



Policies and Tools

for Hospital Palliative Care Programs

**A Crosswalk of National Quality Forum
Preferred Practices**

Center to
Advance
Palliative Care™

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In 2006, the National Quality Forum (NQF) issued a report detailing 38 *Preferred Practices for Palliative and Hospice Care Quality*.¹ NQF used the *Clinical Practice Guidelines for Quality Palliative Care* as the starting point for developing *Preferred Practices* and was guided in its deliberations by the following definitions:

Palliative care refers to patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.

Hospice care is a service delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical, psychosocial, and spiritual support as they enter the terminal stage of an illness or condition. It also supports family members coping with the complex consequences of illness, disability, and aging as death nears. Hospice care further addresses the bereavement needs of the family following the death of the patient.²

The Center to Advance Palliative Care (CAPC) has developed a document that provides a crosswalk between The Joint Commission standards and palliative care.³ This document will assist programs in developing the necessary policies and associated clinical tools and resources to ensure that a palliative care program meets the NQF's *Preferred Practices*. This document is divided into three sections:

I. Index of Preferred Practices, Policies, Tools and Resources

II. Sample Policies developed by existing hospital-based palliative care programs. Hospitals can adapt these tools to fit their institutions' needs.

III. Tools/Resources to implement the *Preferred Practices*. Hospitals can adapt these tools to fit their institutions' needs.

References

¹ National Quality Forum, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report* (Washington, DC: National Quality Forum, 2006), www.qualityforum.org.

² National Consensus Project for Quality Palliative Care, *Clinical Practice Guidelines for Quality Palliative Care* (National Consensus for Quality Palliative Care, 2004), www.nationalconsensusproject.org.

³ Center to Advance Palliative Care, *Crosswalk of Joint Commission Standards and Palliative Care Policies: Procedures and Assessment Tools* (New York: Center to Advance Palliative Care, 2007), www.capc.org.

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A. Preferred Practices

Preferred Practice	Policies That Address the Preferred Practices	Tools/Resources
1. Provide palliative and hospice care by an interdisciplinary team of skilled palliative care professionals, including, for example, physicians, nurses, social workers, pharmacists, spiritual care counselors and others who collaborate with primary health care professional(s).	Scope of Practice (#1)	Job Descriptions (A) Core Competencies (B)
2. Provide access to palliative and hospice care that is responsive to the patient and family 24 hours a day, seven days a week.	Referral Process (#2)	Referral Criteria (C)
3. Provide continuing education to all health professionals on the domains of palliative care and hospice care.	Palliative Care Committee (#3)	Educational Needs Assessment (D)
4. Provide adequate training and clinical support to assure that professional staff are confident in their ability to provide palliative care for patients.	Palliative Care Committee (#3)	Training Materials/Web Resources (R)
5. Hospice care and specialized palliative care professionals should be appropriately trained, credentialed and/or certified in their area of expertise.	Scope of Practice (#1) Palliative Care Committee (#3)	AAHPM Credentialing Policy Statement (S) Hospital Credentialing Application (E)
6. Formulate, utilize and regularly review a timely care plan based on a comprehensive interdisciplinary assessment of the values, preferences, goals and needs of the patient and family and, to the extent that existing privacy laws permit, ensure that the plan is broadly disseminated, both internally and externally, to all professionals involved in the patient's care.	Care Planning (#4)	Patient/Family Meeting Record (F)
7. Ensure that on transfer between health care settings, there is timely and thorough communication of the patient's goals, preferences, values and clinical information so that continuity of care and seamless follow-up are assured.	Continuity of Care (#5)	FAMCARE Scale (G)
8. Health care professionals should present hospice as an option to all patients and families when death within a year would not be surprising, and reintroduce the hospice option as the patient declines.	End-of-Life Care (#6) Care of the Imminently Dying (#7)	NHPCO Patient/Family Education Booklets (T)



Preferred Practice	Policies That Address the Preferred Practices	Tools/Resources
9. Patients and caregivers should be asked by palliative and hospice programs to assess physicians'/health care professionals' ability to discuss hospice as an option.	Palliative Care Committee (#3)	
10. Enable patients to make informed decisions about their care by educating them on the process of their disease, prognosis, and the benefits and burdens of potential interventions.	Patient Self-Determination (#8) Patient/Family/Caregiver Education (#9)	NHPCO Patient/Family Education Booklets (T)
11. Provide education and support to families and unlicensed caregivers based on the patient's individualized care plan to assure ensure safe and appropriate patient care.	Patient/Family/Caregiver Education (#9)	NHPCO Patient/Family Education Booklets (T)
12. Measure and document pain, dyspnea, constipation and other symptoms using available standardized scales.	Assessment and Treatment of Physical/Emotional Symptoms (#10) Pain Management and Opioid Prescribing (#11)	Consultation Report (H) Inpatient Progress Note (I) NPCRC Clinical Tools (U)
13. Assess and manage symptoms and side effects in a timely, safe and effective manner to a level acceptable to the patient and family.	Assessment and Treatment of Physical/Emotional Symptoms (#10)	FAMCARE Scale (G) Opioid Order Forms (N)
14. Measure and document anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms using available standardized scales.	Assessment and Treatment of Physical/Emotional Symptoms (#10)	H. Consultation Report (H) Inpatient Progress Note (I) NPCRC Clinical Tools (U)
15. Manage anxiety, depression, delirium, behavioral disturbances and other common psychological symptoms in a timely, safe and effective manner to a level acceptable to the patient and family.	Assessment and Treatment of Physical/Emotional Symptoms (#10)	FAMCARE Scale (G)
16. Assess and manage psychological reactions of patients and families to address emotional and functional impairment and loss, including stress, anticipatory grief and coping, in a regular ongoing fashion.	Assessment and Treatment of Physical/Emotional Symptoms (#10)	Social Worker Assessment (J) Spiritual Care Assessment (K)
17. Develop and offer a grief and bereavement care plan to provide services to patients and families prior to, and for at least 13 months after, the patient's death.	End-of-Life Care (#6) Care of the Imminently Dying (#7)	NHPCO Patient/Family Education Booklets (T)

Preferred Practice	Policies That Address the Preferred Practices	Tools/Resources
<p>18. Conduct regular patient and family care conferences with physicians and other appropriate members of the interdisciplinary team to provide information, discuss goals of care, disease prognosis and advance care planning, and offer support.</p>	<p>Care Planning (4)</p>	<p>Patient/Family Meeting Record (F)</p>
<p>19. Develop and implement a comprehensive social care plan that addresses the social, practical and legal needs of the patient and caregivers, including but not limited to: relationships, communication, existing social and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability/stress, access to medicines and equipment.</p>	<p>Care Planning (4)</p>	<p>Patient/Family Meeting Record (F)</p> <p>Social Worker Assessment (J)</p>
<p>20. Develop and document a plan based on assessment of religious, spiritual and existential concerns using a structured instrument and integrate the information obtained from the assessment into the palliative care plan.</p>	<p>Care Planning (4)</p>	<p>Spiritual Care Assessment (K)</p> <p>Patient/Family Meeting Record (F)</p>
<p>21. Provide information about the availability of spiritual care services, and make spiritual care available either through organizational spiritual care counseling or through the patient’s own clergy relationships.</p>	<p>Pastoral Care Priorities (12)</p>	
<p>22. Specialized palliative and hospice care teams should include spiritual care professionals appropriately trained and certified in palliative care.</p>	<p>Scope of Practice (1)</p>	<p>Core Competencies (B)</p>
<p>23. Specialized palliative and hospice spiritual care professionals should build partnerships with community clergy and provide education and counseling related to end-of-life care.</p>	<p>Pastoral Care Priorities (12)</p>	

Preferred Practice	Policies That Address the Preferred Practices	Tools/Resources
<p>24. Incorporate cultural assessment as a component of comprehensive palliative and hospice care assessment, including, but not limited to: locus of decision making, preferences regarding disclosure of information, truth telling and decision making, dietary preferences, language, family communication, desire for support measures such as palliative therapies and complementary and alternative medicine, perspectives on death, suffering and grieving and funeral/burial rituals.</p>	<p>Care Planning (#4)</p>	<p>NHPCO Patient/Family Education Booklets (T)</p>
<p>25. Provide professional interpreter services and culturally sensitive materials in the patient's and family's preferred language.</p>	<p>Interpreters (#13)</p>	<p>Use of Interpreters (L)</p>
<p>26. Recognize and document the transition to the active dying phase and communicate to the patient, family and staff the expectation of imminent death.</p>	<p>Care of the Imminently Dying (#7)</p> <p>Removal of Mechanical Ventilation in the Dying Patient (#16)</p>	<p>End-of-Life Care Checklist (M)</p> <p>Teaching the Family What to Expect When the Patient Is Dying (O)</p>
<p>27. Educate the family on a timely basis regarding the signs and symptoms of imminent death in an age-appropriate, developmentally appropriate and culturally appropriate manner.</p>	<p>Care of the Imminently Dying (#7)</p> <p>Patient/Family/Caregiver Education (#9)</p>	<p>Teaching the Family What to Expect When the Patient Is Dying (O)</p> <p>NHPCO Patient/Family Education Booklets (T)</p>
<p>28. As part of the ongoing care planning process, routinely ascertain and document patient and family wishes about the care setting for site of death, and fulfill patient and family preferences when possible.</p>	<p>Care Planning (#4)</p>	<p>Social Worker Assessment (J)</p>
<p>29. Provide adequate dosage of analgesics and sedatives as appropriate to achieve patient comfort during the active phase and address concerns and fears about using narcotics and analgesics hastening death.</p>	<p>Care of the Imminently Dying (#7)</p> <p>Removal of Mechanical Ventilation in the Dying Patient (#16)</p>	<p>NHPCO Patient/Family Education Booklets (T)</p> <p>Opioid Order Forms (N)</p>
<p>30. Treat the body after death with respect according to the cultural and religious practices of the family and in accordance with local law.</p>	<p>Care of the Imminently Dying (#7)</p>	<p>NHPCO Patient/Family Education Booklets (T)</p>

Preferred Practice	Policies That Address the Preferred Practices	Tools/Resources
<p>31. Facilitate effective grieving by implementing in a timely manner a bereavement care plan after the patient's death when family remains the focus of care.</p>	<p>Care of the Imminently Dying (#7)</p>	
<p>32. Document the designated surrogate/decision maker in accordance with state law for every patient in primary, acute and long-term care and in palliative and hospice care.</p>	<p>Scope of Practice (#1) Patient Self-Determination (#8)</p>	<p>Social Worker Assessment (J)</p>
<p>33. Document the patient/surrogate preferences for goals of care, treatment options and setting of care at first assessment and at frequent intervals as conditions change.</p>	<p>Care Planning (#4) Patient Self-Determination (#8)</p>	<p>Consultation Report (H) Inpatient Progress Note (I) Social Worker Assessment (J)</p>
<p>34. Convert the patient treatment goals into medical orders and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services and hospital care, through a program such as the Physician Orders for Life-Sustaining Treatment (POLST) program.</p>	<p>Continuity of Care (#5) Patient Self-Determination (#8)</p>	<p>POLST (P)</p>
<p>35. Make advance directives and surrogacy designations available across care settings while protecting patient privacy and adherence to HIPAA regulations, e.g., by Internet-based registries or electronic personal health records.</p>		<p>POLST (P)</p>
<p>36. Develop healthcare and community collaborations to promote advance care planning and the completion of advance directives for all individuals, for example, the Respecting Choices and Community Conversations on Compassionate Care programs.</p>		<p>POLST (P)</p>
<p>37. Establish or have access to ethics committees or ethics consultation across care settings to address ethical conflicts at the end of life.</p>	<p>Ethics Committee Consultation (#14)</p>	<p>Whom Do You Call, Palliative Care or Ethics? (Q)</p>

Preferred Practice	Policies That Address the Preferred Practices	Tools/Resources
<p>38. For minors with decision-making capacity, document the child’s views and preferences for medical care, including assent for treatment, and give appropriate weight in decision making. Make appropriate professional staff members available to both the child and the adult decision maker for consultation and intervention when the child’s wishes differ from those of the adult decision maker.</p>	<p>Consent for Diagnosis/Treatment in Pediatrics (#15)</p>	

B. Policies

Policy Number and Name	NQF Preferred Practice #
1 Palliative Care: Scope of Practice	1, 5, 22, 32
2 Palliative Care: Referral Process	2
3 Palliative Care: Palliative Care Committee	3, 4, 5, 9
4 Palliative Care: Care Planning	6, 18, 19, 20, 24, 28, 33
5 Palliative Care: Continuity of Care	7, 34
6 End-of-Life Care	8, 17
7 Care of the Imminently Dying	8, 17, 26, 27, 29, 30, 31
8 Patient Self-Determination	10, 32, 33, 34
9 Palliative Care: Patient/Family/Caregiver Education	10, 11, 27
10 Palliative Care: Assessment and Treatment of Physical/Emotional Symptoms	12, 13, 14, 15, 16
11 Pain Management and Opioid Prescribing	12
12 Pastoral Care Priorities	21, 23
13 Interpreters	25
14 Ethics Committee Consultation	37
15 Consent for Diagnosis/Treatment in Pediatrics	38
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C. Tools/Resources

Tool/Resource Letter and Name	NQF Preferred Practice #
A Job Descriptions	1
B Core Competencies in Palliative Care	1, 22
C Palliative Care Referral Criteria	2
D Educational Needs Assessment	3
E Hospital Credentialing Application	5
F Patient/Family Meeting Record	6, 18, 19, 20
G FAMCARE Scale	7, 13, 15
H Consultation Report	12, 14, 33
I Inpatient Progress Note	12, 14, 33
J Social Worker Assessment	16, 19, 28,32, 33
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S AAHPM Credentialing Policy Statement	5
T NHPCO Patient/Family Education Booklets	8, 10, 11, 17, 24, 27, 29, 30
U NPCRC Clinical Tools	12, 14



II. Sample Policies

Palliative Care and Other Hospital Policies in Support of NQF Preferred Practices

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Palliative Care: Scope of Practice

Purpose: To define the practice of palliative care

Responsibility: Palliative care team

Definition

1. “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 serious and/or life-threatening illness. Palliative care may be complementary to curative or life-prolonging therapies that are being used to meet patient-defined goals of care.
2. “Palliative care clinicians” may include some or all of the following—physicians, nurses or advance practice nurses, social workers, chaplains, psychologists, pharmacists. All palliative care clinicians are certified in palliative care (or have equivalent training) and are credentialed to provide palliative care services.

Procedure

- A. The palliative care team will work to:
 - Optimize symptom control
 - Optimize functional status when appropriate
 - Promote the highest quality of life for patient and family
 - Educate patients and family to promote understanding of the underlying disease process and expected future course of the illness
 - Establish an environment that is comforting and healing
 - Plan for discharge to the appropriate level of care in a timely manner
 - Assist actively dying patients and their families in preparing for and managing life closure
 - Serve as educators and mentors for staff
 - Promote a system of care that fosters timely access to palliative care services
- B. The process of providing palliative care services includes:
 1. Initial and subsequent assessments are carried out through patient and family interviews, review of medical records, discussion with other providers, physical examination, and review of laboratory, diagnostic tests and procedures.
 2. Assessment includes documentation of:
 - Disease status/treatment history
 - Functional status and expected prognosis
 - Comorbid medical and psychiatric disorders
 - Physical, psychological and spiritual symptoms and concerns
 - Advance care planning preferences/surrogate decision maker(s)
 3. All initial and ongoing assessments data are reviewed on a regular basis. Assessment findings are the basis for the care planning process.
 4. Reassessment is performed as needed by the clinical situation.

Palliative Care: Referral Process

Purpose: To outline procedures for initiating a palliative care consultation

Responsibility: Palliative care team; attending physicians

Procedure

A. 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.
2. If the referral comes from anyone other than an attending physician, a member of the palliative care team notifies the primary care physician of the referral and requests permission to provide a consultation.¹

B. Prioritizing requests for palliative care consults:

1. Emergent (Immediate): In the event of an emergent problem (e.g., severe uncontrolled pain), the palliative care team member on call will respond immediately to the consult request.
2. Urgent (2 to 4 hours): In the event of an urgent medical problem, the palliative care team member on call responds as soon as possible or within a one-hour time frame.
3. Nonurgent: All nonurgent consultations are completed within 24 hours.

C. Responding to a consult request:

1. The palliative care team responds to all requests for referrals/consultations.
2. If the palliative care team member determines that an initial assessment or continued follow-up is not appropriate, the palliative care team will work with the attending physician to facilitate patient access to the appropriate resource(s).

D. Role of the palliative care team after initial consultation:

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. The role may involve:

1. Providing advice to patient/family or staff (e.g., no orders are written by the palliative care team)
2. Consulting with orders (e.g., providing pain management and symptom control; supporting the primary physician during family meetings)
3. Taking total responsibility for the patient (e.g., when the palliative care physician becomes the primary attending)

E. On-call schedule:

To ensure access to palliative care services, an on-call schedule is created for coverage 24 hours per day, 7 days per week.

¹ The requirement for attending physician permission will vary by institution.

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policy

Palliative Care: Palliative Care Committee

Purpose: To outline the roles/responsibilities of the palliative care committee

Responsibility: Palliative care committee

Procedure

1. The palliative care committee will report to the chief medical and nursing officers and consist of the following members:
 - Two representatives from the palliative care program—one physician and one nurse
 - One representative from hospital and/or nursing administration
 - One representative from nursing administration
 - One representative from the critical care subcommittee
 - One representative from the ethics committee
 - One representative from each of the following services or administrative committees: critical care committee, cardiovascular medicine service, the neuroscience services, surgical services, consult/liaison psychiatry service, medicine service
 - One representative each from the hospital departments of social services, chaplaincy services, pharmacy and organ procurement
2. The palliative care subcommittee will meet at least quarterly.
3. The palliative care subcommittee will establish and direct efforts to meet or exceed Joint Commission/NQF palliative care/hospice standards, and as part of this effort, is responsible for:
 - Overseeing clinical programs that relate to palliative care, including but not limited to the palliative care program, the bereavement program and hospital initiatives to improve pain management
 - Monitoring palliative care clinical care practices through evaluation of data concerning pain and symptom control, advance directives, utilization of hospital resources, hospice referrals and patient/family satisfaction
 - Developing and implementing palliative care education initiatives for all staff health professionals to include competency-based metrics for relevant clinical staff
 - Making recommendations to the medical executive committee regarding appropriate changes in patient care policies and procedures

Palliative Care: Care Planning

Purpose: To ensure that care planning is individualized, interdisciplinary and 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 (e.g., clergy, friends).
3. The care plan process includes structured assessment and documentation to include:
 - Physical and psychological assessment, which addresses the current disease status, treatment options, functional status, expected prognosis, symptom burden and psychological coping
 - Social and spiritual assessment, which addresses the social, practical, religious, spiritual, existential concerns, and legal needs of the patient and caregivers, including but not limited to: relationships, communication, existing social and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability and stress, access to medicines and equipment
 - Cultural assessment, including, but not limited to, locus of decision making, preferences regarding disclosure of information, truth telling and decision making, dietary preferences, language, family communication, desire for complementary and alternative medicine, perspectives on death, suffering and grieving, and funeral/burial rituals
4. Care planning conferences (aka family meetings) with a patient and family will occur regularly to determine the most appropriate goals of care as indicated by the clinical conditions, and are coordinated by the palliative care team in conjunction with the attending physician and other hospital staff.
5. Care plan changes are based on the evolving needs and preferences of the patient and family over time, recognizing the complex, competing and shifting priorities in goals of care.
6. The palliative care team provides support for decision making, develops and carries out the care plan and communicates the plan to patient, family, involved health professionals and to the providers involved with patient transfer to different internal or external care settings.

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policy

5 policy

Palliative Care: Continuity of Care

Purpose: To ensure continuity of care upon discharge for patients receiving palliative care consultative services

Definition

“Continuity of care” is the multidisciplinary coordination of care that includes or considers all clinical diagnoses, treatments, psychosocial needs, patient preferences and personal resources.

Responsibility: Palliative care team; all clinical staff

Procedure

1. A palliative care team member is responsible for working with other health care staff (e.g., social service providers, discharge planners) for coordinating the discharge plan.
2. A team member synthesizes the plan of care and works to convert the patient’s treatment goals into medical orders that are transferable across care settings.
3. A team member confirms access to services that can assist following discharge:
 - Physician specialists
 - Nursing home/intermediate care facilities
 - Hospice
 - Home health care
 - Outpatient palliative care
 - Durable medical equipment services
 - Rehabilitation services
 - Counseling services
 - Transportation
 - Rehabilitation
 - Medications
4. A team member reviews the legibly written discharge plan with the patient/surrogate and/or caregivers prior to discharge and assesses comprehension using the teach-back method.
5. A team member confirms that the referring agencies receive copies of the discharge planning documents, the physician’s orders and any other clinical documentation and relevant information.

End-of-Life Care

Purpose: To define the integration of hospice and palliative care as a key component of family-centered, compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families

Definition

“End-of-life care” is not bounded by a specific prognosis; rather, it involves the recognition of the irreversibility of a life-limiting medical condition(s) that will likely result in death.

Responsibility: All clinical staff

Procedure

1. Meeting patient and family needs is the central focus of care when cure or maintaining the continuum of health is no longer possible. Optimal care requires exceptional communication among clinical staff and a recognition that a team approach, inclusive of many health care disciplines, is necessary.
2. Patients are treated with respect to their individual wishes for care and treatment with consideration of their values, religion and philosophy. A request to discontinue treatment will be honored with the same support and respect as the decision to continue treatment.
3. The palliative care consultation service is available to assist with symptom management, prognosis determination, patient and family support, disposition planning and other issues related to end-of-life decisions.
4. Hospice services are recognized as an integral part of the continuum of care. Patients who have an expected prognosis of six months or less, assuming the disease follows its usual course, should be offered hospice services.
5. Bereavement support and chaplaincy services are available to patients and their family members. Nursing, social services and the chaplaincy program are available to provide resources to families. The bereavement services coordinator can assist with the care team and with aftercare.
6. In the event of questions or differences of opinion among the patient, family or health care team members about the treatment goals, consultation is available from the hospital ethics committee.



Care of the Imminently Dying

Purpose: To provide a standard of care integrating high-quality, family-centered compassionate care, guided by a sense of respect, empathy and concern, that addresses the unique needs of patients and their families

Definition

“Imminently dying” (*aka* actively dying) specifies the period of a patient’s illness when death can be reasonably expected to occur within 14 days. Common signs/symptoms of imminent death include: sedation or delirium, death rattle, no use of oral or artificial hydration/nutrition, and no plans for further life-sustaining treatments.

Responsibility: All clinical staff

Procedure

Care will include:

1. Documentation in the medical record that a patient is “imminently” or “actively” dying
2. Communication with the patient, family and surrogate decision makers that death is imminent
3. Preparing patient and family for what to expect during the normal dying process
4. Managing pain and other physical/psychological symptoms effectively
5. Educating/counseling patients and families concerning the appropriate use of pain and symptom treatments
6. Providing treatment of symptoms according to the wishes of the patient or family
7. Providing options for out-of-hospital care, including home or residential hospice services
8. Respecting the patient’s privacy, values, religion, culture and philosophy
9. Involving the patient and family in all aspects of care
10. Responding to the psychological, social, emotional, spiritual and cultural concerns of the patient and family, including children and teens affected by the death
11. Treating the body postdeath with respect according to the cultural and religious practices of the family and in accordance with local law
12. Addressing issues of body or organ donation, autopsy and funeral planning with sensitivity
13. Providing bereavement resources through the hospital and community

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policy

Patient Self-Determination

Purpose: To ensure that patients and/or their surrogates make informed decisions about proposed medical treatments

Definition

“Patient self-determination” includes making treatment decisions, designating a health care proxy, establishing advance directives, deciding to request or refuse to continue or discontinue care and/or choosing whether or not to attempt resuscitation.

Responsibility: Attending physicians

Procedure

The attending physician will:

1. Establish ongoing communication and documentation with the patient and surrogate that includes discussions of:
 - Health status
 - Current disease(s) and expected future course, including prognosis
 - Treatment options
 - Patient preferences
 - Spiritual and cultural beliefs and values that influence preferences
 - The right of the patient to choose and to change his/her choices at any time
 - The legal options for expressing desires through advance care planning documents/directives
2. Begin discussion 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 ensure that all choices are documented on appropriate forms.
5. Honor advance directives in accordance with hospital policy and state statutes.
6. Provide empathy and support as patients/surrogates make decisions.
7. Document all communication in the medical record and convey patient/surrogate decisions to other health care team members.



Palliative Care: Patient/Family/Caregiver Education

Purpose: To ensure that the patient/family/caregivers receive education and training specific to the patient's needs and abilities

Responsibility: Palliative care team, attending physicians, nursing, social services

Procedure

1. During the assessment process, patient/family/caregiver educational needs and cognition/emotional abilities are assessed and documented. The following is a list of common issues to be addressed, depending on the patient's unique clinical circumstances:
 - Pain and symptom management, including side-effect management
 - Advance care planning and advance directives
 - Anticipated future medical needs
 - Home or institutional support options (e.g., home hospice services)
 - What to expect in the normal course of the disease
 - Signs/symptoms of approaching death
 - Community services (e.g., bereavement, counseling)
 - Whom to call for routine and emergency needs
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.
4. Age-, language- and educationally appropriate educational materials (written, Internet, oral) will be provided to meet the needs identified in the assessment process.

Assessment and Treatment of Physical/Emotional Symptoms

Purpose: To ensure that all patients who are experiencing pain, physical symptoms and emotional symptoms are managed with quality and consistency throughout their hospitalization

Definition

“Physical/emotional symptoms” include the entire range of symptoms associated with serious illness. The most common symptoms include: pain, nausea, dyspnea, anxiety, depression, constipation, anorexia and fatigue.

Responsibility: Palliative care team, attending physicians, nursing

Procedure

1. The palliative care team completes a comprehensive assessment. The assessment considers:
 - Diagnosis
 - Presenting problems
 - Current treatments, medication profile and side effects
 - Current pain/symptom management regimen
 - Patient concerns
 - Patient/family preferences
 - Spiritual and cultural beliefs and values that influence treatments
2. The patient is asked to characterize his/her symptoms using a hospital-approved assessment scale at the time of initial assessment and at regularly prescribed intervals following the assessment, and after initiation of therapy.
3. The team proposes a comprehensive treatment plan; the team confers with the patient and family and confirms plan elements.
4. The team instructs the patient/family on any self-care procedures.
5. The team works with the nursing staff to ensure the implementation and monitoring of the treatment plan.
6. The nursing staff works with the team to assess the patient’s response to treatment, including:
 - Response to medications or nonpharmacological interventions
 - Symptom relief measured on a consistently utilized scale
 - Adverse events/reactions/side effects
 - Satisfaction with intervention
7. The treatment plan is modified based on ongoing assessment.
8. Timely referrals are made to specialists when standard treatments fail to improve physical or psychological symptoms.
9. The team ensures that all assessments, recommendations, interventions and responses 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.
10. Prior to discharge a plan is established for continuing care requirements and family/caregiver education/support (see Policies #5 and #9).

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Pain Management and Opioid Prescribing

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

Responsibility: All clinical staff

Procedure

A. Standards for assessment

1. The fundamental principles of pain management will be followed as defined in Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain of the American Pain Society.
2. The patient's culture and age will be assessed upon admission. This is a joint responsibility of nursing and medical staff members. The assessment and treatment of pain will be consistent with the patient's cultural and age-specific needs. All patients will be assessed for pain by using the Pain Assessment Hierarchy: self-report of pain; presence of pathological condition or procedure that usually causes pain; pain behavior; proxy pain rating; autonomic response. The pain rating tool, Visual Analog Scale (VAS), includes a numeric, face, color and descriptive scoring. The pain assessment includes the quality and location of pain, functional limitations caused by pain and the expectations and perceptions of patients and their significant others.
3. Pain is the fifth vital sign and will be assessed on admission, with vital signs (not exceeding every four hours), upon self-report of pain, and if pain of the nonverbal patient is presumed. Pain will be reassessed after each intervention and documented as a VAS score or behavior change.
4. A plan of care will be established to deal with pain; the plan should involve both pharmacological and nonpharmacological interventions. The patient's pain goal will be identified (functional improvement and/or VAS score) and will be documented as such so that all team members will know the expectations of care and will incorporate the pain goal in discharge planning.
5. If the patient's goal for pain management or significant progress toward the goal is not achieved in a timely manner, a consultation for assistance is encouraged. It is recommended that a guideline of 24 hours be used by the admitting health care team for determining the need for consultation. In the event of questions or differences of opinion among the patient, family or health care team, there is an administrative chain of command to support appropriate ordering of pain medicines (see C below).

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B. Standards for opioid therapy

1. Use of the Opioid Order Form

The Opioid Order Form is to be used for all scheduled and PRN opioid orders for inpatients and outpatients occupying inpatient beds for observation and/or recovery purposes. The Opioid Order Form is not required in the following situations:

- Ambulatory patients in clinics and treatment/diagnostic areas
- Procedural areas (e.g., OR, GI lab, interventional radiology, cardiac catheterization lab)
- PACU
- One-time doses
- PCA/IV infusions of opioids (use Opioid Infusion Order Form)
- Epidural

2. Dose ranges and titration doses

Medications ordered by prescribers for a time range (q2–4 hr) will be interpreted and added to the patient's Medication Administration Record (MAR) as the most frequent interval. A maximum twofold dose range is allowed. If the range exceeds a twofold increment in dose, the range will be automatically adjusted to a twofold range based on the lowest dose ordered. This adjustment will appear on the patient's electronic Medication Administration Record.

Opioid orders written as “titrate to comfort” are vague and unacceptable. For patients with uncontrolled pain, opiate titration orders may be written. These orders must include both starting and maximum dose, and a specified increase based on the clinical assessment. The maximum dose cannot exceed a 100% increase over the starting dose with the exception of palliative care or end-of-life patients where the maximum dose is 200% over the starting dose.

3. Product selection

Patients requiring continuous opioid therapy may be on only one continuous or long-acting opioid at a single time. This includes the following:

- Opioid via PCA with basal rate
- Opioid via continuous infusion
- Extended-release morphine
- Extended-release oxycodone
- Transdermal fentanyl patch

Patients requiring a short-acting or rapid-onset opioid or opioid-combination product may be prescribed only a single product at any time. These include:

- Morphine
- Hydromorphone
- Oxycodone
- Oxycodone/acetaminophen (Percocet)
- Codeine/acetaminophen (Tylenol #3)
- Hydrocodone/acetaminophen (Vicodin)

Regimens for opioid and acetaminophen-combination products may not be prescribed in such a manner where the dose of acetaminophen could exceed 4000mg in a 24-hour period.

Meperidine use is restricted to the following two situations:

- Infusion-related reactions (e.g., amphotericin, immune globulin)
- Short-term, procedure-related use for no more than 48 hours and at doses not to exceed 600mg in a 24-hour period

C. Resources for pain management assistance

1. Administrative chain of command
Staff RN, then house staff, then attending physician, then nursing administration, then hospital chief of staff
2. Pain resource professionals
Unit-based nurses and pharmacists with focused pain education
3. Acute pain service
Inpatient management of acute, mostly surgical, pain
4. Palliative care service
Pain management for patients with serious and/or life-threatening illness and cancer
5. Pain management clinic
Nonemergent inpatient and outpatient consultation for assessment and triage of chronic nonmalignant pain

Pastoral Care Priorities

Purpose: To ensure that chaplaincy staff members, in providing pastoral services, pay special attention to those patients and family members with the greatest need

Responsibility: Pastoral care staff

Procedure

1. The department shall be staffed on the day shift, Monday through Friday, with at least the equivalent of two full-time and two part-time staff members. At least one chaplain shall be in the hospital or on call 24 hours daily, seven days per week.
2. Assignment of staff to treatment units shall be made in consultation with nursing department managerial staff, with priority given to those units where patient condition is typically most acute and length of stay is longest. Due to limitations of staffing, department staff shall be more dependent on and attentive to referrals from nursing, social services and medical personnel.
3. Chaplains assigned to priority units shall endeavor to make initial contact with newly admitted patients to assess their individual need for spiritual and emotional support, including presurgical visits.
4. All chaplains shall cooperate with staff to determine the spiritual needs of patients as per multidisciplinary meetings.
5. Department staff shall be encouraged to attend and/or conduct funerals as requested; the chaplain involved shall be compensated for time and mileage.
6. Pastoral care staff should build partnerships with community clergy and provide education and counseling related to end-of-life care.
7. Chaplaincy staff will be trained and certified in Clinical Pastoral Education (CPE); see www.acpe.edu and www.healthcarechaplaincy.org.

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Interpreters

Purpose: To ensure that those patients requiring an interpreter for foreign language, visual or hearing impairment/sign language are provided with meaningful access to medical services through effective communication, including but not limited to oral and/or telephone interpretation

Responsibility: All hospital staff

Procedure

1. Foreign-language, visually and hearing-impaired and sign-language interpreter services should be available.
2. The need for foreign-language, visually or hearing-impaired interpreter services shall be determined upon registration.
3. Contact the social services department or administrative representative and provide the following information:
 - Patient name and location
 - The situation requiring interpretation
 - Date and time the service is needed
 - Estimated duration of the service
 - Any specific interpretation needs
4. Excluding trained hospital interpreting staff, it is not recommended to utilize hospital staff for interpretation needs, since most are not trained in medical interpretation. Hospital staff may be used as interpreters in emergency situations and in circumstances where the hospital has determined that the staff member is a qualified interpreter.
5. If the patient requests that a family member serve as an interpreter, the patient will be offered the hospital-designated interpreter services and told that these services are available free of charge. If the patient declines to use this interpreter service, staff should document the refusal. If there is concern that the family member is not qualified to provide proper interpretation, staff may request that a hospital-designated interpreter be allowed to sit in to aid in interpretation.
6. Patients may refuse the hospital's designated interpreter and choose their own interpreter. In these instances, the patient must sign an interpreter waiver form (Receipt of Interpreter Services). Fees for interpreter services will then be the responsibility of the patient. The signed waiver form will be filed in the medical record.
7. The patient's language/interpreter needs shall be documented in his/her medical record.
8. Patient complaints regarding interpreter services should be directed to the supervisor of social services.

Ethics Committee Consultation

Purpose: To bring the expertise and experience of others to bear on a situation that requires clarification of issues and values related to patient care

Responsibility: All hospital staff

Procedure

A. Access to ethics consultation

The ethics committee works through initial analysis of case problems by one of several ethics consultants who are members of the ethics committee. As appropriate, the consultant may act as sole consultant, may assemble and lead an ethics team from available members of the ethics committee or may ask the chair to convene the entire ethics committee. The request for the consultation may be made by the attending physician, by the patient or surrogate for nondecisional patients, by immediate family members, by involved nursing staff or house staff, by involved social workers or by a chaplain. Requests from nurses, chaplains, patients and family should be relayed to the administrative representative or the director of nursing, who will contact the ethics team leader.

Ethics consultation requests during normal business hours may be placed through the operator, who will contact the ethics team member on call. After hours or on weekends and holidays, any request for ethics consultation must be directed to the administrative representative. The administrative representative will ensure that all hospital policies are addressed and will determine whether an ethics consultation is appropriate. He/she will also assist in determining if the consult can wait until normal business hours. When appropriate, the administrative representative will ask the operator to contact a member of the ethics committee at home.

The operator will have a list of current ethics committee members and contact numbers, including an order in which members should be called. If the ethics committee member contacted determines that an emergency ethics committee meeting needs to take place, the operator will assist by contacting the other committee members.

B. Response to request for consultation

The ethics consultant will determine the nature of the ethical problem and whether an ethics consultation is appropriate. The attending physician and the director of nursing will be notified of an ethics consult. Once a determination is made that an ethics consultation is appropriate, the ethics consultant may attempt to resolve the problem through a telephone consultation. If the problem cannot or, in the consultant's judgment, should not be resolved in this manner, the consultant should proceed as follows:

C. Patient consent for consultation

Under most circumstances, the consultant will see the patient. If the patient is decisional, the consultant will notify him or her of the nature of the visit. If the patient objects to the consultation, it should be discontinued. If the patient is not decisional or decision-making capacity is uncertain, the agent or proper surrogate must be notified of the ethics consultation at the earliest reasonable opportunity. If the surrogate or agent objects, the consultation should be discontinued.

Patient or surrogate refusals of consultation are to be reported to the ethics committee chair, who may wish to have the ethics committee and clinical staff discuss the type of ethical problem involved as a generic issue but without the use of the patient's chart and without identifying the patient. On occasion, the physician or other health care team member may wish to have the committee or consultant discuss a specific issue without identifying the patient to the committee. In either case, the patient (surrogate) does not have to be notified of such a generic discussion of the issue.

D. Initial evaluation

After patient or surrogate consent to consultation, the ethics consultant will, as appropriate:

1. Discuss the case with the attending physician, house staff and involved nursing staff.
2. Interview patient, family members and other involved persons and care givers.
3. Review the chart.

E. Decision whether to convene full ethics committee

1. If the problem is uncomplicated, common or has been previously encountered by the committee and the assessment of the ethics committee can be anticipated, the consultant may resolve it without the full ethics committee meeting.
2. If, in the judgment of the ethics consultant, the full ethics committee should review the case, the chair should convene a meeting.

F. Full ethics consultation

1. The ethics committee secretary will notify members of the meeting time and place.

2. Other persons invited to be present at the meeting may include:
 - Patient, if decisional
 - Relatives, the agent or a surrogate of the nondecisional patient
 - Attending physician
 - House staff of the attending team
 - Nurses caring for the involved patient
 - Social workers and chaplains caring for the involved patient
 - Bioethics graduate students
 - Other physicians or health care professionals whose expertise is required for deliberation about the present clinical problem
3. All present will be reminded of the need for confidentiality and cautioned not to discuss the case in any context in which the patient can be identified.
4. Discussion will then proceed along the general guidelines that follow.
5. Assessment of the ethical problem (by consultant or full ethics committee) will consider:
 - Medical facts
 - Patient preference, if known
 - Other relevant factors
6. Problem assessment and recommendation(s):
 - The ethical problem should be delineated.
 - Ethically appropriate recommendation(s) should be made.
7. Reporting:
 - A note of a full-committee or in-person consultation will be placed on the chart by a member of the ethics committee, unless the attending physician requests otherwise.
 - A report of all consultations, including telephone contacts, will be made in the minutes of the ethics committee with due regard for patient confidentiality.
 - Minutes of ethics committee meetings will go to the medical executive committee.

Consent for Diagnosis and Treatment in Pediatrics

Purpose: To outline the process for obtaining consent of minors

Responsibility: All hospital staff

Procedure

For minor patients, authorization by the patient's parent or guardian is required. Only one parent's consent and/or signature is required; however, it is best practice to have both parents' consent. The person giving the consent must be competent. There are exceptions to the parental/guardian consent requirement (see below).

In addition, every effort should be made to inform the minor, to the extent possible with the patient's age, maturity and condition, of the facts and circumstances of proposed treatment. For minors with decision-making capacity, document the child's views and preferences for medical care, including assent for treatment, and give appropriate weight in decision making. Make appropriate professional staff members available to both the child and the adult decision maker for consultation and intervention when the child's wishes differ from those of the adult decision maker.

If there is a disagreement regarding an alternative plan of care, the following options are available:

- Palliative care service may assist with further discussions and/or assist in advocating for the patient/family with focus on palliation and comfort care.
- An ethics advisory committee consultation may be requested.

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Removal of Mechanical Ventilation in the Dying Patient

Purpose: To assist physicians, nurses, clergy and other staff to provide a compassionate process for removing mechanical ventilation (RMV) in the dying patient. This guideline is to be used when death is the expected outcome following RMV. Examples include patients with severe irreversible brain injury, metastatic cancer, overwhelming sepsis, etc.

Procedure

A. Step 1: Decision and documentation

1. The prognosis, options and goals of care have been fully explored with the patient/legal surrogates/family; consensus has been reached that RMV with expected death is the optimal treatment course. The attending physician must be involved in this discussion. The patient's primary nurse, social worker, chaplain and palliative care nurse may be included in this discussion unless the family requests otherwise. Related issues to be discussed prior to RMV include:
 - Withdrawal of artificial hydration/feeding
 - Withdrawal of blood pressure support
 - Withdrawal of antibiotics and blood products
 - Withdrawal of ET tube after ventilator is discontinued
 - Wishes concerning organ donation (contact WDN to determine options)

Note: there is no compelling ethical or medical rationale for continuing any of these treatments once a decision has been made to RMV.

2. The attending physician documents in the medical record the date/time of the RMV discussion, who was present and the agreed goals and plan. A DNR order is written; an order is written to initiate bereavement protocol.
3. When prolonged survival is expected (>2 hours), the palliative care team is notified of the plan for RMV and potential for transition to the inpatient palliative care ward.
4. A time/date is established for RMV.

B. Step 2: Preparation for RMV

1. A senior physician (attending physician or ICU fellow or senior resident) will be available before, during and immediately after RMV, to supervise symptom control and provide counseling/support to family and staff. An order is written to D/C ventilator.

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2. The primary nurse and physician will provide information to the patient or family about the following (see “Staff Support Information for Patients and Families About Ventilator Withdrawal,” attached):
 - Who can attend during the RMV process
 - Potential outcomes: rapid vs. delayed death, potential symptoms/signs
 - Process of withdrawal: ventilator, ET tube, other tubes
 3. Notify respiratory therapy of RMV timing; ask therapist to be present.
 4. Notify chaplain; ask family/surrogates if they wish chaplain or other clergy present before or during RMV.
 5. Premedication for sedation: Note: The primary goal of sedation is to prevent dyspnea post extubation; unintentional apnea following sedative administration may occur, but in general, if all parties are agreed upon the plan of care, a decision to continue with ventilator withdrawal is appropriate; reversing agents (e.g., Narcan) should not be administered.
 - Discontinue paralytics and test for return of neuromuscular function.
 - Administer a bolus dose of morphine 2–10 mg IV and start a continuous morphine infusion at 50% of the bolus dose/hr (fentanyl or hydromorphone are acceptable alternatives).
 - Administer 1 to 2 mg of midazolam IV (or lorazepam).
(Note: Sedation should also be administered to the comatose patient.)
 - Titrate meds to minimize anxiety and achieve the desired state of sedation prior to extubation.
 - Have additional medication (morphine and versed or lorazepam) drawn up and ready to administer at the bedside, if needed to provide symptom relief.
 - If needed, other acceptable agents for sedation prior to and following extubation include pentobarbital or propofol.
 6. If previously discussed and agreed to, discontinue blood pressure support medication, artificial hydration and feeding, and remove OG/NG tubes.
 7. Remove restraints and unnecessary medical paraphernalia. Discontinue vital signs, labs, X-rays, pulse oximetry.
- C. Step 3: Removal of mechanical ventilation
1. Ensure adequate sedation.
 2. Prepare space at the bedside for family members.
 3. Ask respiratory therapist to silence all ventilator alarms; set FIO₂ to 21% and remove PEEP. Observe for signs of respiratory distress; adjust medication.

4. Reduce IMV rate to 4 and/or pressure support to 6 over 5 to 15 minutes. Observe for signs of respiratory distress and adjust medications to optimize patient comfort. Deflate endotracheal tube cuff, extubate and suction (if necessary) once comfort is achieved and the family consents to extubation. Remove ventilator from bedside.
 5. If continued intubation is desired by family or physician, place patient on T-piece, remove ventilator from bedside and continue to suction as necessary. Adjust medications to alleviate respiratory distress.
 6. Leave on T-piece or deflate endotracheal tube, extubate and suction as needed. Move ventilator away from bedside.
 7. Observe for signs of respiratory distress; adjust medication.
- D. Step 4: Actions following RMV
1. Document in the medical record the procedure, medications and immediate outcome of the process of RMV.
 2. Continually monitor for adequate sedation.
 3. Transfer patient to inpatient palliative care ward or other non-ICU bed if vital signs remain stable after 2 hours.

References

Rubinfeld GD, Crawford SW. Principles and practice of withdrawing life-sustaining treatment in the ICU. In Curtis JR and Rubinfeld GD, eds., *Managing Death in the Intensive Care Unit*. Oxford, UK: Oxford University Press; 2001:127–47.

Krieger BP. Compassionate extubation: withdrawing mechanical ventilator support. *Mediguide to Pulmonary Medicine*. 2001; 8:1–5.

Staff Support Information for Patients and Families about Ventilator Withdrawal

The support of families is a critical aspect of care for the dying patient who is to be removed from a ventilator. Before ventilator withdrawal, the following issues should be discussed.

Potential outcome of ventilator withdrawal

When all other life-sustaining treatments have been stopped, including artificial hydration and nutrition, there are several possible outcomes: rapid death within minutes (typically in patients with sepsis on maximal blood pressure support), death within hours to days, or stable cardiopulmonary function leading to a different set of care plans, including potential hospital discharge. If the latter possibility is realistic, future management plans should be discussed prior to ventilator removal, since some families may desire to resume certain treatments, notably artificial hydration/nutrition. Generally, by the nature of the underlying illness and the established goals, it is fairly easy to predict which category will be operative, but all families should be prepared for some degree of prognostic uncertainty.

The procedure of ventilator withdrawal

Explain how the family, clergy and others can be at the bedside before, during and after withdrawal. If asked, explain and model that they can show love and support through touch, wiping of the patient's forehead, holding a hand and talking to him or her.

Never make assumptions about what the family understands; describe the procedure in clear, simple terms and answer any questions. Families should be told beforehand the steps of withdrawal and whether or not it is planned/desired to remove the endotracheal tube. In addition, they should be counseled about the use of oxygen and medications for symptom control. Tell families that the sedative medication may lead to decreased breathing, but this does not represent euthanasia or assisted suicide. Assure them that the patient's comfort is of primary concern. Explain that breathlessness may occur, but that it can be managed. Confirm that you will have medication available to manage any discomfort. **Ensure that they know that the patient will likely need to be kept asleep to control his/her symptoms and that involuntary moving or gasping do not reflect suffering if the patient is properly sedated or in a coma.**

Support the decision

When a family is able to make a definite decision for ventilator withdrawal, such a decision is always emotionally charged. Families will constantly second-guess themselves, especially if the death appears to linger following ventilator withdrawal. Support, guidance and leadership from the entire medical team is crucial, as the family will be looking to the team to assure them that they are "doing the right thing". Furthermore, it is common for families to have concerns that their decision constitutes euthanasia or assisted suicide; explicit support, education and explanations from the team will be needed.

Removal of Mechanical Ventilation in the Dying Patient: Nursing Checklist

Progress Notes

- Chart documentation: goal of care and plan; date/time for RMV is established
- Decisions established re: hydration/feeding/pressors/antibiotics/ET tube

Orders

- DNR order
- Order to discontinue ventilator
- Premedications and emergency medications at bedside for pain, dyspnea, sedation
- Bereavement protocol initiated

Staff

- Respiratory therapy, palliative care, social services, chaplaincy notified
- Senior physician is present for RMV (attending, fellow, senior resident)

Families

- Information provided to families
- Referral call to Donor Network

Procedural steps

- Ventilator alarms silenced
- Suction equipment ready
- T-piece and/or aerosol delivery devices available at bedside
- Restraints removed
- Side rails down

III. Tools/Resources

Palliative Care Clinical Tools in Support of NQF Preferred Practices

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Job Descriptions: Hospital-Based Palliative Care

Palliative Care Program Director (Hospital)

Job Title: Palliative Care Program Director

Reports to: Senior VP for Medical Affairs

Status: Full-time

Purpose of the position:

- Provides operational leadership for all palliative care services
- Provides clinical leadership and expertise within the palliative care clinical team
- Proactively identifies opportunities to improve the patient and family experience of care and improve the efficiency and effectiveness of resource use
- Ensures compliance with legal, regulatory and clinical policies and procedures

Job responsibilities:

- Oversees the work of the palliative care clinical team members
- Participates and takes clinical leadership in the development and review of appropriate clinical protocols
- Leads monthly and periodic team meetings for the operational and administrative functions of palliative care program
- Coordinates annual strategic planning for palliative care program
- Develops and oversees metrics to demonstrate program impact
- Oversees program budget, review of performance measures and use of staff resources proportional to activity and patient care
- Regularly reviews financial and operational impact of palliative care program on the hospital and produces summaries for leadership review
- Leads the identification of education needs for hospital staff and development of effective educational strategies
- Provides outreach to community agencies and health care settings as appropriate
- Ensures that clinical protocols, utilization review, case management, quality assurance and compliance programs are implemented according to hospital policies
- Ensures compliance with Joint Commission and other regulatory standards; participates in quality assurance and peer review programs; and ensures compliance with and implementation of any resulting recommendations
- Functions as spokesperson for the program internally and externally
- Works with hospital leadership to enhance the palliative care program's community outreach to physicians, the public, health care facilities and other applicable organizations in the community



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- Works with the director of development to secure philanthropic support for palliative care services

Job qualifications:

- Doctor of Medicine with five (5) years of clinical experience beyond board certification and one (1) year of administrative experience or Advance Practice Nurse with a minimum of five (5) years of clinical experience and one (1) year of administrative experience
- Board certified or eligible in hospice/palliative medicine or equivalent experience
- ≥ One (1) year's experience working as part of an interdisciplinary team
- Current state medical or nursing license and in good standing with medical/nursing board
- Credentialed for full scope of practice at the hospital
- Management and leadership experience preferred
- Experience with ethics consultations preferred
- Experience with quality improvement methodology preferred

Palliative Care Physician (Hospital)

Title: Consulting Physician, Palliative Care

Reports to: Palliative Care Program Director

Status: Full-time

Purpose of the position:

Provides palliative care palliative care consultations within the hospital

Job responsibilities:

- Provides inpatient consultation services in palliative care
- Facilitates clarification of patient and family goals of care
- Consults with the attending physician and the interdisciplinary team to establish a written plan of care at intervals specified in the plan
- Facilitates access to appropriate supportive care services
- Educates staff and coworkers
- Provides full and appropriate documentation of patient care services to support professional billing for these services
- Participates in on-call coverage with the interdisciplinary team
- Participates in weekly interdisciplinary team meetings to review active cases
- Assists in the development of standards of care
- Performs other duties as requested
- Adheres to the practice of confidentiality regarding patients, families, staff, and the organization

Job qualifications:

- Doctor of Medicine with two (2) years' experience beyond board certification; licensed to practice medicine in the state
- Board certified or eligible in hospice/palliative medicine or equivalent experience
- One (1) year's experience working as part of an interdisciplinary team
- Willing to participate in staff, volunteer and physician palliative care education
- Current state medical license and in good standing with medical board
- Credentialed for full scope of practice at the hospital

Supervisory responsibilities: None

Advanced Practice Nurse (Hospital)

Job Title: Advanced Practice Nurse, Palliative Care

Reports to: Palliative Care Program Director

Status: Full-time

Purpose of the position:

Works in collaboration with a physician and other palliative care team members in an active practice to deliver palliative care and related health care services to patients and families

Job responsibilities:

- Performs bedside palliative care patient/family evaluation
- Assists with diagnosis, treatment and management of acute and chronic health conditions
- Orders, performs and interprets laboratory and radiology tests within scope of professional practice
- Prescribes medications including controlled substances to the extent delegated and licensed
- Orders treatments and durable medical equipment as indicated
- Performs other therapeutic or corrective measures as indicated, including urgent care
- Consults with palliative care physician or designees as needed, informs primary physician of services provided and collaborates with other physicians as needed
- Assists in all facets of care coordination for palliative care referrals
- Prepares and maintains accurate patient records, charts and documents to support sound medical practice and reimbursement for services provided
- Complies with applicable laws and regulations with respect to collaborative agreements
- Initiates reimbursement for services rendered
- Provides training and continuing education for staff
- Assists in development of clinical practice guidelines/standards in support of quality palliative care
- Adheres to the practice of confidentiality regarding patients, families, staff and the organization

Job qualifications:

- Advanced Practice Nurse licensed in the state
- Registered Nurse licensed in the state
- Controlled Substance license
- Excellent interpersonal and communication skills

Supervisory Responsibilities: None

Palliative Care Social Worker (Hospital)

Job Title: Social Worker, Palliative Care

Reports to: Palliative Care Program Director

Status: Full-time

Purpose of the position:

Provides clinical and administrative support regarding psychosocial patient/family needs to the palliative care consultation team and palliative care service director

Job responsibilities:

- Is available daily (M–F) for the palliative care team
- Provides psychosocial support to palliative care patients by working as a member of the palliative care consultation team
- Attends weekly interdisciplinary team meetings to review active cases
- Assists the team to facilitate patient/family meetings in clarifying goals of care and plan of care
- Coordinates team efforts with appropriate hospital departments to ensure smooth discharge planning and clear follow-up and continuity postdischarge
- Attends monthly and periodic team meetings for the operational and administrative functions of the palliative care service
- Assists the palliative care program director to ensure excellent patient care services, coordinating educational and outreach services, participating in quality improvement initiatives, and linking team efforts with other hospital departments and with outpatient and community services
- Serves as a liaison with community hospices, home health care and nursing homes to ensure care coordination and appropriate assignments and resource allocation to meet patient needs throughout the continuum of care

Job qualifications:

- Master of Social Work with a minimum of two (2) years of clinical experience
- Prior experience working in hospice or palliative care preferred

Supervisory responsibilities: None

Core Competencies in Palliative Care

General Medicine

Has broad understanding of and experience in the care of serious or life-threatening diseases/conditions, including course of illness, prognostic factors, common complications/syndromes and symptoms. In particular: cancer, chronic lung/heart/kidney/liver/endocrine/rheumatologic/vascular/infectious diseases; progressive neurological disorders; and serious trauma.

Pain and Symptom Management

Appropriately manages pain and other distressing physical symptoms of disease, illness or treatment in a timely manner and achieves outcomes and side effects 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? How are you feeling inside yourself?"

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 members as they focus on their relationships. This may include reconciliation of relationships. Provides helpful tools and/or recourses 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?"

B

tool

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.

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, e.g., selecting funeral home and making funeral arrangements; notifying SRS and other agencies, Medicare, and attorney who handles estate; addressing financial issues; canceling appointments; etc. (This could be presented to the family in a brochure or 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 and/or send a card or letter to the family expressing 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 patient and family knowledge and questions. Refers to appropriate resources for additional information and support. Provides anticipatory guidance and reading materials 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. Recognizes value of all team members in caring for seriously ill patients and their families.

Referral Criteria

The following criteria have been suggested or are in actual use at leading palliative care centers. Some hospitals use this material solely in marketing, while others have established these as defining criteria for automatic consultations.

General Referral Criteria

- Presence of a serious illness and one or more of the following:
- New diagnosis of life-limiting illness for symptom control, patient/family support
- Declining ability to complete activities of daily living
- Weight loss
- Progressive metastatic cancer
- Admission from long-term care facility
- Two or more hospitalizations for the same illness within three months
- Difficult-to-control physical or emotional symptoms
- Patient, family or physician uncertainty regarding prognosis
- Patient, family or physician uncertainty regarding appropriateness of treatment options
- Patient or family requests for futile care
- DNR order uncertainty or conflicts
- Uncertainty or conflicts regarding the use of nonoral feeding/hydration in cognitively impaired, seriously ill or dying patients
- Limited social support in setting of a serious illness (e.g., no family support system, lives alone, homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress

Intensive Care Unit Criteria

- Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., advanced dementia)
- Two or more ICU admissions within the same hospitalization
- Prolonged or failed attempt to wean from ventilator
- Multiorgan failure
- Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision making
- Coma or PVS lasting more than two weeks



Cancer Criteria

- Metastatic or locally advanced cancer progressing despite systemic treatments
- Karnofsky < 50 or ECOG > 3
- Brain metastases, spinal cord compression or neoplastic meningitis
- Malignant hypercalcemia
- Progressive pleural/peritoneal or pericardial effusions

Neurological Criteria

- Folstein Mini Mental Score < 20
- Feeding tube being considered for any neurological condition
- Status epilepticus > 24 hours
- ALS or other neuromuscular disease considering mechanical ventilation
- Any recurrent brain neoplasm
- Parkinson's disease with poor functional status or dementia
- Advanced Alzheimer's or other dementia with poor functional status and one or more hospitalizations for infection in the last six months
- Coma or PVS lasting more than two weeks

Educational Needs Assessment

The Educational Needs Assessment tool can be used with physicians or nurses to gather information on their self-confidence and comfort with common palliative care clinical tasks. The tool is best administered preceding an educational intervention to guide curriculum planning.

- I. Please rank your degree of competence with the following patient/family interactions and patient management topics, using the following scale:

4 = Competent to perform independently

3 = Competent to perform with minimal supervision

2 = Competent to perform with close supervision/coaching

1 = Need further basic instruction

1. ___ Conducting a family conference to discuss goal setting
2. ___ Giving bad news to a patient or family member
3. ___ Discussing DNR orders
4. ___ Discussing home hospice referral
5. ___ Discussing a shift in treatment approach from curative to comfort care
6. ___ Discussing treatment withdrawal (e.g., antibiotics, hydration, ventilator)
7. ___ Managing requests for futile treatments
8. ___ Performing a basic pain assessment
9. ___ Using oral opioid analgesics
10. ___ Using parenteral opioid analgesics
11. ___ Using adjuvant analgesics (e.g., tricyclics, steroids, anticonvulsants)
12. ___ Converting from one opioid to another
13. ___ Assessing and managing delirium
14. ___ Assessing and managing dyspnea
15. ___ Assessing and managing nausea/vomiting
16. ___ Assessing and managing constipation
17. ___ Assessing patient decision-making capacity
18. ___ Discussing advance directives with patients
19. ___ Managing common opioid side effects (sedation confusion, nausea, constipation)

D
tool

- II. Clinicians often have concerns that certain medical decisions may either be contrary to accepted legal, ethical or professional standards or that they may be contrary to their own personal beliefs. For each of the situations listed below, please indicate the type and amount of concern you have, using the following scale:
- 4 = Very concerned**
3 = Somewhat concerned
2 = Somewhat unconcerned
1 = Not concerned
- A. Decision: Providing maximal pain relief throughout a cancer patient's illness, even before the terminal phase. Concerns:
1. ___ This violates state law.
 2. ___ This violates medical practice standards and represents malpractice.
 3. ___ This violates accepted ethical norms.
 4. ___ This violates my personal religious or ethical beliefs.
- B. Decision: Withdrawing nonoral feedings (G-tube or NG tube) from a decisional terminal cancer patient who asks for such feeding to be discontinued. Concerns:
1. ___ This violates state law.
 2. ___ This violates medical practice standards and represents malpractice.
 3. ___ This violates accepted ethical norms.
 4. ___ This violates my personal religious or ethical beliefs.
- C. Decision: Withdrawing IV hydration from a terminal cancer patient who can no longer take oral fluids and who is clearly dying. Concerns:
1. ___ This violates state law.
 2. ___ This violates medical practice standards and represents malpractice.
 3. ___ This violates accepted ethical norms.
 4. ___ This violates my personal religious or ethical beliefs.
- D. Decision: Withdrawing parenteral antibiotics from a nondecisional dementia patient with urosepsis, at the request of his/her power of attorney for health care or legal guardian. Concerns:
1. ___ This violates state law.
 2. ___ This violates medical practice standards and represents malpractice.
 3. ___ This violates accepted ethical norms.
 4. ___ This violates my personal religious or ethical beliefs.

- E. Decision: Withdrawing ventilator support from a nondecisional dementia patient at the request of his/her power of attorney for health care or legal guardian. Concerns:
1. ___ This violates state law.
 2. ___ This violates medical practice standards and represents malpractice.
 3. ___ This violates accepted ethical norms.
 4. ___ This violates my personal religious or ethical beliefs.

III. Please indicate which of the following topics you would like included in future education programs, using the following codes:

1 = Yes

2 = No

1. ___ Pain assessment and management
2. ___ Assessment and management of nausea and vomiting
3. ___ Assessment and management of delirium
4. ___ Assessment and management of dyspnea
5. ___ Assessment and management of constipation
6. ___ Giving bad news
7. ___ Running a family conference
8. ___ Discussing prognosis
9. ___ Managing requests for futile treatments
10. ___ Hospice care: the who, why, when and where
11. ___ Ethics: DNR orders, advance directives, decision-making capacity
12. ___ Use of intravenous hydration and/of nonoral feedings in palliative care
13. ___ Spirituality in palliative care—role of the physician

Palliative Medicine: Hospital Credentialing Application

Name: _____

Primary care specialty/subspecialty: _____

Supervising physician (if applicable): _____

In addition to the requirements outlined in the medical staff bylaws, applicant must possess:

- Board certification in an ABMS-approved specialty
- Board certification in hospice and palliative medicine by the American Board of Hospice and Palliative Medicine, or be actively participating in the process to obtain certification via an ABMS-approved specialty

Core Privileges

Evaluation, consultation and provision of palliative care services to patients with serious or life-threatening illness, in the inpatient or outpatient setting.

Consultations

I acknowledge that in providing services to patients whose conditions are outside my training and usual area of practice, I will seek appropriate consultation or refer to a practitioner who has expertise in managing such cases.

Emergency Privileges

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, any medical staff member is authorized and will be assisted to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the member's license but regardless of department affiliation, staff division or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

Acknowledgment

I hereby request privileges in palliative care medicine. I understand that I am bound by the applicable hospital bylaws and policies of _____ and hereby that I meet the criteria for the privileges I am requesting.

Signature: _____ Date: _____

Recommendation: Request Approved Request Denied

Signature, Medical Director, Palliative Care Service

Date



Patient/Family Meeting Record

Date: _____ Care Conference Coordinator: _____

Patient: _____ Conference Date, Time, and Location: _____

Diagnosis: _____

Purpose of meeting:

Participants in meeting and relationships:

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) Other:

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:

Communication to other health professionals involved in patient care:

Chart updated to reflect care plan: Date: _____ Initials: _____

Tentative date for next Patient/Family Meeting: _____



FAMCARE Scale

Instructions:

Think about the care that your family member has received. Please circle the letters that best match your experience.

VS = Very Satisfied

S = Satisfied

U = Undecided

D = Dissatisfied

VD = Very Dissatisfied

How satisfied are you with:

1. The patient's pain relief	VS	S	U	D	VD
2. Information provided about the patient's prognosis	VS	S	U	D	VD
3. Answers from health professionals	VS	S	U	D	VD
4. Information given about side effects	VS	S	U	D	VD
5. Referrals to specialists	VS	S	U	D	VD
6. Availability of a hospital bed	VS	S	U	D	VD
7. Family conferences held to discuss the patient's illness	VS	S	U	D	VD
8. Speed with which symptoms are treated	VS	S	U	D	VD
9. Doctor's attention to patient's description of symptoms	VS	S	U	D	VD
10. The way tests and treatments are performed	VS	S	U	D	VD
11. Availability of doctors to the family	VS	S	U	D	VD
12. Availability of nurses to the family	VS	S	U	D	VD
13. Coordination of care	VS	S	U	D	VD
14. Time required to make a diagnosis	VS	S	U	D	VD
15. The way the family is included in treatment and care decisions	VS	S	U	D	VD
16. Information given about how to manage the patient's pain	VS	S	U	D	VD
17. Information given about the patient's tests	VS	S	U	D	VD
18. How thoroughly the doctor assesses the patient's symptoms	VS	S	U	D	VD
19. The way tests and treatments are followed up by the doctor	VS	S	U	D	VD
20. Availability of the doctor to the patient	VS	S	U	D	VD



INSERT HOSPITAL NAME

Palliative Care Consultation Report

Name

MRN #

Visit #

Sex/DOB

Admit Date

Date: _____

Requesting MD: _____

Consultant MD: _____

Reason for Consultation: Pain Non-pain Symptoms Plan of Care Transition Planning

Consultation Requested to Evaluate: _____

Chief Complaint: _____

Recommendations: _____

HPI Summary: (location, quality, duration, timing, context, modifying factors, severity, assoc. signs/sx)

Review of Systems and Symptom Assessment:

System	Neg.	System	Neg.	System	Neg.	System	Neg.	System	Neg.
Constitutional		Cardiovascular		GU		Neurologic		All/Imm	
ENMT		Respiratory		Hem/Lymph		Psychiatric		Skin	
Eyes		GI		Musculoskeletal		Endocrine			

All other systems negative

Review of systems unobtainable (patient unable to communicate because of disease severity/cognitive impairment)

Abnormalities/Describe Symptoms:

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

Source: Patient Family Team (circle all that apply)

Depression () Anorexia () Inactivity () Dyspnea () Anxiety ()
 Nausea () Drowsiness () Constipation () Agitation () Physical Discomfort ()
 Dementia: Yes No Delirium: Yes No Coma: Yes No
 Pain score: (0-10 scale): _____ Karnofsky _____%

Palliative Care Pager Number:

Palliative Care Office Number:

CHART COPY



INSERT HOSPITAL NAME

Palliative Care Consultation Report

Date: _____
 Requesting MD: _____
 Consultant MD: _____

Name
MRN #
Visit #
Sex/DOB
Admit Date

Reason for Consultation: Pain Non-pain Symptoms Plan of Care Transition Planning

Consultation Requested to Evaluate: _____

Chief Complaint: _____

Recommendations: _____

HPI Summary: (location, quality, duration, timing, context, modifying factors, severity, assoc. signs/sx)

Review of Systems and Symptom Assessment:

System	Neg.	System	Neg.	System	Neg.	System	Neg.	System	Neg.
Constitutional		Cardiovascular		GU		Neurologic		All/Imm	
ENMT		Respiratory		Hem/Lymph		Psychiatric		Skin	
Eyes		GI		Musculoskeletal		Endocrine			

All other systems negative
 Review of systems unobtainable (patient unable to communicate because of disease severity/cognitive impairment)

Abnormalities/Describe Symptoms:

ESAS (0-none, 1-mild, 2-moderate, 3-severe) **Source:** Patient Family Team (circle all that apply)
 Depression () Anorexia () Inactivity () Dyspnea () Anxiety ()
 Nausea () Drowsiness () Constipation () Agitation () Physical Discomfort ()
 Dementia: Yes No Delirium: Yes No Coma: Yes No
 Pain score: (0-10 scale): _____ Karnofsky _____ %

Palliative Care Pager Number: _____ Palliative Care Office Number: _____

DEPARTMENT COPY

INSERT HOSPITAL NAME

Palliative Care Consultation Report

Name

MRN #

Visit #

Sex/DOB

Admit Date

Date: _____

Requesting MD: _____

Consultant MD: _____

Reason for Consultation: Pain Non-pain Symptoms Plan of Care Transition Planning

Consultation Requested to Evaluate: _____

Chief Complaint: _____

Recommendations: _____

HPI Summary: (location, quality, duration, timing, context, modifying factors, severity, assoc. signs/sx)

Review of Systems and Symptom Assessment:

System	Neg.	System	Neg.	System	Neg.	System	Neg.	System	Neg.
Constitutional		Cardiovascular		GU		Neurologic		All/Imm	
ENMT		Respiratory		Hem/Lymph		Psychiatric		Skin	
Eyes		GI		Musculoskeletal		Endocrine			

All other systems negative

Review of systems unobtainable (patient unable to communicate because of disease severity/cognitive impairment)

Abnormalities/Describe Symptoms:

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

Source: Patient Family Team (circle all that apply)

Depression () Anorexia () Inactivity () Dyspnea () Anxiety ()
 Nausea () Drowsiness () Constipation () Agitation () Physical Discomfort ()
 Dementia: Yes No Delirium: Yes No Coma: Yes No
 Pain score: (0-10 scale): _____ Karnofsky _____%

Palliative Care Pager Number:

Palliative Care Office Number:

CHART COPY

INSERT HOSPITAL NAME

Palliative Care Consultation Report

Date: _____
 Requesting MD: _____
 Consultant MD: _____

Name
MRN #
Visit #
Sex/DOB
Admit Date

Reason for Consultation: Pain Non-pain Symptoms Plan of Care Transition Planning

Consultation Requested to Evaluate: _____

Chief Complaint: _____

Recommendations: _____

HPI Summary: (location, quality, duration, timing, context, modifying factors, severity, assoc. signs/sx)

Review of Systems and Symptom Assessment:

System	Neg.	System	Neg.	System	Neg.	System	Neg.	System	Neg.
Constitutional		Cardiovascular		GU		Neurologic		All/Imm	
ENMT		Respiratory		Hem/Lymph		Psychiatric		Skin	
Eyes		GI		Musculoskeletal		Endocrine			

All other systems negative
 Review of systems unobtainable (patient unable to communicate because of disease severity/cognitive impairment)

Abnormalities/Describe Symptoms:

ESAS (0-none, 1-mild, 2-moderate, 3-severe) Source: Patient Family Team (circle all that apply)
 Depression () Anorexia () Inactivity () Dyspnea () Anxiety ()
 Nausea () Drowsiness () Constipation () Agitation () Physical Discomfort ()
 Dementia: Yes No Delirium: Yes No Coma: Yes No
 Pain score: (0-10 scale): _____ Karnofsky _____%

Palliative Care Pager Number: _____ Palliative Care Office Number: _____

CHART COPY

INSERT YOUR HOSPITAL'S NAME

Palliative Care Inpatient Progress Note

Name

MRN #

Visit #

Sex/DOB

Admit Date

Date: _____

Chief Complaint: _____

() Pain () Non-pain symptoms () Plan of care () Transition planning

Current Symptoms: 0-none 1-mild 2-moderate 3-severe If moderate to severe, describe: _____

Source: Patient Family Team (circle all that apply)

Depression () Anorexia () Inactivity () Dyspnea () Anxiety ()

Nausea () Drowsiness () Constipation () Agitation () Physical Discomfort ()

Dementia: Yes No Delirium: Yes No Coma: Yes No

Pain severity: (0-10 scale) _____ Karnofsky _____%

HPI: (location, quality, duration, timing, context, modifying factors, severity, assoc. signs/sx)

Assessment/Recommendations:

Past History: unchanged from _____ Date Family History: unchanged from _____ Date Social History: unchanged from _____ Date

Note any changes: _____

Current Medications:

Review of Systems and Symptom Assessment:

System	Neg.	System	Neg.	System	Neg.	System	Neg.	System	Neg.
Constitutional		Cardiovascular		GU		Neurologic		All/Imm	
ENMT		Respiratory		Hem/Lymph		Psychiatric		Skin	
Eyes		GI		Musculoskeletal		Endocrine			

All other systems negative

Review of systems unobtainable (patient unable to communicate because of disease severity/cognitive impairment)

Abnormalities/Describe Symptoms:

Palliative Care Pager Number:

Palliative Care Office Number:



Palliative Care Inpatient Progress Note

Physical Exam: BP _____ Pulse _____ RR _____ Temp _____ O2sat _____
 nl nl nl nl
 Constitutional Respiratory GU Skin/integumentary
 ENMT Cardiac Musculoskeletal Neurological
 Eyes GI/Abdomen Hem/Lymph Psychiatric
 Abnormalities:

Laboratory and Other Data Review:

Purpose of the Counseling Session: () Goals of Care () Transition Planning () Other, specify: _____

Counseling Session Participants: _____

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

Summary of Patient/Family Counseling Session:

Fellow/Resident _____ / _____
Print Name Signature Dictation Code Date Time (AM/PM)

Attending/NP Documentation (List description of any counseling/care coordination discussions):

Transition Planning Discussed () _____
 Goals of Care Addressed () _____
 Spiritual Support Offered () _____

Total Attending/NP time: _____ minutes
 () More than fifty percent of time during encounter was spent on counseling and/ or care coordination as documented above
Prolonged time spent in face-to-face patient contact: _____ minutes
Prolonged time codes must be listed separately in addition to original E&M code billed

Attending/NP _____ / _____
Print Name Signature Dictation Code Date Time (AM/PM)

Palliative Care Pager Number: _____ Palliative Care Office Number: _____

Social Worker Assessment

Patient's Name: _____ DOB: _____

Age: _____ SS#: _____

Address: _____ Phone: _____

Primary caregiver: _____ Phone: _____

Address: _____

Diagnosis: _____ Onset: _____

MD(s): _____

Prognosis: _____

Current goal of care: Curative Rehabilitation Life-prolonging Comfort

Mental status: Alert Oriented Lethargic Nonresponsive/Coma

Coping status: Coping well Coping with some difficulty Significant coping difficulty
Comments: _____

Emotional status: Anxious Agitated Depressed
 Tearful Shock Anger

Comments: _____

Learning needs: Cultural Religious Motivational
 Physical Cognitive Language

Comments: _____

Home situation: _____

Support systems: Good Fair Poor

Comments: _____

Financial status: Adequate Marginal Crisis

Medicare #: _____ Medicaid #: _____

Private insurance name: _____ Group #: _____ Policy #: _____

Comments: _____

Advance directives: Living Will Power of Attorney Other: _____



Health care surrogate (name): _____

Contact info: _____

Patient's wishes related to goals and location of care (if applicable):

Patient's/family goals and expectations for this hospitalization:

Preferences regarding death (place, family presence, rituals):

Summary Assessment:

Referrals/Needs:

- Hospice
- Nursing home/intermediate care facilities
- Home health care
- Outpatient palliative care
- Durable medical equipment services
- Rehabilitation services
- Counseling services
- Transportation
- Rehabilitation
- Medication assistance
- Counseling
- Education
- Other

Palliative Care Social Worker: _____

Pager#: _____

Spiritual Care Assessment

Faith Group: _____ Particular Affiliation: _____
Pastor: _____ Phone: _____
Patient/family _____ gives consent to contact Pastor: Yes No

Areas to address

1. What is the patient's/family's source of strength?
2. What relationships have been significant in the past 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):

Chaplain's signature _____ Date _____



Use of Interpreters in Palliative Care (Fast Facts and Concepts #154)

During times of emotional stress and conversations that touch the inner soul, it is most comforting and safe for patients and families to describe feelings and thoughts in their primary language. This “Fast Fact” reviews key issues when using interpreters in the palliative care setting.

Using Health Care Interpreters vs. Family

- Medical interpreters who have completed specific training and follow national standards/ethics of practice (National Council on Interpreting in Healthcare) should be utilized in caring for patients with limited English proficiency.
- Although using family members may seem convenient, it is fraught with problems. There is no assurance that they will have the necessary language skills to convey medical information, and the patient may not feel comfortable expressing his/her feelings through family members. Family members may misinterpret medical phrases, censor sensitive/taboo topics, or summarize discussions rather than translate them completely. Family members may have strong emotions that affect their objectivity and impartiality. In addition, being the bearer of bad news or discussing contentious information may have negative implications for a family member following the encounter.
- Assure the patient and family that confidentiality will be maintained.

Interview Strategies

- Brief the interpreter before meeting with the patient/family. Explain the purpose of the encounter, your role and the physical setup of the room. It is important to warn the interpreter ahead of time if you will be discussing end-of-life issues and/or using the word “dying”. Emphasize that your statements should not be changed and that if your statement cannot be translated directly, the interpreter should alert you to rephrase.
- You and the interpreter should plan to be at eye level with the patient and you should directly face the patient while speaking, just as you would in a noninterpreter situation. Avoid the tendency of the patient and provider to give the appearance of speaking to the interpreter rather than to each other. When at the bedside, you and the interpreter should be on the same side of the bed next to each other to prevent unnecessary turning of the patient’s head from side to side.
- Keep your sentences and questions concise.
- Avoid saying to the interpreter, “Ask him . . .” or “Tell her . . .” Speak directly to the patient using the first person: “I am here today to talk to you about . . .”
- Professional interpreters are required to interpret all information that is provided as outlined in their code of ethics. Do not tell the interpreter, “Do not translate this . . .”
- Resist the tendency to raise your voice when trying to communicate with someone who speaks a different language.
- Pause at the end of each statement to allow the interpreter time to interpret.



- Pay attention to nonverbal clues that the patient/family is confused or that your comments were misinterpreted (e.g., puzzled look or furrowed brow). Stop and clarify that the interpreter and patient/family have understood the information.
- Following the interview, give the interpreter an opportunity to ask you questions or make comments about the encounter. If the discussion was emotionally charged, check in with the interpreter by asking questions such as “How are you doing?” or “Was that very distressing for you?”

The need to use an interpreter implies that significant cultural differences exist between you and the patient/family. Professional interpreters can help you provide effective and efficient communication that is culturally sensitive. Check with your institution to see what resources are available to work with patients whose English proficiency is limited. Companies that provide trained telephone language interpreters for health care workers include Language Line (<http://www.language.com>), Pacific Interpreters (www.pacificinterpreters.com), CyraCom International (www.cyracom.net), Telelanguage (<http://www.telelanguage.com>) and MultiLingual Solutions (<http://www.mlsolutions.com>).

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End-of-Life Care Checklist

Family spokesperson notified of change in patient's condition:

Name: _____

Address: _____

Phone: _____

Relationship 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
- Chaplaincy notified Defers services (indicate time to reassess) _____
- Social services notified Defers services (indicate time to reassess) _____

Time-of-Death Checklist:

Y N

- Medical examiner notified Not applicable
- Medical records notified
- Death notice form completed by MD Not applicable
- Postmortem care completed
- Sympathy card initiated

Other:

Disposition of belongings:

- To family
- To morgue/funeral home with body
- To security
- To police
- No belongings

List items sent:

Initials: _____ Signature: _____ Date: _____ Time: _____

Front

Opioid Analgesic Order Form

Verbal Orders are to be read back to prescriber

(Please use ball point pens ONLY and press firmly)

Allergies: _____

Note: **True opioid allergies are rare** and manifested by bronchospasm & anaphylactoid reactions. Nausea, sedation and/or delirium are **NOT** allergies.

List recent opioid medication use prior to admission (include dose):

Medication	Dose	Medication	Dose	Medication	Dose
------------	------	------------	------	------------	------

Short-acting Opioids – Choose only one

- Use oral when patient able to tolerate
- Maximum two-fold increment for range orders

IV Short-acting Opioids

- morphine 2-4 mg IV every 1 hour PRN moderate to severe pain
- morphine ____ mg IV every 1 hour PRN moderate to severe pain
- hydromorphone 0.2-0.4 mg IV every 1 hour PRN moderate to severe pain
- hydromorphone ____ mg IV every 1 hour PRN moderate to severe pain
- fentanyl 25-50 mcg IV every 1 hour PRN moderate to severe pain
- other: _____ IV every ____ hour(s) PRN moderate to severe pain

PO Short-acting Opioids / Tramadol

- oxycodone 5-10 mg PO every 2 hours PRN moderate to severe pain
- oxycodone ____ mg PO every 2 hours PRN moderate to severe pain
- morphine 10 mg PO every 2 hours PRN moderate to severe pain
- morphine ____ mg PO every 2 hours PRN moderate to severe pain
- hydromorphone 2 mg PO every 2 hours PRN moderate to severe pain
- hydromorphone ____ mg PO every 2 hours PRN moderate to severe pain
- tramadol 50-100 mg PO every 6 hours PRN mild to moderate pain
- other: _____ PO every ____ hours PRN moderate to severe pain

Short-acting Opioid-Acetaminophen Combination Products (Maximum 4000 mg acetaminophen in 24 hours)

- oxycodone/acetaminophen 5-325 mg tablet (PERCOCET) 1-2 tablets PO every 4 hours PRN moderate to severe pain
- oxycodone/acetaminophen 5-325 mg/5 mL (ROXICET) 5-10 mL PO every 4 hours PRN moderate to severe pain
- hydrocodone/acetaminophen 5-500 mg tablet (VICODIN) 1 tablet PO every 4 hours PRN moderate to severe pain
- hydrocodone/acetaminophen 2.5-167 mg/5 mL (LORTAB) 10-20 mL PO every 4 hours PRN moderate to severe pain
- codeine/acetaminophen 30-300 mg tablet (TYLENOL #3) 1-2 tablets PO every 4 hours PRN mild to moderate pain
- codeine/acetaminophen 12-120 mg/5 mL (TYLENOL #3) 12.5-25 mL PO every 4 hours PRN mild to moderate pain
- other: _____ PO every ____ hours PRN moderate to severe

Long-acting Opioids (ONLY for patients with chronic pain and/or established opioid tolerance) **Choose only one**

- Do not start sooner than 12 - 24 hours post-op • (See Opioid policy for criteria - CPM.0050)
- morphine CR (MS CONTIN) ____ mg PO every 12 hours (dose in 15 mg increments)
- oxycodone CR (OXYCONTIN) ____ mg PO every 12 hours (dose in 10-20 mg increments)
OXYCONTIN will be switched to MS CONTIN equivalent per therapeutic interchange unless patient on prior to admission.
- fentanyl patch ____ mcg/hour transdermally every 72 hours
- methadone _____ (see reverse for restriction information)

- Each new opioid order supersedes all previous opioid orders. **Any opioid not included** on this order sheet **will be discontinued.**
- Use Opioid Infusion Orders to order continuous opioid infusions or patient controlled analgesia (PCA) therapy

Provider Signature: _____ ID No: _____

Date: _____ Time: _____

RN Signature: _____

Date: _____ Time: _____

****SIGNATURE, CREDENTIALS, DATE AND TIME REQUIRED WITHIN 48 HOURS FOR VERBAL AND TELEPHONE ORDERS.****

Physician Orders



ORIGINAL - Medical Records
WHITE - Pharmacy
CANARY - Nursing

Froedtert HOSPITAL
Froedtert & Community Health

9200 West Wisconsin Avenue
P.O. Box 26099
75000 Milwaukee, WI 53226-3596

Physician Order Sheet - Item # 3687

N
tool

Front

Opioid Infusion Order Sheet

(Please use ball point pens ONLY and press firmly)

Transportation Information: WC CART BED PORTABLE O₂ IV

PCA

1. Discontinue all previously ordered opiates.

	Morphine	Hydromorphone (Dilaudid)	Other _____
PCA Dose	_____ mg IV	_____ mg IV	_____ (dose)
Lockout Interval	_____ minutes	_____ minutes	_____ minutes
Basal/Continuous Rate (optional)	_____ mg/hour IV	_____ mg/hour IV	_____ (dose) hour

3. Initial PCA dose may be administered IV push.

A loading dose of _____ may be administered via PCA Pump or IV push. (Initial PCA dose will be available to the patient after the initial lockout is completed).

4. Family may initiate dose (Palliative Care Only)

5. RN may initiate dose (Palliative Care Only)

6. Naloxone (Narcan) to be available at all times in patient medication cabinet. If cabinet not available, Naloxone (Narcan) will be available in AcuDose.

7. Opioid dose adjustment guidelines:

For mild to moderate pain, increase dose by 25-50%.

For moderate to severe pain, increase dose by 50-100%.

Do not increase by more than 100% of initial dose.

Continuous rate may be titrated to a maximum of _____.

PCA dose may be titrated to a maximum of _____.

8. Monitoring:

a. VS on initiation and every 4 hours

b. RR + Pulse Ox every 1 hour x 8 after initiation of PCA and with any increase in dosage; then every 4 hours

c. Initiate continuous pulse oximetry if:

1. Age greater than 80 years.

OR

2. Patient has one or more risk factors: (MD to complete)

Significant renal, hepatic or cardiac dysfunction

COPD

History of sleep apnea

Morbid obesity

Concurrent use of CNS depressant medication

9. Medications:

Senokot-S 1-2 tabs b.i.d. (hold if loose stools) or Opioid Bowel regimen (see back).

Diphenhydramine 25-50 mg po/IV every 8 hours prn itching not accompanied by hives.

10. Physician will be notified if:

• Pain goal not met • Nausea / Vomiting / Pruritis

11. If Modified Ramsey Sedation Scale greater than or equal to 4 or RR less than or equal to 8 or Pulse Ox less than 92% or SBP less than 90 mm Hg:

• Discontinue PCA infusion immediately

• Contact physician

• Initiate continuous pulse oximetry

• Administer oxygen to maintain Pulse Ox greater than 92%

• Monitor VS every 15 minutes

• Administer Naloxone (Narcan) 0.04 mg IV every 2 minutes PRN. (See dilution instructions on back)

Maximum dose 0.8 mg (2 vials)

Provider Signature: _____ ID No: _____

Date: _____ Time: _____

RN Signature: _____ Date/Time: _____

SIGNATURE, CREDENTIALS, DATE AND TIME REQUIRED WITHIN 48 HOURS FOR VERBAL AND TELEPHONE ORDERS.

Physician Orders



ORIGINAL - Medical Records
WHITE - Pharmacy
CANARY - Nursing

Froedtert HOSPITAL
Froedtert & Community Health

9200 West Wisconsin Avenue
P.O. Box 26099
Milwaukee, WI 53226-3596

Physician Order Sheet - Item # 28365

Teaching the Family What to Expect When the Patient Is Dying (Fast Facts and Concepts #149)

Family members look to the physician and nurse to help them know what to expect when a loved one is dying. No matter what the underlying causes, there is a common final pathway that most patients travel. Indicate your desire to be helpful. Say, “Many families like to know what may happen so they will be prepared; is that true for you?” If the family members say yes, describe the features on this list and answer their questions.

1. **Social withdrawal:** This is normal for the dying patient as the person becomes less concerned about his or her surroundings. Separation begins first from the world—no more interest in newspapers or television; then from people—no more neighbors visiting; and finally from children, grandchildren and perhaps even those persons most loved. With this withdrawal comes less need to communicate with others, even with close family.
2. **Food:** The patient will have a decreased need for food and drink as the body is preparing to die. This is one of the hardest things for some family to accept. There is a gradual decrease in interest in eating and appetite, even for favorite foods. Interest may come and go. The patient is not starving to death; this reflects the underlying disease. Liquids are preferred to solids. Follow the patient’s lead and do not force feed.
3. **Sleep:** The patient will spend more and more time sleeping; it may be difficult for him/her to keep the eyes open. This is a result of a change in the body’s metabolism as a result of the disease. Tell family to spend more time with the patient during those times when he/she is most alert; this might be the middle of the night.
4. **Disorientation:** The patient may become confused about time, place and the identity of people around him/her; he/she may see people who are not there. Some patients describe seeing family members who have already died. Sometimes patients describe welcoming or beckoning. While the patient may not be distressed, it is frequently distressing to family or health care professionals. Gently orient the patient if he or she asks. There is no need to “correct” the patient if he or she is not distressed.
5. **Restlessness:** The patient may become restless and pull at the bed linens. These symptoms are also a change in the body’s metabolism. Talk calmly and assuredly with the patient so as not to startle or frighten him/her. If the patient is a danger to himself/herself or others, you may prescribe sedating neuroleptics (e.g., chlorpromazine) or neuroleptics (e.g., haloperidol) in combination with benzodiazepines (e.g., lorazepam) to help the patient rest (see “Fast Fact” #1).
6. **Decreased Senses:** Clarity of hearing and vision may decrease. Soft lights in the room may prevent visual misinterpretations. Never assume that the patient cannot hear you, as hearing is the last of the five senses to be lost.
7. **Incontinence** of urine and bowel movements is often not a problem until death is very near. Invite family to participate in direct care; the nurse can help place absorbent pads under the patient for more comfort and cleanliness, or a urinary catheter may be used. The amount of urine will decrease and the urine will become darker as death nears.



8. **Physical Changes:** As death approaches, certain physical changes may take place.
- a. The blood pressure decreases; the pulse may increase or decrease.
 - b. The body temperature can fluctuate; fever is common.
 - c. There is increased perspiration, often with clamminess.
 - d. The skin color changes: flushed with fever, bluish with cold. A pale yellowish pallor (not to be confused with jaundice) often accompanies approaching death.
 - e. Breathing changes also occur. Respirations may increase, decrease or become irregular; periods of no breathing (apnea) are common.
 - f. Congestion will present as a rattling sound in the lungs and/or upper throat. This occurs because the patient is too weak to clear the throat or cough. The congestion can be affected by positioning, may be very loud, and sometimes just comes and goes. Anticholinergic medications (like transdermal scopolamine or sc/iv scopolamine or glycopyrrolate) can decrease secretions (see “Fast Fact” #109). Elevating the head of the bed and swabbing the mouth with oral swabs offers comfort and gives the family something to do.
 - g. The arms and legs may become cool to the touch. The hands and feet become purplish. The knees, ankles and elbows are blotchy. These symptoms are a result of decreased circulation.
 - h. The patient will enter a coma before death and not respond to verbal or tactile stimuli.

How to know that death has occurred:

- No breathing and heartbeat.
- Loss of control of bowel or bladder.
- No response to verbal commands or gentle shaking.
- Eyelids slightly open; eyes fixed on a certain spot.
- Jaw relaxed and mouth slightly open.

References

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Physician Orders for Life-Sustaining Treatment (Fast Facts and Concepts #178) The National POLST Paradigm Initiative

A health-systems barrier in the care of seriously ill and dying patients has been the inability to develop a system by which a patient's preferences for life-sustaining treatment are both documented and honored across different care sites. Various regional and statewide programs have tackled this problem with variable success. The Physician Orders for Life-Sustaining Treatment (POLST) program was started in Oregon in 1991. Based on the ease of use and community acceptance, POLST is now being used in other regions. This "Fast Fact" will review key elements of the POLST project.

POLST was developed as a one-page advance-care planning document to be completed by health care professionals, together with a patient or surrogate decision maker. It was designed to follow patients through all care settings (e.g., hospitals, hospice, long-term care and home care), and as developed in Oregon, widespread buy-in was obtained to support its application across a community of health provider locations. The actual form is divided into several sections:

1. CPR decision: resuscitate or DNR
2. Medical intervention decisions: comfort only vs. limited additional interventions vs. full treatment
3. Antibiotics: none vs. limited use vs. use for life-prolonging intent
4. Medically administered nutrition: none vs. defined trial period by tube vs. long-term use of tube
5. Health care professional signature (patient/surrogate signature is strongly recommended or required, depending on state/region using form)

How it works

Completion of the brightly colored voluntary POLST form is recommended when a patient has a serious illness, generally with a life expectancy of one year or less. The health care professional turns the patient's values (expressed personally, through an advance directive or the patient's legal representative, if the patient lacks decision-making capacity) into action by marking specific orders. The orders are valid when signed by a physician (or NP/PA, depending on individual state regulations). Many state/regional POLST programs require the patient's or legal agent's signature in addition to the clinician's to make the form valid. The POLST form is placed in the medical record and accompanies the patient across all care settings.

Data from completed research projects are available on the POLST Web site (www.polst.org). Key findings indicate that patients' values are accurately reflected in the orders, that the orders are followed by first responders, that life-sustaining treatment orders beyond CPR (e.g., artificial nutrition) are useful and that implementation can evolve to become a standard of care. Numerous communities and states are developing, or have implemented, programs similar to Oregon's, with the guidance of the National POLST Paradigm Initiative Task Force: West Virginia—Physician Orders for Scope of Treatment (POST); New York—Medical Orders for Life-Sustaining Treatment (MOLST); Washington State, Wisconsin and Pennsylvania—POLST.



The POLST Web site has sample downloadable forms (or contact the state/region's program), downloadable education materials and videos, a map of states and regions using the form and information on how to get started in building a coalition of health care professional organizations. Samples of most materials are available at no cost to help facilitate development of other POLST paradigm programs. There may be a low cost for larger orders to help cover expenses of a state or regional program's coordinating center. The Center for Ethics in Health Care at Oregon Health Sciences University coordinates the national initiative.

References

Hickman SE, Hammes BJ, Moss AH, Tolle SW. Hope for the future: Achieving the original intent of advance directives. *The Hastings Center Report* Special Report 2005 Nov-Dec;35(6):S26-30.

<http://www.polst.org>

Tolle SW, Tilden VP, Nelson CA, Dunn PM. A prospective study of the efficacy of the physician order form for life-sustaining treatment. *J Am Geriatr Soc*. 1998 Sep;46(9):1097-1102.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY					
<p style="text-align: center;">Physician Orders for Life-Sustaining Treatment (POLST)</p> <p>First follow these orders, then contact physician, NP, or PA. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.</p>	<p>Last Name</p> <hr/> <p>First Name/ Middle Initial</p> <hr/> <p>Date of Birth</p> <hr/>				
A	<p>CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse <u>and</u> is not breathing.</p> <p><input type="checkbox"/> Attempt Resuscitation/CPR <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (<u>A</u>llow <u>N</u>atural <u>D</u>eath)</p> <p>When not in cardiopulmonary arrest, follow orders in B, C and D.</p>				
B	<p>MEDICAL INTERVENTIONS: Person has pulse <u>and/or</u> is breathing.</p> <p><input type="checkbox"/> Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</p> <p><input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.</p> <p><input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.</p> <p>Additional Orders: _____</p>				
C	<p>ANTIBIOTICS</p> <p><input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms.</p> <p><input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs.</p> <p><input type="checkbox"/> Use antibiotics if life can be prolonged.</p> <p>Additional Orders: _____</p>				
D	<p>ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible.</p> <p><input type="checkbox"/> No artificial nutrition by tube.</p> <p><input type="checkbox"/> Defined trial period of artificial nutrition by tube.</p> <p><input type="checkbox"/> Long-term artificial nutrition by tube.</p> <p>Additional Orders: _____</p>				
E	<p>REASON FOR ORDERS AND SIGNATURES</p> <p>Discussed with:</p> <p><input type="checkbox"/> Patient</p> <p><input type="checkbox"/> Parent of Minor</p> <p><input type="checkbox"/> Health Care Representative</p> <p><input type="checkbox"/> Court-Appointed Guardian</p> <p><input type="checkbox"/> Other: _____</p> <p style="text-align: right;">My signature below indicates these orders are consistent with the person's preferences, if known. See medical record for further documentation.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <td style="width: 60%; padding: 5px;">Print Physician/NP/PA Name and Phone Number ()</td> <td style="width: 40%; padding: 5px;">Office Use Only</td> </tr> <tr> <td style="padding: 5px;">Physician/NP /PA Signature (mandatory)</td> <td style="padding: 5px;">Date</td> </tr> </table>	Print Physician/NP/PA Name and Phone Number ()	Office Use Only	Physician/NP /PA Signature (mandatory)	Date
Print Physician/NP/PA Name and Phone Number ()	Office Use Only				
Physician/NP /PA Signature (mandatory)	Date				
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED					

Whom Do You Call, Palliative Care or Ethics?

Physicians are often confused about when to call the palliative care service (PCS) vs. when to call the ethics committee for a consultation. This guide has been developed to help practitioners.

The palliative care service is a clinical consultation service accessed like any other medical consultation service. The purpose of the PCS is to support the optimal care of seriously ill patients through prompt attention to distressing physical symptoms, identification of goals, assistance with decision making concerning level of medical interventions, clarification of advance care planning and support for families and other health care team members.

Ethics committee consults are provided by ethics committee members, a multidisciplinary group of health professionals and others under the aegis of the medical staff office. The purpose of an ethics committee consultation is to bring ethics expertise to bear on a situation that requires clarification of issues and values, and to make recommendations for resolution of ethical issues. Ethics consults provide recommendations to the medical team, patient and family.

Consultation with palliative care services is suggested when the issue involves a medical or patient-care situation involving a patient who has a life-threatening or terminal illness (such as cancer, ESRD or end-stage dementia), or in whom the withdrawal of treatment will likely lead to death; common scenarios include:

- Staff-family conflict over appropriate level of care (DNR orders, transfer to ICU, artificial nutrition, etc.)
- Staff-staff conflict
- Family questions regarding appropriateness of life-prolonging interventions such as artificial feeding/hydration, dialysis, chemotherapy, etc.
- Questions regarding withdrawal of medical interventions
- Protocols for withdrawing medical interventions, including cardiopulmonary support, sedation, artificial hydration/feeding
- Medical interventions to relieve distressful symptoms (e.g., pain, terminal delirium, nausea, dyspnea)
- Questions regarding concerns that further medical intervention would only serve to prolong the dying process

Consultation with the ethics committee is suggested when the issue involves ethical concerns about professionalism, informed consent, decision-making capacity, confidentiality, advance directives, organ donation, genetics, reproductive issues and conflicts of values. Such situations may include:

- Ethical matters in the care of minors (including mature and emancipated minors) and patients with nonterminal dementia, or psychiatric or developmental disorders
- Conflicts concerning patients with serious or life-threatening illness where the palliative care service has been unable to resolve the issue



	PALLIATIVE CARE	ETHICS
Availability	24/7	24/7
Who may request consultation	Physicians; although others may request service, no formal consult will be done without MD order.	Physicians, nurses, patients, families, others with legitimate interest in the patient.
Authority	Similar to any other medical consultation: recommendations made to the attending MD. Will assume order writing for symptom control on request of attending physician.	Recommendations made to attending MD and patient/family.
Evaluation	Complete medical and psychosocial evaluation of patient/family unit; symptom control; goals of care decisions; family support; disposition issues; medical team concerns and values. Daily follow-up during hospital stay; outpatient follow-up as needed or requested by MD.	Medical facts (diagnosis and prognosis), team recommendations, patient preferences, clarification of patient and family values, health care team values, relevant laws and policies.
Chart records	All consults are charted like any other medical consultation.	Charted like any other medical consult, unless attending declines.
Hospital oversight	Oversight via palliative care committee.	All consults reviewed by full ethics committee and reported to medical executive committee.

Training Materials/Web Resources

American Academy of Hospice and Palliative Medicine (AAHPM)

www.aahpm.org

The American Academy of Hospice and Palliative Medicine (AAHPM) is dedicated to expanding access of patients and families to high-quality palliative care and advancing the discipline of hospice and palliative medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research and public policy.

AAHPM Pocket Guide to Hospice/Palliative Medicine

Gainesville, FL: American Academy of Hospice and Palliative Medicine, 2003.

www.aahpm.org/bookstore/index.html#guide

This clinic-oriented reference describes palliative medicine interventions for improving a patient's quality of life, particularly at the end of life. It is specifically targeted to medical residents and practicing physicians not already expert in end-of-life care.

AAHPM Unipac Series: Hospice/Palliative Care Training for Physicians AAHPM, 2003

www.aahpm.org/bookstore/index.html

Eight-part series of self-instructional books covering physical and psychological symptoms, ethics and legal aspects of end-of-life care

Association for Clinical Pastoral Education, Inc. (ACPE)

www.acpe.edu

ACPE is a multicultural, multifaith organization devoted to providing education and improving the quality of ministry and pastoral care offered by spiritual caregivers of all faiths through the clinical educational methods of Clinical Pastoral Education.

Center to Advance Palliative Care (CAPC)

www.capc.org

Technical assistance and training for development of nonhospice palliative care programs; leadership support and development; downloadable tools; spreadsheets; brochures and professional training resources

Communication Teaching Modules for the End-of-Life Educator

David E. Weissman, MD, and Kathy Biernat, MS. Milwaukee, WI: Medical College of Wisconsin, 1998.

www.eperc.mcw.edu

This six-part educational curriculum includes educational objectives, role plays, learner handouts, Power Point slides (provided on disk), a videotape and evaluation instruments to assist the instructor in teaching about communication issues in palliative care. The sections include: "Breaking Bad News," "Setting Treatment Goals," "Conducting a Family Conference," "DNR Orders," "Referral to Hospice" and "Spiritual Issues."

Compendium of Pediatric Palliative Care

Children's International Project on Palliative/Hospice Services (ChiPPS). Alexandria, VA:

National Hospice & Palliative Care Organization

<http://www.nhpco.org>

Comprehensive reference on pediatric palliative care, can be used as a self-study guide



Education and Training Curriculum for Pediatric Palliative Care

Children's International Project on Palliative/Hospice Services (ChiPPS). Alexandria, VA:

National Hospice & Palliative Care Organization

www.nhpco.org

This core curriculum can be used to design, develop and implement individualized educational and training programs. Its contents are designed to be relevant to the needs of many, varied populations of health care professionals and others who work with or wish to work with children or adolescents who are diagnosed as having, living with or dying from a life-threatening condition.

The End-of-Life Nursing Education Consortium (ELNEC)

www.aacn.nche.edu/el nec/curriculum.htm

The ELNEC core curriculum has been developed to prepare qualified nurse educators to provide end-of-life education for nursing students and practicing nurses, and to provide resources to facilitate that instruction.

End-of Life/Palliative Education Resource Center

www.eperc.mcw.edu

Contains searchable educational material, is home to “Palliative Care Fast Facts and Concepts” and publishes a biweekly e-newsletter of educational information for palliative care professionals

Education on Palliative and End-of-Life Care (EPEC) Curriculum

www.epec.net

EPEC has designed a core set of educational materials to enhance training presentations in palliative and end-of-life care. Use these materials to adapt to any educational format, from full two-day conferences to single-topic grand round presentations, medical school curricula, seminars or even self-study.

“Fast Facts and Concepts”

www.eperc.mcw.edu

One-page quanta of key clinical information, ideal for brief educational encounters, self-study or handouts

The HealthCare Chaplaincy

www.healthcarechaplancy.org

The HealthCare Chaplaincy is a multifaith community of professionals from many cultures dedicated to caring for persons in spirit, mind and body. Members are committed to excellence and leadership in pastoral care, education and research.

Initiative for Pediatric Palliative Care

www.ippcweb.org

The IPPC Curriculum, currently under development, is composed of five modules. The modules are designed to facilitate individual clinician learning and strengthen an institution's programs and services. These goals are accomplished by focusing on knowledge, attitudes, skills and institutional practice.

Harvard Medical School Center for Palliative Care Program in Palliative Care Education and Practice (PCEP)

www.hms.harvard.edu/cdi/pallcare

The Program in Palliative Care Education and Practice offers intensive learning experiences for physician and nurse educators who wish to become experts in the clinical practice and teaching of comprehensive, interdisciplinary palliative care, as well as gain expertise in leading and managing improvements in palliative care education and practice at their own institutions.

Palliative Care: A Self-Study CME Course

www.eperc.mcw.edu

EPERC has developed a self-study CME course containing 18 key topics in palliative care. The course is divided into five modules (Palliative Care, Pain, Other Symptoms, Communication, Last Days); 23 CME credits are available.

A Practical Guide to Communication Skills in Clinical Practice

Dr. Robert Buckman et al. Toronto, ON: Medical Audio Visual Communications, 1998

dwc@mavc.com

Comprehensive guide to communication skills presented as a set of four well-designed, easy-to-navigate CD-ROMs (also available as five videotapes)

The Social Work in Hospice and Palliative Care Network

www.swhpn.org

Emerging network of social work organizations and leaders who seek to further the field of end-of-life and hospice/palliative care

Toolkit for Nurturing Excellence at End-of-Life Transition (TNEEL)

Diana Wilkie, PhD, RN, FAAN, et al. Chicago: University of Illinois at Chicago, 2004.

<http://www.tneel.uic.edu>

Education package designed for nurse educators

AAHPM Credentialing Policy Statement

Statement on Credentialing in Hospice/Palliative Medicine
Approved by the Board of Directors, April 2006

Preamble

The American Academy of Hospice and Palliative Medicine recognizes the need for a process to credential physician specialists who seek employment in hospices, hospitals, long-term care facilities, palliative care clinics and managed care organizations. This document is written to provide guidance to credentialing organizations as hospice and palliative medicine gains recognition as a medical subspecialty.

The American Board of Hospice and Palliative Medicine (ABHPM) has certified physicians since 1996. ABHPM will offer its last examination in 2006, and it is anticipated that the first American Board of Medical Specialties (ABMS) exam in hospice and palliative medicine will be given in 2008. During an initial period that is expected to run from 2008 through 2012, physicians with substantial experience in hospice and palliative medicine may be admitted to the examination on the basis of their experience. After this period is over, only those who complete an ACGME-accredited hospice and palliative medicine fellowship will be eligible for certification as a specialist.

As the subspecialty of hospice and palliative medicine evolves, the Academy's position on credentialing will be reviewed.

Guiding Principles

Credentialing should be guided by the following principles:

- Physicians may practice hospice and palliative medicine at a generalist level or a specialist level. Through the credentialing process, organizations seek to ensure that physicians who engage in specialist-level practice have appropriate education or experience, and demonstrated knowledge and skills consistent with standards for specialists developed by the specialty itself.
- For hospice programs, credentialing indicates that a physician can apply the skills of a specialist in hospice and palliative medicine to the tasks of a hospice staff physician or medical director. In all practice settings, credentialing indicates that a physician can apply the skills of a specialist in hospice and palliative medicine as a consultant or primary care provider.
- The privilege to practice as a specialist in hospice and palliative medicine should be considered separate from other privileges, such as those applied to the practice of internal medicine or family medicine or pediatrics, which may overlap with these privileges but should be credentialed separately.
- Board certification or board eligibility in hospice and palliative medicine or training in the subspecialty is assumed to define a basic set of knowledge and skills. Other physicians can document by their training and experience that they are competent to care for patients with life-limiting illnesses and their families.
- Credentialing should rely, if possible, on processes already established by the specialty, such as board certification, but also must build on these processes by specifically designating and evaluating a set of specialist-level skills and practices that must be offered by credentialed specialists in hospice and palliative medicine.



- These guidelines may have the most utility when put into the format of a competency checklist.
- The privileges to offer additional procedures performed on patients with life-limiting illnesses should be granted only to those physicians who specifically request them and can demonstrate the appropriate training and skills.

Specialist-Level Knowledge and Skills

Health care organizations may credential a physician in hospice and palliative medicine who demonstrates evidence of specialist-level knowledge and skills in this discipline. The following principles apply to this process:

- Certification by ABHPM, or certification in hospice and palliative medicine by an ABMS board, indicates that a physician has met criteria for training and experience established by the specialty and passed an examination demonstrating specialist-level knowledge of palliative care. Certification is highly desirable among those who seek credentialing and, in the absence of conflicting information, is sufficient evidence of the ability to provide core elements of care.
- Eligibility for certification indicates that a physician has met the criteria to sit for the examination but has not yet taken it or performed satisfactorily. In the absence of conflicting information, board eligibility should be viewed as good evidence that a physician is able to provide core elements of care, including the assessment and management of physical, psychosocial and spiritual sources of suffering experienced by patients with life-limiting illnesses and their families, as well as has attained the specific knowledge and skills to encompass the following domains:
 - ◆ Prognostication, course of illness, and the nature of illness burden during the advanced phase of disease in diverse populations with life-threatening diseases
 - ◆ Neuropsychiatric comorbidities in populations with life-threatening diseases
 - ◆ Psychosocial complications in populations with life-threatening diseases
 - ◆ Specialist-level management of pain and nonpain symptoms
 - ◆ Effective and empathic communication, particularly surrounding salient issues at the end of life
 - ◆ Management of spiritual distress associated with life-threatening diseases
 - ◆ Management of the dying process and events surrounding death
 - ◆ Ethical and legal decision making, particularly surrounding issues in end-of-life care
 - ◆ Grief and bereavement support for the family and broader community
 - ◆ Interdisciplinary care planning and the optimal use of hospice and other systems of palliative care for populations with advanced illness
 - ◆ Goals and specific tasks clinical and administrative within the purview of a medical director employed by a certified hospice program
 - ◆ Regulatory requirements of the hospice Medicare benefit
 - ◆ Quality improvement methodology in populations with advanced illnesses

- Credentialing organizations seeking evidence of training, clinical experience or specific knowledge consistent with specialist-level hospice and palliative medicine should consider the physician's participation in relevant types of graduate medical education, continuing medical education, employment experience providing either primary care or consultative services and volunteer experience.

Core Privileges for Specialists in Hospice and Palliative Medicine

- Physicians who are credentialed to provide specialist-level care should be assumed to have the knowledge and skills to provide the core elements of hospice and palliative care. Accordingly, credentialing should subsume the following core privileges:
- Provision of primary care or consultative services to all patients with life-threatening illness who require, or may require, specialist-level palliative care services.
- Development of an interdisciplinary institution-based palliative care consultation service, or participation in a hospice interdisciplinary team, as appropriate.
- Provision of all physician care appropriate to institution-based palliative care consultation services or a hospice team, including patient and family assessment, empathic communication with patient and family, care planning and coordination of care, clarification of goals of care, management of common medical disorders commensurate with training and experience, appropriate referral to consulting services and community resources and quality improvement activities.
- Provision of appropriate advanced symptom control techniques such as parenteral infusional techniques. Invasive symptom control therapies such as neural blockade and neuraxial infusion are not considered core elements and should be credentialed separately.
- Provision of physician care in the management of the imminently dying patient, including care of medical disorders, effective communication, coordination with the medical care team and decision making grounded in the principles of hospice and palliative medicine, ethics, and appropriate law.

NHPCO (National Hospice and Palliative Care Organization) Patient/Family Education Booklets

This organization's Web site offers numerous helpful publications.
Go to: "Marketplace", then search "Consumer Education Brochures."

About Caregiving

Explains how to provide care while protecting the physical, mental and emotional health of patients and caregivers alike. Gives advice on adapting a home for patient care, lifting and moving patients safely, respecting their privacy and many other issues.

About Dementia

Discusses numerous causes of dementia other than Alzheimer's, including stroke, depression, drug interactions and nutritional deficiencies. Stresses that some forms of dementia may be treatable; urges early diagnosis; lists sources of assistance.

About Depression

Addresses a common but widely misunderstood problem. Helps readers better recognize, understand and cope with depression in themselves and others. Emphasizes that depression can be dealt with successfully; points readers toward sources of assistance.

About DNR Orders (Do Not Resuscitate)

Brings the facts about DNR orders into focus. Explains what they are, who creates them and why they are important. Discusses what happens when CPR is given, stresses that DNR orders cover only CPR, and tells how they can be canceled. Also reviews nonhospital DNR orders; explains advance directives, noting that they do not replace DNR orders; urges readers to discuss their wishes with their physician and family members; and more.

About Dying

Helps others understand the experiences of a dying person. Explains the five common responses to the idea of dying—denial, anger, bargaining, depression and acceptance—and how they're reflected in outward behavior.

About Grief

Helps people understand their feelings, recognize the stages of grief, cope with loss and continue to lead fulfilling lives.

About Hospice (Braille version)

Tool for public, patient and family education. Explains what hospice is and how it focuses on each person's unique needs. Discusses the services provided and introduces the members of the hospice team. Answers questions and guides people to sources.

About Parkinson's Disease

Puts the facts about this complex disorder into simple, reader-friendly terms. Explains how Parkinson's is diagnosed, how it develops and the symptoms that appear in early and later stages. Looks at how symptoms are controlled, provides tips on coping with the disorder, lists sources of help and support, and includes special advice for caregivers.



About Spiritual and Religious Competencies

Helps staff learn why and how to consider patients' beliefs when providing care. Discusses certain Joint Commission guidelines that require spiritual and religious competencies, tells staff how to assess a patient's needs and features a chart containing key facts about several major religions and spiritual traditions. Includes worksheets to help readers identify their own beliefs, their patients' religious affiliations and ways to customize the care they provide.

Advance Medical Directives

Explains how to make health care wishes known through an advance directive, and how such a document can help protect them, their family and physicians. Urges people to consider their values and discuss their choices with family members, and lists sources of information. Durable power of attorney version.

Age-Specific & Cultural Competencies

Every staff member who comes in contact with patients should have this handbook! Helps employees learn about, develop and implement the age-specific and cultural competencies that you, your patients—and the Joint Commission want them to have. Quizzes and worksheets enable staff to assess patients' views on health, consider their own values and beliefs, and identify specific job tasks that will help them develop competencies and improve their job performance.

Caregivers Need Care Too (CareSource)

Helps caregivers understand that their feelings and needs are important and not uncommon. Guides them to ways and resources that will make caregiving efforts less stressful and more effective.

Caring for a Loved One with a Terminal Illness

Identifies the challenges of caring for people with advanced disease. Tells how to create a safe environment, facilitate daily living and manage problems. Also stresses the need for caregiver to keep his or her own needs and health in mind.

Caring for Someone with Alzheimer's Disease

Identifies the challenges of caring for people with this condition. Tells how to create a safe environment, facilitate daily living and manage problems. Also stresses the need for caregiver to keep his or her own needs and health in mind. Lists sources of help.

End-of-Life Decisions

Stresses importance of making choices that feel right.

Funeral Planning

Outlines the issues people need to consider and the choices they have. It covers disposition options, the role of the funeral director, types of expenses and payment plans, ceremonies, selecting a resting place and more.

Going Through Bereavement

The death of a loved one engenders a wide range of reactions in people; this booklet helps readers understand feelings they may have, and how those feelings may affect them. It also stresses the importance of taking care of oneself and getting help if it's needed during the healing process. Includes practical advice about developing new interests and moving past bereavement.

Grief: Living with Loss

A sensitive way to deal with a difficult subject. This booklet helps people understand their feelings, recognize the stages of grief, cope with loss and continue to lead fulfilling lives. Same content as *About Grief* (see above), but featuring a “real life, real people” illustration style.

Hospice Under Medicare (Braille version)

A practical guide that helps people explore the hospice option.

Los Hospicios bajo Medicare

Spanish translation of *Hospice Under Medicare*. A practical guide that helps people explore the hospice option.

Let's Start Talking

by National Hospice Foundation. As Americans age, it's more important than ever that families learn about and discuss end-of-life care. Let's Start Talking delivers the facts about hospice care so families can make an informed choice about what is best for them.

Managing Stress: A Guide for Health-Care Workers

Acknowledges the prevalence of stress in the health-care professions, examines the serious consequences of untreated stress and outlines practical stress reduction and management techniques. Urges readers to seek help and avoid unhealthy behaviors. Includes a section on stress related to terrorism and bioterrorism.

Palliative Care: Comfort Caring at the End of Life

Takes a positive approach to helping terminally ill patients attain the highest quality of life possible. This reassuring booklet explains what palliative care is; describes treatment options for pain, depression and other symptoms; tells patients how to make their care wishes known; and addresses the psychological and spiritual aspects of their care. Helps patients assess their goals, understand the role of hospice care and know where to turn for help.

Patient and Family Guide to Care (CareSource)

Explains hospice care, the family's role in hospice care, the hospice team, information and skills for family caregivers and patient and family rights.

Patient Safety in the Home

Practical guide to adapting the home environment to patients' safety needs. Includes tips on avoiding slips and falls, fire prevention, managing medications, home-care products, emergency preparedness and more.

Planning a Funeral or Memorial Service

Helps the family understand what a funeral or memorial service is, how it may be beneficial to them and what the appropriate service is for themselves or a loved one.

Sobre Hospicios

Spanish translation of *About Hospice*. A tool for public, patient and family education, it explains what hospice is and how it focuses on each person's unique needs. Discusses the services provided and introduces the members of the hospice team. Answers questions and guides people to sources.

Spirituality & Pastoral Care (CareSource)

Helps older adults, individuals who are dying and their families understand that spirituality means different things to different people and provides suggestions for supporting their needs.

Using Cultural Competencies in Health Care

Helps staff members understand how culture can affect a patient's health beliefs and practices. Identifies specific cultural factors to consider when treating patients, and provides tips on communicating effectively with patients of different cultures. Includes a quiz to help you test staff-member knowledge and document your training efforts.

Working Through Grief: A Handbook for Coping with Loss

Interactive guide that gives readers a clear understanding of the grieving process, validates the emotions they're experiencing, and dispels common myths about grief. Activities include keeping a journal of thoughts and emotions, tracking and maintaining health issues, evaluating legal and financial matters and developing a personal plan for coping with loss.

NPCRC (National Palliative Care Research Center) Clinical Tools

The NPCRC Web site contains many useful tools for gathering clinical data. Go to: www.npcrc.org, then click on “Resources/Measurement and Evaluation Tools.”

Tools are divided into five categories:

- Pain and Symptom Management
- Functional Status
- Psychosocial Care
- Caregiver Assessment
- Quality of Life



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