Australian
College of
Nursing
Voice of influence

Ms Jennifer Hill
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Australian Commission on Safety and Quality in Health Care
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Dear Ms Hill

Re: Draft *National Consensus Statement on End-of-Life Care in Acute Hospitals*

In response to an invitation received from the Australia Commission on Safety and Quality in Health Care (the Commission), Australian College of Nursing (ACN) is pleased to provide feedback on the draft *National Consensus Statement on End-of-Life Care in Acute Hospitals*.

As a key national organisation representing nurses, many of whom are involved in the care of people at the end-of-life and their families, ACN welcomes the development of the *National Consensus Statement*. This Statement is a timely and important document which ACN believes will contribute to improving end-of-life care. ACN particularly appreciates the patient-centred focus of the Statement, and the attention the document pays to the importance of shared decision-making between the interdisciplinary team, the patient, substitute decision-maker, family and carers.

ACN would like to take this opportunity to provide the Commission with feedback on the *National Consensus Statement* as attached. We also include a letter of support for ACN's submission from Palliative Care Nurses Australia.

Please do not hesitate to contact me for further information or discussion on this matter.

Yours sincerely

Adjunct Professor Debra Thoms FACN (DLF)
Chief Executive Officer

14 April 2014

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Palliative Care Nurses Australia

10th April 2014

Kathleen McLaughlin
Executive Manager Member Relations
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Dear Kathleen,

Submission to the Australian Commission on Safety and Quality in Health Care's (ACSQHC) draft *National Consensus Statement on End-of-Life Care in Acute Hospitals*

Thank you for the opportunity to provide comment on the draft National Consensus Statement.

Palliative Care Nurses Australia (PCNA) is pleased to support the Australian College of Nursing (ACN) position in its submission to the Australian Commission on Safety and Quality in Health Care draft *National Consensus Statement on End-of-Life Care in Acute Hospitals*.

PCNA is in overall agreement with the statements contained in the ACN submission and will provide a more detailed submission directly to the Commission.

Yours sincerely

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SUBMISSION DATE: 15/04/2014

Submission to the Australian Commission on Safety and Quality in Health Care's (ACSQHC) draft *National Consensus Statement on End-of-Life Care in Acute Hospitals*

In preparing this submission Australian College of Nursing (ACN) consulted its members on the *Consensus Statement on End-of-Life Care in Acute Hospitals* (the Statement), which elicited considerable interest from ACN members.

General Comments

ACN acknowledges that to ensure safe and high-quality end-of-life care in the acute hospital setting, the delivery of care must be patient and family centred and provided by a well-supported interdisciplinary team. It is important to recognise that the effectiveness of many of the essential elements of care within hospital systems is highly dependent on the role and presence of nurses who are the health professionals in constant attendance during end-of-life care. Quality nursing care during end-of-life can profoundly impact a person's quality of life, comfort and dignity, and have both an immediate and enduring bearing on their families and carers.

Systems to support high quality care in acute hospitals must include nursing services with the capability and capacity to effectively delivery patient-centred care. It is essential that the provision of nursing care during end-of-life is receptive and responsive to the changing and unanticipated needs of patients and their families and carers throughout the patient journey. Care plans should be developed in consultation with patients and their families and amendable to their changing needs and circumstances, while also clearly incorporating nursing care requirements and activities. Patient, family and carer engagement is an essential consideration for all care planning and delivery throughout end-of-life care and is largely achieved through regular and ongoing nursing engagement. Designated nurses, who are easily accessible to patients, families and carers, should be nominated to foster care relationships and to provide regular information updates on any aspect of their medical and nursing care. The role of nurses and these essential elements of end-of-life care should be recognised and reflected throughout the Statement.

1. Is the intended purpose and scope of the Consensus Statement clear?

1.1 Comments to the scope of the Statement

ACN considers the intended purpose of the Statement to be clear. ACN supports the Statement's purposes of:

- setting out recommended practice for recognising and responding to people in need of end-of-life care in acute hospitals (page 2);
- outlining a proposed national approach to end-of-life-care in acute hospitals (on page 8 of the Statement); and
- providing guidance to health services as to the development of systems for the delivery of high quality end-of-life care (page 2).

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1.2 Comments to the purpose of the Statement

The Statement's scope describes:

- the periods of time where it may be opportune to apply the elements of the Statement; and
- acute hospitals as the intended clinical setting for the Statement.

ACN believes that the Statement's scope should also identify the intended audience and suggests that the document is useful in informing individuals or families about the care that they may expect in acute hospitals once a person approaches the end-of-life. Further, people who receive end-of-life care transfer in and out of acute hospitals and such care transitions involve communication and collaboration with health care providers outside the acute hospital. To this end, the document would be of benefit to paramedics, residential care providers, general practitioners and community nurses who could be included as intended audiences for the Statement.

In *Figure 1: Opportunities to provide end-of-life care interventions in acute hospitals*, wording could be included to indicate an anticipated timeframe in relation to the uncertain timing of death, as articulated in the preceding paragraphs. For example, 'Likely to die soon (timing may be uncertain)' could be changed to 'Likely to die soon (medium term but timing may be uncertain)'; and 'Dying (timing may be uncertain)' could be changed to 'Dying (short term but timing may be uncertain).'

2. Does the Consensus Statement accurately reflect what you think the expected standard of care and practice should be?

ACN believes that the Statement should put a greater emphasis on the normality of death. Presenting dying as an expected life event is important in acute hospitals as acute hospitals tend to focus more on avoiding death than on providing comfort and preparation for death. Any lack of acknowledgement of death as a normal life event to prepare for will negatively influence the successful implementation of end-of-life standards of care and associated practices.

ACN members consider the Statement's standards of care and practice to be comprehensive in the main. However, ACN members perceive the Statement's care standards and practices to fail to address the following care issues:

- The importance of medication review as part of end-of-life care, particularly if a patient is dying.
- The establishment of formal lines of communication with external service providers for end-of-life patients who move from hospital to aged care or other care settings.
- Addressing the special needs of people with mental illness who are receiving end-of-life-care, including end-of-life patients who require help with decision-making but lack family support.
- A lack of evidence demonstrating how patients' and their families' views informed the formulation of the Statement's content.
- The inclusion of a flowchart outlining the application of the essential elements in end-of-life care may be useful for clinicians.

3. Are the guiding principles clearly outlined? How do you think they could be applied in practice?

3.1 Clear outline of guiding principles

ACN considers the outline of the guiding principles to be clear, however suggests that the first sentence of guiding principle 1 could be rewritten to better reflect that:

- dying is a universal and expected human life event; and
- medical attention may be a component of care for the dying patient.

ACN suggests the following statement: *Dying is a human experience that often includes a medical component.*

ACN proposes that two additional guiding principles be added:

1. End-of-life care is every clinician's responsibility. This principal is important because it challenges clinician conceptions such as 'I am too busy' or 'I am not senior enough' or 'I am not a palliative care specialist' that may prevent clinicians from engaging in end-of-life-care.
2. Care should be responsive to culture. This principle incorporates the broad definition of culture and extends to include the diversity of cultural and linguistic backgrounds.

3.2. Application of guiding principles in action

The question of how the guiding principles could be applied in practice elicited many responses from ACN members. Members considered the successful application of the guiding principles to depend on the following preconditions:

- A collaborative interdisciplinary relationship.
- Education in end-of-life care for all clinicians.
- Support for clinicians with various resources but in particular with the time required to deliver end-of-life care.
- Organisational readiness and ability to shape a hospital workforce's culture in relation to end-of-life care.

4. Are the essential elements clearly outlined? How do you think they could be applied in practice?

4.1 Clear outline of essential elements

ACN believes that the essential elements could be more clearly outlined if some of the headings better reflected the content. ACN suggests the following changes:

A) Process of care suggest change to *Attributes of end-of-life care*

1. **Patient-centred communication and shared decision making** no change suggested
2. **Team work and co-ordinated care** no change suggested
3. **Components of care** suggest change to *Patient-centred care*
4. **Using triggers to help recognize patients approaching end-of-life** suggest change to *Monitoring changes in pathophysiology*
5. **Responding to concern** suggest change to *Interdisciplinary team responsiveness to psychological and social needs*

4.2 How can the essential elements be applied in practice?

Effective leadership is required to achieve the essential elements identified for safe and high quality end-of-life care in acute hospitals. An amount of development work will need to be undertaken in many acute hospitals to support the incorporation of the essential elements into practice. This will include:

- leadership to shape culture;
- development of clinical practice policies;
- development of end-of-life care skills; and
- development or strengthening of interdisciplinary approaches to care

Leadership to shape culture
Members indicate that shaping hospital culture to actually embrace end-of-life care is an important prerequisite for the delivery of this type of care. ACN identifies role modelling as a practical and effective leadership tool in achieving cultural change. Senior staff, such as medical directors and nursing unit managers, can support culture by consistently role-modelling the delivery of physical and psychosocial care to end-of-life patients and their families. Role modelling by senior staff demonstrates and reinforces the importance of this care in a credible way to junior staff. Nursing unit managers are absolutely essential in ensuring that the principles of end-of-life care are upheld by the nursing teams they manage. As care of the dying is a core skill of nursing, nursing unit managers should be considered as crucial agents who make a critical contribution to the practical implementation of the essential elements of end-of-life care.

Clinical practice policies
ACN members recognise the codification of the essential elements into policies and procedures as an important preparatory step in the introduction of the essential elements. Operational change could further be supported through clinical pathways that operationalise the essential elements. For example, end-of-life clinical pathways should specifically include a review of patient medications to reduce prescribed medicines to the minimum required.

End-of-life care skills
ACN is of the view that introducing the essential elements requires support for clinicians' development of end-of-life care skills. Members consider many professionals in the health care team to lack the communication skills to talk to dying patients and their families. Some unease was also expressed by members about the lack of clinical confidence of some nurses when delivering end-of-life care.

The Commission mentions the inclusion of mentoring and teaching whenever responders to calls for assistance give advice (point 5.10, pp. 22). ACN believes that mentoring and teaching are crucial components in increasing confidence and skills end-of-life care. The Statement should more often highlight opportunities for clinical leaders to engage in mentoring, teaching and role-modelling.

Interdisciplinary approaches to care
Strong interdisciplinary approaches to professional development, care planning, coordination and delivery, and communication will be necessary to support the implementation of the essential elements into practice.

ACN makes the following specific suggestions for the enhancement of section A) Processes of care:

1. Patient-centred communication and shared decision-making

Key points

- On page 12 the box titled **Key points** states under 'Patient-centred communication and shared decision-making' that a series of conversations with patients may be necessary for clinicians to elicit patients' goals, values and wishes regarding their end-of-life care. ACN believes that the Statement should emphasise the importance of conducting a number of conversations with patients by using the terms 'initial conversation', 'subsequent conversation' and 'follow-up conversation'.

Actions (pp.13-14)

- Point 1.3: Clinicians should seek to understand and be respectful and sensitive to the preferences and needs of people from all backgrounds, not just from culturally and linguistically diverse backgrounds.
- Point 1.4 on 'Arranging for the appropriate people to be in attendance': The nurse responsible for a patient's care should be included in the bracketed list of proposed attendants. Social workers, doctors, chaplains, etc. will eventually leave the ward; however, the nursing team is available to the patient for 24 hours to address any questions, anxieties and fears, and to provide end-of life care.
- Point 1.4: Clinicians need to ensure that patients, family members and substitute decision makers are empowered to actively participate in shared-decision-making.
- Point 1.5: It is important that not only patients, substitute decision makers, families and carers, but also clinicians are notified of the 'person responsible' for leading and coordinating an individual's end-of-life care. Patients, decision-makers, families and carers should also be informed of who is responsible for managing the *nursing care* across the continuum of end-of-life.
- Point 1.10: The documentation in patients' notes should include recommended actions for plans of care that are 'not agreed'. It is not unusual for end-of-life scenarios to involve conflict between the patient, the family and/or the team of health care professionals.

2. Team work and coordination of care

Actions (pp. 15-16)

ACN suggests including a statement on the importance of nursing care plans being clearly communicated to patients, substitute decision makers, family and carers, and identifying key points of contact responsible for the management of nursing care.

3. Components of care

Actions (pp. 17-18)

- Point 3.3: ACN believes that it is important for clinicians to engage in discussions with patients about the topic of organ donation, including providing resources available to inform decision-making.
- Point 3.8 may be better placed following point 3.4 in order to support point 3.4.
- Point 3.11: The statement 'a clear and convincing reason' is very broad and open to subjective interpretation. It could be clarified what constitutes 'a clear and convincing reason'.
- Point 3.13: This statement could be read to suggest that acute care is not a preferable setting for death and would benefit from rewording.

4. Using triggers to help recognize patients approaching the end of life

Actions (pp. 19)

- Point 4.1: This statement could be reworded in order to clarify that the 'surprise' question is a question clinicians ask themselves, as opposed to patients or family.
- Point 4.3: Patients' or family members' responses/comments should be included as one of the most important triggers for clinicians to recognise that people may be approaching the end of their life and for clinicians to engage in an 'initial conversation'.

5. Responding to concern

Concerns about end-of-life care issues may be directly related to nursing care and therefore responses are more appropriately provided by a member of the nursing team which may include Clinical Nurse Consultants, Nurse Practitioners and Nursing Unit Managers. The introductory paragraphs in this section relate predominantly to a medical response to concerns overlooking the central nursing components in end-of-life care.

Key points

- 'When managing conflict, complex family dynamics or ethical dilemmas, responders may require access to a person who is skilled in mediation, bioethics and/or the law.'

  ACN would like to note that a number of nurses hold formal qualifications in bioethics and may be available to provide multidisciplinary teams with advice on ethical issues.

Actions

- Point 5.4: A 'multidisciplinary review of the goals of care and the treatment plan' should result in further recommended action(s) for follow-up or ongoing communication in case there are unaddressed concerns, unmet end-of-life care needs or family conflicts.

ACN suggestions for the enhancement of the essential elements in part B) Organisational prerequisites:

7. Education and training

Key points

The Commission recommends that education 'should also include education and training for junior medical staff regarding how to have discussions and conversations about end-of-life care.' As stated previously, apart from nurses, all other multidisciplinary team members attend to people in hospitals on a sessional basis. Following any end-of-life conversation, the nurse caring for the individual will provide follow-up communication and respond to any questions, fears and anxieties that patients and their family may have.

Actions (pp. 25-26)

- Point 7.6: Education for clinicians should include: 1) the jurisdictional legal framework for clinical practice, and 2) an ethical framework which will be comfortable to use and work within for all involved.
- Point 7.7: Clinician education should further address specific cultural competencies for providing end-of-life care to Aboriginal and Torres Strait Islander people and people from CALD backgrounds.

ACN also believes it is important to refer to the importance of psycho-social and spiritual issues when outlining what education should cover.

8. Supervision and support for interdisciplinary team members

ACN highly commends the Commission for devoting a section to the very important issue of how hospital staff may experience emotions of sadness and loss following a patient's death. Hospitals often do not offer support or acknowledgement of staff's feelings of loss and grief. ACN recommends that, in addition to the systems approaches suggested in the Statement, the Commission also include strategies for shaping hospital culture, such as:

- encouragement of staff to offer each other informal emotional support (as included under point 8.4);
- encouragement of clinicians and the patient's family to spend some time grieving together; and
- friendly recognition by management of stress and grief experienced by clinicians.

ACN would also encourage the Commission to explore strategies that ensure the successful implementation of a policy framework for the provision of psychological supports to clinicians.

9. Evaluation, audit and feedback

Actions (pp. 28-29)

- Point 9.5: 'Measures of the safety and quality of end-of-life care could include:.'

  ACN suggests that following the first dot point, 'Correct treatment of symptoms', a second dot point is added that reads, 'Documentation of patient's wishes'.

- Point 9.6: The timing of any family and volunteer follow up should be determined by the evaluation/audit methodology used. The example of 6 months provided could be misleading and therefore ACN suggests omitting.

10. Systems to support high-quality care

Actions (pp. 30)

- Point 10.4: ACN suggests input from specialist palliative care providers should not be limited to people with complex palliative needs. Patients with non-complex palliative care needs and staff may benefit from support and leadership from specialist palliative care providers.

5. Is there any terminology that needs further exploration or clarification?

ACN makes the following suggestions for improving the terminology section:

- ACN suggests that the 'Terminology' section be presented after the 'Table of content 'and before the 'Introduction'.
- On page 3, the explanation of the term 'clinician' needs to be expanded to identify the occupational groups: Medical, Nursing and Allied Health staff.
- Although the definition of 'end-of-life care' on page 3 states that end-of-life care is sometimes referred to as terminal care, it is suggested that the document use consistent terminology when referring to end-of-life care. The term 'terminal care' is used on pp. 7, 17, and 22 but not in the remainder of the document.
- On page 4, under 'Limitations of medical treatment' the sentence 'Examples of these terms include limitations of medical treatment, withdrawing or withholding of **care** or treatment, limitations of **care**, futile treatment and appropriateness of treatment'. ACN believes that the word **care** should be removed from the sentence because withdrawing *treatments* versus *care* is very different. A person's **care** should never be withdrawn.
- On page 5 ACN suggests defining the difference between palliative care and regular medical care.
- ACN proposes that 'cognitive impairment' be added to the 'Terminology section', as many terminally ill older Australians who suffer from dementia, psychosis or dual diagnoses die in acute hospitals.
- Further, ACN suggests adding the following terms to the 'Terminology' section:
  - dual diagnosis
  - dementia

  - psychosis
  - delirium
  - co-morbidity
  - chronic disease
  - non-communicable terminal disease
- The term 'cultural distress' used on page 17 should be clarified and a definition added to the 'Terminology' section.
- The term 'responders,' used under Key points on page 21 should be added to the 'Terminology' section.

6. What enablers exist to help with implementing the elements of the Consensus Statement? How can these be leveraged to promote best practice?

In their responses to question 6, ACN members focus on necessary, future rather than existing enablers for the implementation of the Consensus Statement. The list below identifies the enablers ACN members believe are crucial to the promotion of best practice in end-of-life care:

- Communication with the patient and family members, including discussions with them over time about the process of dying and what to expect.
- Education in end-of-life care beginning at the undergraduate level, followed by integrating students and beginning career clinicians in end-of-life care by working with senior clinicians in end-of-life care.
- Interdisciplinary meetings around care for people at end-of-life.
- Long-term funding for education in end-of-life care.
- Some form of accountability for those who underperform in the care of people at end-of-life, along with reward systems for health care professionals that excel. Lack of end-of-life care may become an adverse event that has to be notified to the health service.
- A national consensus framework across all public hospitals in Australia in order for acute hospitals to operate uniformly in the delivery of end-of-life care from state to state.

One existing lever identified is the potential to use psychiatric liaison services in end-of-life care as they are skilled and competent in assessing bio-psychosocial needs of people and their decision-making capacity. Psychiatric liaison service providers also tend to be skilled communicators and may be able to mentor and/or advise multidisciplinary teams.

7. What barriers to implementing the elements of the Consensus Statement exist? How do you think these can be addressed?

Factors intrinsic and extrinsic to acute hospitals affect the implementation of the Consensus Statement. ACN members believe the key barriers to implementing the elements of the Consensus Statement to be clinicians' availability of time, resources and the acute hospital culture which privileges the delivery of acute care over the provision of end-of-life-care.

Intrinsic: Clinicians' time and other resources

ACN members state that clinicians' lack of time poses a barrier to the implementation of new guidelines and

attending end-of-life care education. In terms of resources, members considered a lack of educational resources as a critical inhibiting factor in the implementation of new practices to improve end-of-life care. In particular in acute hospitals, the number of senior nurses able to train graduates in end-of-life care on a personal level is considered insufficient.

Important factors influencing the implementation of the essential elements are also clinicians' knowledge, skills, beliefs, values and attitudes. The beliefs, values, attitudes and dignity of patients and their families are other important factors affecting the implementation.

Intrinsic: Accountability unclear
Implementation will require the clarification of who will accept accountability and leadership for the introduction into clinical practice of the essential elements.

Intrinsic: Acute care culture
ACN members advise that acute hospital staff is guided by a philosophy of survival, cure and recovery and that this constitutes a significant barrier towards implementing the essential end-of-life care elements. Successful implementation of the essential elements depends on shifting acute hospitals' culture of care towards accepting death as a normal event for many patients, rather than a failure of the system.

Factors extrinsic to the hospital
Hospitals are part of the larger health care system. Further, they are embedded in the communities they serve. Thus many factors extrinsic to hospitals may affect the implementation of best practice in end-of-life care. The list below identifies some of these factors:

- Political factors
    - health policy at State and Federal level (e.g. Advance Care Directives)
    - operational policies at local, State, and Federal levels (e.g. when patients transition between primary care or institutional aged care is involved)
- Financial factors
    - ACN suggests that it may be worth investigating whether Output Based Funding supports or could support acute hospitals fiscally to deliver high quality end-of-life care
- Social factors
    - equity and fairness as principles underpinning care delivery, and communication and shared decision-making within the social context of the patient
- Cultural factors
    - a general culture in society of denying death as an expected life event and fear of death

8. In what ways can consumers engage with acute hospitals to help implement the elements of the Consensus Statement?

Acute hospitals can seek input from consumers in order inform how they can deliver better quality of end-of-life care. Hospitals can provide consumers with opportunities to share their perceptions of health care professionals' actions that contributed to a good or bad death of their loved one in a range of fora. Hospitals can use models drawn from mental health services, which have been drawing on consumer networks for some time.

ACN suggests the following ways for consumers to engage with acute hospitals:

- Consumers can be enlisted as members of focus groups and multidisciplinary workshops during the planning stage of implementation of the essential elements.

- ACN members strongly support consumer involvement in the education of health care professionals in end-of-life practices. In particular, consumers' sharing their experiences with the end-of-life care received by their relatives was considered very important content for such education programs.
- ACN suggests that acute hospitals run regular workshops or open fora for staff and consumers to discuss the topics related to good and bad death.
- Consumers can become involved in ongoing monitoring of end-of-life care through membership on hospital governance committees or local advisory groups.
- Hospitals can benefit from family members' feedback when assessing their end-of life practice.

9. What principles and elements do you think need to be addressed most urgently in acute hospitals?

ACN members consider the following elements under the heading 'Process of care' as requiring the most urgent attention:

- Patient-centred communication;
- Team work;
- Using triggers to help recognize patients approaching end of life; and
- Responding to concern

Of the 'Organisational prerequisites,' the element 'Education and training' is perceived to be most important. Further, the development of a body of relevant policies and processes in support of end-of-life care was also considered necessary. Linking the body of governance documents to safety and quality standards could increase clinical policy support for end-of-life care.

ACN members are also concerned with current cultures of care in hospitals. Cultures should be transformed to make high quality end-of-life care a priority and should challenge a 'not my job' attitude amongst staff. Culture change could be supported by clarity about the legal status of:

- advanced care plans and directives;
- Not for Resuscitation Orders; and
- substitute decision makers.

10. What resources or tools do you need to help you implement the elements of the Consensus Statement?

ACN members identify the following resources and tools:

- Time, staff and other resources to support planning and implementation.
- Implementation supported by focus group discussions with clinicians and consumers.
- Education presented in a workshop format and delivered by those with experience working in end-of-life care.
- Education taking the form of simulation sessions of medium/short term dying scenarios involving consumers and clinicians. Such education should focus on feelings (such as fear) and the communication skills required for end-of-life conversations.

- Simple tools such as step by step guides through end-of-life care.
- Clear hospital communication regarding end-of-life care with all clinicians but in particular with senior clinicians and consumers.

11. What resources or tools already exist that could be used to help implement the elements of the Consensus Statement?

Resources and tools that could be used to help implement the elements of the Consensus Statement include:

- CareSearch
  - This palliative knowledge network is a free, online resource that provides evidence-based knowledge about how consumers, families, patients and healthcare professionals can help people die peacefully in acute care.
- National Palliative Care Standards
- Program of Experience in the Palliative Approach (PEPA) education
- The Palliative Care Outcomes Collaborative (PCOC) –
  - End-of-life stages are not referred to in the Statement, but ACN believes that they can be a useful decision aid along with 'the question' and prognostic indicators. If PCOC is included it would need to be defined.

Additional resources include:

- Clinical Nurse Consultants
- Liaison Psychiatry services
- Mental Health Nurse Practitioners
- Social Workers
- Ward or team based plans

12. Additional Comments

ACN members regard this document as very valuable overall. Members' greatest concerns are finding ways to accomplish the change necessary in hospital cultures for a systematic implementation of end-of-life care and obtaining the resources required for the project. The Commission may consider proposing jurisdictional level drivers for the implementation of end-of-life care. The introduction of KPIs that meaningfully capture quality elements of end-of-life care by the jurisdictions may improve end-of-life care.

In ACN's view the Statement's particular strengths are:

- the pro-active approach to seeking a series of conversations with consumers about their end-of-life wishes through the routine use of trigger questions;
- repeated assessment of consumers' end-of-life care needs;
- the emphasis on enabling all team members, including junior clinicians, to engage with the team and voice concerns; and
- the inclusion of escalation processes at appropriate points.

Additional comments fell under question 12, where ACN members include the following observations:

- Case study
  - It would be beneficial to include the importance of Eric's nurse, Charlotte, engaging in a discussion with Eric and his family about the nursing care plan, including expected changes in nursing care needs and the type of care to be provided during end-of-life stages.
  - The timing of Dr Patel's approach to the family to discuss the possibility of corneal and whole eye donation may not be 'best practice'. Discussions about organ donation should have taken place earlier in Eric's period of hospitalisation. Further, as Eric's doctor, Dr Patel may not be the most appropriate person to discuss organ donation. Rather, someone not involved in the direct provision of care may be more appropriate to have the discussion with Eric.
  - ACN suggests matching specific essential elements to the parts of the story where they are applied to illustrate 'How does the element look in practice?'
  - ACN suggests that a different name be used for the doctor in the case study given the high profile case in recent years in Bundaberg, QLD related to the deaths of patients and charges of manslaughter against a Dr Patel.

Furthermore, the points listed under the headings 'Actions' often include statements that are principles or recommendations. In ACN's view the document's readability would be enhanced if actions were listed under the heading 'Actions', principles under the heading 'Principles' and recommendations under the heading 'Recommendations'.