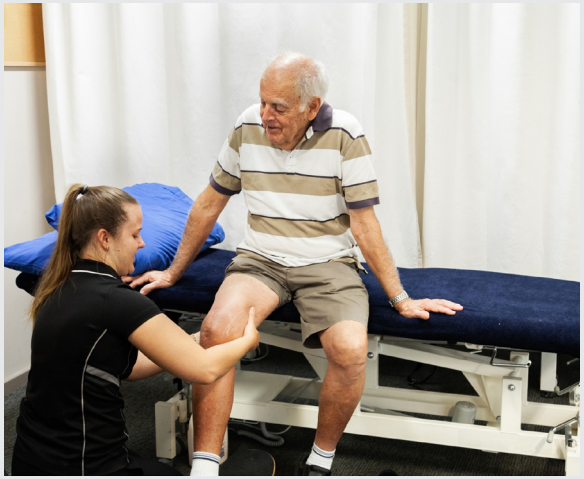
ELLC End of Life Law for Clinicians

Meeting Quality and Safety Standards in Aged Care

End of Life Law for Clinicians (ELLC) is a free training program for aged care health professionals about end of life decision-making laws. ELLC supports the delivery of safe, person-centred, high-quality end of life care in aged care by improving clinicians' knowledge and confidence applying the law in practice.



This guide shows how each ELLC online training module aligns with the:

» **Strengthened Aged Care Quality Standards (Final draft) (2023)**. The Standards will apply with the new *Aged Care Act 2024* (Cth) from 1 July 2025.

» ***National Consensus Statement: Essential elements for safe and high-quality end-of-life care**.

ELLC provides free education on end of life law in **13 online training modules**. This training can be used by health professionals and aged care providers to:

» meet their obligations based on their registration category under the new *Aged Care Act 2024* (Cth) and Standards.

» deliver training on person-centred rights-based care, caring for people living with dementia, responding to medical emergencies, and other areas required by the Standards.

» demonstrate continuous improvement and innovation in end of life, palliative and aged care.

» deliver education, recommended by the National Consensus Statement, on:
  - decision-making, capacity and consent,
  - Advance care planning,
  - substitute decision-making,
  - shared and support decision-making,
  - relevant state and territory legislation and regulatory frameworks, and
  - other end of life legal issues including refusal of treatment, withholding and withdrawing treatment, futile or non-beneficial treatment, and voluntary assisted dying.

CPD hours may be claimed from the RACGP, ACRRM or your professional organisation. Certificates of completion are available.

Contact ELLC for further information about how the training can support your clinical practice or aged care service.

*The National Consensus Statement 'applies to all services where health care is provided to people approaching the end of their life, including hospitals, hospices, residential aged care facilities and home settings' (p. 1).

MODULE 2

Capacity and consent to medical treatment

Part 1 of this Module explores the requirements of valid consent. Part 2 explores when an adult will have capacity to make decisions about medical treatment.

Learning outcomes

» Identify when consent to medical treatment is required and when it will be valid.

» Define the concept of capacity, and explain how it is determined.

Strengthened Aged Care Quality Standards (Final draft) (2023)

Standard 1: The Person

Outcome 1.1: Person-centred care

The provider understands that the safety, health, wellbeing and quality of life of older people is the primary consideration in the delivery of care and services.

The provider understands and values the older person, including their identity, culture, ability, diversity, beliefs and life experiences. Care and services are developed with, and tailored to, the older person, taking into account their needs, goals and preferences.

Actions:

1.1.1 The way the provider and workers engage with older people supports them to feel safe, welcome, included and understood.

1.1.2 The provider implements strategies to:

b. identify and understand the individual communication needs and preferences of the older person

d. deliver care that meets the needs of older people with specific needs and diverse backgrounds, including Aboriginal and Torres Strait Islander peoples and people living with dementia.

Outcome 1.2: Dignity, respect and privacy

The provider delivers care and services in a way that:

a. is free from all forms of discrimination, abuse and neglect

b. treats older people with dignity and respect

c. respects the personal privacy of older people.

The provider demonstrates they understand the rights of older people set out in the Statement of Rights and has practices in place to ensure that they deliver care and services consistent with those rights being upheld.

Actions:

1.2.1 The provider implements a system to recognise, prevent and respond to violence, abuse, racism, neglect, exploitation and discrimination.

1.2.2 Older people are treated with kindness, dignity and respect.

1.2.3 The relationship between older people, their family and carers is recognised and respected.

National Consensus Statement on End of Life Care (2023)

Guiding Principle No. 1: Be person-centred and include family and carers

People have the right to direct their own care, whenever possible. Families and carers should be involved, in accordance with the person's expressed wishes and/or legislation.

Guiding Principle No. 3: Provide people with information they can understand

People should be provided with health information that they can understand and be supported to make decisions at the end of their life. If a person lacks capacity to participate in decision-making about their care, a substitute decision-maker should make decisions according to their best interpretation of the preferences of the person, but only after options for supported decision-making have been exhausted.

Essential Element 2: Person-centred communication and shared decision making

Healthcare workers should adopt a person-centred approach to communication and decision-making, to assist a person who is dying to make choices about their care. *See Actions 2.1–2.13.*

Strengthened Aged Care Quality Standards (Final draft) (2023)

Outcome 1.3: Choice, independence and quality of life

Older people can exercise choice and make decisions about their care and services, with support when they want or need it.

Older people are provided timely, accurate, tailored and sufficient information, in a way they understand.

Older people are supported to exercise dignity of risk to achieve their goals and maintain independence and quality of life.

Actions:

1.3.1 The provider implements a system to ensure information given to older people to enable them to make informed decisions about their care and services:

a. is current, accurate and timely
b. is plainly expressed and presented in a way the older person understands.

1.3.2 The provider implements a system to ensure that older people give their informed consent where this is required for a treatment, procedure or other intervention.

1.3.3 The provider implements a system:

a. to ensure older people who require support with decision-making are identified and provided access to the support necessary to make, communicate and participate in decisions that affect their lives
b. that involves family and carers in supporting decision-making where possible
c. that uses substitute decision-makers only after all options to support an older person to make decisions are exhausted.

1.3.4 The provider supports older people to access advocates of their choosing.

Standard 2: The Organisation

Outcome 2.2: Quality and safety culture

The governing body leads a culture of safety, inclusion and quality that focuses on continuous improvement, embraces diversity and prioritises the safety, health and wellbeing of older people and the workforce.

Actions:

2.2.1 The governing body leads a positive culture of quality care and services and continuous improvement and demonstrates that this culture exists within the organisation.

2.2.2 In strategic and business planning, the governing body:

a. prioritises the safety, health and wellbeing of older people and workers
b. ensures that care and services are accessible to, and appropriate for, people with specific needs and diverse backgrounds, Aboriginal and Torres Strait Islander peoples and people living with dementia
c. actively engages and consults with workers
d. considers legislative requirements, organisational and operational risks, workforce needs and the wider organisational environment.

Outcome 2.9: Human resource management

Actions:

2.9.6 All workers regularly receive competency-based training in relation to core matters, at a minimum:

a. the delivery of person-centred, rights-based care
b. culturally safe, trauma aware and healing informed care
c. caring for people living with dementia
d. responding to medical emergencies
e. the requirements of the Code of Conduct, the Serious Incident Response Scheme, the Quality Standards and other requirements relevant to the worker's role.

National Consensus Statement on End of Life Care (2023)

Essential Element 5: Responding to concerns

When concerns are raised about a person approaching the end of their life or decision-making is particularly complex, timely and appropriate assistance should be obtained from a suitably skilled healthcare worker or team.

Responding to concerns may require the support of additional healthcare workers, or the use of videoconferencing or teleconferencing to access off-site help, such as specialist palliative care or consultants. A person skilled in mediation and/or the law should be available for managing conflict, complex family dynamics or ethical issues. *See Actions 5.1–5.9.*

Essential Element 7: Support, education and training

All healthcare workers should have a shared understanding of the healthcare services terminology, policies, processes and practices. Education should include:

» Decision-making, capacity and consent
» Shared decision making
» Advance care planning
» Person-centred care
» How to have conversations about end-of-life
» Inclusion and diversity
» Cultural safety.

Strengthened Aged Care Quality Standards (Final draft) (2023)		National Consensus Statement on End of Life Care (2023)
Standard 3: The Care and Services ***Outcome 3.3: Communicating safety and quality*** Critical information relevant to the older person's care and services is communicated effectively with the older person, between workers and with family, carers and health professionals involved in the older person's care. Risks, changes and deterioration in an older person's condition are escalated and communicated as appropriate. **Actions:** **3.3.1** The provider implements a system for communicating structured information about older people and their care and services that ensures critical information is effectively communicated in a timely way to workers, family, carers and health professionals involved in the older person's care. **3.3.2** The provider's communication system is used when: a. the older person commences receiving care and services b. the older person's needs, goals or preferences change c. risks emerge, there is a change, deterioration or an incident that impacts the older person d. handover or transitions of care occurs between workers or others involved in the older person's care. **3.3.3** The provider implements processes for older people, family, carers and health professionals involved in the older person's care to escalate concerns about the older person's health, safety or wellbeing. **3.3.4** The provider implements processes to: a. correctly identify and match older people to their care and services b. provide Care Statements to older people in residential aged care.	**Standard 5: Clinical Care** ***Outcome 5.6: Cognitive impairment*** Older people who experience cognitive impairment whether acute, chronic or transitory receive comprehensive care that optimises clinical outcomes and is aligned with their needs, goals and preferences. **Actions:** **5.6.1** The provider identifies and responds to the complex clinical care needs of people with delirium, dementia and other forms of cognitive impairment by: a. identifying and mitigating clinical risks b. delivering increased care requirements c. being alert to deterioration and underlying contributing clinical factors. **5.6.2** The provider collaborates with older people with cognitive impairment, family, carers and others to understand the person and to optimise clinical care outcomes.	

MODULE 3 Withholding and withdrawing life-sustaining medical treatment

This Module focuses on withholding and withdrawing life-sustaining treatment from adults.

It establishes a foundation for later modules on Advance Care Planning and Advance Care Directives (Module 4), Substitute decision-making for medical treatment (Module 5), Futile or non-beneficial treatment (Module 8), and Emergency treatment for adults (Module 9).

Learning outcomes

Identify:

» When a decision to withhold or withdraw life-sustaining treatment can be made.

» The circumstances under which such as decision needs or does not need to be followed.

Strengthened Aged Care Quality Standards (Final draft) (2023)

Standard 1: The Person

Outcome 1.1: Person-centred care

Noted above: See Module 2, Actions 1.1.1 – 1.1.2.

Outcome 1.2: Dignity, respect and privacy

Noted above: See Module 2, Actions 1.2.1 - 1.2.3.

Standard 2: The Organisation

Outcome 2.2: Quality and safety culture

Noted above: See Module 2, Actions 2.2.1 – 2.2.2.

Outcome 2.9: Human resource management

Noted above: See Module 2, Action 2.9.6.

Standard 5: Clinical Care

Outcome 5.4 Comprehensive Care

Older people receive comprehensive, safe and quality clinical care that is evidence-based, person-centred and delivered by qualified health professionals.

Clinical care encompasses clinical assessment, prevention, planning, treatment, management and review, minimising harm and optimising quality of life, reablement and maintenance of function.

The provider has systems and processes that support coordinated, multidisciplinary care, in partnership with the older person, family and carers that is aligned with their needs, goals and preferences.

The provider supports early identification of and response to changing clinical needs.

Actions:

5.4.1 The provider implements an assessment and planning system that supports partnering with the older person, family, carers and others to set goals of care and support decision making.

5.4.2 The provider conducts a comprehensive clinical assessment on commencement of care, at regular intervals and when needs change, that includes:

a. facilitating access to a comprehensive medical assessment with a general practitioner
b. identifying, documenting and planning for clinical risks, acute conditions and exacerbations of chronic conditions
c. identifying an older person's level of clinical frailty and communication barriers and planning clinical care to optimise the older person's quality of life, independence, reablement and maintenance of function
d. identifying and providing access to the equipment, aids, devices and products required by the older person.

5.4.3 The provider refers and facilitates access to relevant health professionals and medical, rehabilitation, allied health, oral health, specialist nursing and behavioural advisory services to address the older person's clinical needs.

5.4.4 The provider implements processes to:

a. deliver coordinated, multidisciplinary and holistic comprehensive care in line with the care and services plan
b. communicate and collaborate with others involved in the older person's care, in line with the older person's needs and preferences
c. facilitate access to after-hours and urgent clinical care
d. provide timely notification to the person's general practitioner, family, carers and health professionals involved in the older person's care when clinical incidents or changes occur.

5.4.5 The provider implements processes to monitor clinical conditions and reassess when there is a change in diagnosis or deterioration in behaviour, cognition, mental, physical or oral health, and at transitions of care.

National Consensus Statement on End of Life Care (2023)

Guiding Principle No. 6. Ensure the right to refuse medical treatment

Decisions regarding treatment may be made in advance and remain valid unless the person or substitute decision-maker, family or carers state otherwise.

Guiding Principle No. 7. Not be burdensome or harmful

It is unethical to provide burdensome investigations, treatments and transfers that can be of no benefit and harmful to people.

Guiding Principle No. 8. Not offer unreasonable hope

Unless required by law, clinicians are not obliged to initiate or continue treatments that will not offer a reasonable hope of benefit or improve a person's quality of life.

Essential Element 4: Comprehensive care

The goal of healthcare workers providing end-of-life care should be to deliver comprehensive care that is culturally safe and appropriate to the needs and condition of the person at the end of their life. It should also be aligned with their expressed wishes and goals.

Clearly communicate medical decisions, including the rationale, to discontinue or not instigate non-beneficial observations, investigations or treatments with the person, and document those decisions. *See Actions 4.1–4.14.*

Essential Element 5: Responding to concerns

Noted above: See Module 2.

Essential Element 7: Support, education and training

Noted above: See Module 2.

Strengthened Aged Care Quality Standards (Final draft) (2023)	National Consensus Statement on End of Life Care (2023)

Outcome 5.7 Palliative care and end-of-life care

The older person's needs, goals and preferences for palliative care and end-of-life care are recognised and addressed and their dignity is preserved.

The older person's pain and symptoms are actively managed with access to specialist palliative and end-of-life care when required, and their family and carers are informed and supported, including during the last days of life.

Actions:

5.7.1 The provider has processes to recognise when the older person requires palliative care or is approaching the end of their life, supports them to prepare for the end-of-life and responds to their changing needs and preferences.

5.7.2 The provider supports the older person, their family, carers and substitute decision maker to:

a. continue end-of-life planning conversations
b. discuss requesting or declining aspects of personal care, life-prolonging treatment and responding to reversible acute conditions
c. review advance care planning documents to align with their current needs, goals and preferences.

5.7.3 The provider uses its processes from comprehensive care to plan and deliver palliative care that:

a. prioritises the comfort and dignity of the older person
b. supports the older person's spiritual, cultural, and psychosocial needs
c. identifies and manages changes in pain and symptoms
d. provides timely access to specialist equipment and medicines for pain and symptom management
e. communicates information about the older person's preferences for palliative care and the place where they wish to receive this care to workers, their carers, family and others
f. facilitates access to specialist palliative care and end-of-life health professionals when required
g. provides a suitable environment for palliative care
h. provides information about the process when a person is dying and about loss and bereavement to family and carers.

MODULE 4 Advance Care Planning and Advance Care Directives

This Module explores Advance Care Planning and the law relating to Advance Care Directives, including when an Advance Care Directive can apply and when it must be followed.

Learning outcomes

Identify:

» What an Advance Care Directive is, and the information it can contain.

» When an Advance Care Directive can apply, and when it must be followed.

Strengthened Aged Care Quality Standards (Final draft) (2023)

Standard 1: The Person

Outcome 1.1: Person-centred care

Noted above: See Module 2, Actions 1.1.1 - 1.1.2.

Outcome 1.2: Dignity, respect and privacy

Noted above: See Module 2, Actions 1.2.1 - 1.2.3.

Outcome 1.3: Choice, independence and quality of life

Noted above: See Module 2, Actions 1.3.1 - 1.3.4.

Standard 2: The Organisation

Outcome 2.2: Quality and safety culture

Noted above: See Module 2, Actions 2.2.1 – 2.2.2.

Outcome 2.9: Human resource management

Noted above: See Module 2, Action 2.9.6.

Standard 3: The Care and Services

Outcome 3.1: Assessment and planning

Older people, and others involved in their care, are actively engaged in developing and reviewing their care and services plans through ongoing communication.

Care and services plans describe the current needs, goals and preferences of older people, including risk management and preventative care strategies. Care and services plans are regularly reviewed and are used by workers to guide the delivery of care and services.

Actions:

3.1.1 The provider implements a system for assessment and planning that:

a. identifies and records the needs, goals and preferences of the older person

b. identifies risks to the older person's health, safety and wellbeing and, with the older person, identifies strategies for managing these risks

c. supports preventative care and optimises quality of life, reablement and maintenance of function

d. involves relevant health professionals where required

e. directs the delivery of quality care and services.

National Consensus Statement on End of Life Care (2023)

Guiding Principle No. 1. Be person-centred and include family and carers

Noted above: See Module 2.

Guiding Principle No. 2. Align with values, needs and wishes

End-of-life care should consider a person's expressed wishes regarding the circumstances, environment and place in which they wish to die. Their needs, goals and wishes for end-of-life care may change over time.

Guiding Principle No. 4. Consider cultural, spiritual and psychosocial needs

Meeting the cultural, spiritual and psychosocial needs of people and their families and carers is as important as meeting their physical needs. This may include considerations such as beliefs and practices around the end of a person's life and dying, and the time it may take to shape practices and processes accordingly.

Essential Element 1: Recognising End of Life

The first step in providing safe and high-quality end-of-life care is to recognise people who would benefit from such care. *See Actions 1.1–1.2.*

Essential Element 2: Person-centred communication and shared decision making

Noted above: See Module 2.

Strengthened Aged Care Quality Standards (Final draft) (2023)	National Consensus Statement on End of Life Care (2023)

Standard 3: The Care and Services (continued)

3.1.2 Assessment and planning is based on ongoing communication and partnership with the older person and others that the older person wishes to involve.

3.1.3 The outcomes of assessment and planning are effectively communicated to:

a. the older person, in a way they understand
b. the older person's family, carers and others involved in their care, with the older person's informed consent.

3.1.4 Care and services plans are individualised and:

a. describe the older person's needs, goals and preferences
b. are current and reflect the outcomes of assessments
c. include information about the risks associated with care and services delivery and how workers can support older people to manage these risks
d. are offered to, and able to be accessed by, the older person
e. are used and understood by workers to guide the delivery of care and services.

3.1.5 Care and services plans are reviewed regularly, including when:

a. the older person's needs, goals or preferences change, or the care and services plan is not effective
b. the older person's ability to perform activities of daily living, mental health, cognitive or physical function, capacity or condition deteriorates or changes
c. the care that can be provided by an older person's family or carer changes
d. transition occurs
e. risks emerge or there are changes or an incident that impacts the older person
f. care responsibility changes between others involved in the older person's care.

3.1.6 The provider has processes for advance care planning that:

a. support the older person to discuss future medical treatment and care needs, in line with their needs, goals and preferences, including beliefs, cultural and religious practices and traditions
b. support the older person to complete and review advance care planning documents, if and when they choose
c. support the older person to nominate and involve a substitute decision maker for health and care decisions, if and when they choose
d. ensure that advance care planning documents are stored, managed, used and shared with relevant parties, including at transitions of care.

Standard 5: Clinical Care

Outcome 5.4 Comprehensive care

Noted above: See Module 3, Actions 5.4.1 - 5.4.5

Essential Element 4: Comprehensive care

Noted above: See Module 3.

Essential Element 5: Responding to concerns

Noted above: See Module 2.

Essential Element 7: Support, education and training

Noted above: See Module 2.

MODULE 5 Substitute decision-making for medical treatment

This Module explores who can be a substitute decision-maker for an adult, when they can make decisions, how they should make decisions, and when a substitute decision-makers' decision needs to be followed.

Learning outcomes

Identify:

- What decisions a substitute decision-maker can make, and how they should make decisions.
- The appropriate substitute decision-maker for a person who does not have capacity.
- When a substitute decision-maker's decision needs to be followed.

Strengthened Aged Care Quality Standards (Final draft) (2023)		National Consensus Statement on End of Life Care (2023)
Standard 1: The Person ***Outcome 1.1: Person-centred care*** Noted above: See Module 2, Actions 1.1.1 - 1.1.2. ***Outcome 1.2: Dignity, respect and privacy*** Noted above: See Module 2, Actions 1.2.1 - 1.2.3. ***Outcome 1.3: Choice, independence and quality of life*** Noted above: See Module 2, Actions 1.3.1 - 1.3.4. **Standard 2: The Organisation** ***Outcome 2.2: Quality and safety culture*** Noted above: See Module 2, Actions 2.2.1 – 2.2.2. ***Outcome 2.9: Human resource management*** Noted above: See Module 2, Action 2.9.6.	**Standard 3: The Care and Services** ***Outcome 3.1: Assessment and planning*** Noted above: See Module 3, Actions 3.1.1 - 3.1.6. **Standard 5: Clinical Care** ***Outcome 5.4 Comprehensive care*** Noted above: See Module 3, Actions 5.4.1 - 5.4.2, 5.4.4. ***Outcome 5.6: Cognitive impairment*** Noted above: See Module 2, Action 5.6.2. ***Outcome 5.7 Palliative care and end-of-life care*** Noted above: See Module 3, Action 5.7.3.	**Guiding Principle No. 1. Be person-centred and include family and carers** *Noted above: See Module 2.* **Guiding Principle No. 2. Align with values, needs and wishes** *Noted above: See Module 4.* **Guiding Principle No. 3. Provide people with information they can understand** *Noted above: See Module 2.* **Guiding Principle No. 4. Consider cultural, spiritual and psychosocial needs** *Noted above: See Module 4.* **Guiding Principle No. 6. Ensure the right to refuse medical treatment** *Noted above: See Module 3.* **Essential Element 2: Person-centred communication and shared decision making** *Noted above: See Module 2.* **Essential Element 5: Responding to concerns** *Noted above: See Module 2.* **Essential Element 7: Support, education and training** *Noted above: See Module 2.*

MODULE 6 Legal protection for administering pain and symptom relief

Part 1 of this Module explores the law on providing pain and symptom relief at the end of life, and the doctrine of double effect. It explains how the lawful provision of pain and symptom relief is different from voluntary assisted dying.

Part 2 considers the legal status of palliative sedation and voluntarily stopping eating and drinking.

Learning outcomes

- Explain the doctrine of double effect and its application in practice.
- Differentiate between the lawful provision of pain and symptom relief, and voluntary assisted dying.

Strengthened Aged Care Quality Standards (Final draft) (2023)		National Consensus Statement on End of Life Care (2023)
Standard 1: The Person ***Outcome 1.1: Person-centred care*** Noted above: See Module 2, Actions 1.1.1 – 1.1.2. ***Outcome 1.2: Dignity, respect and privacy*** Noted above: See Module 2, Actions 1.2.1 - 1.2.3. **Standard 2: The Organisation** ***Outcome 2.2: Quality and safety culture*** Noted above: See Module 2, Actions 2.2.1 – 2.2.2. ***Outcome 2.9: Human resource management*** Noted above: See Module 2, Action 2.9.6. **Standard 5: Clinical Care** ***Outcome 5.5 Clinical Safety*** **Action 5.5.8** The provider implements processes to manage pain by: a. assessing the older person's pain including where the older person experiences challenges in communicating their pain b. planning for, monitoring and responding to the older person's need for pain relief c. ensuring pain management is available 24-hours a day.	***Outcome 5.7 Palliative care and end-of-life care*** Noted above: See Module 3, Actions 5.7.1 – 5.7.2. **Other Actions:** **5.7.3** The provider uses its processes from comprehensive care to plan and deliver palliative care that: a. prioritises the comfort and dignity of the older person b. supports the older person's spiritual, cultural, and psychosocial needs c. identifies and manages changes in pain and symptoms d. provides timely access to specialist equipment and medicines for pain and symptom management e. communicates information about the older person's preferences for palliative care and the place where they wish to receive this care to workers, their carers, family and others f. facilitates access to specialist palliative care and end-of-life health professionals when required g. provides a suitable environment for palliative care h. provides information about the process when a person is dying and about loss and bereavement to family and carers. **5.7.4** The provider implements processes in the last days of life to: a. recognise that the older person is in the last days of life and respond to rapidly changing needs b. ensure medicines to manage pain and symptoms, including anticipatory medicines, are prescribed, administered, reviewed and available 24-hours a day c. provide pressure care, oral care, eye care and bowel and bladder care d. recognise and respond to delirium e. minimise unnecessary transfer to hospital, where this is in line with the older person's preferences.	**Essential Element 1: Recognising End of Life** *Noted above: See Module 4.* **Essential Element 4: Comprehensive care** *Noted above: See Module 3.* **Essential Element 7: Support, education and training** *Noted above: See Module 2.* **Essential Element 10: Systems to support high-quality care** **Action 10.2:** Ensure systems appropriately identify essential palliative medicines and provide access to them for people at the end of their life for example provision for anticipatory prescribing. These systems should align with the Medication Safety Standard, where applicable.

MODULE 7 Children and end of life decison-making

There is no Module 7 for the aged care course. Module 7 of ELLC courses is about children and end of life decision-making. If you wish to complete Module 7, you can access it from 'Other modules' on the ELLC Aged Care course homepage.

MODULE 8 Futile or non-beneficial treatment

This Module explores the law about futile or non-beneficial treatment, and when it can be withheld or withdrawn from an adult or child at the end of their life.

Learning outcomes

- Explain who decides when treatment is futile or non-beneficial, and how it is decided.
- Identify when a decision to withhold or withdraw futile or non-beneficial treatment can be made.

Strengthened Aged Care Quality Standards (Final draft) (2023)		National Consensus Statement on End of Life Care (2023)
Standard 1: The Person ***Outcome 1.1: Person-centred care*** Noted above: See Module 2, Actions 1.1.1 – 1.1.2. ***Outcome 1.2: Dignity, respect and privacy*** Noted above: See Module 2, Actions 1.2.1 - 1.2.3. **Standard 2: The Organisation** ***Outcome 2.2: Quality and safety culture*** Noted above: See Module 2, Actions 2.2.1 – 2.2.2. ***Outcome 2.9: Human resource management*** Noted above: See Module 2, Action 2.9.6.	**Standard 5: Clinical Care** ***Outcome 5.7 Palliative care and end-of-life care*** Noted above: See Module 3, Action 5.7.2.	**Guiding Principle No. 7. Not be burdensome or harmful** *Noted above: See Module 3.* **Guiding Principle No. 8. Not offer unreasonable hope** *Noted above: See Module 3.* **Essential Element 4: Comprehensive care** *Noted above: See Module 3.* **Essential Element 5: Responding to concerns** *Noted above: See Module 2.* **Essential Element 7: Support, education and training** *Noted above: See Module 2.*

MODULE 9 Urgent treatment for adults

This Module explores how the law responds to situations where decisions about urgent (emergency) treatment are needed for adults. It explains when life-sustaining treatment can be withheld or withdrawn in an emergency.

Learning outcomes:

Identify when life sustaining treatment can be:

» given in an emergency

» withheld or withdrawn in an emergency.

Strengthened Aged Care Quality Standards (Final draft) (2023)

Standard 1: The Person

Outcome 1.1: Person-centred care

Noted above: See Module 2, Actions 1.1.1 – 1.1.2.

Outcome 1.2: Dignity, respect and privacy

Noted above: See Module 2, Actions 1.2.1 – 1.2.3.

Outcome 1.3: Choice, independence and quality of life

Noted above: See Module 2, Actions 1.3.1 – 1.3.2.

Standard 2: The Organisation

Outcome 2.2: Quality and safety culture

Noted above: See Module 2, Actions 2.2.1 – 2.2.2.

Outcome 2.9 Human Resource management

Actions:

2.9.6 All workers regularly receive competency-based training in relation to core matters, at a minimum:

a. responding to medical emergencies.

Standard 5: Clinical Care

Outcome 5.5 Clinical Safety

Noted above: See Module 6, Action 5.5.8.

Outcome 5.7 Palliative care and end-of-life care

Noted above: See:

» Module 3, Action 5.7.2.

» Module 6, Action 5.7.4.

Standard 7: The Residential Community

Outcome 7.2: Transitions

Older people experience a well-coordinated transition to or from the provider for planned and unplanned transitions.

There is clear responsibility and accountability for an older person's care and services between workers, health professionals and across organisations.

Actions:

7.2.1 The provider has processes for transitioning older people to and from hospital, other care services and stays in the community, and ensures that:

a. use of hospitals or emergency departments are recorded and monitored

b. there is continuity of care for the older person

c. older people, their family and carers as appropriate, are engaged in decisions regarding transfers

d. receiving family, carers, health professionals or organisations are given timely, current and complete information about the older person as required.

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Essential Element 4: Comprehensive care

Noted above: See Module 3.

MODULE 10 Managing conflict

This Module explores what legal and other avenues are available to manage conflict around end of life decision-making. The focus is on disputes about treatment for a person who does not have capacity, as this is where conflict most often arises.

Learning outcomes

- Identify clinical and legal processes for managing disputes where a person does not have decision-making capacity.
- Describe the role of guardianship bodies, courts and tribunals in resolving disputes about medical treatment.

Strengthened Aged Care Quality Standards (Final draft) (2023)		National Consensus Statement on End of Life Care (2023)
Standard 1: The Person ***Outcome 1.1: Person-centred care*** Noted above: See Module 2, Actions 1.1.1 – 1.1.2. ***Outcome 1.2: Dignity, respect and privacy*** Noted above: See Module 2, Actions 1.2.1 - 1.2.3. **Standard 2: The Organisation** ***Outcome 2.2: Quality and safety culture*** Noted above: See Module 2, Actions 2.2.1 – 2.2.2. ***Outcome 2.6: Feedback and complaints management*** Older people, workers and others are encouraged and supported to provide feedback and make complaints about care and services, without reprisal. Feedback and complaints are acknowledged, managed transparently and contribute to the continuous improvement of care and services.	**Actions:** **2.6.1** The provider implements a complaints management system to receive, record, respond to and report on complaints. **2.6.2** The provider encourages and supports older people, family and carers, workers and others to provide feedback and make complaints. **2.6.3** Older people are empowered to access advocates, language services and other ways of raising and resolving feedback and complaints. **2.6.4** The provider takes timely action to resolve complaints and uses an open disclosure process when things go wrong. **2.6.5** The provider collects and analyses feedback and complaints data. Outcomes are reported to the governing body, older people and workers and inform the provider's quality system to improve the quality of care and services. **2.6.6** The provider regularly reviews and improves the effectiveness of the complaints management system. ***Outcome 2.9: Human resource management*** Noted above: See Module 2, Action 2.9.6.	**Essential Element 5: Responding to concerns** *Noted above: See Module 2.*

MODULE 11 Voluntary assisted dying

This Module explores the law on voluntary assisted dying (VAD) in Australia, and its intersection with laws on medical treatment decision-making, and pain and symptom relief.

Learning outcomes

- Describe the legal status of VAD in Australia.
- Understand the eligibility criteria and processes for accessing VAD in jurisdictions where it is lawful.
- Differentiate between VAD and other practices including providing pain and symptom relief, and withholding and withdrawing life-sustaining treatment.

Strengthened Aged Care Quality Standards (Final draft) (2023)		National Consensus Statement on End of Life Care (2023)
Standard 1: The Person ***Outcome 1.1: Person-centred care*** Noted above: See Module 2, Actions 1.1.1 – 1.1.2. ***Outcome 1.2: Dignity, respect and privacy*** Noted above: See Module 2, Actions 1.2.1 - 1.2.3. **Standard 2: The Organisation** ***Outcome 2.2: Quality and safety culture*** Noted above: See Module 2, Actions 2.2.1 – 2.2.2. ***Outcome 2.9: Human resource management*** Noted above: See Module 2, Action 2.9.6(a).	**Standard 5: Clinical Care** ***Outcome 5.7 Palliative care and end-of-life care*** Noted above: See: » Module 3, Actions 5.7.1 – 5.7.2. » Module 6, Actions 5.7.3 – 5.7.4.	**Scope:** Healthcare services should familiarise themselves with the legislation in their jurisdiction and ensure patients and their families have access to appropriate information. People opting for voluntary assisted dying should continue to receive the safe and high-quality end-of-life care described in this document. **Essential Element 6: Leadership and governance** Healthcare services should use established systems and processes, as required by applicable standards, to deliver end-of-life care. Approaches to managing eligible patients' access to voluntary assisted dying also need to be considered. **Essential Element 7: Support, education and training** Provide relevant education to all members of the workforce about recognising people at the end of their life and managing their care. Make sure education is provided at the commencement of employment and as part of regular professional development.

MODULE 12 Aboriginal and/or Torres Strait Islander peoples and end of life law

This Module explores the law on end of life decision-making in the context of caring for Aboriginal and/or Torres Strait Islander peoples, families and communities.

Learning outcomes

- Understand the legal considerations that can arise when caring for Aboriginal and/or Torres Strait Islander peoples and families at the end of life.
- Recognise how health professionals can provide Culturally Safe and Culturally Responsive end of life care.

Strengthened Aged Care Quality Standards (Final draft) (2023)

Standard 1: The Person

Outcome 1.1: Person-centred care

Noted above: See Module 2, Actions 1.1.1.

Other Actions:

1.1.2 The provider implements strategies to:

a. identify the older person's individual background, culture, diversity, beliefs and life experiences as part of assessment and planning and use this to direct the way their care and services are delivered
b. identify and understand the individual communication needs and preferences of the older person
c. ask and record if an older person identifies as an Aboriginal and Torres Strait Islander person
d. deliver care that meets the needs of older people with specific needs and diverse backgrounds, including Aboriginal and Torres Strait Islander peoples and people living with dementia
e. deliver care that is culturally safe, trauma aware and healing informed, in accordance with contemporary, evidence-based practice
f. support older people to cultivate relationships and social connections, including, for older people who are Aboriginal and Torres Strait Islander persons, connection to community, culture and country
g. continuously improve its approach to inclusion and diversity.

Outcome 1.2: Dignity, respect and privacy

Noted above: See Module 2, Actions 1.2.1 - 1.2.3.

Outcome 1.3: Choice, independence and quality of life

Noted above: See Module 2, Actions 1.3.1 - 1.3.4.

Standard 2: The Organisation

Outcome 2.2: Quality and safety culture

Noted above: See Module 2, Actions 2.2.1 – 2.2.2.

Outcome 2.6: Feedback and complaints management

Noted above: See Module 10, Actions 2.6.1 – 2.6.6.

Outcome 2.9: Human resource management

Action 2.9.6 All workers regularly receive competency-based training in relation to core matters, at a minimum:

a. the delivery of person-centred, rights-based care
b. culturally safe, trauma aware and healing informed care.

Standard 3: The Care and Services

Outcome 3.1: Assessment and planning

Noted above: See Module 4, Actions 3.1.1 – 3.1.6.

Outcome 3.2: Delivery of care and services

Care and services are provided in a way that is culturally safe and appropriate for people with specific needs and diverse backgrounds.

Actions:

3.2.1 Older people receive culturally safe, trauma aware and healing informed care and services that:

a. are provided in accordance with contemporary, evidence-based practices
b. meet their current needs, goals and preferences
c. optimise their quality of life.

See also Module 2, Actions 3.2.2, 3.2.5, 3.2.6, and 3.2.9.

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Guiding Principle No. 4. Consider cultural, spiritual and psychosocial needs

Noted above: See Module 4.

Essential Element 1: Recognising end of life

Aboriginal or Torres Strait Islander people likely to die within days or weeks will often prefer to return home to die on Country. This will often require involvement from, or collaboration with, specific Aboriginal or Torres Strait Islander community members. Healthcare services should liaise with Aboriginal or Torres Strait Islander communities to support appropriate communication and involvement.

Essential Element 2: Person centred and shared decision making

Communication styles should be tailored, and cultural differences related to decision-making should be accommodated to the extent that the person wishes. Healthcare workers should introduce themselves in person to Aboriginal and Torres Strait Islander people who are involved, wherever possible.

Essential Element 4: Comprehensive Care

Consideration should also be given to supporting people at the end of their lives to return to Country and providing end-of-life care on Country whenever possible and in alignment with the person's wishes.

Essential Element 6: Leadership and Governance

Cultural safety creates an environment that is safe for Aboriginal and Torres Strait Islander people and aims to address institutional racism and discrimination.

Strengthened Aged Care Quality Standards (Final draft) (2023)		National Consensus Statement on End of Life Care (2023)
Standard 5: Clinical Care ***Outcome 5.4 Comprehensive care*** Noted above: See Module 3, Actions 5.4.1 – 5.4.5. ***Outcome 5.5 Clinical Safety*** Noted above: See Module 6, Action 5.5.8. ***Outcome 5.6: Cognitive impairment*** Noted above: See Module 2, Actions 5.6.1 and 5.6.2. ***Outcome 5.7 Palliative care and end-of-life care*** Noted above: See: » Module 3, Actions 5.7.1 – 5.7.2. » Module 6, Actions 5.7.3 – 5.7.4.	**Standard 7: The Residential Community** ***Outcome 7.2: Transitions*** Noted above: See Module 9, Action 7.2.1.	**Essential Element 7: Support, education and training** Ensure healthcare workers are taught culturally safe approaches to providing end-of-life care to Aboriginal and Torres Strait Islander peoples.

MODULE 13 Inclusive end of life decision-making with people from diverse populations

This Module explores the law on end of life decision-making in the context of caring for LGBTIQ+ people, people from culturally and linguistically diverse and/or refugee backgrounds, people with disability, and people with frailty.

Learning outcomes

- Understand the legal considerations that can arise when caring for LGBTIQ+ people, people from culturally and linguistically diverse and/or refugee backgrounds, people with disability, and people with frailty.
- Recognise how health professionals can provide safe, inclusive, accessible end of life care to people from diverse populations, and their families and support networks.

Strengthened Aged Care Quality Standards (Final draft) (2023)

Standard 1: The Person

Outcome 1.1: Person-centred care

Noted above: See:

- Module 2, Action 1.1.1.
- Module 12, Action 1.1.2.

1.1.3 The provider and workers recognise the rights, and respects the autonomy, of older people, including their right to intimacy and sexual and gender expression.

Outcome 1.2: Dignity, respect and privacy

Noted above: See Module 2, Actions 1.2.1 - 1.2.3.

Outcome 1.3: Choice, independence and quality of life

Noted above: See Module 2, Actions 1.3.1 - 1.3.4.

Standard 3: The Care and Services

Outcome 3.1: Assessment and planning

Noted above: See Module 4, Actions 3.1.1 – 3.1.6.

Outcome 3.2: Delivery of care and services

Noted above: See:

- Module 12, Action 3.2.1
- Module 2, Actions 3.2.2, 3.2.5, 3.2.6, and 3.2.9.

Standard 2: The Organisation

Outcome 2.2: Quality and safety culture

Noted above: See Module 2, Actions 2.2.1 – 2.2.2.

Outcome 2.6: Feedback and complaints management

Noted above: See Module 10, Actions 2.6.1 – 2.6.6.

Outcome 2.9: Human resource management

Noted above: See Module 2, Actions 2.9.6.

Standard 5: Clinical Care

Outcome 5.4 Comprehensive care

Noted above: See Module 3, Actions 5.4.1 – 5.4.5.

Outcome 5.5 Clinical Safety

Noted above: See Module 6, Action 5.5.8.

Outcome 5.6: Cognitive impairment

Noted above: See Module 2, Actions 5.6.1 and 5.6.2.

Outcome 5.7 Palliative care and end-of-life care

Noted above: See:

- Module 3, Actions 5.7.1 – 5.7.2.
- Module 6, Actions 5.7.3 – 5.7.4.

Standard 7: The Residential Community

Outcome 7.1: Daily living

Older people receive services and supports for daily living that optimise their quality of life, promote use of their skills and strengths and enable them to do the things they want to do. Older people feel safe in their service environment.

7.1.6 Older people can maintain relationships of choice free from judgement, including intimate relationships, and engage in sexual activity.

Outcome 7.2: Transitions

Noted above: See Module 9, Action 7.2.1.

National Consensus Statement on End of Life Care (2023)

Guiding Principle No. 4. Consider cultural, spiritual and psychosocial needs

Noted above: See Module 4.

Essential Element 2: Person-centred communication and shared decision making

Noted above: See Module 2.

Essential Element 4: Comprehensive care

Noted above: See Module 3.

Essential Element 7: Support, education and training

Noted above: See Module 2.

MODULE 14 End of life law in aged care

This module explores common legal issues that may arise at the end of life in residential aged care and home and community care, and the provision of safe, high quality, person-centred end of life and palliative care.

Learning outcomes

- Understand how the law applies to issues that arise when providing end of life care in aged care
- Recognise how to deliver safe high quality person-centred end of life and palliative care

Strengthened Aged Care Quality Standards (Final draft) (2023)

Standard 1: The Person

Outcome 1.1: Person-centred care

Noted above: See Module 2. See Actions 1.1.1 – 1.1.3.

1.1.4 Workers have professional and trusting relationships with older people and work in partnership with them to deliver care and services.

Outcome 1.2: Dignity, respect and privacy

Noted above: See Module 12. See Actions 1.2.1 – 1.2.2.

1.2.3 The relationship between older people, their family and carers is recognised and respected.

Outcome 1.3: Choice, independence and quality of life

Noted above: See Module 2. See Actions 1.3.1 – 1.3.6.

Standard 2: The Organisation

Outcome 2.2: Quality and safety culture

Noted above: See Module 12.

Standard 3: The Care and Services

Outcome 3.1: Assessment and planning

Noted above: See Module 3. See Actions 3.1.1 – 3.1.6.

Outcome 3.2: Delivery of care and services

Noted above: See Module 12. See Actions 3.2.1 – 3.2.2, 3.2.6 and 3.2.9.

Outcome 3.3 Communicating for safety and quality

Critical information relevant to the older person's care and services is communicated effectively with the older person, between workers and with family, carers and health professionals involved in the older person's care. Risks, changes and deterioration in an older person's condition are escalated and communicated as appropriate.

Actions:

3.3.1 The provider implements a system for communicating structured information about older people and their care and services that ensures critical information is effectively communicated in a timely way to workers, family, carers and health professionals involved in the older person's care.

3.3.2 The provider's communication system is used when:

a. the older person commences receiving care and services
b. the older person's needs, goals or preferences change
c. risks emerge, there is a change, deterioration or an incident that impacts the older person
d. handover or transitions of care occurs between workers or others involved in the older person's care.

3.3.3 The provider implements processes for older people, family, carers and health professionals involved in the older person's care to escalate concerns about the older person's health, safety or wellbeing.

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Guiding Principle No. 1. Be person-centred and include family and carers

Noted above: See Module 2.

Guiding Principle No. 2. Align with values, needs and wishes

Noted above: See Module 4.

Guiding Principle No. 3. Provide people with information they can understand

Noted above: See Module 2.

Guiding Principle No. 4. Consider cultural, spiritual and psychosocial needs

Noted above: See Module 4.

Guiding Principle No. 5. Include qualified, skilled and experienced multidisciplinary care

Effective communication, collaboration and teamwork that ensures continuity and coordination between teams, within and between settings, during transitions, and across multiple episodes of care is required.

Guiding Principle No. 6. Ensure the right to refuse medical treatment

Noted above: See Module 3.

Guiding Principles No. 7. Not be burdensome or harmful

Noted above: See Module 3.

Guiding Principles No. 8. Not offer unreasonable hope

Noted above: See Module 3.

Essential Element 1: Recognising End of Life

Noted above: See Module 4.

Strengthened Aged Care Quality Standards (Final draft) (2023)	National Consensus Statement on End of Life Care (2023)

Outcome 3.4: Coordination of care and services

Older people receive planned and coordinated care and services, including where multiple health and aged care providers, family and carers are involved in the delivery of care and services.

Actions:

3.4.1 The provider, in partnership with the older person, identifies others involved in the older person's care and ensures coordination and continuity of care.

3.4.2 Carers are recognised as partners in the older person's care and involved in the coordination of care and services.

3.4.3 The provider facilitates a planned and coordinated transition to or from the provider in collaboration with the older person and other providers of care and services, and this is documented, communicated and effectively managed.

Standard 5: Clinical Care

Outcome 5.4 Comprehensive care

Noted above: See Module 4. See Actions 5.4.1 – 5.4.2, 5.4.4.

Outcome 5.6: Cognitive impairment

Noted above: See Module 2. See Action 5.6.2.

Outcome 5.7: Palliative care and end-of-life care

Noted above: See Module 3. See Actions 5.7.1 – 5.7.4

Standard 7: The Residential Community

Outcome 7.2: Transitions

Noted above: See Module 9. See Actions 7.2.1.

7.2.2 The provider facilitates access to services offered by health professionals, other individuals or organisations when it is unable to meet the older person's needs.

Essential Element 2: Person-centred communication and shared decision making

Noted above: See Module 2.

Essential Element 4: Comprehensive care

Noted above: See Module 3.

Essential Element 7: Support, education and training

Noted above: See Module 2.

Essential Element 8: Care setting

The care setting is an important consideration for both a person at the end of their life and their family. When visiting care settings outside the home, family members may experience a lack of space and privacy, reporting feelings of 'being watched' and not being able to talk openly with their loved ones. Access to private physical spaces for gatherings contributes to the quality of care offered at the end of a person's life. The provision of spaces for cultural practices such as family gatherings, chanting or other important rituals associated with end of life should be considered. *See Actions 8.1 – 8.5.*

Essential element 10: Systems to support high-quality care

Organisations should consider opportunities to systematise the approach to end-of-life care where this will support best practice. End-of-life care should be integrated into existing organisational systems, and safety and quality systems to support sustainability and provide opportunities for organisational learning. *See Action 10.3.*

Register for the ELLC Aged Care course at ellc.edu.au and select Aged Care to enrol.

To receive further information and updates please email endoflifelaw@qut.edu.au

About End of Life Law for Clinicians

The ELLC training program is funded by the Australian Government Department of Health and Aged Care as a National Palliative Care Project. It is administered by the Australian Centre for Health Law Research, Faculty of Business and Law, Queensland University of Technology (QUT), in partnership with the Faculty of Health, QUT.

QUT Australian Centre for Health Law Research

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