2004 Crosswalk of JCAHO Standards and Palliative Care – with PC Policies, Procedures and Assessment Tools

Center to Advance Palliative Care
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About the Document

The Center to Advance Palliative Care (CAPC) has developed this document to provide hospitals with the policy and administrative foundation for delivering palliative care services that are consistent with JCAHO standards. CAPC has previously developed documents highlighting how palliative care could fulfill various JCAHO standards. Those documents also provided a brief description of how, or why, the standard is applicable to a palliative care service and/or programs and may be found on their website, www.capc.org. Hospitals with palliative care programs excel in assuring compliance with JCAHO.

With the release of the 2004 JCAHO standards, CAPC built on its earlier efforts and has developed this document to describe how palliative care satisfies the 2004 JCAHO standards. Additionally, it provides policies and procedures and associated tools to provide the foundation of a high quality palliative care program. The intent of this document is to assist programs in implementing quality palliative care in accordance with JCAHO Standards.

Introduction

A palliative care program aims to improve the quality of life for patients with advanced illness and their families. This document will assist programs in developing the necessary policies and procedures to ensure a quality palliative care program. The core content is divided into the following five sections:

- Index of Standards by Policies - An index of the policies organized under key processes in a palliative care program. For each policy, related JCAHO standards as well as tools are identified.
- Overview of 2004 Standards - An overview of JCAHO standards organized in accordance with JCAHO 2004 chapters (i.e. Ethics, Rights and Responsibilities). This overview maps the JCAHO standards to applicable policies, procedures and associated tools.
- Palliative Care Policies and Procedures by Key Processes - Sample policies and procedures developed from best practices and Palliative Care Centers of Excellence throughout the country. Hospitals can adapt these policies and procedures to fit their institutions.
- Tools to Support Quality Palliative Care - Tools needed to implement the standards and document that the standards have been met.
- Clinical Treatment Protocols/Guidelines for Palliative Care - Additional clinical treatment protocols/guidelines that are useful in delivering quality palliative care.

Crosswalk of Standards by Policies

Key Process: Referral

Policy: Defining Scope of Care

- > RI 2.10- The hospital respects the rights of patients
- > RI 2.30- Patients are involved in decisions about care, treatment and services provided
- > RI 2.70- Patients have the right to refuse care, treatment and services in accordance with the law and regulation
- > RI 2.80- The organization addresses the wishes of patients related to end-of-life decisions
- > RI 2.100- The hospital respects patients rights to and need for effective communication
- > RI 2.160- Patients have a right to pain management
- > PC 5.60- The organization coordinates the care, treatment and services provided to a patient as part of the plan of care, treatment and services and consistent with the organizations scope of care, treatment and services
- ▪ Tool: Description of Core Competencies

Policy: Palliative Care Referral

- > RI 1.40- When care, treatment and services are subject to internal and external review that results in denial of care, treatment, services or payment, the organization makes decisions regarding the provision of ongoing care, treatment and services or discharge based on the assessed needs of the patient
- > RI 2.30- Patients are involved in decisions about care, treatment and services provided
- > RI 2.80- The organization addresses the wishes of patients related to end-of-life decisions
- > RI 2.160- Patients have a right to pain management
- > PC 5.60- The organization coordinates the care, treatment and services provided to a patient as part of the plan of care, treatment and services and consistent with the organizations scope of care, treatment and services
- > PC 8.10- When pain is identified, the patient is assessed and treated in the organization or referred for treatment
- > PC 8.70- Comfort and dignity are optimized during end-of-life care
- > PC15.10- A process addresses the needs for continuing care, treatment and services after discharge or transfer
- > PC 15.20- A patient's transfer or discharge to another level of care, treatment and services, different professionals, or different settings is based on patient's assessed needs and the organizations capabilities
- ▪ Tool: Palliative Care Consultation Report
- ▪ Tool: Palliative Care Screening Tool

Policy: Prioritizing and Responding to Referrals in a Timely Manner

- > PC 2.120- The organization defines in writing the timeframe(s) for conducting the initial assessment
- ▪ Tool: Palliative Care Consultation Report

Key Process: Assessment

Policy: Performing Initial Assessments (non-emergent/non-urgent) and Reassessments

- > RI 1.40- When care, treatment and services are subject to internal and external review that results in denial of care, treatment, services or payment, the organization makes decisions regarding the provision of ongoing care, treatment and services or discharge based on the assessed needs of the patient
- > RI 2.30- Patients are involved in decisions about care, treatment and services provided

- RI 2.70- Patients have the right to refuse care, treatment and services in accordance with the law and regulation
- RI 2.80- The organization addresses the wishes of patients related to end-of-life decisions
- RI 2.160- Patients have a right to pain management
- PC 2.20- The organization defines in writing the data and information gathered during the assessment and reassessment process
- PC 2.120- The organization defines in writing the timeframe(s) for conducting the initial assessment
- PC 2.130- Initial assessments are performed as defined by the organization
- PC 2.150- Patients are reassessed as needed
- PC 3.230- Diagnostic testing necessary for determining the patient's health care needs is performed
- PC 4.10- Development of a plan for care, treatment and services is individualized and appropriate to the patient's needs, strengths, limitations and goals
- PC5.50- Care, treatment and services are provided in an interdisciplinary, collaborative manner
- PC 5.60- The organization coordinates the care, treatment and services provided to a patient as part of the plan of care, treatment and services and consistent with the organizations scope of care, treatment and services
- PC 8.10- When pain is identified, the patient is assessed and treated in the organization or referred for treatment
- PC8.50- Unless contraindicated, the organization accommodates patients' needs to be outdoors when patients experience long lengths of stay
- PC 8.70- Comfort and dignity are optimized during end-of-life care
- PC15.10- A process addresses the needs for continuing care, treatment and services after discharge or transfer
- PC 15.20- A patient's transfer or discharge to another level of care, treatment and services, different professionals, or different settings is based on patient's assessed needs and the organizations capabilities
- Tool: Palliative Care Consultation Report
- Tool: Palliative Care Progress Notes
- Tool: Social Work Consultation Note
- Tool: Spiritual Care Assessment
- Tool: Initial Assessment/Plan of Care
- Tool: Consultation Tracking Form

Key Process: Care Planning

Policy: Patient Care Planning

- RI 2.160- Patients have a right to pain management
- PC 4.10- Development of a plan for care, treatment and services is individualized and appropriate to the patient's needs, strengths, limitations and goals
- PC5.50- Care, treatment and services are provided in an interdisciplinary, collaborative manner
- PC 5.60- The organization coordinates the care, treatment and services provided to a patient as part of the plan of care, treatment and services and consistent with the organizations scope of care, treatment and services
- PC 8.10- When pain is identified, the patient is assessed and treated in the organization or referred for treatment
- PC15.10- A process addresses the needs for continuing care, treatment and services after discharge or transfer

- PC 15.20- A patient's transfer or discharge to another level of care, treatment and services, different professionals, or different settings is based on patient's assessed needs and the organizations capabilities
- Tool: Initial Assessment/Plan of Care

Policy: Guidelines for Staff About Patient and Family Conferences

- RI 2.30- Patients are involved in decisions about care, treatment and services provided
- RI 2.80- The organization addresses the wishes of patients related to end-of-life decisions
- RI 2.160- Patients have a right to pain management
- PC 4.10- Development of a plan for care, treatment and services is individualized and appropriate to the patient’s needs, strengths, limitations and goals
- PC5.50- Care, treatment and services are provided in an interdisciplinary, collaborative manner
- PC 5.60- The organization coordinates the care, treatment and services provided to a patient as part of the plan of care, treatment and services and consistent with the organizations scope of care, treatment and services
- PC 8.10- When pain is identified, the patient is assessed and treated in the organization or referred for treatment
- PC8.50- Unless contraindicated, the organization accommodates patients’ needs to be outdoors when patients experience long lengths of stay
- PC 8.70- Comfort and dignity are optimized during end-of-life care
- PC15.10- A process addresses the needs for continuing care, treatment and services after discharge or transfer
- PC 15.20- A patient's transfer or discharge to another level of care, treatment and services, different professionals, or different settings is based on patient's assessed needs and the organizations capabilities
- Tool: Patient/Family Care Conference Record

Key Process: Treatment

Policy: Assessment and Treatment of Pain and Symptoms

- RI 2.160- Patients have a right to pain management
- MM 6.10- The effects of medication on patients are monitored
- PC 6.10- The patient receives education and training specific to the patient’s needs and as appropriate to care, treatment and services provided
- PC 8.10- When pain is identified, the patient is assessed and treated in the organization or referred for treatment
- Tool: Consultation Report
- Tool: Progress Notes
- Tool: Consultation Tracking Form
- Tool: Initial Assessment/Plan of Care
- Tool: Patient/Family Care Conference Record
- Tool: Palliative Care Intervention Form

Policy: Patient Self-Determination

- RI 2.30- Patients are involved in decisions about care, treatment and services provided
- RI 2.70- Patients have the right to refuse care, treatment and services in accordance with the law and regulation
- RI 2.80- The organization addresses the wishes of patients related to end-of-life decisions
- PC 8.70- Comfort and dignity are optimized during end-of-life care
- Tool: Consultation Report
- Tool: Progress Notes

- <u>Tool</u>: Social Work Consultation Note
- <u>Tool</u>: Palliative Care Intervention Form
- <u>Tool</u>: Consultation Tracking Form

Policy: Maximizing Quality of Life

> <u>PC8.50</u>- Unless contraindicated, the organization accommodates patients' needs to be outdoors when patients experience long lengths of stay
> <u>PC 8.70</u>- Comfort and dignity are optimized during end-of-life care

- <u>Tool</u>: Social Work Consultation Note
- <u>Tool</u>: Patient/Family Care Conference Record
- <u>Tool</u>: Progress Notes
- <u>Tool</u>: Consultation Report

Policy: End of Life Care

> <u>RI 2.70</u>- Patients have the right to refuse care, treatment and services in accordance with the law and regulation
> <u>RI 2.80</u>- The organization addresses the wishes of patients related to end-of-life decisions
> <u>PC 8.70</u>- Comfort and dignity are optimized during end-of-life care

- <u>Tool</u>: End of Life Care Checklist

<u>Key Process: Discharge Planning</u>

Policy: Continuity of Care

> <u>RI 1.40</u>- When care, treatment and services are subject to internal and external review that results in denial of care, treatment, services or payment, the organization makes decisions regarding the provision of ongoing care, treatment and services or discharge based on the assessed needs of the patient
> <u>RI 2.160</u>- Patients have a right to pain management
> <u>RI 2.30</u>- Patients are involved in decisions about care, treatment and services provided
> <u>PC5.50</u>- Care, treatment and services are provided in an interdisciplinary, collaborative manner
> <u>PC 5.60</u>- The organization coordinates the care, treatment and services provided to a patient as part of the plan of care, treatment and services and consistent with the organizations scope of care, treatment and services
> <u>PC 8.10</u>- When pain is identified, the patient is assessed and treated in the organization or referred for treatment
> <u>PC 8.70</u>- Comfort and dignity are optimized during end-of-life care
> <u>PC15.10</u>- A process addresses the needs for continuing care, treatment and services after discharge or transfer
> <u>PC 15.20</u>- A patient's transfer or discharge to another level of care, treatment and services, different professionals, or different settings is based on patient's assessed needs and the organizations capabilities
> <u>PC 15.30</u>- When patients are transferred or discharged, appropriate information related to the care, treatment and services provided is exchanged with other providers

- <u>Tool</u>: Consultation Report
- <u>Tool</u>: Progress Notes
- <u>Tool</u>: Initial Assessment/Plan of Care
- <u>Tool</u>: Patient/Family Care Conference Record
- <u>Tool</u>: Palliative Care Intervention Form

<u>Key Process: Patient Education</u>

Policy: Patient Education

> <u>PC 6.10</u>- The patient receives education and training specific to the patient's needs and as appropriate to care, treatment and services provided

- > PC 6.30- The patient receives education and training specific to the patient's abilities as appropriate to the care, treatment and services provided by the organization
- ▪ Tool: Social Work Consultation Note
- ▪ Tool: Progress Notes
- ▪ Tool: Palliative Care Intervention Form

Key Process: Quality Improvement

Policy: Quality Improvement Plan & Program Evaluation

- > PI 1.10- The organization collects data to monitor its performance
- > PI 2.10- Data are systematically aggregated and analyzed
- > PI 2.20- Undesirable patterns or trends in performance are analyzed
- > PI 2.30- Processes for identifying and managing sentinel events are defined and implemented
- > PI 3.10- Information from data analysis is used to make changes that improve performance and patient safety and reduce the risk of sentinel events
- > PI 3.20- An ongoing, proactive program for identifying and reducing unanticipated adverse events and safety risks to patients is defined and implemented
- ▪ Tool: Consultation Tracking Form
- ▪ Tool: Palliative Care Intervention Form

Overview of 2004 JCAHO Standards

by Chapters with Related Policies and Procedures and Tools

Standard	How it Applies to Palliative Care Key Processes	Policies and Procedures that Address the Standard	Tools to Implement the Standard
RI Ethics, Rights and Responsibilities			
RI.1.40 When care, treatment and services are subject to internal and external review that results in denial of care, treatment, services or payment, the organization makes decisions regarding the provision of ongoing care, treatment, services or discharges based on the assessed needs of the patients	Referral Assessment Discharge Planning	> Palliative Care Referral > Performing Initial Assessments and Reassessments > Continuity of Care	Consultation Report Progress Notes Palliative Care Intervention Form
RI.2.10 The hospital respects the rights of patients	Referral	> Defining Scope of Care	Description of Core Competencies
RI.2.30 Patients are involved in decisions about care, treatment and services provided	Referral Assessment Care Planning Treatment Discharge Planning	> Defining Scope of Care > Palliative Care Referral > Performing Initial Assessments and Reassessments > Guidelines for Staff About Patient and Family Conferences > Patient Self-Determination > Continuity of Care	Description of Core Competencies Consultation Report Progress Notes Spiritual Care Assessment Social Work Consultation Note Patient/Family Care Conference Record Consultation Tracking Form Palliative Care Intervention Form

Standard	**How it Applies to Palliative Care Key Processes**	**Policies and Procedures that Address the Standard**	**Tools to Implement the Standard**
RI.2.70 Patients have the right to refuse care, treatment and services in accordance with law and regulation	Referral	> Defining Scope of Care	Description of Core Competencies
		> Palliative Care Referral	Consultation Report
	Assessment	> Performing Initial Assessments and Reassessments	Progress Notes
	Treatment	> Patient Self-Determination	Palliative Care Intervention Form
RI.2.80 The organization addresses the wishes of the patient relating to end of life decisions	Referral	> Defining Scope of Care	Description of Core Competencies
		> Palliative Care Referral	Consultation Report
	Assessment	> Performing Initial Assessment and Reassessments	Progress Notes Social Work Consultation Note
	Care Planning	> Guidelines for Staff About Patient and Family Conferences	Patient/Family Care Conference Record
	Treatment	> Patient Self Determination	Consultation Tracking Form Palliative Care Intervention Form
		> End of Life Care	End of Life Care Checklist
	Discharge Planning	> Continuity of Care	Palliative Care Intervention Form
RI.2.100 The hospital respects the patients rights to and need for effective communication	Referral	> Defining Scope of Care	Description of Core Competencies Hospital-wide Communication Policy*
RI.2.160 Patients have the right to pain management	Referral	> Defining Scope of Care	Description of Core Competencies
		> Palliative Care Referral	Consultation Report

Standard	**How it Applies to Palliative Care Key Processes**	**Policies and Procedures that Address the Standard**	**Tools to Implement the Standard**
	Assessment	> Performing Initial Assessments and Reassessments	Progress Notes
	Care Planning	> Patient Care Planning	Initial Assessment/Plan of Care
		> Guidelines for Staff About Patient and Family Conferences	Patient/Family Care Conference Record
	Treatment	> Assessment and Treatment of Pain and Symptoms	Consultation Tracking Form
	Discharge Planning	> Continuity of Care	Palliative Care Intervention form
PC Provision of Care			
PC.2.20 The organization defines in writing the data and information gathered during assessment and reassessment	Assessment	> Performing Initial Assessments and Reassessments	Consultation Report Progress Notes Social Work Consultation Note Spiritual Care Assessment
PC.2.120 The organization defines in writing the timeframe(s) for conducting the initial assessment	Referral	> Prioritizing and Responding to Referrals in a Timely Manner	Hospital On-call Palliative Care Schedule*
	Assessment	> Performing Initial Assessments	Consultation Report
PC.2.130 Initial assessments are performed as defined by the organization	Assessment	> Performing Initial Assessments and Reassessments	Consultation Report Progress Notes Social Work Consultation Note Spiritual Care Assessment Initial Assessment/Plan of Care

Standard	**How it Applies to Palliative Care Key Processes**	**Policies and Procedures that Address the Standard**	**Tools to Implement the Standard**
PC.2.150 Patients are reassessed as needed	Assessment	> Performing Initial Assessments and Reassessments	Consultation Report Progress Notes Social Work Consultation Note Spiritual Care Assessment Initial Assessment/Plan of Care
PC.3.230 Diagnostic testing necessary for determining patients health care needs is performed	Assessment	> Performing Initial Assessments and Reassessments	Progress Notes
PC.4.10 Development of a plan for care, treatment and services is individualized and appropriate to the patient's needs, strengths, limitations and goals	Assessment	> Performing Initial Assessments and Reassessments	Consultation Report Progress Notes Spiritual Care Assessment Social Work Consultation Note
	Care Planning	> Patient Care Planning > Guidelines for Staff About Patient and Family Conferences	Initial Assessment/Plan of Care Patient/Family Care Conference Record
PC.5.50 Care, treatment and services are provided in an interdisciplinary, collaborative manner	Assessment	> Performing Initial Assessments and Reassessments	Consultation Report Progress Notes Spiritual Care Assessment Social Work Consultation Note
	Care Planning	> Patient Care Planning > Guidelines for Staff About Patient and Family Conferences	Initial Assessment/ Plan of Care Patient/Family Care Conference Record
	Treatment	> Assessment and Treatment of Pain and Symptoms	Palliative Care Intervention Form

Standard	**How it Applies to Palliative Care Key Processes**	**Policies and Procedures that Address the Standard**	**Tools to Implement the Standard**
	Discharge Planning	> Continuity of Care	Hospital Discharge Summary Form*
PC.5.60 The organization coordinates the care, treatment and services provided to a patient as part of the plan for care, treatment and services and consistent with the organization's scope of care, treatment and services	Referral	> Defining Scope of Care > Palliative Care Referral	Description of Core Competencies Consultation Report Palliative Care Screening Tool
	Assessments	> Performing Initial Assessments and Reassessments	Progress Notes
	Care Planning	> Patient Care Planning > Guidelines for Staff About Patient and Family Conferences	Initial Assessment/Plan of Care Patient/Family Care Conference Record
	Discharge Planning	> Continuity of Care	Palliative Care Intervention Form
PC.6.10 The patient receives education and training specific to the patient's needs and as appropriate to the care, treatment and services provided	Treatment	> Assessment and Treatment of Pain and Symptoms	Palliative Care Intervention Form
	Patient Education	> Patient Education	Social Work Consultation Note Progress Notes
PC.6.30 The patient receives education and training specific to the patient's abilities as appropriate to the care, treatment, and services provided by the organization	Patient Education	> Patient Education	Social Work Consultation Note Progress Notes Palliative Care Intervention Form
PC.8.10 When pain is identified, the patient is	Referral	> Palliative Care Referral	Consultation Report

Standard	**How it Applies to Palliative Care Key Processes**	**Policies and Procedures that Address the Standard**	**Tools to Implement the Standard**
assessed and treated in the organization or referred for treatment	Assessment	> Performing Initial Assessments and Reassessments	Progress Notes
	Care Planning	> Patient Care Planning > Guidelines for Staff About Patient/Family Conferences	Initial Assessment/Plan of Care Patient/Family Care Conference Record
	Treatment	> Assessment and Treatment of Pain and Symptoms	Consultation Tracking Form
	Discharge Planning	> Continuity of Care	Palliative Care Intervention Form
PC.8.50 Unless contraindicated, the organization accommodates patient’s need to be outdoors when patients experience long lengths of stay	Assessment	> Performing Initial Assessments and Reassessments	Consultation Report Progress Notes Social Work Consultation Note
	Care Planning	> Guidelines for Staff About Patient/Family Conferences	Patient/Family Care Conference Record
	Treatment	> Maximizing Quality of Life	Palliative Care Intervention Form
PC.8.70 Comfort and dignity are optimized during end-of–life care	Referral	> Palliative Care Referral	Consultation Report
	Assessment	> Performing Initial Assessments and Reassessments	Progress Notes Social Work Consultation Note
	Care Planning	> Guidelines for Staff About Patient and Family Conferences	Patient/Family Care Conference Record

Standard	**How it Applies to Palliative Care Key Processes**	**Policies and Procedures that Address the Standard**	**Tools to Implement the Standard**
	Treatment	> Patient Self Determination > Maximizing Quality of Life > End of Life Care	Consultation Tracking Form Progress Notes End of Life Care Checklist
	Discharge Planning	> Continuity of Care	Palliative Care Intervention Form
PC.15.10 A process addresses the needs for continuing care, treatment and services after discharge or transfer	Referral	> Palliative Care Referral	Consultation Report
	Assessment	> Performing Initial Assessments and Reassessments	Progress Notes Social Work Consultation Note
	Care Planning	> Patient Care Planning > Guidelines for Staff About Patient and Family Conferences	Initial Assessment/Plan of Care Patient/Family Care Conference Record
	Discharge Planning	> Continuity of Care	Palliative Care Intervention Form Hospital Discharge Summary Form*
PC.15.20 A patient's transfer or discharge to another level of care, treatment and services, different professionals, or different settings is based on the patient's assessed needs and the organization's capabilities	Referral	> Palliative Care Referral	Consultation Report
	Assessment	> Performing Initial Assessments and Reassessments	Progress Notes Social Work Consultation Note
	Care Planning	> Patient Care Planning > Guidelines for Staff About Patient and Family Conferences	Initial Assessment /Plan of Care Patient/Family Care Conference Record

Standard	How it Applies to Palliative Care Key Processes	Policies and Procedures that Address the Standard	Tools to Implement the Standard
	Discharge Planning	> Continuity of Care	Palliative Care Intervention Form Hospital Discharge Summary Form*
PC15.30 When patients are transferred or discharged, appropriate information related to the care, treatment and services provided is exchanged with other providers	Discharge Planning	> Continuity of Care	Palliative Care Intervention Form Hospital Discharge Summary form*
MM Medication Management			
MM.6.10 The effects of medication(s) on patients are monitored	Treatment	> Assessment and Treatment of Pain and Symptoms	Progress Notes Hospital-wide Policy on Medication Management*
PI Improving Organizational Performance			
PI.1.10 The organization collects data to monitor its performance	Quality Improvement	> Quality Improvement Plan & Program Evaluation	Consultation Tracking Form Palliative Care Intervention Form Patient Satisfaction Form*
PI.2.10 Data are systematically aggregated and analyzed	Quality Improvement	> Quality Improvement Plan & Program Evaluation	Palliative Care Intervention Form
PI.2.20 Undesirable patterns or trends in performance are analyzed	Quality Improvement	> Quality Improvement Plan & Program Evaluation	Minutes of Palliative Care Quality Improvement Meetings
PI.2.30 Processes for identifying and managing sentinel events are defined and implemented	Quality Improvement	> Quality Improvement Plan & Program Evaluation	Hospital-Wide Sentinel Events Form*
PI.3.10 Information from data analysis is used to make changes that improve performance and patient safety and reduce the risk of sentinel events	Quality Improvement	> Quality Improvement Plan & Program Evaluation	Minutes of Palliative Care Quality Improvement Meetings

Standard	**How it Applies to Palliative Care Key Processes**	**Policies and Procedures that Address the Standard**	**Tools to Implement the Standard**
PI.3.20 An ongoing, proactive program for identifying and reducing unanticipated adverse events and safety risks to patients is defined and implemented	Quality Improvement	> Quality Improvement Plan & Program Evaluation	Palliative Care QI plan
MS Medical Staff			
MS.2.20 The management and coordination of each patient's care, treatment and services is the responsibility of a practitioner with appropriate privileges	Education	Hospital–Wide Credentialing and Privileging	
MS.2.30 In hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the program in carrying out his or her patient care responsibilities	Education	Hospital-Wide Supervision of Medical Staff	
MS.5.10 All licensed independent practitioners and other practitioners privileged through the medical staff process participate in continuing education	Education	Hospital-Wide Medical Staff Continuing Education	

* Existing Hospital Forms

Policies and Procedures for Palliative Care

SUBJECT:	**REFERENCE #:** **PAGE:** **OF:**
DEPARTMENT:	**EFFECTIVE**:
APPROVED BY:	**REVISED**:

Title: Defining Scope of Care

Purpose: To define the practice of palliative care and ensure appropriate referrals into the palliative care service.

Definition:
Palliative Care:

- Is the comprehensive care and management of the physical, psychological, emotional and spiritual needs of patients (of all ages) and their families with chronic, debilitating, or life threatening illness
- May be complementary to other therapies that are available and appropriate to the identified goals of care

The Palliative Care Program:

- Consists of an MD, RN and/or NP, MSW, and clergy
- Defines immediate and long term goals of care and promotes advance care planning
- Optimizes symptom control
- Optimizes functional status when appropriate
- Promotes the highest quality of life for patient and family
- Educates patients and family to promote understanding of the underlying disease process
- Establishes an environment that is comforting and healing
- Plans for discharge to the appropriate level of care in a timely manner
- Assists actively dying patients and their families in preparing for and managing self-determined life closure

The Palliative Care Team:

- Serves as educators and mentors for staff
- Promotes timely access to palliative care services
- Collaborates with primary care professionals in developing a plan of care
- Provides physical, psychological, social and spiritual support to patient and family
- Facilitates care planning with family to meet multidimensional care needs caused by life-limiting illness
- Facilitates patient understanding of diagnosis and prognosis to promote informed choices
- Assists patients in establishing goals of care and establishing priorities
- Encourages advanced care planning

Core competencies of the palliative care team are found in Appendix A so that the palliative care needs of patients can be matched and coordinated expeditiously and to demonstrate that these competencies are consistent with the hospital’s scope of care.

SUBJECT:	**REFERENCE #:**
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Title: The Palliative Care Referral

Purpose: To assist physicians, staff, patients and families in making appropriate palliative care referrals and to help coordinate the care, treatment and services to patients needing palliative care in a timely manner.

Policy: The referral process is be handled according to the procedure below

Responsibility: Referring staff/ physicians, palliative care team

Procedure:

Making a referral:

1. A referral to the palliative care service can come from many sources: physicians, nurses, family members, patients, social workers and clergy are some of the more common sources.
2. If the referral comes from hospital staff, patient or a family member, a member of the palliative care team notifies the primary care physician of the referral and request permission to provide a consultation.
3. If the primary physician decides to obtain a palliative care referral, a palliative care consult/referral needs to be completed (see Consultation Report in Appendix A).
4. It is suggested that the referring physician use the attached screening tool when considering a palliative care consult (see Palliative Care Screening Tool in Appendix A).

Responding to a consult request:

1. The palliative care team responds to all requests for referrals/consultations even if the initial request seems inappropriate for continued follow-up (e.g., address uncontrolled post –operative pain). These consultations are opportunities to build relationships with referring physicians and educate staff on the scope and benefits of palliative care.
2. If the palliative care team member determines that a palliative care referral is not appropriate for continued follow-up, the palliative care team helps resolve the current situation and facilitates patient access to the appropriate resource(s).

Role of the palliative care team after initial consultation:

1. Based on the specific needs of the patient, there is discussion between the palliative care team member and the primary physician to determine the role of the palliative care team.
2. The role of the palliative care team can be:
    a. One of providing advice to patient/family or staff (e.g., no orders are written by the palliative care physician/nurse practitioner)
    b. Consulting with orders (e.g., provide pain management and symptom control)
    c. Taking total responsibility for the patient (e.g., where the palliative care physician becomes the primary attending)

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3. Once a decision is made about the role of the palliative care team, the patient and family members (as appropriate) are involved in subsequent assessment, planning and treatment of the patient.

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Title: Prioritizing and Responding to Referrals in a Timely Manner

Purpose: To prioritize all initial consult requests and to ensure patients and family have access to palliative care services 24 hours/day -7 days/week.

Policy: Responses to palliative care consults are prioritized based on emergent, urgent and non-urgent needs of the patients.

Responsibility: Palliative care team and referring physicians

Procedure:
Prioritizing requests for palliative care consults:

1. Emergent: (Immediate) In the event of an acute, emergent problem, where a palliative care consult is needed (e.g., severe uncontrolled pain), the palliative care team member on call responds immediately to the consult request.
2. Urgent: (2-3 hours) In the event of an urgent medical problem, where a palliative care consult is needed, the palliative care team member on call responds as soon as possible or within a one-hour time frame.
3. Non-urgent: All non-urgent initial assessments are performed within 24 hours of the referral.

On-call schedule:

1. To ensure access to palliative care services, an on-call schedule is created for 24-hour/day coverage - 7 days/week.
2. A member of the palliative care team is designated to make the schedule.
3. If the scheduled on-call person cannot be on call it is the responsibility of the scheduled on-call person to find coverage or notify the palliative care team leader.

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Title: Performing Initial Assessments (non- emergent/non-urgent) and reassessments

Purpose: To ensure timely initial assessments with consistency in data collection.

Policy: All referred patients (non-emergent/non-urgent) have an initial assessment within 24 hours of the initial referral. Assessments are performed in accordance with the procedure below.

Responsibility: Palliative care team

Procedure:

1. The palliative care team performs comprehensive, formal assessments of the patient and family.
2. Typically a physician performs the initial assessment.
3. A nurse practitioner or team nurse may conduct an initial assessment.
4. Initial and subsequent assessments are carried out through patient and family interviews, review of medical records, discussion with other providers, physical examination and assessment, and relevant laboratory and/or diagnostic tests or procedures.
5. Assessment includes documentation of disease status; functional status; comorbid medical and psychiatric disorders; physical, and psychological symptoms; functional status; social, cultural, spiritual, and advance care planning concerns and preferences. Assessment of children must be conducted with consideration of age and stage of neurocognitive development.
6. The following assessment forms (found in Appendix A) should be used depending on the needs of the patient.
    - Consultation Report
    - Progress Notes
    - Social Work Consultation Note
    - Spiritual Care Assessment
7. An interdisciplinary Initial Assessment/Plan of Care sheet is provided in Appendix A to be used as needed to summarize the findings from each discipline.
8. An administrative Consultation Tracking Form (see Appendix A) is completed at the time of the initial assessment. The purpose of the form is two-fold:
    a. To collect data for program monitoring
    b. To use as a rounding instrument to compile data on the progress of the patient. This form is not a permanent part of the patient's record
9. All initial and ongoing assessments data are reviewed on a regular basis.
10. Assessment findings are the basis for the care planning process.

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Title: Patient Care Planning

Purpose: To ensure care planning is individualized, interdisciplinary and based on the assessed needs of the patient.

Policy: All patients have an interdisciplinary, individualized, documented care plan that is based on the assessed needs of the patient.

Responsibility: Palliative care team

Procedure:

1. The care plan is based upon an ongoing assessment, determined by goals set with patient and family, and with consideration of the changing benefit/burden assessment at critical decision points during the course of illness.
2. The care plan is developed through the input of patient, family, caregivers, involved health care providers and the palliative care team with the additional input, when indicated, of other specialists and caregivers, such as school professionals, clergy, friends, etc.
3. Care plan changes are based on the evolving needs and preferences of the patient and family over time, and recognize the complex, competing and shifting priorities in goals of care.
4. The interdisciplinary team coordinates and shares the information, provides support for decision-making, develops and carries out the care plan, and communicates the palliative care plan to patient and family, to all involved health professionals, and to the responsible providers when patients transfer to different care settings.
5. The sharing of information is documented on the Initial Assessment/Plan of Care Form in Appendix A.

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Title: Guidelines for Staff About Patient and Family Conferences

Purpose: To ensure patients and their family (when appropriate) are involved in decisions about care, treatment and services provided. To provide guidance on conducting patient and family conferences.

Definition:
Family Conference: A meeting among the patient, family and health care team to facilitate communication about the plan of care, transition or discharge plan, and patient and family goals and resources. Most conferences are held to prevent or address communication issues and to resolve identified or anticipated issues.

Definition:
Care Conference: A formal or informal meeting of health care professionals involved in the care of a patient to communicate and/or develop the plan of care. The patient/family are not present.

Responsibility: Palliative care team

Procedure:

1. Patient or family presents one or more of the following indicators for a conference:

Indicators for Family Conference and Care Conferences

Family Conference (May also indicate need for care conference)	Care Conference only
Change in patient status/changing goals of care	
Health care provider/family miscommunication or conflict	No clear physician leader Need for coordination among multiple specialties
Unusually long length of stay	Health care team disagreement
Blanket, absolute direction from family (e.g. "Do everything for the patient,") including when treatment is futile or of minimal benefit	No primary (or consistent) assignment of nurse to patient
Differing messages from family members	Nurses request to not care for the patient
Boundary conflicts	Patient and/or family seen as "difficult"
Family conflict or mistrust of caregivers	Acute or chronic mental health condition complicating plan of care
Uninvolved family/adult orphan	
Alternative sites of care are indicated	
Health care providers need information about patient/family cultural and spiritual beliefs	
Debriefing after a death	

2. Requesting a care conference:
    a. Any member of the palliative care team may suggest a care conference.
    b. This typically occurs during rounds or interdisciplinary discussions. All members of the palliative care team are responsible for identifying the need for a conference.
    c. The palliative care team leader designates a member of the team to be responsible for organizing the conference and inviting team members.

3. Attendance:
    a. The patient, family, others the patient wishes to invite
    b. Attending and consulting physicians, nurse, care coordinator, and other team members involved in the care or whose expertise is needed to include
    c. Social worker, chaplain, rehabilitation therapists, pharmacists, home care staff, clinical nurse specialists

4. Preparation for the meeting:
   Some members of the team may need to meet prior to the conference to:
    a. Discuss need and purpose
    b. Make sure the right people are at the table
    c. Identify lead physician to present medical information from all services
    d. Identify facilitator (usually not a physician)
    e. Identify goals
    f. Resolve or identify team conflicts around plan of care. All parties need to be at the team conference, if involved in conflict
    g. Come to consensus on plan of care

5. Facilitator’s role:
   Facilitator’s roles can vary depending on group facilitation skills of attendees and relationship with the patient and family. Facilitators may include any of the disciplines. Tasks include:
    a. Facilitate introductions
       -Explain purpose and goals of conference
       -Review ground rules
    b. Ask patient and family to identify their questions, concerns and goals
    c. Invite review of medical status
    d. Facilitate discussion among those present
    e. Clarify understanding, especially of medical terminology
    f. Summarize discussion, identify follow-up and document on Patient Conference Record (see Appendix A)

6. Format of conference:
    a. Set atmosphere for collaborative respectful discussion
        (i) Discuss purpose of and need for patient/family conference
        (ii) Identify goals and desired outcomes of family conference
        (iii) Identify family needs and wishes
    b. Provide setting for discussion of diagnosis, implication of illness and treatment options
    c. Identify current and anticipated issues and stressors

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d. Identify resources among patient, family, staff and community that can support patient and family coping
    - (i) Explore and identify hopes and goals beyond elimination of current issues. This frequently cannot be addressed until feelings about presenting concerns and problems have been expressed.
    - (ii) Document follow-up on Patient/Family Care Conference Record, and need for additional meeting(s).

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Title: Assessment and Treatment of Pain and Symptom Management

Purpose: To ensure all palliative care patients who are experiencing pain are managed with quality and consistency throughout their hospitalization.

Policy: All patients have a right to pain and symptom management regardless of admitting diagnosis and reason for referral to the palliative care team.

Responsibility: The palliative care team ensures all patients referred to the palliative care service have a comprehensive pain and symptom assessment performed within 24 hours of the time of the referral.

Procedure:

1. The attending physician/palliative care team completes a review of systems and document a comprehensive pain and symptom assessment. The assessment considers:
    a. Diagnosis
    b. Presenting problems
    c. Current treatments and medication profile
    d. Current pain management regimen
    e. Patient concerns
    f. Patient/family preferences
    g. Spiritual, cultural beliefs and values that influence treatments
2. The patient is asked to characterize pain using a hospital approved pain assessment scale upon time of initial assessment and at regularly prescribed intervals following the assessment and after initiation of therapy.
3. The pain and symptom assessment includes a documented baseline from which to plan and monitor response to therapy.
4. The team proposes a comprehensive pain and symptom treatment plan.
5. The team confers with the patient and family to educate them about pain and symptom management and to discuss the plan of care with them.
6. The team instructs the patient/family on any self-care procedures.
7. The team works with the nursing staff to assure the implementation and monitoring of the treatment plan.
8. The nursing staff works with the team to assess the patient's response to the treatment. This includes:
    a. Response to medications
    b. Pain relief measured on a consistently utilized pain scale
    c. Side effects
    d. Adverse events/ reactions
    e. Level of sedation
    f. Satisfaction with intervention
9. The team, in conjunction with the nursing staff, monitors the patient's response to therapy and modifies the plan based on ongoing assessment.

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10. When pain is assessed as intractable and all usual methods have failed, the team refers the patient to other pain management resources such as a pain team, anesthesia service and psychiatry.
11. The team assures that all assessments, recommendations, interventions and response to therapy are documented in the medical record, and that changes in the plan of care are communicated to the team and the nursing staff in writing and verbally at the time they occur.
12. Forms to document the assessments, recommendations and interventions and response to therapy include but are not limited to:
    a. Consultation Report
    b. Progress Notes
    c. Consultation Tracking Form
    d. Initial Assessment/Plan of Care
    e. Patient/Family Care Conference Record
    f. Palliative Care Intervention Form
13. Prior to discharge the patient is assessed for continuing care requirements for pain and symptom management.
14. The patient/family are educated about home care and referred to other providers as needed.

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Title: Patient Self-Determination

Purpose: To ensure patients and/or their surrogate make informed decisions about their treatment and the services they receive.

Policy: All patients and/or their surrogate are informed about their illness, prognosis and care options in a timely manner in order to make treatment decisions based on reasonable expectations.

Definition: Patient self-determination includes making treatment decisions, designating a health care proxy, establishing advance directives, deciding to refuse/discontinue care and/or choosing not to be resuscitated.

Responsibility: Attending physician supported by the palliative care team

Procedure:

1. The attending physician/palliative care team establishes ongoing communication with the patient and surrogate that includes discussions of:
    a. Health status
    b. Disease and expected course
    c. Treatment options
    d. Patient preferences
    e. Spiritual, cultural beliefs and values that influence preferences
    f. The right of the patient to choose and to change their choices at any time
    g. The legal requirements for expressing desires and the meaning of the documents and or directives
2. Begin discussions with the patient and/surrogate at the time of diagnosis and continue to communicate with the patient throughout the course of care.
3. Validate the patient’s/surrogate’s understanding of the information presented and introduce new information and choices as the patient’s condition changes.
4. Define terminology including DNR, power of attorney for health care and living will, and assure that all choices are documented on appropriate, institutionally specific forms.
5. Provide empathy and support as patients/surrogates make decisions.
6. Refer patients to other community resources that may help them with their individual concerns.
7. Document all communication in the medical record and convey patient wishes to the health care team.
8. Forms to document communication related to patient self-determination include but are not limited to:
    a. Consultation Report
    b. Progress Notes
    c. Palliative Care Intervention Form
    d. Social Work Consultation Note
    e. Consultation Tracking Form

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Title: Maximizing Quality of Life

Purpose: To ensure the palliative care team accommodates patient's needs and wishes related to their physical environment.

Policy: The physical environment is routinely assessed to accommodate patient's wishes and preferences.

Responsibility: Palliative care team

Procedure:

1. When feasible, care is provided in the setting preferred by the patient and their family.
2. The care setting addresses safety and provides a comfortable environment for the patient and family. This may include characteristics such as space for the families to visit, rest, eat, or prepare meals, private consultation space to meet with palliative care team and other professionals, flexible or open visiting hours, privacy pet therapy and other needs identified by the family.
3. The setting addresses the unique care needs of children as patients, family members or visitors.
4. Cultural, religious and spiritual articles of patient preferences are accommodated and respected in the care setting.
5. Patients wishing to go outside are accommodated unless contraindicated. Preferences to go outside are assessed as appropriate and documented in the plan of care.
6. The following forms are used to document accommodations for patient preferences:
    a. Consultation Report
    b. Progress Notes
    c. Social Work Consultation Note
    d. Patient/Family Care Conference Record

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Title: End of Life Care

Purpose: Death, though a natural process, is frequently seen in the hospital setting as untimely. A sensitive recognition of the natural progress of disease states balanced with meeting the patient and family goals is a critical part of health care. Palliative care service is committed to meeting the unique needs of each patient throughout the span of their individual illness. The purpose of this document is to define the integration of palliative care at the end of life and to provide a standard of care integrating high quality, family centered compassionate end of life care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families. Comfort and dignity of the patient guides all aspects of end of life care.

Policy:

1. Palliative care affirms life and regards dying as a normal process. It neither hastens nor postpones death. It is committed to providing relief from pain and other distressing symptoms. By integrating psychological and spiritual aspects of patient care, it offers a support system to help patients live as actively as possible until death. It is focused on maintaining the personal dignity and self-respect of the patient. The family is considered the unit of care. It requires a team approach, which recognizes that all health care workers have roles to play. Leadership of the patient's health care team may vary according to the patient's particular needs.
2. Patients should be treated with respect to their individual wishes for care and treatment. A request to forego treatment should be honored with the same support and respect the decision to undergo treatment. Advance Directives are honored with respect to treatment planning. In all instances, there continues to be many things that we can do for patients when the disease is irreversible.
3. All efforts are made to educate staff to recognize the importance of dealing with issues at the end of life. The issues are physical, psychological, social, spiritual and cultural. Without attention to all spheres of the patient's being, suffering is not fully attended to.
4. Hospice services are recognized as an integral part of the continuum of care.
5. Bereavement support is available to family members through a number of different avenues. Family members of patients involved in home hospice programs are automatically incorporated into such a program. The social services and chaplaincy programs are available to provide resources to families in the inpatient areas.
6. The palliative care team is available to assist with symptom management issues, prognosis determination, planning for disposition, patient and family support, and other issues related to end of life decisions.
7. In the event of questions of differences of opinion among the patient, family, or health care team members about the suitability of the treatment goals or of any major limitation of maintenance therapy, further efforts to reach understanding are required. Consultation is available from the Hospital Ethics Committee.

8. When a patient begins to exhibit end of life clinical changes a member of the palliative care team confirms code status via the chart and/or appropriate attending team and initiate end of life care.
9. End of life care includes:
    a. Managing pain aggressively and effectively
    b. Providing treatment of symptoms according to the wishes of the patient or family
    c. Respecting the patient's privacy, values, religion and philosophy
    d. Involving the patient and family in every aspect of care, including the decision making process for end of life issues
    e. Responding to the psychological, social, emotional, spiritual and cultural concerns of the patient of family, including children and teens affected by the death, prior to, and at the time of the patient's death
    f. Assuring that all staff caring for the patient is aware of the patient's wishes and respectful of their decisions.
    g. Sensitivity addressing issues such as organ donation and autopsy
10. A physician's order is required prior to initiation of the bereavement checklist.

Responsibility: Palliative care team

Procedure:

1. Notify MD of patient change of condition.
2. In collaboration with MD and other disciplines, identify and speak with family spokesperson to make them aware of changes occurring and expected outcomes.
3. Initiate end of life care.
    a. Initiate bereavement checklist and place in chart (see End of Life Care Checklist in Appendix A)
    b. Place bereavement symbols on patient's door, chart and assignment board (optional)
    c. Follow checklist and document accordingly:
        (i) Appropriate care plans initiated
        (ii) Resuscitation status clarified
        (iii) Patient relations notified
        (iv) Quiet room obtained
        (v) Hospitality basket requested
        (vi) Literature given
        (vii) State donor network notified
        (viii) Communicator notified
        (ix) Administrative representative, PCD, PCS notified
        (x) Chaplain notified
        (xi) Social services notified
4. If a change of status occurs, such as the dying process is reversed, patient is stabilized, the patient is prepared for transfer to another facility, home, or hospice, mark the End of Life Care Checklist as discontinued and resolve care plans as appropriate.

5. When patient dies, complete lower half of checklist (Time of Death Checklist)
    a. Medical Examiner notified
    b. Medical records notified
    c. Donor Form completed (if applicable)
    d. Death Notice Form completed by MD
    e. Authorization of Autopsy Form completed by MD
    f. Post Mortem Care completed
    g. Sympathy Card initiated
6. Send one copy of checklist to medical records and one copy to bereavement coordinator.

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Title: Continuity of Care

Purpose: To assure continuity of care upon discharge from the palliative care service.

Policy: Prior to discharge, all patients receive a comprehensive assessment by the palliative care team. The discharge plan is developed based on the assessment, the patient's current status, the resources available in the home and in the community, and the care needs of the patient. The team refers patients to clinical and community resources based on their documented needs and regardless of their ability to pay for services. When an agency/program denies care, treatment or services, or when a payer denies reimbursement, the team works with the patient and family to identify alternative sources of care and support.

Definition:
Continuity of care: The multidisciplinary coordination of care that includes or considers all clinical diagnoses, treatments, psychosocial needs, patient preferences and personal resources.

Responsibility: Palliative care team

Procedure:

1. Discharge planning is considered a factor from the time of admittance to the palliative care program.
2. A member of the team is responsible for the multidisciplinary coordination that drives the discharge plan.
3. Based on presenting problems, appropriate team members assess the patient and develop a plan of care (see Care Planning Policy).
4. The team leader synthesizes the plan of care and obtains input from team members. He/she works with the patient and family to devise and document a comprehensive discharge plan including referrals to other agencies.
5. The team leader arranges access to services that can assist the patient with various social needs. This includes, but is not limited to:
    a. Home care
    b. School or work reentry
    c. Transportation
    d. Rehabilitation
    e. Medications
    f. Counseling
6. The team leader initiates referrals to appropriate providers, services, agencies, and community resources. This includes, but is not limited to:
    a. Physician specialists
    b. Nursing home/intermediate care facilities
    c. Hospice
    d. Home health
    e. Outpatient palliative care
    f. Durable medical equipment services

   g. Rehabilitation services
   h. Counseling services
7. The palliative care team documents the assessment and plan of care within the medical record. The documented data from the following forms is synthesized to form the basis for the discharge plan:
   a. Consultation Report
   b. Progress Notes
   c. Initial Assessment/Plan of Care
   d. Patient/Family Care Conference Record
   e. Consultation Tracking Form
8. A member of the palliative care team identifies all assessed needs on the hospital discharge planning form and reviews the discharge plan with the patient/surrogate and/or caregivers prior to discharge.
9. The team leader assures that the referring agencies receive copies of the discharge planning documents, the physician’s orders, and any other clinical documentation and relevant information.
10. In addition to the above documentation form, a Palliative Care Intervention Form is completed upon discharge. The purpose of this form is to document what has been done for the patient from assessment through discharge, to ensure quality and to evaluate program effectiveness. The form and accompanying directions can be found in Appendix A.

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Title: Patient Education

Purpose: To ensure the patient receives education and training specific to the patient's needs and abilities.

Policy: The patient's educational needs and abilities are assessed during the initial assessment process and are continually reassessed as the care, treatment and services are provided.

Responsibility: Palliative care team

Procedure:
1. During the assessment process, patient's educational needs and cognition/emotional abilities are assessed (see Social Work Consultation Note and Progress Notes in Appendix A).
2. Educational/counseling needs are routinely assessed and reassessed throughout care and treatment.
3. When educational needs are identified, they are incorporated into the plan of care (see Patient Care Planning policy).
4. Refer to hospital wide patient education policy.

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Title: Quality Improvement

Purpose: To ensure the quality improvement process is carried out according to the established plan.

Policy: The palliative care service meets quarterly to review quality improvement initiatives identified in the Quality Improvement Plan. The plan is reviewed annually and recommendations are submitted via hospital wide QI reporting mechanisms.

Procedure: Quality Improvement Plan – to be developed

Tools to Support Quality Palliative Care

APPENDIX A

Description of Core Competencies in Palliative Care

Competency Focus	Description of Competency
Pain and Symptom Management	Appropriately manages patient pain and other distressing physical symptoms of disease, illness or treatment in a timely manner and achieves outcomes acceptable to the patient/family. Management may include referral to appropriate specialist and/or acceptance and support of the patient's decision to include complementary therapies in treatment.
Emotional	Supports patient and family expression of emotional needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and/or professionals with expertise in this area. May use open-ended questions such as "How are you doing? How are things going in your life? What, if anything, are you feeling anxious about?"
Psychosocial	Provides an environment to support patient and family expression of psychosocial needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and/or professionals with expertise in this area. Integrates this area with each interaction. May use open-ended questions such as "How are you doing? How are things going in your life? How have things changed for you in your life? How are your spirits?"
Spiritual/Cultural	Manages interactions to support patient and family expression of spiritual needs, strengths and cultural practices. Creates environment that allows integration of dialogue about spiritual issues within care experience. Refers to spiritual care staff and community resources as congruent with patient/family values. Communicates cultural care preferences of patients/families to others. May use questions such as "What is the meaning of this illness to you and for your life? What lessons would you want to share? How has your sense of time changed? What strength have you called upon as you go through this illness? Are there specific religious or family traditions you would like us to consider?"
Relationship – Family and Community	Addresses desires and needs for support from family and friends. Determines if there has been a change in family communication. Facilitates family communication of specific issues by structure of interactions. Provides anticipatory guidance for family as they focus on their relationships. This may include reconciliation of relationships. Provides helpful tools and/or refers for assistance with family communication. May use questions such as "How have things been within your family? Are there things you would like to say to your family or things you would like them to know? Friend? Colleague? How much change has occurred with your social relationships outside the family?"
Honoring Patient Care Wishes	Understands and communicates patient and family wishes prior to crises or impending death. Honors wishes as care goals change. Carries out interventions that make a difference for patient comfort and/or recovery. Supports patient and family when they refuse treatment. Provides welcoming environment for family to stay with patient.

Competency Focus	Description of Competency
Dying and Death	Identifies those who are approaching last days of life. Communicates honestly to patient/family about approaching death and helps make the most of the last days. Determines patient/family wishes regarding place of death and seeks to have death occur where desired. Assists family to give patient permission to die, to say good-bye and to bring reconciliation to family relationships.
After Death	Prepares family for events that occur immediately following death, i.e. select funeral home, make funeral arrangements, notify agencies such as SRS, Medicare, attorney who handles estate, financial issues, canceling appointments etc. Hints: This could be presented to the family in a packet of information.
Bereavement	Manages interactions with the bereaved that support communication of clinical concerns and questions as appropriate. Actively initiates referrals for support during bereavement.
Relationship	Establishes rapport with patient and family. Is viewed as "present, really listening, caring and trustworthy." Initiates contact with bereaved family as appropriate to relationship (e.g., call to family to express condolences).
Communication	Is available physically and mentally for patient and family communication. Delivers difficult information in honest, clear manner. Maintains hope by focusing on palliative care when cure or life prolongation is no longer possible. Focuses on helping patient/family live in way meaningful to them.
Teaching	Assesses for patient and family knowledge and questions. Refers to appropriate resources for additional information and support. Provides anticipatory guidance about illness, treatments, possible outcomes and health system issues.
Team Collaboration	Provides care with a team approach that includes patient and family as integral and essential members of the care team.

Palliative Care Consultation Report

Name
Unit #
Sex/DOB
Physician Service

REFERRING PHYSICIAN

Date/Time

Requesting MD:
(Last Name, First Name)

Consultant MD:
(Last Name, First Name)

Reason for Consult: Pain ( ) Non-Pain Symptoms ( ) Plan of Care ( )

Consultation Requested to evaluate

Problem List:

Recommendations:

(1)

(2)

(3)

(4)

(5)

HPI Summary:

Review of Systems and Symptoms Assessment:

Systems	Neg.	System	Neg.	System	Neg.	System	Neg.	System	Neg.
Constitutional		Endocrine		GU		Musculoskeletal		Respiratory	
Cardiovascular		Eyes		Hem/Lymph		Neurologic		Skin	
ENMT		GI		All/Immunology		Psychiatric			
( ) Patient unable to communicate because of disease severity/cognitive impairment and review of systems unobtainable									
Abnormalities:									

ESAS (0-none, 1-mild, 2-moderate, 3-severe)

Pain ( ) Depression ( ) Anorexia ( ) Inactivity ( ) Dyspnea ( )
Nausea ( ) Drowsiness ( ) Constipation ( ) Agitation ( ) Physical Discomfort ( )
Dementia Yes ( ) No ( ) Delirium Yes ( ) No ( ) Coma Yes ( ) No ( )
Karnofsky________________________%

CONSULTING PHYSICIAN

Palliative Care Consultation Report

Name
Unit #
Sex/DOB
Physician Service

REFERRING PHYSICIAN

CONSULTING PHYSICIAN

PMHx: ______________________ Family Hx: ______________________
Social HX:
Home Care Services: ______________________
Contact Person ______________________ ( )
Name Telephone

DNR: Yes No Living Will: Yes No
Health Care Proxy ______________________ ( )
Name Telephone

Physical Examination BP Pulse RR Temp O2 sat

	nl		nl		nl		nl
Appearance		Respiratory/ Chest		GI/Abdomen		Skin/ Integumentary	
HEENT		Cardiac		GU		Neurologic	
Neck		Pulses		Musculoskeletal/ Strength		Psychiatric	
LN							
Abnormalities:							

Medication, Laboratory and Other Data Review:

Fellow/Resident______________________ ______________________
Please print dictation code

Fellow/Resident______________________ ______/________/________ ________
Signature date/time

Choose appropriate documentation: (Either 1 or 2)

1. Attending Documentation:	2. Documentation of Attending Physician Counseling Coordination
	I, as the attending physician, personally, provided:

Attending time spent in face-to-face patient contact: _______minutes

Attending time spent on unit spent in counseling, care coordination _______minutes

Total time _______minutes

Attending______________________ ______________________
Please print dictation code

Attending______________________ ______/________/________
Signature date

PALLIATIVE CARE SCREENING TOOL

Criteria – Please consider the following criteria when determining the palliative care score of this patient

2. ***Basic Disease Process*** **SCORING**

   a. Cancer (Metastatic/Recurrent)
   b. Advanced COPD
   c. Stroke (with decreased function by at least 50%)
   d. End stage renal disease
   e. Advanced cardiac disease – i.e., CHF, severe CAD, CM (LVEF<25%)
   f. Other life-limiting illness

   Score 2 points EACH

3. ***Concomitant Disease Processes*** **SCORING**

   a. Liver disease
   b. Moderate renal disease
   c. Moderate COPD
   d. Moderate congestive heart failure
   e. Other condition complicating cure

   Score 1 point overall

4. ***Functional status of patient*** ***Score as specified below***

Using ECOG Performance Status (Eastern Cooperative Oncology Group)

ECOG	Grade	**Scale**	
	0	**Fully Active, able to carry on all pre-disease activities without restriction**.	Score 0
	1	**Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work.**	Score 0
	2	**Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.** **Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.**	Score 1
	3	**Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.**	Score 2
	4		Score 3

5. ***Other criteria to consider in screening*** ***Score 1 point EACH***

- Team/patient/ family needs help with complex decision-making and determination of goals of care ____
- Patient has unacceptable level of pain or other symptom distress > 24 hour ____
- Patient has uncontrolled psychosocial or spiritual issues ____
- Patient has frequent visits to Emergency Department (>1 x mo for same diagnosis) ____
- Patient has more than one hospital admission for the same diagnosis in last days ____
- Patient has prolonged length of stay (> five days) without evidence of progress ____ ____
- Patient has prolonged stay in ICU and/or transferred from ICU to ICU settin without evidence of progress ____
- Patient is in an ICU setting with documented poor prognosis ____

TOTAL SCORE

SCORING GUIDELINES:	**TOTAL SCORE = 2 No intervention needed** **TOTAL SCORE = 3 Observation only** **TOTAL SCORE = 4 Consider Palliative Care Consult (requires physician order)**

____
SIGNATURE STAFF MEMBER COMPLETING FORM

____
DATE

Palliative Care

Progress Notes

Name
Unit #
Sex/DOB
Physician Service

Date/Time

CC:

Objective Findings: (location, quality, duration, timing, context, modifying factors, sign/sxs):

Current Symptoms (0-none, 1-mild, 2-moderate, 3-severe)

Pain ( ) Depression ( ) Anorexia ( ) Inactivity ( ) Dyspnea ( )
Nausea ( ) Drowsiness ( ) Constipation ( ) Agitation ( ) Physical Discomfort ( )
Delirium Yes ( ) No ( ) Coma Yes ( ) No ( )

Counseling Session Participants:

Patient unable to participate because of illness severity or cognitive impairment (Y/N)

Location: ( )Patient's room ( ) Nursing unit conference room ( ) Other (specify)

Summary of Patient/Family Counseling Session:

Assessment/Recommendations:

Past History: ( ) Not pertinent Family History: ( ) Not pertinent Social History: ( ) Not pertinent

Current Medications Review:

Review of Systems and Symptoms Assessment:

Systems	Neg.	System	Neg.	System	Neg.	System	Neg.	System	Neg.
Constitutional		Endocrine		GU		Musculoskeletal		Respiratory	
Cardiovascular		Eyes		Hem/Lymph		Neurologic		Skin	
ENMT		GI		All/Immunology		Psychiatric			
( ) Patient unable to communicate because of disease severity/cognitive impairment and review of systems unobtainable									
Abnormalities:									

Progress Notes (cont.)

Physical Examination BP Pulse RR Temp O2 sat

	nl		nl		nl		nl
Appearance		Respiratory Chest		GI/Abdomen		Skin/ Integumentary	
HEENT		Cardiac		GU		Neurologic	
Neck		Pulses		Musculoskeletal/ Strength		Psychiatric	
LN							
Abnormalities:							

Laboratory and Other Data Review:

Fellow/Resident___________________________ ________________________

Please print dictation code

Fellow/Resident___________________________ ______/________/________

Signature date

Choose appropriate documentation: (Either 1 or 2)

1. Attending Documentation:	2. Documentation of Attending Physician Counseling Coordination
	I, as the attending physician, personally, provided:

Attending time spent in face-to-face patient contact: _______minutes

Attending time spent on unit spent in counseling, care coordination _______minutes

Total time _______minutes

Attending___________________________ ________________________

Please print dictation code

Attending___________________________ ______/________/________

Signature date

PATIENT NAME
PLATE

SOCIAL WORK CONSULTATION NOTE

Patient's Name____ DOB____________ Age__________
SS#__________________________
Address____ Phone: ________________________
Primary Caregiver____ Phone: ________________________
Address____
Diagnosis____ Onset _________________________
M.D.____ Prognosis_______________________

Coping Status:
________ Coping Well
________ Coping with some difficulty
________ Difficulty coping

Mental Status:
_______Alert
_______ Oriented
_______ Confused
_______ Non-responsive

Emotional Status:
______ Anxious
______ Depressed
______ Agitated
______ Shock/Numbness
______ Lethargic
______ Angry

Learning Needs:
______ Cultural
_______ Religious
_______ Emotional
_______ Motivational
_______ Physical
_______ Cognitive
_______ Language

Support Systems: ______ Adequate ______Inadequate

Financial Status: ______Adequate ______Inadequate
Medicare #____
Medicaid#____
Private Insurance Name______________________ Group #________________Policy#________________
Comments____

Advance Directives: ________Health Care Surrogate (name)____________________________________

Living Will: ______ **Durable Power of Attorney (name)**____________________________________
Patient's Wishes related to end of life decisions (if applicable)_____________________________________
____

Patient's/Family
Goals: ____

Assessment:____

Needs: _____Supportive Counseling _____Family Conference ______Education
_____ D/C Planning _____CBH Social Services ______Cultural Considerations
_____ Environmental preferences (dietary, outdoor needs, space for family visits, preference for religious articles, etc.)

Referral: ___**Crisis Intervention** ____**Community Resources** ____**Cancer Support Group**
____Transportation _____Medication Assistance _____Social Service SSD/SSI
____Hospice _____DME _____Home Health Care
____Local Social Service/Bereavement Support _____Visit _____Telephone

Comments: ____

Palliative Care Social Worker____________________________________ Pager#______________________

SPIRITUAL CARE ASSESSMENT

PATIENT NAME
PLATE

Faith Group ______________________ Particular Affiliation_______________________

Pastor: _____________________________________ Phone: ______________________

Patient/family ___________gives consent for chaplain to contact Pastor: Yes__ No __
Name

Areas To Be Addressed

1. What is the patient's/family's source of strength?
2. What relationship/s have been significant in the pat and at this time?
3. What group or organization has been important for providing strength?
4. What network will be available at home?
5. What are the spiritual needs at this time and how can the chaplain be of help?

Theological Issues

1. Image of God: ____
2. Relationship with God: ____
3. Important spiritual resources: Prayer__Scripture__Sacraments__Worship__

   Other____

Spiritual issues to address (use back of form if necessary):

Proposed spiritual component of Care Plan (use back of form if necessary):

Chaplin's signature _________________________________ Date ________________

SPIRITUAL CARE ASSESSMENT (CONT).

PATIENT NAME
PLATE

PALLIATIVE CARE SERVICE COMPLEMENTARY THERAPY

THERAPY REQUESTED:

___Relaxation Therapy

___ Massage Therapy

___ Music Therapy

___ Aromatherapy

___ Guided Imagery

___ Restorative Yoga

___ Pet Therapy

___ Other (specify)

CLINICAL INFORMATION RELATED TO REQUESTED THERAPY:

____

____

____

CLINCAL GOALS FOR THERAPY:

____

PATIENT’S GOAL FOR THERAPY:

____

Referring Clinician/MD ___________________________________ Date_______________

PALLIATIVE CARE CONSULT SERVICE

INITIAL ASSESSMENT/PLAN OF CARE

Reason for referral ____________________

Referred by ____________ Location of patient________ Date of consult__________

History ____________________

Evaluations:

Medical ____________________

Spiritual ____________________

Psychosocial ____________________

Nursing ____________________

Diagnoses/Problem list:

Medical ______________________

Spiritual ______________________

Psychosocial ______________________

Nursing ______________________

Recommendations:

Medical ______________________

Spiritual ______________________

Psychosocial ______________________

Nursing ______________________

Goals ____
____
____
____
____

Signatures staff members completing form:
Medical ______________________ **Spiritual** __________________

Psychosocial _______________________ **Nursing** ___________________

Patient/Family Care Conference Record (Front)

Date

Care Conference Coordinator

Patient Conference Date, Time, and Location

Diagnosis

Purpose

How are the patient's wishes known?

Patient cognitive/verbal ______________Patient's previous request _________________
Advance Health Care Directive _________Other _________________________________
If patient is a child (8-18), requires assent.

Who is the decision-maker for the patient?
Patient ________________ Proxy (specify) ________________
Parents (if child is under 18) ________________

Issues to be addressed (consider patient update, current problems/stressors, needs and goals of patient/family, desired outcome of conference, accommodating going outside)

Discussion/Outcomes/Follow-up

Kardex updated to reflect Care plan: Date__________ Initials__________
Tentative date for next Patient Planning Session_________________________

Patient/Family Care Conference Record (Back)

Family Members:	Notified?	Attended?
Care Coordinator:		
Primary Nurses:	Notified?	Attended?
Primary Service:	Notified?	Attended?
Attending		
Fellow		
Resident		
Secondary Service:		
Secondary Service:		
Other Services		
Cardiopulmonary Services		
Pharmacist		
Clinical Nurse Specialist		
Social Worker		
Physical Therapist		
Chaplain		
Psychologist		
Dietician		
Patient Representative		
Child Family Life Specialist		
Other:		
Signature:		

CONSULTATION TRACKING FORM

UNIT: ____________________

SERVICE: ________________

PATIENT NAME PLATE

1. **SS# __ __ __ - __ __ - __ __ __ __**
2. DOB___/___/___ Pt ID_____-___-___-___
3. B#________________________

4. **Gender**
   a. Male
   b. Female

5. **Ethnicity**
   a. European American
   b. Latino
   c. Asian
   d. Somali
   e. African American
   f. Native American
   g. Other _____________

6. **Marital status**
   a. Single
   b. Married/partner
   c. Divorced
   d. Widowed

7. **Spiritual and Faith Community**
   a. Christian
   b. Jewish
   c. Muslim
   d. Other _______________________

8. **Date of referral __ __/__ __/ __ __**

9. **Date of first contact __ __/__ __/__ __**

10. **Last visit__ __/__ __/ __ __**

11. **TLC team member making first contact**
    a. Nurse
    b. Social Worker
    c. Spiritual Health
    d. Medical Director
    e. MD _________________________

2. **Reason for patient referral (check all that apply):**
   a. Team/patient/family needs help with complex decision-making and determination of goals of care
   b. Pain and symptom management
   c. Has frequent visits to the emergency room
   d. Psychosocial, spiritual or cultural issues
   e. Family/patient request
   f. Has more than one hospital admission for the same diagnosis in the last 30 days
   g. Has prolonged length of stay (> than 5 days) without evidence of progress
   h. Has prolonged stay in ICU and/or transferred from ICU to ICU setting without evidence of progress
   i. Is in an ICU setting with documented poor prognosis

3. **Did a specific event trigger referral?**
   ____
   ____
   ____

4. **Who particularly needed education during this consultation? (Circle all that apply)**
   a. Attending
   b. Other consulting services
   c. House staff
   d. Medical students
   e. Nurses
   f. Other hospital personnel
   g. Family

5. **Team estimation of life expectancy**
   a. <24 hours
   b. Days, but <1 week
   c. Weeks, but <1 month
   d. Months--<6
   e. Months--6-12
   f. >1 year

Consultation Tracking Form Continued

16. ECOG performance status at first contact

a. No symptoms, fully functional
b. <50% of day in bed
c. >50% of day in bed
d. bed-bound

17. Who initially contacted the team?

a. Housestaff
b. Staff nurses
c. Social worker
d. Spiritual Health
e. Care coordinator ________________
f. Other __________________________

18. Physician making referral:

____
Specialty:
____

19. Primary diagnosis (that triggers team involvement – *Please circle*)

a. Cancer - head and neck
b. Cancer - lung (small cell)
c. Cancer - lung (non-small cell)
d. Cancer - breast
e. Cancer - esophagus / GE junction
f. Cancer - stomach
g. Cancer - colon
h. Cancer - renal
i. Cancer - liver
j. Cancer - pancreas
k. Cancer - prostate
l. Cancer - ovary / uterus / cervix
m. Cancer - lymphoma______________________
n. Cancer - brain/neuro_____________________
o. Cancer - unknown primary
Cell type - ______________________
p. Cancer - other __________________
q. AIDS
r. Dementia
s. Cardiac _______________________
t. Renal _________________________
u. Neurologic _____________________
v. Pulmonary _____________________
w. Multi-system ___________________
x. Other _________________________

20. If patient died while on consultation service, what was quality of death?

a. Patient: Excellent good fair poor
b. Family: Excellent good fair poor

21. Secondary diagnoses

a. Hepatic disease _____
b. Diabetes _____
c. Cardiac _____
d. Renal _____
e. Pulmonary _____
f. Neurological _____
g. Psychiatric _____
Other _________________________
____

22. Indicate any extraordinary conditions (e.g., dialysis, intubation, dopamine, etc.)

____
____
____
____

23. Disposition

a. Died (date) ____________________
b. D/C from service ________________
c. D/C to home ___________________
d. D/C to home with PC Outpatient Follow-up _____________________
e. D/C to home with Hospice_________
f. D/C to home with other home care or Hospice services________________
g. D/C to long term care facility ______
h. D/C to LTC with Hospice Partner ___
i. D/C to LTC with other Hospice_____
j. Residential Hospice_____________

EDMONTON SYMPTOM ASSESSMENT 0-3 SCALE

0=none, 1=mild, 2=moderate, 3=severe

DATE									
Pain									
Activity									
Nausea									
Depressed									
Anxious									
Fatigue									
Appetite									
Well-being									
Dyspnea									
Constipation									

DATE									
Drowsiness									
Confusion									
Agitation									
Diarrhea									
Sore or dry mouth									
Cough									
Insomnia									

Other: ____

____

Consultation Tracking Form Continued

OUTCOMES: Impacted by team (check all that apply)

______ Pt/Family Conference occurred

______ Code status clarified

______ Affected early discharge- Approx. # days saved: 1-2 3-5 6-10

______ Health Care agent identified

______ Discharge to less acute setting: ________________________

______ Health Care directive clarified

______ Diagnostic tests reduced: ______________________________

______ Pharmaceuticals reduced: ______________________________

______ Additional sheet attached with further outcome information or story

______ Pain and symptom managed: Significant recommendations made that altered course

______ Provided primary psychosocial support

______ Provided primary spiritual support

______ Provided significant education and support to staff

_______Affected withdrawal life prolonging therapies

STAFF adoption of recommendations: minimal some/early some/late full/early full/late

Pt/Family adoption of recommendations: minimal some/early some/late full/early full/late

____Date & Initial when item addressed.

☐ Indicates item must be addressed to complete form

END OF LIFE CARE CHECKLIST

Yes **No**

______ Family spokesperson identified & notified of change in patient's condition.

*Please Id this spokesperson ***here*** for future follow-up and bereavement aftercare. Include
Name ____
Address____
Phone ____________________**Relation to patient** ___________________________________

Y	N	
__	__	Appropriate Care Plans Initiated
__	__	Resuscitation Status Clarified
__	__	Bereavement Protocol Initiated
__	__	Patient Relations Notified
__	__	Quiet Room Obtained
__	__	Hospitality Basket Requested
__	__	Literature Given
__	__	State Donor Network Notified
__	__	Communicator Notified
__	__	Chaplaincy Notified ☐ Defers Services (Indicated time to reassess) ______
__	__	Social Services Notified ☐ Defers Services (Indicate time of reassess)____

TIME OF DEATH CHECKLIST

Y	*N*	
__	__	Medical Examiner Notified ☐ Not Applicable
__	__	Medical Records Notified
__	__	DN Form Completed (*Authorization for Donation/Removal of Anatomical Gift)*
__	__	Death Notice Form Completed by MD ☐ Not Applicable
__	__	Post-mortem Care Completed
__	__	Sympathy Card Initiated. Sent to: ☐ Spokesperson identified above.

Other: ____
____

Disposition of Belonging: ☐To Family ☐To Morgue/Funeral Home with body
☐To FH Security ☐To Police ☐No belongings
List items sent ____
____

Initials: ____ Sign: __________________________ Initials: _____ Sign: ____________________
Initials: ____ Sign: __________________________

Instructions for the Palliative Care Intervention Form

1. The form is to be completed when the patient is discharged.
2. A physician or nurse may complete the form.
3. Chart availability is not necessary to complete the form.
4. Complete the top section of the form.
5. The 1st column (left-hand side) identifies interventions suggested by the Palliative Care Team (PCT).
6. The next column identifies which interventions were recommended for the patient.
7. Selection in this column is either:
    a. If the palliative care team recommended a particular intervention, circle " Yes (PCT)"
    b. If the intervention was recommended by someone other than the palliative care team, circle "Yes (Not PCT)"
    c. If the intervention was not recommended circle "no".
    d. If the intervention did not apply, circle "NA"
8. The third column identifies which of the recommended interventions were implemented.
    a. If the recommendation was implemented mark the "yes "column.
    b. If the recommendation was not implemented choose one of the implementation codes. 11-19
    c. If the recommendation was partially implemented, choose one of the implementation codes 21-29.
9. Continue this procedure on page 2 and 3 and complete bottom sections of page 2 and 3.

PALLIATIVE CARE SERVICE – Intervention Form

Patient Name: ________________________________ **Nursing Unit** ____________________________

MEDICAL RECORD # ___ ___ ___ ___ ___ ___ ___ SERIAL # ___ ___ ___ ___ ___ ___ ___ ___ ___

Discharge Date: ___ ___ - ___ ___ - ___ ___ Date of Death: ___ ___ - ___ ___ - ___ ___

Pain Consult: Yes – 1 No - 0

INTERVENTION	RECOMMENDATION					IMPLEMENTATION			
	Yes (PCT)	Yes (Not PCT)	No	NA	Yes	No (Code)	Partial (Code)	Don't Know	**IMPLEMENTATION CODES**
Advance Directive									Not Implemented:
DNR	1	2	0		1			8	**11. MD refused**
Proxy	1	2	0		1			8	**12. Pt. Refused**
Non-hosp DNR	1	2	0		1			8	**13. Family refused**
Living Will	1	2	0		1			8	**14. Change in clinical status**
Communication with PCT re: Goals of Care									**15. Alternate plan** **16. Health system barrier**
PCT/Patient	1	2	0	9	1			8	**17. Pending implementation, pt. died**
PCT/Family	1	2	0	9	1			8	**18. Don't Know**
PCT/Unit Staff	1	2	0	9	1			8	**19. NA**
PCT/Attending	1	2	0	9	1			8	
Consult									
Psych Consult	1	2	0	9	1			8	
Spiritual Needs	1	2	0	9	1			8	
Symptoms: Yes – 1 No- 0									**Partially Implemented:**
Pain 1 0	1	2	0		1			8	**21. MD refused**
Dyspnea 1 0	1	2	0		1			8	**22. Pt. Refused**
Nausea 1 0	1	2	0		1			8	**23. Family refused**
Anxiety 1 0	1	2	0		1			8	**24. Not timely**
Depression 1 0	1	2	0		1			8	**25. Other dose/ Med or Route**
Delirium 1 0	1	2	0		1			8	**26. PRN instead of ATC**
Constipation 1 0	1	2	0		1			8	**27. Other**
Diarrhea 1 0	1	2	0		1			8	**28. Don't Know**
Phys Discomfort 1 0	1	2	0		1			8	**29. NA**
Other 1 0 *Specify:*	1	2	0		1			8	

RECOMMENDATIONS/IMPLEMENTATION : Decisions to Forego, Family/Pt. Support, Rehab

INTERVENTION	**RECOMMENDATION**					**IMPLEMENTATION**			**IMPLEMENTATION CODES**
	Yes (PCT)	**Yes (Not PCT)**	**No**	**NA**	**Yes**	**No (Code)**	**Partial (Code)**	**Don't Know**	
Decision to Forego Treatment									
1. Tube feed	**1**	**2**	**0**	**9**	**1**			**8**	Not Implemented:
2. TPN	**1**	**2**	**0**	**9**	**1**			**8**	**11. MD refused**
3. IV fluids	**1**	**2**	**0**	**9**	**1**			**8**	**12. Pt. Refused**
4.Antibiotics	**1**	**2**	**0**	**9**	**1**			**8**	**13. Family refused**
5.Vent	**1**	**2**	**0**	**9**	**1**			**8**	**14. Change in clinical status**
6. ICU care	**1**	**2**	**0**	**9**	**1**			**8**	**15. Alternate plan**
7. Vasopressors	**1**	**2**	**0**	**9**	**1**			**8**	**16. Health system barrier**
8. Venipuncture	**1**	**2**	**0**	**9**	**1**			**8**	**17. Pending implementation, pt. died**
9. Needle sticks (e.g. Finger sticks)	**1**	**2**	**0**	**9**	**1**			**8**	**18. Don't Know**
10. Other	**1**	**2**	**0**	**9**	**1**			**8**	**19. NA**
Specify:									
Family/Pt. Support									
1. Supportive counseling	**1**	**2**	**0**	**9**	**1**			**8**	**Partially Implemented:**
2. Relaxation	**1**	**2**	**0**	**9**	**1**			**8**	**21. MD refused**
3. Guided imagery	**1**	**2**	**0**	**9**	**1**			**8**	**22. Pt. Refused**
4. Volunteers	**1**	**2**	**0**	**9**	**1**			**8**	**23. Family refused**
5. Massage	**1**	**2**	**0**	**9**	**1**			**8**	**24. Not timely**
6. Patient Ed	**1**	**2**	**0**	**9**	**1**			**8**	**25. Other dose, Med or Route**
Rehabilitation									**26. PRN instead of ATC**
1. PT	**1**	**2**	**0**	**9**	**1**			**8**	**27. Other**
2. OT	**1**	**2**	**0**	**9**	**1**			**8**	**28. Don't Know**
3. Speech	**1**	**2**	**0**	**9**	**1**			**8**	**29. NA**
4. Other	**1**	**2**	**0**	**9**	**1**			**8**	

SYMPTOM ASSESSMENT (Over last 24 hrs. prior to discharge):

Pain	**(______)**	**Depression**	**(______)**	**Anorexia**	**(______)**	**0-none**
Inactivity	**(______)**	**Anxiety**	**(______)**	**SOB**	**(______)**	**1-mild**
Nausea	**(______)**	**Drowsiness**	**(______)**	**Phys. Discomfort**	**(______)**	**2-moderate**
Constipation	**(______)**	**Agitation**	**(______)**	**COMA**	**(______)**	**3-severe**

History of Dementia: Yes - 1 No - 2 DK - 9
Upon discharge was there a plan for symptom management? Yes – 1 No – 2 DK - 9

During hospitalization, did pt. have capacity to participate in decisions about life sustaining therapy/goals of care? Yes – 1 No – 2 DK - 9

INTERVENTION	RECOMMENDATION				IMPLEMENTATION				IMPLEMENTATION CODES
	Yes (PCT)	Yes (Not PCT)	No	NA	Yes	No (Code)	Partial (Code)	Don't Know	
Discharge Plan									Not Implemented:
1. D/C from Palliative Care	1	2	0		1			8	**11. MD refused**
2. PCT follow as inpatient	1	2	0		1			8	**12. Pt. Refused**
3. Home – no caregiver	1	2	0		1			8	**13. Family refused**
4. Home – relative/friend care	1	2	0		1			8	**14. Change in clinical status**
5. Home – CHHA caregiver	1	2	0		1			8	**15. Alternate plan**
6. Home – private pay caregiver	1	2	0		1			8	**16. Health system barrier**
7. Home hospice	1	2	0		1			8	**17. Pending implementation, pt. died**
8. Outpatient Palliative Care	1	2	0		1			8	**18. Don't Know**
9. Supportive Care	1	2	0		1			8	**19. NA**
10. In- patient hospice	1	2	0		1			8	
11. Other hospital	1	2	0		1			8	**Partially Implemented:**
12. Nursing Home-no hospice	1	2	0		1			8	**21. MD refused**
13. Nursing Home w/hospice	1	2	0		1			8	**22. Pt. Refused**
14. Nursing Home w/Palliative Care	1	2	0		1			8	**23. Family refused**
15. IMA/GERI Home M.D. Care	1	2	0		1			8	**24. Not timely**
16. Other	1	2	0		1			8	**25. Other dose, Med or Route**
Specify:									**26. PRN instead of ATC**
									27. Other
									28. Don't Know
									29. NA

PRIMARY DISEASE – circle one

1. CA 2. HIV 3. Lung 4. Liver 5. Kidney 6. Dementia 7. Stroke or Coma

8. Cardiac 9. Other (specify): ________________________________

Advance Directive – circle all that apply

1. Health Care Proxy: Yes – 1 No – 0 2. Living Will: Yes – 1 No – 0

3. Surrogate: Yes – 1 No – 0 4. Previously expressed Wishes: Yes – 1 No – 0

Name of Best Person to Contact for Follow-up Information: *Full Name* ____

*Relationship*________________________________ *Tel.# (______) _____________- ___________________*

Degree of involvement:	**0**	**1**	**2**	**3**	**9**
Involvement Codes:	**0- not involved**	**1- minimal**	**2- moderate**	**3- very involved**	**9- no contact person**

Clinical Treatment Protocols/Guidelines for Palliative Care

APPENDIX B

Clinical Treatment Protocols/Guidelines

The following clinical treatment guidelines frequently used in palliative care can be found at www.capc.org:

1. Managing conflicts concerning requests to withhold or withdraw life sustaining medical treatment
2. (No) Code do not resuscitate (DNR) in an inpatient setting and DNR orders
3. Non-oral hydration and feeding in advanced dementia or at the end of life
4. Use of analgesics: selection, route, PCA
5. Sedation and ventilator withdrawal: Use of Pentobarbital for sedation and ventilator withdrawal
6. Pediatric pain assessment and management