

NCP Clinical Practice Guidelines for Quality Palliative Care, 4th edition Evidence of Practice and Action Plan

Domain 1: Structure and Processes of Care

Guideline/Criteria	Evidence	Action Plan
<p>Guideline 1.1 Interdisciplinary team Since palliative care is holistic in nature, it is provided by a team of physicians, advanced practice registered nurses, physician assistants, nurses, social workers, chaplains, and others based on need. The palliative care team works with other clinicians and community service providers supporting continuity of care throughout the illness trajectory and across all settings, especially during transitions of care. Depending on care setting and patient population, IDT members may be certified palliative care specialists in their discipline and/or have additional training in palliative care. Primary care and other clinicians work with interdisciplinary colleagues to integrate palliative care into routine practice.</p>		
1.1.1 The IDT provides care focused on individual physical, functional, psychological, social, spiritual, and cultural needs.		
1.1.2 The IDT encourages all team members to maximize their professional skills for the benefit of patients and families.		
a. Physicians focus on the illness trajectory, prognosis, and medical treatments, making patient visits or providing supervision in collaboration with advanced practice registered nurses or physician assistants (see Domain 2: Physical Aspects of Care).		
b. Nurses provide direct patient care, serving as patient advocate, care coordinator, and educator. Nurses are at the center of the immediate assessment and reassessment of patient needs (see Domain 2: Physical Aspects of Care).		
c. Advanced practice providers (physician assistants and advanced practice registered nurses) expand the capacity to deliver complex care and provide direct care (see Domain 2: Physical Aspects of Care).		



Guideline/Criteria	Evidence	Action Plan
d. Social workers attend to family dynamics, assess and support coping mechanisms and social determinants of health, identify and facilitate access to resources, and mediate conflicts (see Domain 3: Psychological and Psychiatric Aspects of Care and Domain 4: Social Aspects of Care).		
e. Chaplains, as the spiritual care specialists, assess and address spiritual issues and help to facilitate continuity with the patient’s faith community as requested (see Domain 5: Spiritual, Religious, and Existential Aspects of Care).		
f. Clinical pharmacists optimize medication management through a thorough review of the patient’s medications to identify therapies to further palliate symptoms, resolve or prevent potential drug-related toxicities, and recommend dose adjustment and deprescribing where appropriate.		
1.1.3 The IDT may also include other professionals with credentials, experience, and skills to meet the needs of the patient and family, including: mental health professionals, child life specialists, nursing assistants, nutritionists, respiratory therapists, occupational therapists, physical therapists, speech and language pathologists, massage, art, and music therapists, community health workers, paramedics, emergency medical technicians, psychologists, psychiatric-mental health advanced practice registered nurses, case managers, traditional medicine practitioners, and volunteers.		
1.1.4 The IDT facilitates the implementation and ongoing refinement of the palliative care plan in communication with all care providers to support patient and family goals.		
1.1.5 The IDT provides developmentally appropriate and culturally sensitive care to patients and families.		
1.1.6 The team meets regularly to discuss patient care, IDT functioning, and operational details essential to the provision of quality		



Guideline/Criteria	Evidence	Action Plan
palliative care. The frequency of IDT meetings is based on the needs of the population served, the care setting(s), and service model.		
1.1.7 The patient and family have access to palliative care staff 24 hours a day, seven days a week by phone or telehealth applications.		
1.1.8 The IDT accesses and ensures continuity with community services for families caring for neonates, children, or adults with a serious illness.		
1.1.9 Policies and procedures are in place for prioritizing and promptly responding to referrals and ongoing patient and family care needs.		
1.1.10 For programs with volunteers, policies and procedures are in place to guide volunteer services including recruitment, screening, training, role clarification, support, supervision, and performance evaluation.		
1.1.11 A palliative care specialty team includes a certified palliative care specialist. The setting of care or reimbursement may further dictate which clinician must be certified.		
Guideline 1.2 Comprehensive Palliative Care Assessment An interdisciplinary comprehensive assessment of the patient and family forms the basis for the development of an individualized patient and family palliative care plan.		
1.2.1 An initial comprehensive assessment is completed as soon after the referral as is reasonably possible.		
1.2.2 Each member of the IDT contributes to a comprehensive assessment as soon as reasonably possible, depending on the urgency of patient needs.		
1.2.3 The initial assessment includes conversations with the patient, family caregivers, clinicians, and others according to the patient's preferences.		



Guideline/Criteria	Evidence	Action Plan
1.2.4 The initial assessment is conducted in person by one or more IDT members, depending on the needs and concerns of the patient, is documented, and includes:		
a. Patient and family understanding of the serious illness, goals of care, treatment preferences, and a review of signed advance directives, if available		
b. A determination of decision-making capacity or identification of the person with legal decision-making authority		
c. A physical examination including identification of current symptoms and functional status		
d. A thorough review of medical records and relevant laboratory and diagnostic test results		
e. A review of the medical history, therapies, recommended treatments, and prognosis		
f. The identification of comorbid medical, cognitive, and psychiatric disorders		
g. A medication reconciliation, including over-the-counter medications		
h. Social determinants of health, including financial vulnerability, housing, nutrition, and safety		
i. Social and cultural factors and caregiving support, including caregiver willingness and capacity to meet patient needs		
j. Patient and family emotional and spiritual concerns, including previous exposure to trauma		
k. The ability of the patient, family, and care providers to communicate with one another effectively, including considerations of language, literacy, hearing, and cultural norms		



Guideline/Criteria	Evidence	Action Plan
I. Patient and family needs related to anticipatory grief, loss, and bereavement, including assessment of family risk for prolonged grief disorder		
1.2.5 The team identifies and documents if the adult patient or a family member served in the military and whether the patient or family member may be eligible for VA benefits.		
1.2.6 For pediatric patients, the team ascertains the developmental status and children or teens' understanding of their disease, as well as parental preferences for their child's care at the time of initial consultation. This is revisited throughout the trajectory of care.		
1.2.7 The IDT performs subsequent assessments at regularly defined intervals and whenever the patient's status significantly changes, new problems are identified, or the patient experiences a transition in health care setting or provider.		
Guideline 1.3 Palliative Care Plan		
In collaboration with the patient and family, the IDT develops, implements, and updates the care plan to anticipate, prevent, and treat physical, psychological, social, and spiritual needs.		
1.3.1 The patient's preferences, needs, values, expectations, and goals, as well as the family's concerns, provide the foundation and framework for the plan of care.		
1.3.2 The IDT collaboratively discusses and documents patient status, patient and family needs, treatment options, and symptom management.		
1.3.3 The IDT develops, implements, and coordinates the care plan in collaboration with the patient and family, other clinicians, and community providers, when indicated and possible.		
1.3.4 The care plan is always accessible to the patient, IDT, and other involved clinicians and, with the patient's consent, is shared with family, caregivers, and community providers.		



Guideline/Criteria	Evidence	Action Plan
1.3.5 The care plan is updated and reviewed at regular intervals and when the patient experiences a significant change in status; changes are based on the evolving needs of the patient and family, with recognition of complex, competing, and shifting priorities in goals of care.		
1.3.6 When appropriate, the patient is referred to hospice.		
1.3.7 The IDT facilitates the implementation of the plan of care to ensure:		
a. The patient and family have access to medications and treatments		
b. New medications, medical equipment, tests, and therapies are authorized by payers		
c. The patient and family can safely and effectively manage and administer medications		
1.3.8 The IDT provides patient and family with anticipatory guidance regarding disease progression and management strategies to maximize quality of life for both the patient and family.		
1.3.9 Treatment and care setting alternatives are documented and communicated to the patient and family to promote informed shared decision-making.		
1.3.10 Treatment recommendations are based on goals of care, assessment of risk and benefit, and best evidence. Re-evaluation of treatment efficacy, patient-family goals, and choices are documented.		
1.3.11 The IDT makes referrals and assists in the integration of the additional providers to support the plan of care.		
1.3.12 When serving as consultants, palliative care specialists contribute to the care plan developed by the referring provider and overtly clarify their ongoing role in care.		



Guideline/Criteria	Evidence	Action Plan
1.3.13 When working with patients with cognitive and/or communication impairment or incapacity, the IDT:		
a. Identifies the availability and willingness of a surrogate decision-maker		
b. Supports the surrogate with education related to signs and symptoms of psychological and psychiatric distress, and techniques to help alleviate distress		
c. Supports health care decision-making in a manner that is patient-focused and goal-concordant using principles of substituted judgment and best interest		
Guideline 1.4 Continuity of Palliative Care		
The IDT has defined processes to ensure access, quality, and continuity of care, especially during transitions of care.		
1.4.1 The IDT has defined processes for identifying patients with palliative care needs specific to the population(s) served.		
1.4.2 Patients and families receive an explanation of the palliative care services and, depending upon the setting of care, a written consent for services is signed by the patient and/or health care surrogate.		
1.4.3 When specialist palliative care is discontinued:		
a. The IDT documents their assessment and recommendations for ongoing care and shares them with the patient and family, as well as involved clinicians		
b. If a patient and family transitions to a care setting where palliative care is unavailable, the IDT reviews the ongoing care plan with the patient and family, as well as the clinicians who will continue or assume care oversight		
1.4.4 Upon the death of the patient, the IDT provides grief support to the family and ensures access to long-term bereavement support for family members (see Domain 7: Care of the Patient Nearing the End of Life).		



Guideline/Criteria	Evidence	Action Plan
1.4.5 The IDT ensures that care providers are informed of the patient's death and plans for bereavement support, as indicated.		
<p>Guideline 1.5 Care Settings</p> <p>Palliative care is provided in any care setting, including private residences, assisted living facilities, rehabilitation, skilled and intermediate care facilities, acute and long-term care hospitals, clinics, hospice residences, correctional facilities, and homeless shelters.</p>		
1.5.1 Care is provided in the setting preferred by the patient and family, if feasible, or the IDT helps the patient and family select an alternative setting.		
1.5.2 The IDT consults and collaborates with the clinicians and other professionals involved in patient care to maximize the patient's safety and sense of control.		
1.5.3 Providers in all settings address the unique needs of children, whether they are patients, family members, or visitors.		
1.5.4 Palliative care facilitates visits with family, friends, and pets in accordance with patient and family preferences and policies within the care setting.		
1.5.5 The IDT shares information and resources regarding palliative care with clinicians and other		
<p>Guideline 1.6 Interdisciplinary Team Education</p> <p>Education, training, and professional development are available to the IDT.</p>		
1.6.1 All members of the IDT have appropriate levels of education, including training in palliative care.		
<p>a. Advanced practice registered nurses, physicians, physician assistants, pharmacists, and physical, occupational or speech therapists have relevant graduate degrees and are licensed in their respective disciplines.</p>		
<p>b. Nurses have appropriate educational preparation to their license and scope of practice.</p>		
<p>c. Social workers have relevant bachelor's and/or graduate degrees and meet state licensing requirements.</p>		



Guideline/Criteria	Evidence	Action Plan
d. Spiritual care providers have relevant master’s degrees and are ideally board certified as a professional chaplain.		
e. Nursing assistants and personal care attendants meet state licensing requirements.		
f. Volunteers, when utilized, must have training relevant to their role.		
1.6.2 IDTs encourage discipline-specific credentialing and certification, or other recognition of competence including specialized training.		
1.6.3 Education, resources, and support are available to enhance IDT communication and collaboration.		
1.6.4 Palliative care staff participate in initial orientation and continuing education focused on the NCP Guidelines and document their participation accordingly.		
1.6.5 All palliative care clinicians receive training regarding the use of opioids, including:		
a. Safe and appropriate use of opioids		
b. Risk assessment for opioid substance use disorder		
c. Monitoring for signs of opioid abuse and diversion		
d. Managing pain for patients at risk for substance abuse		
e. Safe disposal of opioids in home and community settings		
<p>Guideline 1.7 Coordination of Care and Care Transitions</p> <p>Care is coordinated and characterized as the right care at the right time throughout the course of an individual’s disease(s) or condition. The IDT recognizes that transitions of care occur within care settings, between care settings, and between care providers. Care transitions are anticipated, planned, and coordinated to ensure patient goals are achieved.</p>		
1.7.1 IDT members understand how to effectively facilitate communication, care coordination, and transitions of care, sharing information including procedures that safeguard patient and family privacy.		



Guideline/Criteria	Evidence	Action Plan
1.7.2 The IDT establishes policies for optimal communication, including the sharing of documentation with everyone involved in the plan of care.		
1.7.3 Before, during, and after transitions of care, the IDT coordinates with the patient and family and other providers to ensure continuity of care.		
1.7.4 A timely assessment is completed after each care transition.		
<p>Guideline 1.8 Emotional Support to the Interdisciplinary Team</p> <p>Providing palliative care to patients with a serious illness and their families has an emotional impact, therefore the IDT creates an environment of resilience, self-care, and mutual support.</p>		
1.8.1 The program assesses staff for distress and grief.		
1.8.2 Administrative staff, IDT, and volunteers receive emotional support provided free from blame or stigma to alleviate the stress of caring for patients and families.		
1.8.3 The IDT implements interventions to promote staff support and sustainability, such as opportunities to discuss the impact of providing palliative care.		
1.8.4 Workload and workflow are structured to foster professional engagement and maximize time spent on activities that improve patient and family outcomes and staff wellness.		
<p>Guideline 1.9 Continuous Quality Improvement</p> <p>In its commitment to continuous quality improvement (CQI), the IDT develops, implements, and maintains a data-driven process focused on patient- and family-centered outcomes using established quality improvement methodologies.</p>		
1.9.1 The program measures and improves quality by systematically collecting and analyzing data on care processes and outcomes specific to the patient population and organization’s capacity, setting improvement targets, and planning and implementing change. This cycle is repeated in an iterative and ongoing fashion until it achieves sustained improvement.		
1.9.2 The IDT considers the six domains of health care quality as defined in 2001 by the Institute of Medicine (<i>safe, effective,</i>		



Guideline/Criteria	Evidence	Action Plan
<i>patient-centered, timely, efficient and equitable</i>) in the design of its CQI program.		
1.9.3 IDTs identify care coordination measures and integrate these into CQI initiatives.		
1.9.4 To the extent possible, the IDT uses assessment instruments, quality measures, and experience of care surveys that are validated, clinically relevant, and cross-cutting across settings or populations.		
1.9.5 Patients, families, clinicians, and other partners participate in the evaluation of the IDT.		
1.9.6 The IDT participates in quality reporting and accountability programs, as required or necessary to maintain licensure or accreditation.		
<p>Guideline 1.10 Stability, Sustainability, and Growth Recognizing limitations in reimbursement for interdisciplinary palliative care, IDTs endeavor to secure funding for long-term sustainability and growth.</p>		
1.10.1 A community needs assessment is conducted to identify populations in need of palliative care, determine if demand and resources are sufficient to support a sustainable palliative care program model, design services specific to the target population(s), and identify partners.		
1.10.2 Based on the needs assessment, a business plan with anticipated revenue and expenses is developed to ensure continuity of service to patients and families.		
1.10.3 When launching a new program, key performance metrics are agreed on in advance to define when a program is meeting its goals.		
1.10.4 The IDT develops strategic plans to prepare for changes in the target population and market forces, as well as other opportunities or threats that may affect the sustainability and growth of the program.		