National Guidelines for Palliative Care

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Contents

Foreword

In 2010, the Ministry of Health of Singapore commissioned the Lien Centre for Palliative Care to formulate a National Strategy for Palliative Care in consultation with key stakeholders in the healthcare system. In the report released in 2011, one of the goals of the national strategy called for the development of local standards in palliative care. The Standards Development Subgroup of the National Strategy for Palliative Care Implementation Taskforce is now pleased to provide the local community with the inaugural edition of the National Guidelines for Palliative Care.

The integration of palliative care within the healthcare system means that one of the major challenges faced by the workgroup is the need for the guidelines to be applicable across different care settings. Hence, the workgroup has divided service providers into different classes according to the nature and scope of their work in providing palliative care. The indicators derived are based on the level of care expected of each class of service provider.

A participatory process was used in the development of these guidelines. Draft guidelines were developed by the workgroup after an initial literature review and consultation with key stakeholders on service gaps and challenges. With each revision, the views of focal persons were canvassed. Finally, tools were suggested which can be adapted for each provider's use in the use of the guidelines.

The guidelines recognise that individual patients have different needs at different phases of their illness and service providers should be responsive to patients' changing needs. In addition, families and carers need support during the patient's life and in bereavement. It also recognises the importance of training and self-care for staff and the important role of volunteers in palliative care.

It is hoped that these guidelines will provide guidance in the delivery of high-quality care for the terminally ill, minimise gaps in service, improve the quality of training as well as ensure support for all staff and volunteers serving in this field.

This milestone would not have been reached without the contribution of many. We extend our grateful thanks to members of the workgroup who helped to put this document together, the secretariat for their support and all the healthcare professionals who gave us the benefit of their experience and thoughtful comments.

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Introduction

Palliative care in Singapore has come a long way since its humble beginnings in the 1980s. With the ageing population and increasing incidence of cancer and chronic diseases, the demand for palliative care will continue to rise in the future. The National Strategy for Palliative Care, accepted by the Ministry of Health in 2012, outlined ten key goals for palliative care in Singapore. Among them was that there should be local standards of care to ensure the delivery of good quality palliative care.

Patients with life-limiting illnesses and their families have numerous physical, psychosocial and spiritual needs as they approach the end of life. Palliative care aims to meet these needs in a holistic manner. The World Health Organization (WHO) defines palliative care as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual"[1].

These patients and their families receive care from a multitude of healthcare providers across the healthcare spectrum, in settings ranging from primary care in the community to palliative care services in hospices and hospitals. The holistic approach described by WHO should be practised by ***all providers*** who care for such patients and their families, regardless of setting.

As outlined in the National Strategy for Palliative Care, this first edition of the Guidelines for Palliative Care in Singapore aims to articulate a vision for high quality palliative care, through providing evidence-based guidelines for the holistic approach described above.

It is recognised that the different groups of providers across the healthcare spectrum have differing roles in the provision of palliative care. As such, three groups of providers have been identified, and specific indicators have been described for each of these groups. This will be elaborated on in subsequent sections (see ***Definition of Other Terms***).

It is envisioned that in this manner, the Guidelines will promote a whole-of-sector approach to providing accessible, high-quality palliative care in Singapore, so that all who suffer from life-limiting illnesses may live their last days in peace, comfort and dignity.

[1] WHO definition of palliative care (accessed 15 Mar 2013), available at http://www.who.int/cancer/palliative/definition/en/

WHO Definition of Palliative Care

The World Health Organisation describes palliative care as:

> *"…an approach that improves quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual."*

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.[2]

[2] WHO definition of palliative care (accessed 15 Mar 2013), available at http://www.who.int/cancer/palliative/definition/en/

Definition of Other Terms

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

Patient refers to the primary recipient of palliative care.

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

Complex needs may derive from the patient, carer or health care team and the help required may be intermittent or continuous, depending on the level of need and rate of disease progression. Examples of complex levels of need include[3]:

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

The Guidelines identify three groups of healthcare providers: ***Class A***, ***Class B*** and ***Class C*** providers.

- ***Class A providers*** are those whose substantive work is not in caring for patients with life-limiting illnesses, but who will encounter them in the course of work. These include general practitioners in the community, and doctors, nurses and allied health staff in restructured and community hospitals.
- ***Class B providers*** are those who routinely care for a substantive number of patients with life-limiting illness. These include staff of chronic disease management programmes, intensive care units, specialist cancer units, geriatric units, home care providers and nursing homes.
- ***Class C providers*** are those who care solely for patients with life-limiting illness. These include palliative care teams in private, restructured and community hospitals, inpatient hospices and hospice home care and hospice day care providers.

[3] North Yorkshire and York Palliative Care Group. Eligibility criteria for Specialist Palliative Care Services. 2005.

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

How to Use the Guidelines

The Guidelines are presented in three parts:

Guideline – the specific guiding statement

Rationale – the rationale behind adopting the Guideline

Quality Indicators – the specific, measurable indicators that reflect the Guideline in practice. The indicators are organised by the three groups of healthcare providers outlined in the preceding section.

Tools – examples of instruments, methods and other resources helpful in implementing or meeting the Guideline.

Overview of the Guidelines

Domain 1: Patient Care

Guideline 1 – Timely Identification

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

Guideline 2 – Reducing Barriers to Care

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

Guideline 3 – Coordinated Care

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

Guideline 4 – Holistic Assessment and On-going Care Planning

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

Guideline 5 – Advance Care Planning

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

Guideline 6 – Patient-Centred Care

Patients have unique needs and preferences, which may differ depending on their cultural background. The patient's quality of life is improved by care that is customised to their unique physical, cultural, spiritual etc. needs.

Guideline 7 – Care in the Last Days of Life

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

Domain 2: Family and Caregiver Support

Guideline 8 – Caregiver Support

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

Guideline 9 – Bereavement Care

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

Domain 3: Staff and Volunteer Management

Guideline 10 – Qualified Staff and Volunteers

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

Guideline 11 – Staff and Volunteer Self-Care

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

Domain 4: Safe Care

Guideline 12 – Access to and Use of Opioids

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

Guideline 13 – Clinical Quality Improvement

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

Domain 1: Patient Care		
Guideline 1 – Timely Identification People approaching the end of life are identified in a timely manner.		
Rationale	Failure to identify patients with life-limiting illnesses may lead to inappropriate care. Timely identification with appropriate needs assessment helps service providers to meet patients' needs and preferences in a more meaningful way. [1-12]	
Indicators		
A + B	1.1 There is evidence of a system in place to identify people approaching the end of life (i.e. likely to die within the next 12 months).	
Tools		
1	General prognostication and needs identification tools: a) Gold Standards Framework (GSF) Prognostic Indicator Guidance[13] b) Centre to Advance Palliative Care (CAPC) consensus criteria[14] c) Supportive and Palliative Care Indicators Tool (SPICT™)[15]	-
2	Disease-specific indicators of prognosis: a) Heart failure: i. End of Life/ Palliative Education Resource Centre's (EPERC) Fast Facts #143[16] ii. Seattle Heart Failure Model[17] b) COPD: i. EPERC Fast Facts #141[18] ii. BODE scale[19] c) Renal failure i. EPERC Fast Facts #191[20] d) Liver failure ii. EPERC Fast Facts #189[21] e) Dementia: i. EPERC Fast Facts #150[22]	-

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Domain 1: Patient Care

Guideline 2 – Reducing Barriers to Care

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

Rationale	All patients with life-limiting illnesses should be cared for by healthcare professionals using a palliative care approach. Patients with needs that exceed the resourced capabilities of the service provider should have access to palliative care services[1-11]. Similarly, where patients require expertise or care outside the scope of the palliative care service, the ability to call upon other services or providers will enhance the care of the patient.

Indicators

A + B	2.1	Patients are referred to palliative care services or providers in other fields (e.g. counselling support), should their needs exceed the resourced capabilities of the service provider.
	2.2	There is evidence of arrangements to ensure that people approaching the end of life, as well as their families and caregivers, know who to contact for advice.
C	2.3	The service provider triages and assigns priorities to all initial consult requests and ensures that care is delivered in a timely manner.
	2.4	The patient and family have access to specialist support 24 hours a day, seven days a week.
	2.5	The service provider has protocols for responding to palliative care emergencies or urgent needs.
	2.6	The service provider has formal links with specialists or providers in other fields to ensure access to expert advice and management of patients with specific needs in these areas.

Tools

1	Guidelines for referrals to palliative care/hospice services, or other specialists[12]	-
2	Information for patients and families on scope of services provided by palliative care or hospice services and referral procedures[13]	-
3	Protocols for responding to palliative care emergencies or urgent needs	-

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Domain 1: Patient Care

Guideline 3 – Coordinated Care

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

Rationale	Patients may require care from various service providers at different stages of the illness. Poor coordination includes ineffective communication between services, inflexible responses to changes in need over time and fragmented care across different disciplines. The lack of coordination of care and services may increase the stress experienced by patients and their families, and lead to unnecessary resource utilisation (e.g. laboratory investigations, emergency department visits, admissions). Better coordination of care increases quality of life.[1-7]

Indicators

All	3.1	There should be a primary provider coordinating the patient's care.
	3.2	Networks are established between different service providers, to facilitate the provision of seamless and holistic care for patients.
	3.3	The patient, caregivers and family are provided with clear written instructions on how to seek help if needed at any time, including after office hours.
	3.4	During transfers between different care settings, necessary patient information is provided to the receiving service provider.
	3.5	Where the patient's needs fall beyond the usual scope of service, for example personal care needs, referrals are made to other appropriate service providers to meet these needs.
	3.6	A plan is in place for the certification of death during and after office hours.
C	3.7	There is evidence of audits to ensure coordination of care.

Tools

1	Forms to aid staff in transfer of information: a. Hand-over forms when organisational boundaries are crossed (e.g. at clinic visits, referral to emergency departments)	-
2	Data monitoring and collection: a. Monitoring and audit of emergency department visits	-
3	Access to National Electronic Health Record (NEHR)	-

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Domain 1: Patient Care		
Guideline 4 – Holistic Assessment and On-going Care Planning Holistic assessment and on-going care planning are implemented in an interdisciplinary manner to meet the changing needs and wishes of patients, caregivers and families.		
Rationale	Patients approaching the end of life should receive an initial holistic assessment that covers their physical, social, spiritual and cultural needs and preferences. Identified needs and preferences can then be supported by members of the interdisciplinary team.[1-5] Subsequent on-going assessment and care planning should be proactive and responsive to patients' changing needs.	
Indicators		
All	4.1	All patients identified as approaching the end of life undergo documented holistic assessments that cover the patient and family's physical, psychological, social, spiritual and cultural needs and preferences.
	4.2	There is evidence of individualised care plans made after the holistic assessment of the needs of patients, caregivers and families.
B + C	4.3	Assessment and care-planning reflect an interdisciplinary approach.
	4.4	There is evidence of on-going assessment and care planning at appropriate intervals that documents changes in the patient and family's needs, and response to treatment over time.
	4.5	Regular assessment of physical symptoms, and psychological and spiritual needs is conducted with the use of assessment tools where appropriate.
	4.6	There are mechanisms in place to identify and assess risks of self-harm.
Tools		
1	Patient assessment forms: a. Forms and other resources from US providers, assembled by the Center to Advance Palliative Care[6] b. Forms from local Class C providers	- Annex A
2	Symptom assessment tools: a. Edmonton Symptom Assessment System (ESAS)[7-9] b. Palliative Care Outcomes Collaboration (PCOC)[10-12]	-
3	Spiritual assessment tool: a. FICA Spiritual Assessment Tool[13-15] b. "Are you at peace?" One item to probe spiritual concerns at the End of Life[16] c. HOPE Spiritual Assessment Tool[17]	-

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Domain 1: Patient Care		
Guideline 5 – Advance Care Planning All patients at the end of life have access to Advance Care Planning (ACP).		
Rationale	ACP helps to ensure that patients' wishes are respected in the event that they become incapable of participating in treatment decisions, and allows for treatment at the end-of-life to be consistent with the patients' preferences.[1-7]	
Indicators		
All	5.1	There are systems in place to provide patients with life-limiting illness with information about, and access to, Advance Care Planning.
B + C	5.2	The service provider routinely conducts Advance Care Planning to ascertain and document patients' and families' preferences about treatment at the end-of-life, and fulfils these preferences as far as possible.
	5.3	There are systems in place to monitor if patients' Advance Care Plans are honoured.
Tools		
1	Informative, educational and publicity materials for healthcare staff and patients: a. Living Matters resource site[8] (including brochures, FAQs, ACP form templates and a Do-It-Yourself ACP workbook)	-
2	Examples of current referral procedures to trained ACP Facilitators within restructured hospitals	Annex B

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Domain 1: Patient Care		
Guideline 6 – Patient-Centred Care Patients receive care that is customized to their unique needs and preferences as informed by holistic assessments.		
Rationale	Patients have unique needs and preferences, which may differ depending on their cultural background. The patient's quality of life is improved by care that is customised to their unique physical, emotional, cultural and spiritual needs.[1-4]	
Indicators		
All	6.1	Each patient's unique cultural and spiritual needs are taken into consideration in the provision of care services.
	6.2	Information on the patient's condition is openly and sensitively communicated to the patient and family on a regular basis.
C	6.3	Spiritual support and therapy services (e.g. occupational, physical and speech therapy) are made available to patients when needed. Where these competencies do not exist within the service provider, there should be defined links to access these services.
	6.4	In the presence of complex ethical dilemmas beyond the resourced ability of service provider, there are policies and procedures to ensure access to ethics committees (or equivalent).
Tools		
1	Patient assessment forms: a. Forms and other resources from US providers, assembled by the Center to Advance Palliative Care[5] b. Forms from local Class C providers	- Annex A
2	Reference material for healthcare staff: a. Online casebook on "Making Difficult Decisions with Patients and Families", developed by the NUS Centre for Biomedical Ethics[6]	

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Domain 1: Patient Care		
Guideline 7 – Care in the Last Days of Life Care is taken to fulfil the needs of patients in the last days of life, as well as that of their caregivers and families.		
Rationale	During the last hours and days of life the unique needs of patients and families should be taken into consideration, the comfort of patients maximised and their dignity respected.[1-8]	
Indicators		
All	7.1	There is recognition and documentation of the patient's transition to the active dying phase, and communication to the patient, family and staff on the patient's imminent death.
	7.2	The family is educated on a timely basis on the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate and culturally appropriate manner.
	7.3	Symptoms at the end of life are assessed and controlled, with referral to palliative care services if necessary.
	7.4	There is evidence of a plan in place to maximise patient comfort during the active dying phase and to support the family and caregivers.
Tools		
1	Guidebooks for staff: a. The Bedside Palliative Medicine Handbook,[9] a practical guide to palliative medicine in Singapore developed by Tan Tock Seng Hospital	-
2	Education materials for patients and caregivers: a. Singapore Hospice Council's guide to terminal care[10] b. Patient/ caregiver information guides/booklets from local Class C providers	Annex C

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Domain 2: Family and Caregiver Support		
Guideline 8 – Caregiver Support Caregivers of patients with life-limiting illness face significant stress in their roles, and their own practical and emotional needs need to be supported.		
Rationale	Caregivers of patients with life-limiting illness face significant stress in their roles. Studies have shown that caregiving may negatively impact on caregivers' health and work. There are also practical and emotional needs which need to be supported[1-11] in order for them to be able to provide care more effectively.	
Indicators		
All	8.1	The patient's primary caregiver is identified at the initial assessment, and his or her needs are assessed and addressed on an on-going basis.
B + C	8.2	The primary caregiver is provided with education and training on their role, including strategies for self-care and coping with the demands of caregiving.
Tools		
1	Informative materials on resources for patients and caregivers: a. Training i. Schedule of training sessions conducted by the HCA Palliative Caregivers Programme[12] b. Online resource and support portals for patients and caregivers i. awwa's Caregiver Handbook[13] ii. Singapore Silver Pages, an online directory with eldercare information run by the Agency for Integrated Care[14] iii. Singapore Hospice Council Online Resource for Patient and Caregivers[15] iv. Online guide developed by Macmillan Cancer Support[16] v. Online guide developed by National Hospice and Palliative Care Organisation (NHPCO)[17]	-

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Domain 2: Family and Caregiver Support		
Guideline 9 – Bereavement Care Family members affected by a death are offered timely bereavement support appropriate to their needs and preferences.		
Rationale	There should be timely identification of complications in grief experienced by families before and after the patient's death. The provision of direct bereavement support, or referral of families to bereavement services should be based on the assessed needs of the families[1-11]. Psychotherapeutic interventions have been found benefit those who have marked difficulties adjusting to the loss[12].	
Indicators		
All	9.1	Appropriate information about practical death-related issues (e.g. funeral arrangements) should be available when requested.
	9.2	Families and caregivers identified to be at risk of complicated grief are referred to bereavement support services.
B + C	9.3	There is evidence of a system in place to screen caregivers and families for bereavement needs, and to provide direct bereavement support or referral to bereavement support services where necessary.
Tools		
1	Informative materials on bereavement support services: a. Non-exhaustive list of bereavement support services in Singapore b. Pamphlets on grief and bereavement for families and caregivers from local Class C providers	Annex D Annex E
2	Informative materials on funeral services/arrangements upon death: a. NEA online guide[13] on death registration, funeral arrangements and other practical death-related issues	-
3	Checklist for staff for after-death procedures: a. Examples from local Class C providers	Annex F
4	Inventory of Complicated Grief-Revised[14]	-

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Domain 3: Staff and Volunteer Management

Guideline 10 – Qualified Staff and Volunteers

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

Rationale	A competent and adequate workforce is key to the provision of quality care. There should be an adequate team of healthcare professionals with the appropriate training to meet the needs of patients at the end of life.[1-5] As service providers may have different service models, they should customise staffing norms according to the roles and responsibilities of the staff. Volunteers may complement the healthcare team in the provision of care, and must receive the appropriate training to perform their duties effectively.

Indicators

All	10.1	All staff and volunteers demonstrate evidence of palliative care training appropriate to the level of care provided.
C	10.2	Palliative care teams consist of an interdisciplinary team of skilled palliative care professionals, including physicians, nurses and social workers and/or counsellors/pastoral staff. Where these competencies do not exist within a team, there should be clearly defined links to access these through a service level agreement or similar.
	10.3	Staffing levels are adequate to deliver the care needed by patients.
	10.4	Palliative care professionals are appropriately trained, credentialed and/or certified in their area of expertise.
	10.5	Where volunteers are part of the team, there is evidence of policies in place to ensure proper screening, recruitment and on-going training of volunteers.

Tools

1	Informative materials for staff on relevant training: a. List of courses available at the AIC Learning Institute[6] b. List of training available in Singapore	- Annex I
2	Recommended staffing norms: a. **Inpatient hospice**: 2011 National Strategy for Palliative Care (NSPC)[7] b. **Home and day hospice care**: 2009 Singapore Hospice Council Home Care and Day Hospice Services Workgroup Report	- Annex J

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Domain 3: Staff and Volunteer Management		
Guideline 11 – Staff and Volunteer Self-Care Staff and volunteers reflect on practice, maintain effective self-care strategies and have access to support in dealing with the psychological stress associated with working among the terminally ill and bereaved.		
Rationale	The care of patients near the end of life and the support of their family members may have an emotional and spiritual toll on healthcare workers and volunteers.[1-6] The ability to reflect on their practice and opportunities to express their feelings related to interactions with patients and their families should be encouraged as part of the culture of service providers caring for patients near the end-of-life.[7-10]	
Indicators		
B + C	11.1	There are strategies in place to provide situational support, critical incident debriefing and response.
	11.2	Education is provided to help staff and volunteers develop effective coping strategies.
C	11.3	Staff have access to confidential employee assistance programs and/or counselling services.
Tools		
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Domain 4: Safe Care		
Guideline 12 – Access to and Use of Opioids Patients at the end of life should have access to opioids for symptom control, with guidelines and processes in place to ensure safe and effective use.		
Rationale	Opioids are commonly used medications in palliative care. While useful, there are also risks and unwanted effects associated with unregulated use.[1-5] Education and guidelines are necessary to ensure optimal symptom control with minimal side effects.[6-11]	
Indicators		
All	12.1	Service providers caring for patients at the end of life have access to opioids.
	12.2	The use of opioids in the management of symptoms should be directed by evidence, driven by need, and administered under guidelines with appropriate monitoring.
	12.3	There is evidence of patient and caregiver education on the safe use of opioids.
	12.4	There is adherence to the legal requirements of the Misuse of Drugs Act[10] on the prescription, safe storage, dispensing, administration, disposal and report of errors in the use of opioids.
Tools		
1	Reference charts/ guidebooks for clinical staff: a. Opioid conversion charts from local Class C providers b. The Bedside Palliative Medicine Handbook,[10] a practical guide to palliative medicine in Singapore developed by Tan Tock Seng Hospital[11] c. NICE guidelines 2012. Opioids in Palliative Care: safe and effective prescribing of strong opioids for pain in palliative care for adults.[12]	Annex G - - -
2	Educational materials for patients: a. Singapore Hospice Council pamphlet on using morphine	Annex H

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Domain 4: Safe Care		
Guideline 13 – Clinical Quality Improvement The service is committed to improvement in clinical and management practices.		
Rationale	Palliative care services are committed to a high quality of care and support for all patients and their families. Services should strive to benchmark quality through regular and systematic measurement, analysis, review, evaluation, goal setting and revision of care processes.[1-18]	
Indicators		
B + C	13.1	Presence of a framework to guide a program of quality improvement, that consists of: (a) Evidence of dissemination and incorporation of quality improvement (QI) findings into practice (b) Clinical and performance criteria consistent with professional standards (c) An on-going, proactive program for identifying and reducing unanticipated adverse events and safety risks to patients
C	13.2	There is evidence of the implementation of quality improvement projects to support on-going service evaluation and development.
	13.3	There is evidence of on-going evaluation of patients' and families' satisfaction with care, and necessary measures to improve these.
Tools		
1	Quality improvement and assurance framework: a. Examples from local Class C providers	Annex K
2	Resources for standardised and validated clinical assessment tools: a. Palliative Care Outcomes Collaboration (PCOC) Assessment Toolkit[19] b. Toolkit of Instruments to Measure End-of-Life Care (TIME)[20]	-

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