospice Council website. Information for Caregivers: A Guide to Terminal Care⁹⁷ (http://www.singaporehospice.org.sg/caregivers2.html) ▪ Mayo Clinic website. End of life: Caring for a dying loved one⁹⁸ (http://www.mayoclinic.org/healthy-

	<p>living/end-of-life/in-depth/cancer/art-20047600?pg=1)</p> <ul style="list-style-type: none"> ▪ Singapore Silver Pages. Identifying end-of-life signs: Knowing what to do when the final days are approaching.⁹⁹ (https://www.silverpages.sg/caregiving/living/end-of-life/in-depth/cancer/art-20047600?pg=1) ▪ Institution-specific educational materials (See examples in Annex)
7.3 Symptoms at the end of life are assessed and controlled, with referral to palliative care services if necessary.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>“Symptoms at the end of life”: Common symptoms at the end of life include the following:</p> <ul style="list-style-type: none"> ▪ Pain ▪ Dyspnoea ▪ Respiratory secretions/death rattle ▪ Terminal delirium ▪ Nausea/vomiting <p>Class A & B Providers: Symptoms at the end of life are assessed and documented with appropriate frequency, with steps taken to control existing symptoms. Reassessment and revision of the plan occurs on a timely basis. Referral to palliative care services is considered where appropriate.</p> <p>Class C Providers: Symptoms at the end of life are assessed and documented with appropriate frequency. Reassessment and revision of the plan occurs on a timely basis. Symptoms are adequately controlled and/or anticipatory prescribing is done for these patients.</p>	<p>Good Practice: All Providers</p> <ul style="list-style-type: none"> ▪ Symptoms at the end of life are assessed ▪ Where appropriate, steps are taken to control symptoms, with referral to palliative care services if necessary. These steps may include medical or non-medical interventions appropriate for symptom control. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients whose common symptoms (pain, dyspnoea, respiratory secretions/death rattle, terminal delirium, nausea/vomiting) are assessed in the active dying phase. (Case Notes Audit) <p>Numerator: Number of patients whose common symptoms are assessed in the active dying phase. Denominator: Total number of expected deaths.</p> <p>Class C Providers (Inpatient services)</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients whose pain is controlled at the last clinical encounter in the active dying phase. Control is defined as mild or nil pain. (Case Notes Audit) <p>Numerator: Number of patients whose</p>

pain is controlled at the last clinical encounter in the active dying phase.

Denominator: Total number of patients who had pain in the active dying phase.

- Percentage (%) of patients whose dyspnoea is controlled at the last clinical encounter in the active dying phase. Control is defined as mild or nil dyspnoea. (Case Notes Audit)

Numerator: Number of patients whose dyspnoea is controlled at the last clinical encounter in the active dying phase.

Denominator: Total number of patients who had dyspnoea in the active dying phase.

- Percentage (%) of patients for whom anticipatory prescribing is done, which may include medications for pain, dyspnoea, respiratory secretions/death rattle, terminal delirium, nausea/vomiting, where applicable. (Medication Chart Audit)

Numerator: Number of patients for whom anticipatory prescribing is done.

Denominator: Total number of expected deaths.

- Percentage (%) of patients whose bereaved families/caregivers report that physical symptoms were well-controlled in the last days of life. (Caregiver Survey)

Numerator: Number of patients whose bereaved families/caregivers report that physical symptoms were well-controlled in the last days of life.

Denominator: Total number of surveyed bereaved families/caregivers of patients who had expected deaths.

Assessment Tools:

- Edmonton Symptom Assessment System (ESAS)⁵²⁻⁵⁴
(<http://www.palliative.org/newpc/professionals/tools/esas.html>)
- Palliative Care Outcomes Collaboration (PCOC) Dataset forms⁵⁵⁻⁵⁷

	<p>(http://ahsri.uow.edu.au/pcoc/forms/index.html)</p> <ul style="list-style-type: none"> ▪ NQF Bereaved Family Survey⁹⁶ (www.qualityforum.org/WorkArea/linkit.aspx?LinkIdIdentifier=id&ItemID=67383) ▪ PCOC After Death Bereaved Family Survey⁵⁵ <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Watson M, Lucas C, Hoy A, Wells J. Oxford Handbook of Palliative Care, 2nd Edition. Chapter 16: The terminal phase⁹⁴ ▪ Ellershaw J, Wilkinson S (editors). Care of the Dying – A Pathway to Excellence, 2nd Edition. Chapter 3: Symptom control in care of the dying¹⁰⁰ ▪ Hum A, Koh M (editors). The Bedside Palliative Medicine Handbook 2013¹⁰¹ Chapters 3: Terminal Symptoms, Chapter 8: Opioids and Adjuvant Analgesics, Chapter 9: Practical Issues in Palliative Care ▪ CAPC Fast Facts #54 – Opioid Infusions In The Imminently Dying Patient¹⁰² (https://www.capc.org/fast-facts/54-opioid-infusions-imminently-dying-patient/) ▪ CAPC Fast Facts #27 – Dyspnea at the End of Life¹⁰³ (https://www.capc.org/fast-facts/27-dyspnea-end-life/) ▪ CAPC Fast Facts #109 – Death Rattle and Oral Secretions¹⁰⁴ (https://www.capc.org/fast-facts/109-death-rattle-and-oral-secretions/) ▪ CAPC Fast Facts #1 – Diagnosis and Treatment of Terminal Delirium¹⁰⁵ (https://www.capc.org/fast-facts/1-diagnosis-and-treatment-terminal-delirium/)
<p>7.4 There is evidence of a plan in place to maximise patient comfort during the active dying phase and to support the family and caregivers.</p>	
<p>National Palliative Care Guidelines <i>Explanatory Notes</i></p>	<p>Good Practices <i>Suggested Measures to Achieve Better Care</i></p>
<p>Class A Providers: A management plan is in place to maximise</p>	<p>Good Practice: All Providers</p>

<p>patient comfort during the active dying phase and to support family and caregivers. Referral to palliative care services is considered where appropriate.</p> <p>Class B & C Providers: A management plan is in place to maximise patient’s comfort during the active dying phase and to support family and caregivers. This includes medical care plans (e.g. symptom control, discontinuing non-essential drugs, discontinuing unnecessary interventions/monitoring), nursing care plans (e.g. oral, bladder, bowel, skin care) and psychosocial/spiritual care plans.</p> <p>Care is individualized and based on needs and wishes of the patient, caregiver(s) and family. Referral to or activation of medical social worker or pastoral care worker is considered where appropriate.</p>	<ul style="list-style-type: none"> ▪ There is a management plan in place to maximise patient’s comfort and support the family and caregivers during the active dying phase. ▪ It is good practice for all providers to engage or activate the services of a medical social worker / counsellor trained in palliative care for the following: <ul style="list-style-type: none"> ✓ Counselling – end-of-life care, psychosocial and spiritual issues ✓ Family work – e.g. reconciliation, grief counselling <p>Suggested Measures:</p> <p>Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of a system in place to maximize patient’s comfort during the active dying phase. ▪ Evidence of a system in place to support the family and caregivers during the patient’s active dying phase. <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ See resources for 7.1
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Guideline 8: Caregiver Support

Caregivers of patients with life-limiting illness face significant stress in their roles, and their own practical and emotional needs need to be supported.

Rationale: Caregivers of patients with life-limiting illness face significant stress in their roles. Studies have shown that caregiving may negatively impact on caregivers’ health and work. There are also practical and emotional needs which need to be supported in order for them to be able to provide care more effectively.¹⁰⁶⁻¹¹⁶

8.1 The patient’s primary caregiver is identified at the initial assessment, and his or her needs are assessed and addressed on an on-going basis.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A & B Providers: Assessment of the primary caregiver includes identifying needs, desired level of involvement and ongoing willingness and ability to participate in the provision of care.</p> <p>Class C Providers: The above is carried out on an ongoing basis and needs are addressed.</p>	<p>Good Practice: Class B Providers</p> <ul style="list-style-type: none"> ▪ Class B Providers should identify patients’ primary caregivers at the initial assessment. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of patients with primary caregiver identified at the initial assessment. (Case Notes Audit) <p>Numerator: Number of patients with primary caregiver identified at the initial assessment.</p> <p>Denominator: Total number of patients with caregivers.</p> <ul style="list-style-type: none"> ▪ Percentage (%) of survey respondents who report that the primary caregiver’s needs were assessed and addressed in a timely manner. (Caregiver Survey) <p>Numerator: Number of survey respondents who report that the primary caregiver’s needs were assessed and addressed in a timely manner.</p> <p>Denominator: Total number of survey respondents.</p>

	<p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ National Bereavement Survey (VOICES)¹¹⁷ (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216896/VOICES-Survey-Appendix-B.pdf) ▪ E.g. PCOC Survey
<p>8.2 The primary caregiver is provided with education and training on their role, including strategies for self-care and coping with the demands of caregiving.</p>	
<p>National Palliative Care Guidelines <i>Explanatory Notes</i></p>	<p>Good Practices <i>Suggested Measures to Achieve Better Care</i></p>
<p>Class B & C Providers: Primary caregiver has access to caregiver training on practical and emotional aspects of caregiving.</p> <p>Class C Providers: In addition to the above, caregivers have adequate support and information to manage emergency and out of hours situations.</p>	<p>Suggested Measures:</p> <p>Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of survey respondents who report that caregiver training was available. (Caregiver Survey) <p>Numerator: Number of survey respondents who report that caregiver training was available.</p> <p>Denominator: Total number of survey respondents.</p> <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Training <ul style="list-style-type: none"> ✓ HCA Hospice Care Palliative Caregiver Program¹¹⁸ (https://www.hca.org.sg/hospice/services/palliative-caregivers-programme) ▪ Online resource and support portals for patients and caregivers: <ul style="list-style-type: none"> ✓ Singapore Silver Pages. End-Of-Life Care: Caring for your loved one near the end¹¹⁹ (https://www.silverpages.sg/caregiving/End-Of-Life%20Care) ✓ Singapore Hospice Council online resource for patient and caregivers¹²⁰ (www.singaporehospice.org.sg) ✓ Online guide developed by Macmillan Cancer Support¹²¹ (http://www.macmillan.org.uk/information-and-support/index.html) ✓ Online guide developed by the National Hospice and Palliative Care Organization (NHPCO)¹²² (http://www.caringinfo.org/i4a/pages/i)

	<p>index.cfm?pageid=1)</p> <ul style="list-style-type: none">✓ A Handbook for Caregivers developed by AWWA Centre for Caregivers¹²³ (http://www.awwa.org.sg/content/uploads/2015/04/awwa_caregiver_handbook_english_mar2011.pdf)
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Guideline 9: Bereavement Care

Family members affected by a death are offered timely bereavement support appropriate to their needs and preferences.

Rationale: There should be timely identification of complications in grief experienced by families before and after the patient’s death. The provision of direct bereavement support, or referral of families to bereavement services should be based on the assessed needs of the families.¹²⁴⁻¹³⁴ Psychotherapeutic interventions have been found to benefit those who have marked difficulties adjusting to the loss.¹³⁵

9.1 Appropriate information about practical death-related issues (e.g. funeral arrangements) should be available when requested.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Appropriate information includes:</p> <ul style="list-style-type: none"> ▪ Practical-death related issues and funeral arrangements ▪ Post-death matters <ul style="list-style-type: none"> ✓ Financial/legal/housing-related matters including CPF matters, DPS, insurance, banks, lawyers ✓ Important documents and death extract (certified true copy of death certificate) <p>All Providers: Appropriate practical death-related information should be made available and material regularly updated.</p>	<p>Suggested Measures : Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of survey respondents who reported receiving informative materials on funeral services/arrangements upon death of their family member. (Caregiver Survey) <p>Numerator: Number of survey respondents who reported receiving informative materials on funeral services/arrangements upon death of their family member.</p> <p>Denominator: Total number of survey respondents.</p> <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Informative materials on bereavement support services: <ul style="list-style-type: none"> ✓ Example of bereavement support services that families can access (See examples in Annex) ✓ Example of pamphlet on grief and bereavement for families and caregivers from local Class C provider (See examples in Annex) ▪ Informative materials on funeral services/arrangements upon death: <ul style="list-style-type: none"> ✓ Singapore Silver Pages. Preparing for the funeral: Things to note when your loved one is gone¹³⁶

	<p>(https://www.silverpages.sg/caregiving/Preparing%20For%20The%20Funeral)</p> <ul style="list-style-type: none"> ✓ NEA printed version of “When a Loved One Passes Away”¹³⁷ ✓ NEA online guide on death registration, funeral arrangements and other practical death-related issues¹³⁷ <p>(http://www.nea.gov.sg/public-health/care-for-the-dead/other-death-related-matters)</p>
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9.2 Families and caregivers identified to be at risk of complicated grief are referred to bereavement support services.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class A & B Providers: Identify and refer family members and caregivers who have difficulty coping with bereavement to support services.</p> <p>Class C Providers: In addition to the above, provide support to the identified individuals.</p>	<p>Good Practice: Class A & B Providers</p> <ul style="list-style-type: none"> ▪ There should be a system in place to refer family members and caregivers identified that have difficulty coping with bereavement for support. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of a system in place to provide or refer family members and caregivers identified as having difficulty with bereavement for support (e.g. mortality rounds). <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Example of bereavement support services that families can access (See examples in Annex) ▪ Example of pamphlet on grief and bereavement for families and caregivers from local Class C provider (See examples in Annex) ▪ Complicated Grief CAPC Fast Fact #254 – Complicated Grief¹³⁸ (https://www.capc.org/fast-facts/254-complicated-grief/) ▪ The inventory of complicated grief¹³⁹ ▪ Singapore Silver pages. Managing grief: Handling grief after your loved one is gone¹⁴⁰ (https://www.silverpages.sg/caregiving/Managing%20Grief)

9.3 There is evidence of a system in place to screen caregivers and families for bereavement needs, and to provide direct bereavement support or referral to bereavement support services where necessary.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: Timely screening of bereavement needs and provision of bereavement support where necessary is integral in minimising risk for complicated grief.</p>	<p>Good Practice: Class B Providers There should be a system in place to identify family members with bereavement needs, and to provide direct bereavement support or referral to bereavement support services where necessary.</p> <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ See measure in 9.2

Guideline 10: Qualified Staff and Volunteers

Care for those approaching the end of life is delivered by staff and volunteers (where applicable) with the appropriate qualifications and skill mix for the level of service offered, and who demonstrate on-going participation in training and development.

Rationale: A competent and adequate workforce is key to the provision of quality care. There should be an adequate team of healthcare professionals with the appropriate training to meet the needs of patients at the end of life.¹⁴¹⁻¹⁴⁵ As service providers may have different service models, they should customize staffing norms according to the roles and responsibilities of the staff. Volunteers may complement the healthcare team in the provision of care, and must receive the appropriate training to perform their duties effectively.

10.1 All staff and volunteers demonstrate evidence of palliative care training appropriate to the level of care provided.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>“Evidence of palliative care training”: Staffs have relevant qualifications as specified below according to their clinical roles/job descriptions.</p> <p>“Staff and Volunteers” refers to those involved in clinical work or with direct patient or caregiver contact.</p> <p>Palliative Care Courses: Class A & B Providers:</p> <ul style="list-style-type: none"> ▪ Doctors: Post Grad course (GDPM, SHC postgrad course) ▪ Nurses: Introduction to Palliative Care Nursing Course/Certificate in Basic Palliative Care (RN)/ELNEC for nursing ▪ Social Workers: Certificate in Basic Palliative Care/Basic Palliative care course for social workers (PCCSW) <p>Class C Providers:</p> <ul style="list-style-type: none"> ▪ APN: Palliative medicine APN or APN with *1 year clinical experience in palliative medicine: Masters of Nursing (Adult Health) ▪ Staff Nurses: Certificate in Basic Palliative Care/ELNEC or equivalent. ▪ EN: Certificate in introductory Palliative Care or equivalent. ▪ Senior SN/NO/NC/NM: Specialist Diploma 	<p>Good Practice: Class A & B Providers</p> <ul style="list-style-type: none"> ▪ It is good practice for Class A & B Providers to have basic training in palliative care. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Percentage (%) of staff (doctors/nurses/social workers/allied health workers) with palliative care training appropriate to the clinical role. <p>Numerator: Number of staff (doctors/nurses/social workers/allied health workers) with palliative care training appropriate to the clinical role. Denominator: Total number of staff (doctors/nurses/social workers/allied health workers).</p> <ul style="list-style-type: none"> ▪ Percentage (%) of volunteers who received palliative care training appropriate to the level of care provided. (Attendance at recognized courses – See examples in Annex) <p>Numerator: Number of volunteers who received basic palliative care training appropriate to the level of care they</p>

<p>in Palliative Care/Advanced Diploma in Nursing (Palliative Care) or equivalent.</p> <ul style="list-style-type: none"> ▪ Resident Physicians/Regular Locums/Clinical Associates: 3-day Postgraduate Course in Palliative Medicine (SHC)/GDPM/APHN Diploma (Flinders) or equivalent/Staff Registrar Scheme Diploma-SRS. ▪ Specialist: Registrar/Consultants – Advanced Speciality Training in Palliative Medicine or equivalent. ▪ Social Workers: Basic Palliative Care Course for Social Workers (PCCSW) or equivalent. ▪ Allied Health Workers: Certificate in basic palliative care or equivalent. ▪ Regular Volunteers: Basic nursing skills, communications and counselling (Mandatory volunteer orientation and training programmes) or equivalent. 	<p>provided.</p> <p>Denominator: Total number of volunteers involved in clinical work for the past 1 year.</p> <ul style="list-style-type: none"> ▪ Evidence of a system in place to support staff and/or volunteers’ supervision and training. <p>Requirements:</p> <ul style="list-style-type: none"> ▪ Training Log (OJT) – competency check for Class C Providers. <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Informative materials for staff on relevant training: <ul style="list-style-type: none"> ✓ Courses available at the AIC Learning Institute¹⁴⁶ (http://aic-learn.sg/trainingcalendar/) ✓ List of available training in Singapore Singapore Hospice Council website¹²⁰ (http://www.singaporehospice.org.sg/) ▪ Example of training in palliative care and end-of-life care available in Singapore (See examples in Annex)
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10.2 Palliative care teams consist of an interdisciplinary team of skilled palliative care professionals, including physicians, nurses and social workers and/or counsellors/pastoral staff. Where these competencies do not exist within a team, there should be clearly defined links to access these through a service level agreement or similar.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class C Providers: The specialist palliative care service should consist of the following:</p> <ul style="list-style-type: none"> ▪ Palliative medicine consultants (inclusive of visiting consultants) ▪ Palliative care trained nurses ▪ Social workers <p>Furthermore, it recommends a range of expertise provided by:</p> <ul style="list-style-type: none"> ▪ Physiotherapists ▪ Occupational therapists ▪ Dieticians ▪ Pharmacists 	<p>Suggested Measures:</p> <p>Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of interdisciplinary team activity (e.g. Multidisciplinary team meetings) consisting of physician(s), nurse(s), social worker(s) and/or counsellor/pastoral staff as a minimum requirement. <p>Resources for Service Providers: Recommended staffing norms:</p> <ul style="list-style-type: none"> ▪ Inpatient hospice: 2011 National Strategy for Palliative Care Pg 42.¹⁴⁷ ▪ Allied Health Professions Council¹⁴⁸ (http://www.healthprofessionals.gov.sg/co)

<ul style="list-style-type: none"> Chaplains/spiritual care givers <p><i>Note:</i> Where these competencies do not exist within a team, there should be clearly defined links to access these through a service level agreement or similar e.g. Memorandum of Understanding (MOU) with other service providers.</p>	<ul style="list-style-type: none"> ntent/hprof/ahpc/en.html) Staffing norms recommended by the 2009 Singapore Hospice Council Home Care and Day Hospice Services Workgroup Report (See examples in Annex)
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10.3 Staffing levels are adequate to deliver the care needed by patients.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
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Class C Providers:

Despite recent changes to the local healthcare landscape, figures from the 2009 Singapore Hospice Council Home Care and Day Hospice Services Workgroup Report offer minimum suggested staffing levels.

Table 1 for Home Care

Manpower	Description	Min Level of Staffing	Headcount	Full-Time Equivalent (per 100 patients)
DOCTORS	Consultant	1 : 200	1	0.5
	Registrar	1 : 200	1	0.5
	Medical Officer	1 : 200	1	0.5
NURSES	Senior Staff Nurse	1 : 33	3	3
	Senior Staff Nurse / Nurse Clinician	1 : 100	1	1
	Advanced Practice Nurse	1 : 200	1	0.5
PSYCHO-SOCIAL	Medical Social Worker / Counsellor	1 : 50	2	2
	MSW Assistant	1 : 100	1	1
	Volunteer*	1 : 100	1	1
THERAPY	Therapist	1 : 200	1	0.5

*E.g. befriending, assistance with errands, provision of transport for hospital appointments.

Table 2 for Day Care

Description	Min Level of Staffing	Number	Full-Time Equivalent
Nurse / Centre Supervisor	1 : 25	1	1
Admin Asst /Volunteer Coordinator	1 : 25	1	1
Doctor – Medical Officer	1 : 62	1	0.4
Doctor – Consultant	1 : 250	1	0.1
Social Worker	1 : 50	1	0.5
Occupational Therapist	1 : 50	1	0.5
Physiotherapist	1 : 50	1	0.5
Music & Arts Therapists	1 : 100	2	0.25
Day Care Assistants	1 : 8	3	3
Drivers	1 : 8	3	3
Cooks	1 : 25	1	1

Suggested Measures:

Class C Providers

- Evidence that service has a workforce planning strategy.

Recommended Assessment Tools:

- Acuity Score
- RUG-ADL¹⁴⁹
(<http://ahsri.uow.edu.au/pcoc/functionalassessment/index.html>)
- Symptom burden
- Caseload

Resources for Service Providers:

Recommended staffing norms:

- Refer resources in 10.2
- NICE quality statement 16¹⁵⁰
(<https://www.nice.org.uk/guidance/qs13/chapter/Quality-statement-16-Workforce-planning>)
- CAPC Staffing Norms¹⁵¹⁻¹⁵³

General Workers	1 : 25	1	1
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10.4 Palliative care professionals are appropriately trained, credentialed and/or certified in their area of expertise.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>“Appropriately credentialed and/or certified”: Professional training registered or recognized by Professional Organizations/Boards of Specialist Training.</p> <p>Class C Providers:</p> <ul style="list-style-type: none"> ▪ Palliative Care Medical Specialist: Singapore Medical Council (SMC) registered and Specialist Accreditation Board (SAB) accredited specialist training in Palliative Medicine. ▪ Palliative Care trained nurse: Nurse with Advanced Diploma in Palliative Care or its equivalent training by an accredited training institution. <p>Specialist Palliative Care Nurse: Nurse recognised as specialist by their credential of a Masters or PhD from an accredited training institution.</p> <ul style="list-style-type: none"> ▪ Social Worker: Degree in social work or post-graduate diploma in social work with PCCSW. 	<p>Suggested Measures:</p> <p>Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of policies in place to recruit staff with recognized qualifications and provide training in area of work. <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Ministry of Health website – Specialist Accreditation Board (Clinicians)¹⁵⁴, Allied Health Professionals¹⁴⁸ (http://www.healthprofessionals.gov.sg/content/hprof/sab/en.html) ▪ Singapore Nursing Board Website¹⁵⁵ (http://www.healthprofessionals.gov.sg/content/hprof/snb/en.html) e.g. Registration of Nursing/APN

10.5 Where volunteers are part of the team, there is evidence of policies in place to ensure

proper screening, recruitment and on-going training of volunteers.

National Palliative Care Guidelines

Explanatory Notes

Class C Providers:

Screening and recruitment for volunteers should include interviews by volunteer managers or appointed staff member of the organization. All regular volunteers with clinical roles (patient or caregiver contact) should undergo mandatory volunteer training program to ensure patient safety and volunteer wellbeing.

Good Practices

Suggested Measures to Achieve Better Care

Good Practice:

Class C Providers

Core competencies like basic skills in nursing, communication and counselling should be included. Option of advanced training for volunteers should be made available.

Suggested Measures:

Class C Providers

- Evidence of policies in place to guide volunteer recruitment and management.
- Evidence of a volunteer management model/workgroup which reviews volunteer management and training.

Resources for Service Providers:

- EAPC White Paper Report – Volunteering Vision for the Future. Focusing on Volunteering in Europe 2020.¹⁵⁶
(<http://www.eapcnet.eu/Themes/Organisation/Volunteering.aspx>)
- Council on Palliative Care and the McGill Medication Simulation Centre¹⁵⁷:
(<https://www.mcgill.ca/council-on-palliative-care/events-resources/training-videos-volunteers>)

Guideline 11: Staff and Volunteer Self-Care

Staff and volunteers reflect on practice, maintain effective self-care strategies and have access to support in dealing with the psychological stress associated with working among the terminally ill and bereaved.

Rationale: The care of patients near the end of life and the support of their family members may have an emotional and spiritual toll on healthcare workers and volunteers.¹⁵⁸⁻¹⁶³ The ability to reflect on their practice and opportunities to express their feelings related to interactions with patients and their families should be encouraged as part of the culture of service providers caring for patients near the end-of-life.¹⁶⁴⁻¹⁶⁷

11.1 There are strategies in place to provide situational support, critical incident debriefing and response.

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“Situational support”:
Mechanisms for support include those from both internal and external platforms. Examples of internal mechanisms include (but are not limited to) the use of case conferences, multidisciplinary meetings, mortality rounds, ward rounds and Balint or Schwartz rounds within the institution or service. External mechanisms for support include referrals to support services (e.g. psychiatry services) outside of the institution or service.

The use of the type of support depends on the severity of the critical incident. For instance, uneventful deaths are reviewed in brief during mortality rounds; eventful or difficult clinical situations are discussed in details in debriefing sessions.

“Critical incident”:
A critical or traumatic incident can be defined as any sudden event or situation that involves actual, threatened, witnessed or perceived death, serious injury, or threat to the physical and psychological integrity of an individual or group.

Good Practices

Suggested Measures to Achieve Better Care

Good Practice:

Class B & C Providers

- Presence of framework for situational support for staff during critical events

Possible Sources of Evidence:

- Organization policies and procedures
- Clinical incident reports
- Records of interdisciplinary meetings (e.g. MDMs and mortality rounds)
- Agreements with external service providers of staff support

<p>Class B & C Providers: Class B & C Providers shall identify and have access to situational support and/or support resources when required. Support resources can be internet or intranet resource materials on a government or institutional website, or a staff member identified by the institution or service to direct providers to additional support resources when needed. Procedures to identify and respond to critical incidents shall be in place within institutions.</p> <p>Volunteers: Volunteers shall identify and have access to support resources when required. This can be internet or intranet resource materials on a government or institutional website, an identified staff (e.g. volunteer coordinator) to direct these providers to additional support resources when needed, or one who can provide direct support to them.</p>	
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11.2 Education is provided to help staff and volunteers develop effective coping strategies.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class B & C Providers: All Class B & C providers and volunteers working with these providers shall receive education on developing effective coping strategies. Education may be provided within staff or volunteer induction programs, ongoing training or supervision or during volunteer orientations. Volunteer coordinators or managers should be equipped to identify the coping needs of their volunteers.</p>	<p>Good Practice: Class B Providers</p> <ul style="list-style-type: none"> ▪ Education initiatives to help staff/volunteers develop effective coping strategies should be present in the institution/ organization. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of initiatives to help staff/volunteers develop effective coping strategies, such as <ul style="list-style-type: none"> ✓ Orientation programs ✓ Supervision ✓ Review of training and developmental needs ✓ Professional development programs

11.3 Staff have access to confidential employee assistance programs and/or counselling services.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>Class C Providers: Class C Providers shall be able to identify and gain access to available confidential employee assistance programs and/or counselling services (e.g. specialized counselling centres such as Counselling and Care, Focus on the Family, or Family Service Centres with counselling services, etc.). Providers shall be introduced to these programs and/or services during structured sessions (e.g. staff induction programs).</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of policies and procedures to ensure that staff can access confidential employee assistance programs and/or counselling services. <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Spiritual Perspective Scale (SPS)¹⁶⁸ (http://www.incamresearch.ca/content/spiritual-perspective-scale) ▪ Singapore Association for Counselling (SAC)¹⁶⁹ (http://www.sac-counsel.org.sg/) ▪ Family Service Centre (FSC)¹⁷⁰ (http://app.msf.gov.sg/Policies/Strong-and-Stable-Families/Supporting-Families/Family-Service-Centres)

Guideline 12: Access to and Use of Opioids

Patients at the end of life should have access to opioids for symptom control, with guidelines and processes in place to ensure safe and effective use.

Rationale: Opioids are commonly used medications in palliative care. While useful, there are also risks and unwanted effects associated with unregulated use.¹⁷¹⁻¹⁷⁴ Education and guidelines are necessary to ensure optimal symptom control with minimal side effects.^{101,175-179}

12.1 Service providers caring for patients at the end of life have access to opioids.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>“Access to opioids”: Availability of opioids and the ability to administer them to patients.</p> <p>Class A & B Providers: The service provider is aware of available resources in order for the patient to gain access to opioids, including out of hours. This could also be achieved via access to hospitals or home hospice services. Resources (e.g. brochures, website) are available for patients and caregivers to obtain information regarding the use of opioids.</p> <p>Class C Providers:</p> <ul style="list-style-type: none"> ▪ Standard formulary includes opioids. ▪ Service providers have timely access to opioids. 	<p>Good Practice: Class A & B Providers</p> <ul style="list-style-type: none"> ▪ Service Providers should have access to opioids including out-of-hours. ▪ Opioid should be obtained within a reasonable time frame in case of need. (nursing homes < 24 hours) <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence that service provider has access to opioids including out-of-hours. ▪ Percentage of opioid medication orders that fulfil the specified turnaround time. Turnaround time is defined as the interval from the time a medication order is written (manually or electronically) to the time the medication is administered. Stat order: < 1 hour Routine order: < 4 hours (Medication Chart Audit- This measure is not applicable to home care settings) <p>Numerator: Number of opioid medication orders that fulfil the specified turnaround time. Denominator: Total number of opioid medication orders.</p>

12.2 The use of opioids in the management of symptoms should be directed by evidence, driven by need, and administered under guidelines with appropriate monitoring.

National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>“Monitoring”: Monitoring of the correct and safe use of opioids, according to organizational guidelines or SOPs.</p> <p>Class A Providers:</p> <ul style="list-style-type: none"> ▪ The service provider is able to recognize a patient’s need for opioids for symptom control and is aware of available resources (e.g. Class C Providers or emergency medicine departments) for the patient to access opioids. <p>Class B & C Providers:</p> <ul style="list-style-type: none"> ▪ The service provider is able to use opioids appropriately when indicated and in accordance with evidence. ▪ Patients on opioids are monitored for serious side effects. 	<p>Good Practice:</p> <p>Class A & B Providers</p> <ul style="list-style-type: none"> ▪ There should be organizational guidelines or SOPs in place for safe use of opioids. ▪ Patients on opioid infusion should be monitored on a regular and ongoing basis. ▪ Service providers should conduct ongoing review of medication error, at least half yearly. <p>Suggested Measures:</p> <p>Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of organizational guidelines or SOPs for safe use of opioids. ▪ Evidence of a system in place to monitor for signs and symptoms of opioid toxicity for patients on opioid infusion on a regular and ongoing basis. The following should be monitored: <ul style="list-style-type: none"> ✓ Respiration rate ✓ Drowsiness level ✓ Presence of myoclonic jerks ▪ Evidence that service provider conducts ongoing review of medication error, at least half yearly. <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Reference charts/guidebooks for clinical staff: <ul style="list-style-type: none"> ✓ Opioid conversion charts from local Class C providers (See examples in Annex) ✓ NICE guidelines 2012. Opioids in Palliative Care: safe and effective prescribing of strong opioids for pain in palliative care of adults.¹⁸⁰ (http://www.nice.org.uk/guidance/cg140/evidence) ✓ Hum A, Koh M (editors). The Bedside Palliative Medicine Handbook 2013¹⁰¹

12.3 There is evidence of patient and caregiver education on the safe use of opioids.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>All Providers: Patients and caregivers often have misconceptions on the use of opioids and its safety profile. They should have ready access to resources and be provided appropriate information. All providers who prescribe opioids should routinely provide the above information and resources to patients and caregivers.</p>	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of availability of opioid education materials for patients and caregivers <p>Resources for Service Providers:</p> <ul style="list-style-type: none"> ▪ Educational materials for patients: Singapore Hospice Council pamphlet on using morphine (See example in Annex)
12.4 There is adherence to the legal requirements of the Misuse of Drugs Act on the prescription, safe storage, dispensing, administration, disposal and report of errors in the use of opioids.	
National Palliative Care Guidelines <i>Explanatory Notes</i>	Good Practices <i>Suggested Measures to Achieve Better Care</i>
<p>“Misuse of Drugs Act”: The Misuse of Drugs Act 1971 is intended to prevent the non-medical use of certain drugs. It controls medicinal drugs but also those with no current medical uses.</p>	<p>Good Practice: Class A & B Providers</p> <ul style="list-style-type: none"> ▪ There should be policies and procedures in place on receipt, safe storage, prescribing, dispensing, administration, disposal and report of errors on the use of opioids. ▪ There should be documentation on receipt, prescription, dispensing, administration and disposal of opioids according to established protocols. ▪ There should be a system in place for incident reporting of opioid related errors. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> ▪ Evidence of policies and procedures on receipt, safe storage, prescribing, dispensing, administration, disposal and report of errors on the use of opioids. ▪ Evidence of documentation on receipt, prescription, dispensing, administration and disposal of opioids according to established protocols. ▪ Evidence of a system in place for incident reporting of opioid related errors.

Guideline 13: Clinical Quality Improvement

The service is committed to improvement in clinical and management practices.

Rationale: Palliative care services are committed to a high quality of care and support for all patients and their families. Services should strive to benchmark quality through regular and systematic measurement, analysis, review, evaluation, goal setting and revision of care processes.^{151-153,183-197}

- 13.1 Presence of a framework to guide a program of quality improvement, that consists of:
- (a) Evidence of dissemination and incorporation of quality improvement (QI) findings into practice
 - (b) Clinical and performance criteria consistent with professional standards
 - (c) An on-going, proactive program for identifying and reducing unanticipated adverse events and safety risks to patients

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“Quality Improvement”:
Quality improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of patients¹⁹⁸.

Class B & C Providers:

- Policies and procedures for quality improvement/assurance are in place to guide the provision of palliative care for patients.
- Privileging and credentialing standards may apply to specific settings in Class C Providers. For example, APN credentialing and consultant privileging in certain centres.
- All services should have a system for adverse event reporting and death reviews. Specifically for Class C Providers, the latter should cover the domains of symptom control, psychosocial issues, bereavement needs and whether care preferences have been honoured.

Good Practices

Suggested Measures to Achieve Better Care

Good Practice:

Class B Providers

- Class B Providers are encouraged to form a quality improvement/assurance committee or to assign a person to review the quality of care.
- Death reviews should be completed within 1 month of death.

Suggested Measures:

Class C Providers

- Evidence of quality improvement/assurance committee or person to review the quality of care.
- Percentage (%) of deceased patients with death reviews completed within 1 month of death. Death reviews for Class C Providers should include domains of symptom control, psychosocial issues and bereavement needs.

Numerator: Number of deceased patients with death reviews completed within 1 month of death.

Denominator: Total number of deceased patients.

	<p>Resources for Service Providers:</p> <ul style="list-style-type: none"> Quality improvement and assurance framework – Example from local Class C Providers (See examples in Annex)
<p>13.2 There is evidence of the implementation of quality improvement projects to support on-going service evaluation and development.</p>	
<p>National Palliative Care Guidelines <i>Explanatory Notes</i></p>	<p>Good Practices <i>Suggested Measures to Achieve Better Care</i></p>
<p>Class C Providers: Quality improvement projects (QIP) involve systematic activities that are organized and implemented by an organization to monitor, assess, and improve its quality of health care. The activities are cyclical so that an organization continues to seek higher levels of performance to optimize its care for the patients it serves, while striving for continuous improvement¹⁹⁸.</p> <p>The possible domains of QIP, targets of interventions, and types of interventions are in the figure Analytic framework for interventions for advanced and serious illness¹⁹⁹ (See example in Annex).</p>	<p>Good Practice: Class C Providers</p> <ul style="list-style-type: none"> Class C Providers are encouraged to use a recognized quality improvement tool/framework (e.g. PDSA) in the implementation of the quality improvement project. <p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> Evidence of at least one Quality Improvement Project each year.
<p>13.3 There is evidence of on-going evaluation of patients’ and families’ satisfaction with care, and necessary measures to improve these.</p>	
<p>National Palliative Care Guidelines <i>Explanatory Notes</i></p>	<p>Good Practices <i>Suggested Measures to Achieve Better Care</i></p>
<p>Class C Providers: Regular feedback from patients and families should include the following domains:</p> <ul style="list-style-type: none"> Symptom control Psychosocial support Communication Bereavement Care 	<p>Suggested Measures: Class C Providers</p> <ul style="list-style-type: none"> Evidence of routine use of a patient and family satisfaction survey. <p>Assessment Tools:</p> <ul style="list-style-type: none"> National Quality Forum (NQF) Quality of Care at End of Life Measure 0208 – Family Evaluation of Hospice Care (FEHC)⁹⁶ (www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=67383) NSAP Patient Interview Survey²⁰⁰ (www.caresearch.com.au/caresearch/Portals/0/Documents/WhatIsPalliativeCare/NationalProgram/NationalStandardsAssessment)

	<p>Program/NSAPAuditTool2.pdf)</p> <ul style="list-style-type: none">▪ NSAP Family Evaluation of Palliative Care²⁰¹ (www.caresearch.com.au/caresearch/Portals/0/Documents/WhatisPalliativeCare/NationalProgram/NationalStandardsAssessmentProgram/NSAPAuditTool3.pdf)▪ PCOC Carer Experiences Survey⁵⁵▪ Toolkit of Instruments to Measure End of Life Care²⁰² (www.npcrc.org/files/news/afterdeath_bereaved_family_interview_hospital.pdf)
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