



## Palliative care: supplementary care type information

This document is supplementary to the [MP 0164/21 Patient Activity Data Policy](#) and should be read in conjunction with the related and supporting documents of that policy.

Palliative care is a specialised admitted sub-acute care type in which the primary clinical purpose or treatment goal is optimisation of the quality of life for a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial, and/or spiritual needs.

The term 'life-limiting illness' refers to conditions where death is expected to be a direct consequence of the disease process. These illnesses may include, but are not limited to cancer, heart disease, chronic obstructive pulmonary disease, dementia, heart failure, neurodegenerative disease, chronic liver disease, and renal disease.



The term 'living with a life-limiting illness' recognises that individuals may live with these conditions for extended periods and are not solely in the process of dying.

### Palliative care admission criteria

The care type of palliative care is delivered under the management of, or in consultation with, a medical practitioner with specialised expertise in palliative care, and is evidenced by:

- a documented multidisciplinary assessment and management plan in the patient's medical record, that addresses the physical, psychological, emotional, social, and spiritual needs of the patient, and includes negotiated goals of care.
- clinical and functional assessments completed and recorded at the commencement of each palliative phase.



A SPC Medical Practitioner is a Fellow of the Royal Australasian College of Physicians (RACP) [Australasian Chapter of Palliative Medicine \(AChPM\)](#) or equivalent, with recognition via the Australian Health Practitioner Regulation Agency (AHPRA) of specialist qualification in palliative medicine.

## What does 'informed' by a medical practitioner with specialised expertise in palliative care mean?

For adult patients, palliative care must be delivered under the management of, or informed by, a Specialist Palliative Care (SPC) Medical Practitioner. This means the following.

- Care is provided under the clinical oversight or guidance of a Specialist Palliative Care (SPC) Medical Practitioner (SPC medical practitioner).
- The patient is referred to this SPC medical practitioner who:
  - contributes to clinical assessment and care planning
  - provides shared care or consultative input into the patient's management.
- The SPC medical practitioner's involvement may occur through direct, shared, or consultative models of care, and does not require the practitioner to be physically located at the same facility as the patient.
- Where the SPC medical practitioner is not co-located:
  - a clinician at the patient's location continues to deliver day-to-day care
  - local clinicians must be appropriately trained and competent to undertake assessments and complete required documentation
    - the level of expertise of the local clinician does not affect the assignment of care type, provided SPC input is evident.
- To support clinical governance and documentation requirements:
  - the name of the SPC medical practitioner informing the patient's care must be documented in the medical record
  - evidence of SPC input should include contribution to, or endorsement of, the multidisciplinary assessment and management plan.
- The patient's Care Type may be assigned or changed to palliative care where criteria are met; however, this does not necessarily require changes to local clinical governance arrangements (e.g. treating team, specialty allocation, or bed location).
- For paediatric patients, while SPC involvement is expected, care may be delivered through shared-care or consultative models across specialist and generalist providers. In these settings, palliative care is not solely defined by the direct involvement of an SPC medical practitioner, but must be supported by appropriate clinical assessment, documentation, and alignment with the Phase Type framework, reflecting the clinical intent of palliation.



If a hospital or health service does not have access to a Specialist Palliative Care Medical Practitioner, the Care Type cannot be allocated to palliative care. This does not mean the patient cannot receive palliative care services.

## Providing palliative care vs specialist palliative care

To palliate means to ‘make a disease or its symptoms less severe without removing the underlying cause.’

There are a range of terms used internationally to describe palliative care, and some are used interchangeably, which can lead to confusion. In the Western Australian context, it is important to distinguish between palliative care and specialist palliative care.

In this document, the terms palliative care and palliation are used to describe the concept of care, rather than the recognised specialty for data and reporting purposes. Where the specialty is intended, the terms ‘specialist palliative care’ and the care type of ‘palliative care’ are used. Refer to Appendix A for definitions of palliative care.

A patient may be admitted to hospital for the management of an acute condition while simultaneously receiving specialist palliative care for an underlying life-limiting illness. Similarly, a patient does not require a change to the care type of palliative care in order to receive end-of-life or terminal care.

In Western Australia, a service is classified as a specialist palliative care service where it meets the criteria for Palliative Care Level 4 or above. Refer to *Appendix B – Palliative Care Service Classification Levels within the Clinical Services Framework* for further information.

## Counting and classification of palliative care activity

Two National Health Data Collection data items are used to identify and collect information on admissions with palliative care provision:

- additional diagnosis
- care type.

### Additional diagnosis

The provision of palliative care is captured in patient activity data through the clinical coding of palliation using the ICD-10-AM code Z51.5 Palliative care, in accordance with *ICD-10-AM* and *Australian Coding Standard (ACS) 2116 Palliative care*. The assignment of code Z51.5 Palliative care, is independent of the care type for an admitted episode.

All instances where palliation has been provided must be clinically coded as this enhances the available data on the provision of palliative care services for admitted patients. This, in turn, improves the visibility of the care delivered—beyond end-of-life care—and supports more accurate service planning, resource allocation, and funding models.

All admitted episodes of care are coded using the following national classification systems:

- the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)
- the Australian Classification of Health Interventions (ACHI)
- the Australian Coding Standards (ACS).



To assign Z51.5 Palliative care, the palliation does not have to be delivered or informed by a specialist palliative care medical practitioner. Any clinician can provide palliation, SPC involvement is only required for Care Type classification.

The assignment of Z51.5 Palliative care:

- is only ever assigned as an additional diagnosis, not a principal diagnosis
- enables identification of palliative care provision alongside the patient's existing acute condition, including where the Care Type has not changed to palliative care
- requires documented evidence in the patient's medical record that active palliative care has been provided – this may include clinician entries in progress notes and/or a documented care plan
- is not to be assigned for consultation or assessment alone, where no palliative care has been delivered to the patient.

## Care type

Admitted episodes with a care type of 'palliative care' are classified under the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification. This classification requires the use of standardised clinical assessment tools to determine phase of care, functional status, age, and other relevant measures.

The AN-SNAP classification for palliative care is a national system used to inform Activity Based Funding (ABF). Episodes assigned the care type of 'palliative care' attract funding that reflects the complexity and intensity of care, including input from a specialist palliative care medical practitioner.

## Clinical assessment requirements

For palliative care episodes to be classified to the applicable AN-SNAP class, the following are required.

- Phase of care:

An episode may contain a single phase or multiple phases, depending on changes in the patient's condition. The Phase Type (e.g. stable, unstable, deteriorating, terminal) and the date of any phase change must be clearly documented and maintained.

- Clinical assessment requirements:

For adult patients, a functional assessment using the Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) must be completed and recorded at the commencement of each palliative phase.

For paediatric patients, RUG-ADL assessment is not required. Palliative care activity is identified through Phase Type assignment and must be supported by appropriate clinical assessment and documentation demonstrating that the primary intent of care is palliation.

These clinical measures must be recorded in the designated information systems (e.g. webPAS, ePaICIS, or other approved systems).

Without the above clinical measures being completed, the recorded palliative care activity will be deemed invalid and unable to be submitted to the Department of Health. Refer to the Quality Assurance section below for further information.

For further information on Clinical Assessment requirements refer to the *Subacute and Non-acute Data Collection Data Dictionary* a supporting document to the *Patient Activity Data Policy* in the [Information Management Policy Framework](#).

## Changing the care type to palliative care

A patient's care type cannot be changed on the day of formal admission or discharge, as only one admitted care episode per day can be recorded. If it is determined on the day of admission that the primary clinical intent of care is palliative, the care type must be recorded as 'palliative care' at the commencement of the admission, rather than as a same-day change.

For a valid change of care type to 'palliative care', the following criteria must be met.

- The patient is referred to, or care is informed by, a Specialist Palliative Care (SPC) medical practitioner.
- There is documented agreement that the primary clinical intent and purpose of care is palliation.
- The SPC medical practitioner, or an appropriately authorised nominee, authorises the change of care type.
- The date, time, and name of the SPC medical practitioner informing care and authorising the change must be documented in the patient's medical record.
- An appropriate multidisciplinary assessment and management plan is documented in the patient's medical record.
- Clinical assessments required for activity classification and Activity-Based Funding (ABF) are completed and recorded in the applicable information systems (e.g. webPAS, ePalCIS):
  - for adult patients, this includes completion of RUG-ADL assessments at the commencement of each palliative phase
  - for paediatric patients, RUG-ADL assessments are not required; however, palliative care activity must be supported by Phase Type assignment and appropriate clinical documentation demonstrating the intent of palliation
  - refer also to Appendix C, the *WA End-of-life Framework*, which provides a guide to best-practice palliative care across the end-of-life stages.

### Care type change scenarios

The following scenarios illustrate the application of the care type 'palliative care' and Z51.5 coding principles in common clinical situations.

- Acute deterioration / end-of-life care without SPC involvement: an acute patient experiences irreversible clinical deterioration, and a decision is made to provide terminal care (e.g. implementation of the Care Plan for the Dying Person (CPDP)). The patient may continue to be managed within their current Care Type and specialty without specialist palliative care (SPC) involvement, and without a change in care type to palliative care. In this circumstance, the provision of palliation should be recorded through the assignment of ICD-10-AM code 'Z51.5 – Palliative care' as an additional diagnosis.
- Change of care type to palliative care at admission (ED/Short Stay): an SPC medical practitioner is consulted for a patient admitted to an Emergency Department Short Stay Unit. Following assessment, it is determined that the primary clinical intent and purpose of care is palliative.

The Care Type for this episode should be recorded as palliative care from the commencement of the admission. A new episode of care (statistical admission)

must not be created for this change.

- Transfer without local SPC involvement: a patient is transferred to their local hospital for ongoing palliative management under a care plan from the referring service. If the receiving clinician manages the patient without referral to a local SPC service, the criteria for a care type of palliative care is not met.

The provision of palliation should instead be recorded through assignment 'Z51.5 - *Palliative care*' as an additional diagnosis.

- SPC consultation only: a palliative care assessment is conducted by an SPC medical practitioner, and it is determined that further specialist palliative care input is not warranted at this time. A SPC medical practitioner may be consulted for advice on management of the patient, but this does not automatically initiate a change in care type.

Specialist consultation is part of routine clinical practice and does not, in itself, signify commencement of a new episode of care or a change in care type.

- Change of care type from palliative care back to Acute care: a paediatric palliative care patient now requires care that necessitates a transfer back under the management of an Acute Specialist Medical Practitioner. Where the primary clinical intent and purpose of care changes during a palliative care admitted episode, the care type can be changed back via statistical discharge and admission to another care type (such as the Acute care).
- Transfer to another facility for palliative care: a decision has been made to transfer a patient to another hospital for ongoing palliative care. If a patient is waiting to be transferred to another health service for palliative care, the care type is not changed prior to transfer unless the patient meets all the admission criteria for the care type of palliative care.
- Deterioration and death following SPC referral: a patient with cancer is referred to specialist palliative care due to clinical deterioration, and a decision is made to arrange discharge home for terminal care. The patient dies unexpectedly three days later whilst still an inpatient. The care type could have been changed to palliative care once the:
  - patient ceased to receive life prolonging treatment
  - patient received specialist palliative care management
  - it was determined that the primary clinical purpose of care was palliation.

This determination must be authorised by an SPC medical practitioner and supported by appropriate documentation.

## Quality assurance

Regular data quality reports are provided to HSPs by the Principal Data Management Officer for the Subacute and Non-acute Data Collection. These listing reports detail all admitted episodes with a recorded care type of palliative care and identify episodes that are unable to be classified to a valid AN-SNAP code for ABF purposes following the integration and processing of administrative and clinical assessment data. This reflects a requirement of the palliative care type admission criteria.

Where the care type assigned is determined to be non-compliant with the admission criteria outlined above, the admission may require correction, including cancellation or reversal where appropriate.

Additional data quality checks relating to data elements, clinical coding, and policy compliance are managed through the Hospital Morbidity Data Collection (HMDC) validation processes, undertaken by the Data Quality and Assurance team, Information and Performance Governance (IPG).

For details of activity data quality assurance refer to the *Subacute and Non-acute Data Collection Data Dictionary and Hospital Morbidity Data Collection Data Dictionary*, as part of [MP 0164/21 Patient Activity Data Policy](#).

The WA Cancer and Palliative Care Network (WACPCN) coordinates implementation and training of ePalCIS. They can also provide guidance to HSPs and Contracted Health Entities (CHEs) on training and credentialing requirements for capturing Phase of Care and RUG-ADLs for palliative care patients. Email: [Palliativecare.CPCN@health.wa.gov.au](mailto:Palliativecare.CPCN@health.wa.gov.au)

## Frequently asked questions

**Can documentation by a palliative care clinical nurse be used by a coder to assign ICD-10-AM code ‘Z51.5 Palliative Care?’ Our hospital does not have a medical team dedicated to palliative care and they rely on a clinical nurse to assist with palliative care.**

To assign ‘Z51.5 Palliative care,’ a coder requires documentation to indicate:

- the patient has undergone assessment
- a decision has been made to provide the patient with palliative care
- palliative care has been delivered to the patient.

A palliative care clinical nurse may be involved in the assessment and provision of palliative care to the patient, however, the decision to provide the patient with palliative care would lie with their treating medical practitioner (palliative care specialist or otherwise). The coder requires documentation to indicate the treating medical practitioner has decided to provide palliative care to the patient before they can assign ‘Z51.5 Palliative care.’

**Can we confirm whether it is acceptable for a hospital to change a patient’s care type to palliative based on an appropriate clinician providing advice via a teleconference?**

See the section above: ‘Informed by a medical practitioner with specialised expertise in palliative care requirements.’ Provision of palliative care by a SPC medical practitioner located elsewhere is acceptable. The care would need to meet all the care type admission criteria for Palliative care noting that the care type cannot be changed for consultation only teleconference, terminal care just prior to death, or pending a transfer to another hospital where palliative care is to be provided.

**If the health service does not have access to a specialist medical practitioner, can we change the care type?**

If the hospital does not have access to an appropriately qualified SPC medical practitioner (including paediatric SPC where relevant), the care type should not be changed to palliative care, even where the primary focus of care becomes palliative. Assignment to palliative care type requires access to recognised specialist palliative care services; therefore, in the absence of such access, care must continue to be delivered and reported within the existing admitted care episode. This approach recognises that paediatric palliative care may differ from adult models, including the provision of concurrent care alongside active treatment; however, the requirement for access to appropriate specialist palliative care expertise remains unchanged.

**We are concerned we are not capturing the provision of palliative care in admitted (acute care type) patients?**

Whilst some patients may have complex care needs and require access to specialist palliative care, most patients can be cared for by their primary specialist team through end-of-life care, also known as the palliative approach. This is captured in the activity data through the clinical coding of palliation. The classification of palliative care provision using ICD-10-AM code ‘Z51.5 Palliative care’ will record palliation provided within care types other than palliative care.

**What are acceptable synonymous terms for palliative care? Some terms are clearly synonymous with palliative care such as 'end of life care' and 'terminal care.' However, is documentation of 'comfort measures only' considered synonymous with palliative care?**

The *Australian Coding Standard (ACS) 2116 Palliative care* (ICD-10-AM Ninth Edition) clarified that terminology such as 'end of life care' and 'terminal care' are acceptable indicators of palliative care when supported by appropriate clinical context. However, the term 'comfort measures' (e.g. 'comfort measures only') is broader in scope and may be used in a variety of clinical situations. As such, it is not, on its own, sufficient to support assignment of 'Z51.5 Palliative care.'

Clinical coders should refer to ACS 2116 Palliative care to determine whether the criteria for code assignment are met. Where documentation is unclear or insufficient, 'Z51.5 Palliative care' should not be assigned.

## Related documents

The following mandated policy documents should be read in conjunction with this document.

- [MP 0164/21 Patient Activity Data Policy](#), in particular:
  - Admitted Patient Activity Data Business Rules
  - Hospital Morbidity Data Collection Data Dictionary
  - Subacute and Non-acute Data Collection Data Dictionary.

## References

1. End-of-life Palliative Care Strategy 2018-2028. Available from: <https://healthywa.wa.gov.au/-/media/Files/Corporate/general-documents/Health-Networks/Palliative-care/WA-End-of-life-and-Palliative-Care-Strategy-2018-2028.pdf>
2. Government of Western Australia. The End-of-life Framework. Perth, Western Australia: Government of Western Australia; 2016. Available from: [https://ww2.health.wa.gov.au/~/\\_/media/Files/Corporate/general%20documents/End%20of%20Life/PDF/The-End-of-Life-Framework.ashx](https://ww2.health.wa.gov.au/~/_/media/Files/Corporate/general%20documents/End%20of%20Life/PDF/The-End-of-Life-Framework.ashx)
3. Independent Hospital Pricing Authority. (2019). Australian Coding Standards, Eleventh Edition, 1 July 2019. Independent Hospital Pricing Authority, [Darlinghurst, N.S.W.]

## Glossary

Item	Description
ABF	Activity Based Funding
ACS	The Australian Coding Standards (ACS) are a set of rules used by health information managers and clinical coders in the assignment of codes that represent diseases or interventions relevant for episodes of admitted care.
AN-SNAP	Australian National Subacute and Non-Acute Patient Classification
CPDP	Care Plan for the Dying Person
ED	Emergency Department
ePalCIS	WA Health electronic Palliative Care Information System
Episode of care	An episode of care refers to the period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type.
Formal admission	A formal admission is an administrative process that initiates the record of the patient's treatment and accommodation within a hospital.
Formal discharge/separation	A formal separation/discharge is an administrative process that ceases the record of the patient's treatment and accommodation within a hospital.
Health Service Provider (HSP)	<p>A Health Service Provider is a statutory entity established under section 32 of the <i>Health Services Act 2016 (WA)</i> to deliver health services within a defined health service area or function.</p> <p>In Western Australia, the HSPs are:</p> <ul style="list-style-type: none"> <li>▪ North Metropolitan Health Service (NMHS)</li> <li>▪ South Metropolitan Health Service (SMHS)</li> <li>▪ East Metropolitan Health Service (EMHS)</li> <li>▪ WA Country Health Service (WACHS)</li> <li>▪ Child and Adolescent Health Service (CAHS)</li> <li>▪ PathWest Laboratory Medicine WA</li> <li>▪ Health Support Services (HSS)</li> </ul>
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
Medical practitioner	As per the <i>Health Services Act 2016</i> , a medical practitioner is a person registered under the <i>Health Practitioner Regulation National Law (Western Australia)</i> in the medical profession.
RUG-ADL	Resource Utilisation Group Activities of Daily Living
SPC	Specialist palliative care is managed or informed by a SPC medical practitioner and undertaken by a professional palliative care team or service with recognised qualifications or accredited training in palliative care.

SPC Medical Practitioner	A SPC Medical Practitioner is a Fellow of the Australasian Chapter of Palliative Medicine (FACHPM) or equivalent, with recognition via AHPRA of specialist qualification in palliative medicine.
Statistical admission	A statistical admission is an administrative process that captures the commencement of a particular type of care (change of care type).
Statistical discharge	A statistical separation/discharge is an administrative process that captures the end date the patient received a particular type of care (change of care type).
webPAS	WA Health web-based Patient Administration System

## Appendix A – Palliative care definitions

**End of life** is the timeframe during which a person lives with, and is impaired by, a life-limiting/fatal condition, even if the prognosis is ambiguous or unknown. Those approaching end of life will be considered likely to die during the next 12 months.

**End-of-life care** aims to improve the quality of life of people, and their families/carers, who are living with a life-limiting illness. It includes a palliative approach to care, often described using related terms such as supportive care, comfort care, symptom management, and anticipatory care.

It is delivered through a coordinated, multidisciplinary approach across public, private, community, and non-government sectors, recognising that effective care requires collaboration between healthcare providers, the patient, and their support network.

End-of-life care also includes linking the primary treating team with specialist palliative care services and ensuring access to clear information and referral pathways when a patient's needs exceed the capability of the current care team.

**Palliative care** is an approach that improves the quality of life of people, and their families/carers, facing life-limiting illness through the prevention and relief of suffering, including early identification and management of physical, psychosocial, and spiritual needs.

It focuses on symptom relief, supports people to live as actively as possible, and recognises dying as a normal process – neither hastening nor postponing death.

Palliative care is delivered using a multidisciplinary team approach, supporting both the person and their family, including during bereavement, and may be provided alongside life-prolonging treatments where appropriate.

**Specialist palliative care** is undertaken by a professional palliative care team or service with recognised qualifications or accredited training in palliative care. The role of specialist palliative care services includes providing consultation services to support, advise, educate, and mentor specialist and non-specialist teams to provide end-of-life and palliative care and/or to provide direct care to people with complex palliative care needs. See Appendix 2 for more detailed information on the classification of specialist palliative care services.

**Terminal care** refers to care provided to a person in the last hours, days, or weeks of life, and represents the final phase of the palliative care continuum. This phase focuses on comfort, symptom management, and support for the person and their family/carers.

Source: *WA End-of-life Palliative Care Strategy 2018-2028*

## Appendix B – Palliative care service classification levels within the clinical services framework

Delivery of end-of-life care						
End-of-life care			Specialist palliative care			
Medical Services						
	Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
<b>Palliative Care</b>	<ul style="list-style-type: none"> <li>■ Assessment referral and management by GPs.</li> <li>■ Emergency assessment and referral.</li> <li>■ Links with the palliative care network.</li> <li>■ Visiting primary healthcare providers.</li> <li>■ Access to Telehealth services or support.</li> </ul>	<p>As for level 1 plus:</p> <ul style="list-style-type: none"> <li>■ Inpatient care by GP in consultation with specialist services.</li> <li>■ Access to some allied health services.</li> <li>■ 24/7 cover by RN.</li> <li>■ Referral coordination and link with specialist community and inpatient programs.</li> </ul>	<p>As for level 2 plus:</p> <ul style="list-style-type: none"> <li>■ 24/7 cover by clinical nurse with training and/ or experience in palliative care services.</li> </ul>	<p>As for level 3 plus:</p> <ul style="list-style-type: none"> <li>■ Palliative care patients managed by GP and medical practitioner specialising in palliative care.</li> <li>■ Access to specialist SRN.</li> <li>■ Access to designated allied health services.</li> <li>■ Some allied health undergraduate education.</li> </ul>	<p>As for level 4 plus:</p> <ul style="list-style-type: none"> <li>■ Inpatient care by on-site palliative care physician.</li> <li>■ Registrar/RMO.</li> <li>■ Regional referral role.</li> <li>■ Undergraduate teaching and some research role.</li> <li>■ Integrated community consultative service under direction of palliative care physician.</li> <li>■ Links with oncology radiotherapy, anaesthetics, psychiatry, pain clinic and rehabilitation.</li> <li>■ Access to specialised allied health services.</li> </ul>	<p>As for level 5 plus:</p> <ul style="list-style-type: none"> <li>■ Full range of palliative care services with palliative care specialist providing consultancy to other units referral hospitals.</li> <li>■ Emergency services available.</li> <li>■ Statewide referral role.</li> <li>■ Undergraduate and postgraduate teaching role.</li> <li>■ 24/7 on-call specialist.</li> </ul>

Source: *WA End-of-life Palliative Care Strategy 2018-2028*

## Appendix C – The End-of-life Framework

The *End-of-life Framework*<sup>2</sup> is a state-wide model for the provision of comprehensive, coordinated care at end-of-life in Western Australia. It provides direction for best-practice care across a patient's end-of-life trajectory, commencing when they are diagnosed with a life-limiting illness, or their death is expected. It focuses specifically on end-of-life care in acute healthcare settings. It affirms that whilst some patients may have complex care needs and require access to specialist palliative care; most patients can be cared for by their primary care provider or primary specialist team through end-of-life care, also known as the palliative approach.

Figure 1 The *End-of-Life Framework*

Stages*			Triggers	Action
1	<i>Would you be surprised if the patient died in the next 6-12 months?</i>	<b>Advancing disease</b>	<ul style="list-style-type: none"> <li>Known advanced cancer or chronic disease</li> <li>Evidence of disease progression and/or symptoms</li> <li>Patient/family expresses concern about the future</li> <li>Would you be surprised if the patient died in the next 6-12 months?</li> </ul>	<b>Consider:</b> <ul style="list-style-type: none"> <li>Advance Care Planning</li> <li>Palliative Care consultation</li> </ul>
2	<i>Would you be surprised if the patient died this admission or in the next month?</i>	<b>Increasing decline</b>	<b>As for Stage 1 plus:</b> <ul style="list-style-type: none"> <li>Increasing frailty</li> <li>Increasing symptom burden</li> <li>Increasing psychosocial support needs</li> <li>Not responding to treatment or non-adherence with treatment</li> <li>For hospital inpatients, would you be surprised if the patient died this admission?</li> </ul>	<b>Consider:</b> <ul style="list-style-type: none"> <li>Referral to palliative care for ongoing care or</li> <li>palliative care consultation and/or</li> <li>shared care partnerships with palliative care</li> </ul>
3	<i>Irreversible clinical deterioration, life expectancy one week or less</i>	<b>Last days of life</b>	<ul style="list-style-type: none"> <li>Irreversible clinical deterioration</li> <li>Team decision of diagnosis of dying.</li> </ul>	<b>Commence:</b> <ul style="list-style-type: none"> <li>Best practice care of the dying, e.g. <i>Care Plan for the Dying Person</i></li> </ul>
4		<b>Death and bereavement</b>	<ul style="list-style-type: none"> <li>Death of patient</li> </ul>	<b>Consider:</b> <ul style="list-style-type: none"> <li>Bereavement follow-up needs</li> </ul>

\* The stages are provided as a guide and are not intended to be prescriptive – each patient's circumstances will be different and care should be provided accordingly.

For queries regarding this document, please email:  
DoH, Admitted Data Collection: [DoH.AdmittedDataCollection@health.wa.gov.au](mailto:DoH.AdmittedDataCollection@health.wa.gov.au)  
Subacute and Non-acute Data Collection: [sana.data@health.wa.gov.au](mailto:sana.data@health.wa.gov.au)

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