Use of resuscitation plans in decisions at the end of life

Evidence check

September 2021

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Evidence check question

What evidence is available regarding resuscitation planning principles? What do policy makers and professional bodies recommend for the use of resuscitation plans in decisions at the end of life?

In brief

Peer-reviewed sources

A narrative review[1] on how to discuss and document resuscitation plans in decisions at the end of life published in March 2021 found synergy between the needs of consumers and clinicians to best support patients' treatment preferences and support appropriate medical care. Key findings of the review include:

- A systematic approach: The discussion and documentation of resuscitation plans should be embedded into the clinical practice of all treating clinicians. Holding discussions about the withholding or limiting of treatment options early in a patient's diagnosis, and revisiting these on a regular basis, will improve the uptake of resuscitation plans and the experience for clinicians, patients and their families.
- Withholding or limiting treatment decisions: All resuscitation-planning decisions need to be considered within the context of broad goals of care that are informed by the patient's values and treatment preferences. Acknowledging that these may shift during the disease course is important.
- Shared decision making: All discussions about resuscitation planning need to be patient centred and use positively-framed language. The evidence suggests the positive framing of language makes these conversations more comfortable for both the clinician, the patient and their family. Where English proficiency is limited (for the patient and/or their family), clinicians should engage the use of medical interpreters as required.
- Standardised documentation: The plan or form that is adopted can be transferrable between different care settings.

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

There is significant overlap between the principles involved in resuscitation planning and medical goals of care. A systematic review[2] that focused on defining goals of care identified the reasons why the identification of goals of care is important for patients with serious illness. Three consistent themes were identified in the published literature:

- Promote patient autonomy and patient-centred care
- Avoid unwanted care and identify valued care
- Confer psychological support for patients and their families.

The definition proposed based on consensus within the published literature is "the overarching aims of medical care for a patient that are informed by patients' underlying values and priorities, established within the existing clinical context, and used to guide decision about the use of or limitation(s) on specific medical interventions." This definition underpins the key principles for resuscitation planning identified by Dignam *et al*[1].

Grey literature

Lead agencies

The Australian Resuscitation Council (ARC) has developed guidelines for clinical practice and education for healthcare providers[3]. These guidelines have also been endorsed by many peak professional bodies including a number of medical colleges. The ARC guidelines are to be used by healthcare services and jurisdictions to inform the development of local policy and procedures to support resuscitation practices. The key ARC guideline recommendations are provided in Table 2 below.

The Clinical Excellence Commission found that staff experience discomfort initiating conversations about end of life with patients and families, and that clinicians are failing to develop appropriate treatment plans[4]. This report reinforces the importance of holding end-of-life discussions with patients and families early in the disease diagnosis, and the need for all clinicians to be trained in communication skills and clinical management relating to end-of-life care.

The Australian Commission on Quality and Safety in Health Care (ACQSHC) have developed the Comprehensive Care Standard. A focus on patient experience is critical to the delivery of comprehensive care[5]. Goals of care are the clinical and personal goals for a patient's episode of care that are determined in the context of a shared decision-making process. This addresses resuscitation planning and reinforces the principles of shared decision making, clear communication, documentation, renegotiating goals and incorporating these into existing systems and processes of care.

Palliative Care Aged Care Evidence (palliAGED) have completed an evidence review and developed practice points for clinicians to guide their discussions with patients, families and substitute decision makers around goals of care[6]. Their findings correlate with the peer-reviewed literature that there is no consensus on the process or components that should be contained within any goals of care or resuscitation tool.

Australian State Health Organisations

For this evidence check a review of interjurisdictional policies and guideline documentation was also conducted[7-10]. Common themes emerging from these are as follows:

- Shared decision making – all resuscitation planning discussions should be patient focused to understand their values and care preferences.
- Communication – begin the conversation about resuscitation planning early, be flexible and review regularly as circumstances change or at each hospital admission.

- Processes and documentation – should be standardised and clearly documented.

There are a number of differences in the existing policies and guidelines:[7-10]

- Authorising clinicians – some permit credentialed nurse practitioners and junior medical staff to authorise a resuscitation plan; others only permit a senior medical practitioner to authorise a resuscitation plan. In some jurisdictions a general practitioner (GP) completes the resuscitation plan.
- Cohort – some apply only to adults; others apply to adults and paediatric patients.
- Duration – some states have developed resuscitation plans that remain active indefinitely, while others may remain active for a maximum of 12 months. All promote regular review of the plan.
- Application / utility – some variability exists where the resuscitation plan can be applied. In some jurisdictions it is only in facilities that are run by the state, while for others the resuscitation plan is active and should be applied in all settings including inpatient, community, residential aged care facilities and in the home.
- Record keeping – some jurisdictions have electronic resuscitation plans that are recorded in the electronic medical record, but most are still paper based with many encouraging the patient to retain a copy of their plan with them at all times.

The peer-reviewed and grey literature suggests that it is not the content or format of the resuscitation plan that is important. What's most important is the way information is communicated, and the transparency of decisions and shared mutual understanding between treating clinicians, patients and families.

Background

The use of resuscitation plans in end of life decisions in NSW is governed by the Using Resuscitation Plans in End of Life Decisions Policy Directive (PD2014_030)[11]. Since the policy was last updated in 2014, significant developments in the end of life and palliative landscape have been made. They are:

- End of Life and Palliative Care Framework 2019-2024[12]
- End of Life Packages – AMBER care bundle[13], Last Days of Life toolkit[14] and Death screening and database program[15]
- End of Life and Palliative Care Blueprint for Improvement[16]
- Advanced Care Planning electronic medical record solution – incorporating the electronic resuscitation form[11]
- Clinical Principles for End of Life and Palliative Care.[17]

In March 2021, the Office of the Chief Health Officer (NSW Health) transferred the policy directive to the NSW Agency for Clinical Innovation. As the new owner, the agency is responsible for undertaking the review and update of the policy directive and associated forms.

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Resuscitation plan definition

A resuscitation plan is a medically-authorised order to use or withhold resuscitation measures and document other aspects of treatment relevant at end of life. Decisions to withhold cardiopulmonary resuscitation (CPR) and other resuscitation measures seek to avoid unwanted, excessively burdensome or insufficiently beneficial interventions for patients at the end of life. At some point in the course of life-limiting illness, a shift in the focus of care away from aggressive intervention and towards a palliative approach is often the agreed outcome.

Limitations

- This evidence check is based on two recently-published reviews. One focuses on the search term "resuscitation plan" while the second focuses on "goals of care".
- Only documents that described or referred to resuscitation plans or goals of care were included in the grey literature.
- Internationally there are differences in the terminology used in the literature. For this reason, the grey literature evidence is limited to literature emerging from Australian jurisdictions only.

Methods

PubMed and Google searches were undertaken on 16 August 2021 using the terms DNR/Do-Not-Resuscitate, NFR/not-for-resuscitation, allow natural death, decision making, resuscitation orders, resuscitation decisions, advance care directive, advance care planning and goals of care; with references followed up within articles as appropriate. Two reviews have formed the basis of this evidence check; a literature review capturing a 60-year period to February 2021 which explored the evolution of hospital patient No-CPR/Do Not Resuscitate decisions[1] and a systematic review of all publications until 2018 which characterized the use and meaning of the phrase "goals of care" within the healthcare literature pertaining to patients with serious illness[2]. An updated search for articles was conducted between February and September 2021. Peer reviewed articles and grey literature on guidance from other Australian jurisdictions and peak bodies have been included. Jurisdictions where their policy guidance was not readily available online were approached directly to provide copies of their documents and included in Table 3.

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Results

Table 1: Evidence from peer-reviewed literature on use of resuscitation plans in decisions at end of life

Source	Summary
Peer reviewed sources	
Moving from "Do Not Resuscitate" Orders to Standardized Resuscitation Plans and Shared-Decision Making in Hospital Inpatients Dignam et al. 2021[1]	A narrative review describing the evolution of hospital patient No-CPR/Do Not Resuscitate decisions over the past 60 years (to December 2019). The review highlights the pitfalls and barriers of not for resuscitation orders. It aims to identify the optimum method for discussing and documenting recommendations about end-of-life care including cardiac arrest, to best support a patient's treatment preference and support appropriate medical care. The authors recommend the following considerations: • Clinicians should embrace a systemic approach. This approach should include early and recurring discussions between medical staff and patients that are embedded in a hospital culture of shared decision making. Patient's treatment preferences should be viewed within the framework of broader goals of care and comorbidity. • Documentation and implementation of these decisions is then best achieved with standardised resuscitation plans. This enhances completion rates, improves consistency and clarity of documentation, improves rates of discussion, and results in a meaningful care plan that extends beyond the scope of a No-CPR order. • The need for standardised and positively-framed language in documentation, improving the uptake of resuscitation plans, and encouraging patient-centred discussions about burdensome medical intervention earlier in the disease course, not just at end of life. • Discussing and documenting resuscitation decisions using a clear communication framework and standardised plan increases patient and doctor satisfaction, reduces inpatient costs, minimises any perceived or actual patient abandonment and improves quality of life. • A standardised resuscitation plan should be transferrable for use in the community setting.

Source	Summary
	• Improved access and provision of training for staff having discussions about resuscitation planning, to improve their knowledge and comfort with end of life conversations. The authors propose the contents of a resuscitation plan is less important than the shared purpose and understanding of the resuscitation-planning process. This process should be embedded in clinical practice and balance the wishes of the patient and protect them from poor outcomes and non-beneficial care.
Use and Meaning of "Goals of Care" in the Healthcare Literature: a Systematic Review and Qualitative Discourse Analysis Secunda K et al. 2019[2]	The authors of this paper identified the ambiguity of the phrase 'goals of care' despite its ubiquitous use in clinician notes and healthcare literature. This systematic review sough to find a consesnsus operational definition of the phrase. The definition was derived following an analysis of the key themes that were identified in the literature. The definition proposed based on consensus within the published literature is *"the overarching aims of medical care for a patient that are informed by patients' underlying values and priorities, established within the existing clinical context, and used to guide decision about the use of or limitation(s) on specific medical interventions."* The paper also indicates the reasons why the identification of goals of care is important for patients with serious illness. Three consistent themes were clear in the published literature: • Promote patient autonomy and patient-centred care • Avoid unwanted care and identify valued care • Confer psychological support for patients and their families

Table 2: Grey literature on use of resuscitation plans in decisions at end of life

Source	Summary
Grey literature	
Resuscitation Standards for Clinical Practice and Education Provision Australian Resuscitation Council, 2014[3]	ARC has developed standards for resuscitation that have been endorsed by many peak professional bodies. Within their guidance resources they suggest that health care institutions should: • have policy documents available that support the role, function and standards for resuscitation and response systems within the healthcare institution. • document any end-of-life care decisions including decisions around 'Do Not Attempt Resuscitation' or 'Not for Resuscitation'. Such decisions should have been discussed with the patient wherever appropriate. The scope and reasons for such orders should be clearly documented and accessible to relevant staff. This process should be reviewed regularly. The ARC state that all resuscitation guidelines: 1. identify early those patients who are likely to require resuscitation 2. discuss the wishes of the patient (if competent) and/or substitute decision maker what treatments they would like withheld 3. clearly document a resuscitation plan for all patients that is always available (including during patient transfer) 4. ensure institutions have a policy requiring resuscitation decisions (including do not attempt resuscitation or not for resuscitation decisions) be clearly recorded and available to all clinical and managerial staff at all times 5. reflect that the overall responsibility for withholding resuscitation decisions rests with the most senior medical practitioner in charge of the patient's care 6. most senior available member of the medical team to enter the treatment limitation decision/s and the reasons for it in the medical record, including whether the patient and relatives have been informed (and their comments noted), or if no discussion has taken place (with the reasons for this documented)

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Source	Summary
	7. be reviewed regularly 8. that indicate a decision not to attempt resuscitation does not imply “no-treatment”, and that other treatment and care options may continue to be considered and offered (palliative care cannot be refused) 9. have information for staff, patients and relatives about resuscitation decisions provided by the institution in the form of organisational policies, patient brochures and information sheets (but subject to consideration of the individual patient).
Resuscitation Planning Clinical Directive – 7 Step Pathway SA Health, 2016[7]	South Australia Health (SA Health) has a standardised clinical directive for screening, developing and implementing a clinical care plan based around treatment decisions relating to an adult patient (i.e. over 18 years) resuscitation and care at the end of their life. The 7-step pathway applies to all SA Health care settings including community. The key features of the SA Health Resuscitation Care Plan (the Plan) include: • The patient’s Advanced Care Directive/Plan wishes (or family/carer/substitute decision-maker or person responsible) inform the Plan • The Plan is written by the health practitioner responsible for the patient’s care, such as the responsible medical practitioner or credentialed nurse practitioner • Specific clinical decisions and instructions for care and treatment limitations are outlined in the Plan • The Plan may be limited to the current admission or remain in place indefinitely until revoked • The Plan is documented within the patient’s medical record. The clinical directive provides suggested measures that health services can use to monitor their performance in resuscitation planning. They are as follows: • Compliance with a person’s resuscitation wishes at end of life • Resuscitation planning education • Consumer feedback • Documentation. SA Health released the clinical directive with a toolkit of resources to support implementation: • Factsheets

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Source	Summary
	• Forms • Flowcharts • Education and training framework • Evaluation and metrics guidance.
Acute Resuscitation Plan (for adults) - Clinical Guidelines Queensland Health, 2020[8]	Queensland Health has adopted a 7-step Acute Resuscitation Plan (ARP) Pathway (for adults) to assist clinicians to make decisions about resuscitation and other life-sustaining treatment and to develop and document the patient's clinical plan on the ARP form. The pathway was adapted and based on the SA Health 7-step Pathway. The ARP (incorporating the 7-step Pathway) was reviewed in 2020) and includes the following features: • An ARP form can remain active: – for this admission/attendance – until date (not longer than 12 months) – for 12 months. • ARPs can be used in any health setting in Queensland, including but not limited to: ○ public sector and private health services and facilities ○ residential aged care facilities ○ general practice and primary care ○ a patient's home. • While non-Queensland Health organisations can use the ARP form, its usage is subject to the service's policies and procedures • An ARP form should be completed and signed by the most senior medical practitioner available. However, in very limited circumstances (e.g. remote communities) it may be appropriate for a more junior medical practitioner or other health professional to complete the form. In these circumstances, the ARP form must be authorised by the most senior medical practitioner available (by phone, fax or email) and their details recorded on the ARP form. Queensland Health released the clinical guidelines with a toolkit of resources to support implementation including:

Source	Summary
	• Frequently Asked Questions • Flowchart / pathway • Education PowerPoint – for local adaptation • Quick guide.
Medical Goals of Care Plan – 4 Phase Model Tasmanian Government, 2011[9]	Tasmania has redesigned its health system to embed medical goals of care into the admission process for all patients. The Medical Goals of Care Plan is an assessment tool which should be completed for all patients admitted to the hospital. Patients goals of care will fall into one of four categories: • Section A – curative or restorative – no limitations of treatments (default for most admissions) • Section B – curative or restorative, but limitations of treatments • Section C – palliative symptom management and quality of life (prognosis assessed to be 1–2 years) • Section D – terminal care of dying patient (prognosis assessed to be hours or days). The Medical Goals of Care Plan: • Any medical practitioner PGY2+ can complete and approve the plan following consultation with the patient or person responsible and the multidisciplinary team. • A GP can initiate a Goal of Care Plan – GP Liaison Officers appointed to support this process and bring the form back to the hospital. • Decision making is based on determining the appropriate phase of care (Section A-D above) based on an assessment of the probable outcomes of medical treatments at their stage of illness. • Many patients will progress through the four phases of care while others may present at the terminal stage. • The Goals of Care Plan is paper based and scanned into the eMR. • The Goal of Care Plan has no expiration date but should be reviewed at each hospital admission. • Patients are encouraged to have a copy of their Goals of Care Plan and take this with them to all clinical appointments. • Can be used in any setting (hospital, community, residential aged care facility, home).

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Source	Summary
End of Life Program. Care for the Dying in NSW Clinical Excellence Commission, 2012[4]	This body of work was informed by the 2012 Quality Systems Assessment (QSA) program of the Clinical Excellence Commission focused on a self-assessment of end-of-life care in NSW public health organisations. The findings illustrated that clinicians are failing to: • recognise when patients are at risk of dying • develop appropriate treatment plans and • communicate with patients and carers. The greatest challenges related to: • staff discomfort initiating conversations with patients and carers • failure to recognise when patients are starting to die • poor communication between staff and patients and carers. This report reinforces the importance of holding discussions about end of life early in the disease diagnosis with patients and families, and the need for all clinicians to be trained in communication skills and clinical management relating to end-of-life care.

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Source	Summary
Implementing the Comprehensive Care Standard: Identifying goals of care Australian Commission on Safety and Quality in Health Care, April 2019[5]	The Comprehensive Care Standard relates to the delivery of comprehensive care for patients within a health service organisation. A focus on patient experience is critical to the delivery of comprehensive care. This paper provides practical advice for clinicians and health service organisations about goal setting, based on the common principles found in many goal setting tools. Goals of care are the clinical and personal goals for a patient's episode of care that are determined in the context of a shared decision-making process. Important considerations when considering goals of care: • Having a clear, shared understanding of goals of care is crucial for all patients regardless of their diagnosis or prognosis and is particularly important for patients with complex healthcare issues, such as comorbidities or life-limiting illness. • The process of identifying goals of care involves several stages including goal negotiation, goal setting and evaluation. • Identifying goals of care is an iterative process that can change over time. • Agreed goals of care should be clearly communicated and documented. • Goals of care should be integrated into existing systems and processes of care.
Palliative Care Aged Care Evidence Goals of Care, palliAGED 2021[6]	palliAGED have produced an evidence summary and practice points for clinicians about holding discussions about goals of care with patients, families and substitute decision makers. Key messages suggested in the evidence: • While there is consensus about what a goal of care is, there is no consensus on the process or components of goals of care tools or conversations. • Consensus exists that goals of care conversations should be person-centred, multidisciplinary in nature, iterative as the life-limiting illness progresses and complex in nature where there is disagreement between health care providers and/or patient and/or family members. • Goals of care should be documented and flexible to the patient's condition. • The involvement of professional medical interpreters is important to involve in conversations about goals of care where there is limited English proficiency.

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Table 3: Unpublished literature on use of resuscitation plans in decisions at end of life

Source	Summary
Unpublished literature	
Goals of Patient Care Plan Australian Capital Territory[10]	• A pilot of a new Goals of Patient Care Guidance and Form is in progress in the ACT. • It is currently on paper only, but plans are underway to incorporate this into the digital health record system. • Patients admitted at risk of sudden deterioration or death will have a clearly documented Goals of Patient Care Plan within 48 hours of admission. • There are four levels of care provision outlined on the form: 1. All life sustaining treatment 2. Life extending intensive treatment – with treatment ceiling 3. Active ward-based treatment – with symptom and comfort care 4. Optimal comfort treatment – Comfort Care Pathway • Documentation of a Goals of Patient Care Plan can only be made by a senior medical physician (consultant or registrar). • If an agreed plan cannot be made in consultation with the patient and family, the medical officer should obtain a second consultant medical opinion. • Extended use requires consultant endorsement and extensions can be made up to 12 months or a nominated time period of up to 12 months. • The guidelines refer to a Goals of Patient Care Planning tool. This is essentially a one page upside down Supportive and Palliative Care Indicators Tool (SPICT tool) designed to assist medical officers to look at the whole person, rather than take a siloed approach, and try to identify end-of-life concerns earlier. This then informs the Goals of Patient Care Plan. ACT has a trigger for this tool in the hospital-wide Comprehensive Care Plan Risk Assessment Tool. This tool is also being piloted.

References

1. Dignam C, Brown M, Thompson CH. Moving from "Do Not Resuscitate" Orders to Standardized Resuscitation Plans and Shared-Decision Making in Hospital Inpatients. Gerontol Geriatr Med; 2021 Jan-Dec;7:23337214211003431. DOI: 10.1177/23337214211003431
2. Secunda K, Wirpsa MJ, Neely KJ, et al. Use and Meaning of "Goals of Care" in the Healthcare Literature: a Systematic Review and Qualitative Discourse Analysis. Journal of General Internal Medicine; 2020 2020/05/01;35(5):1559-66. DOI: 10.1007/s11606-019-05446-0
3. Australian Resuscitation Council. Resuscitation Standards for Clinical Practice and Education Provision [Internet]. Royal Australasian College of Surgeons, Australia; June 2014 [cited 30 September 2021]. Available from: https://resus.org.au/standards-for-resuscitation-clinical-practice-and-education/
4. Baird H, King B, Kerr R, Walker A. Care for the Dying in NSW. A Review of the Data from the 2012 Quality Systems Assessment. Sydney. Clinical Excellence Commission; 2013 [cited 30 September 2021]. Available from: https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0005/258440/cec-care-for-the-dying-may-2013.pdf
5. Australian Commission on Safety and Quality in Health Care. Implementing the Comprehensive Care Standard- Identifying goals of care [Internet]. NSQHS; April 2019 [cited 30 September 2021]. Available from: https://www.safetyandquality.gov.au/sites/default/files/2019-06/implementing-the-comprehensive-care-standard-identifying-goals-of-care-final-accessible-pdf-24-apr-2019.pdf
6. Palliative Care Aged Care Evidence. Goals of Care [Internet]. palliAGED; June 2021 [cited 30 September 2021]. Available from: https://www.palliaged.com.au/tabid/4312/Default.aspx
7. Government of South Australia. Resuscitation Planning Clinical Directive – 7 Step Pathway [Internet]. SA Health; 2016 [cited 30 September 2021]. Available from: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/end+of+life+care/resuscitation+planning+7+step+pathway
8. Clinical Excellence Queensland. Acute Resuscitation Plan (for adults)_Clinical Guidelines [Internet]. Queensland Health; April 2020 [cited 30 September 2021]. Available from: https://clinicalexcellence.qld.gov.au/sites/default/files/docs/resourses/arp/arp-clinical-guidelines.pdf
9. Department of Health. Medical Goals of Care Plan_4 Phase Model [Internet]. Tasmanian Government; 2011 [cited 30 September 2021]. Available from: https://www.dhhs.tas.gov.au/palliativecare/health_professionals/goals_of_care
10. Australian Capital Territory. Goals of Patient Care Plan (draft). Not available online [cited 30 September 2021]
11. NSW Government. Using Resuscitation Plans in End of Life Decisions [Internet]. NSW Health, Australia; September 2019 [cited 30 September 2021]. Available from https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_030.pdf
12. Community Care and Priority Populations. End of Life and Palliative Care Framework 2019-2024 [Internet]. NSW Health, Australia; Feb 2019 [cited 30 September 2021]. Available from: https://www.health.nsw.gov.au/palliativecare/Publications/eol-pc-framework.pdf
13. Clinical Excellence Commission. AMBER Care Bundle. [Internet]. NSW Health, Australia [cited 30 September 2021]. Available from:https://www.cec.health.nsw.gov.au/improve-quality/quality-improvement-toolkits/amber-care
14. Clinical Excellence Commission. Last Days of Life. [Internet]. NSW Health, Australia [cited 30 September 2021]. Available from: https://www.cec.health.nsw.gov.au/improve-quality/teamwork-culture-pcc/person-centred-care/end-of-life/last-days-of-life
15. Clinical Excellence Commission. Death screening and database program. [Internet]. NSW Health, Australia [cited 30 September 2021]. Available from: https://www.cec.health.nsw.gov.au/improve-quality/teamwork-culture-pcc/person-centred-care/end-of-life/death-screening-and-database-project

16. Agency for Clinical Innovation. End of Life and Palliative Care Blueprint for Improvement [Internet]. NSW Health, Australia [cited 30 September 2021]. Available from: https://aci.health.nsw.gov.au/palliative-care-blueprint/the-blueprint
17. Agency for Clinical Innovation. Clinical Principles for End of Life and Palliative Care Guidelines [Internet]. NSW Health, Australia [cited 30 September 2021]. Available from: https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_016

V.1 22 Sept 2021 | SHPN (ACI) 220061 | TRIM ACI/D22/8 | 978-1-76023-077-7

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.