

# Prepublication Requirements

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the updates to the print manuals (as well as in the online E-dition®), accredited and certified organizations and paid subscribers can also view them in the monthly periodical *The Joint Commission Perspectives*®. To begin your subscription, call 800-746-6578 or visit <http://www.jcrinc.com>.



## New and Revised Standards and Elements of Performance (EPs) for Palliative Care Certification

APPLICABLE TO PALLIATIVE CARE CENTERS

Effective July 1, 2015

### Provision of Care, Treatment, and Services (PCPC)

#### Standard PCPC.1

Patients and families know how to access and use the program's care, treatment, and services.

#### Elements of Performance for PCPC.1

- C 2. The program informs patients and families of how to access care, treatment, and services during business hours.
- C 3. The program informs patients and families of how to contact staff in the case of an emergent situation during or after business hours.
- C 4. The program informs patients and families about ~~their~~ patient rights and responsibilities while receiving care, treatment, or services from the palliative care program.
- C 5. ~~The p~~Program staff assists patients and families with ~~and using~~ identifying and accessing community resources that are available to meet ~~their health care needs~~ patients' physical, psychosocial, and spiritual needs. **M**

**Note:** *Examples of such resources may include, but are not limited to, community service providers, local school personnel, respite care providers, and spiritual leaders.*

- C 6. ~~The p~~Program staff informs patients and families of their responsibility to provide information that is important to care, treatment, and services.
- C 7. ~~The p~~Program staff informs patients and families about their right to refuse any or all of the care, treatment, and services offered by the program.
- C 8. Programs that do not provide hospice care have a process for making referrals to one or more hospices that will accept palliative care patient referrals.

#### Standard PCPC.2

The program communicates with patients and families and involves ~~patients~~ them in decision making.

#### Elements of Performance for PCPC.2

- C 1. ~~The p~~Program staff discuss with patients how they want to receive information, including the type ~~and extent~~ of information, the method in which it is provided, which family members are to receive this information, and whether a surrogate decision-maker is involved in care, treatment, and service. (For information on the role of surrogate decision-makers, see Standard RI.01.02.01)
- A 3. The program respects the patient's right to ~~and need for~~ communication that meets their needs to stay be informed about ~~their his or her care~~ by providing information in a manner tailored to the patient's age, language, and ability to understand.

Key: A indicates scoring category A; C indicates scoring category C; **Ⓢ** indicates that documentation is required; **M** indicates Measure of Success is needed; **⚠** indicates an Immediate Threat to Health or Safety; **⚠** indicates situational decision rules apply; **⚠** indicates direct impact requirements apply; **R** indicates an identified risk area

- C 5. ~~The program staff educates the patient and family on disease processes and prognosis so that they are able to make informed care decisions about their care.~~ (See also PCPC.3, EP 8 and RI.01.02.01, EP 8) **M**
- C 6. ~~The program staff informs the patient and family about the benefits and burdens risks of care, treatment, and services.~~
- C 7. The program involves the patients and family in decisions about ~~their~~ clinical care. **M**
- C 8. Patients and staff mutually agree upon patient-centered goals of care.
- C 9. ~~The program promotes~~ Program staff provide information and education about advance care planning and ~~educates patients about it to the patient and family as appropriate to the patient's clinical status, based on the patient's expressed values, religious or spiritual beliefs, cultural practices, and preferences for care. This information is documented in the medical record.~~
- A 11. ~~The program documents, in the patient's medical record, whether the patient has a designated surrogate decision-maker.~~ In instances in which the patient has a designated surrogate decision-maker, ~~the program a~~ member of the interdisciplinary team documents the surrogate decision-maker's name and contact information in the medical record.
- A 12. The program has a process to provide surrogate decision-makers with guidance on legal and ethical decision making, when needed.
- C 13. If the patient has expressed preferences for treatment as his or her disease progresses, the interdisciplinary team will document these preferences in the medical record.
- C 14. **For palliative care programs that provide care for pediatric patients:** When developmentally appropriate, the child's opinions and preferences are considered when making decisions and providing care.
- C 15. **For palliative care programs that provide care for pediatric patients:** When developmentally appropriate and proper for the clinical circumstance, the program provides age-appropriate information about the child's illness, as well as potential treatments and outcomes, to the child as decided by the child's family.

Standard PCPC.3

The program tailors care, treatment, and services to meet the patient's lifestyle, needs, and values.

**Elements of Performance for PCPC.3**

- C 2. ~~The documented plan of care is developed based on the patient's assessed needs, strengths, limitations, and goals and updated by the interdisciplinary team in collaboration with the patient, his or her family, and health care providers involved in the care of the patient.~~ **M** **A**
- C 3. The plan of care is based on an understanding of the patient's assessed needs in conjunction with the patient's strengths, limitations, values, and preferences goals.
- C 6. ~~The~~ While providing care, treatment, and services, program tries to staff accommodate the patient's and family's cultural preferences ~~while providing care, treatment, and services and practices unless they are contraindicated or the accommodations affect the care of others.~~
- C 8. ~~The program staff informs the patient and family about the outcomes of his or her the patient's~~ care, treatment, and services, including unanticipated outcomes and sentinel events. (For more information, refer to Standard PCPI.4; see also PCPC.2, EP 5)
- C 9. ~~The program staff evaluates and revises the plan of care to meet the patient's and family's ongoing needs and documents the revisions in the patient's medical record.~~ (For more information, refer to Standard PCPC.4) **M** **A**
- C 10. When clinically appropriate, the interdisciplinary team meets with the patient and family to develop a plan of care to meet their needs and preferences during the dying process. **M** **A**

Standard PCPC.4

The interdisciplinary ~~program~~ team assesses and reassesses the patient's needs.

**Elements of Performance for PCPC.4**

- C 1. The interdisciplinary ~~program team performs~~ conducts and documents an initial patient assessment, ~~as including a clinical assessment that is defined by the program, and documents the assessment in the patient's medical record and based on the patient's needs.~~ (For more information, refer to Standards PCIM.2 and PCPM.7) **M** **A**
- C 2 5. As part of the initial assessment, the interdisciplinary program team obtains information about identifies and documents the cultural, spiritual, ~~or~~ and religious beliefs and practices important to the patient and family that influence care, treatment, and services. The scope of this assessment is defined by the program and based on patient needs.

- C 3 2. ~~As part of the initial assessment, the interdisciplinary program team assesses and documents the patient's pain, dyspnea, constipation, and other symptoms and uses, when available, using standardized scales when they are available. The scope of this assessment is defined by the program and based on patient needs.~~ **M**
- C 4 3. ~~As part of the initial assessment, the interdisciplinary program team performs a~~ assesses and documents the patient's functional assessment, as status. The scope of this assessment is defined by the program, and documents the functional assessment in the patient's medical record and based on patient needs. (For more information, refer to Standard PCPM.7)
- C 5 4. ~~As part of the initial assessment, the interdisciplinary program team performs~~ assesses and documents the patient's psychosocial assessment, and documents the psychosocial assessment in the patient's medical record. The scope of this assessment is defined by the program and based on patient needs. (For more information, refer to Standard PCPM.7)
- C 6. ~~As part of the initial assessment, the interdisciplinary program team assesses and documents the patient's anxiety, stress, anticipatory grief, coping, and other psychological symptoms and uses, when available, using standardized scales when they are available. The scope of this assessment is defined by the program and based on patient needs.~~
- C 7 10. ~~The interdisciplinary program team assesses the need and documents the need plan for post-death grief and bereavement services for the patient's and family.~~
- C 8 7. ~~The interdisciplinary program team completes the initial assessment(s) within its defined time frame.~~ **M** **A**
- C 9 8. ~~The interdisciplinary program team reassesses the patient as defined by the program and on a regular basis, including whenever there is a change in the patient's condition or goals, when there is a change in the patient's or family's preferences, and as defined by the program. The reassessment is documented in the patient's medical record.~~ **M** **A**
- C 10. ~~The interdisciplinary program team routinely documents the patient's wishes about his or her care across care settings, including the site of death, and fulfills patient's preferences when possible.~~
- C 44 9. ~~The interdisciplinary program team recognizes and documents the patient's transition to the active dying phase.~~
- A 11. **For palliative care programs that provide care for pediatric patients:** Assessment of infants, children, and

adolescents must consider both the age and cognitive development of the patient.

- C 12. **For palliative care programs that provide care for pediatric patients:** Health care professionals with experience in the developmental stages and needs of infants, children, and adolescents perform and document the psychosocial and developmental assessment.
- C 13. **For palliative care programs that provide care for pediatric patients:** The special care needs of pediatric patients are addressed across palliative care settings. Age and developmentally appropriate methods are used by staff to address the loss, grief, and bereavement needs of dying and grieving children.

#### Standard PCPC.5

The program provides care, treatment, and services according to the plan of care.

#### Elements of Performance for PCPC.5

- C 2. The interdisciplinary team provides compassionate care consistent with the patient's quality of life needs, while preserving the patient's comfort and dignity are priorities.
- C 3. The interdisciplinary team manages the patient's physical symptoms are managed effectively according to the patient's plan of care by utilizing pharmacological and/or nonpharmacological methods according to their effectiveness in minimizing pain and suffering. These symptoms include, but are not limited to, the following:
- Anorexia
  - Confusion
  - Constipation
  - Dyspnea
  - Fatigue
  - Insomnia
  - Nausea
  - Pain
  - Restlessness
- C 4. The patient's psychological symptoms, including anxiety, stress, delirium, behavioral changes, and anticipatory grief, and coping are managed according to the patient's plan of care.
- A 7. The program has a process for provides providing or making referrals for grief and bereavement services for the patient's, if indicated family prior to the patient's death.  
**Note:** The process includes attention to children and adolescents who are family members of the patient.

- C 8. The program has a process to identify ~~patients and~~ families at high risk for complicated grieving and provides referrals for bereavement services available in the organization or community.
- C 9. The program provides education, ~~training,~~ and support to the patient, ~~addressing the patients need for safe and~~ suitable care and family based on their needs and the plan of care.
- C 10. The interdisciplinary team informs the patient's ~~and~~ family when the patient's death is ~~expected~~ determined to be imminent.
- C 13. The interdisciplinary team assesses and then treats or refers patients with symptoms of psychiatric diagnoses such as depression, anxiety, and suicidal ideation. <sup>3</sup>

Standard PCPC.6  
The patient's care is coordinated.

#### Elements of Performance for PCPC.6

- C 3. The program assists staff in obtaining knowledge-based information resources and references that are necessary for the patient's care and self-management and that support the patient's and staff's ability to make decisions.
- C 5. The ~~program~~ interdisciplinary team conducts regular patient care conferences with its members ~~of the interdisciplinary program team~~ to discuss patient-centered goals of care, disease prognosis, and advance care planning, ~~and to offer support.~~ The frequency of these patient care conferences is defined by the program. <sup>M</sup>
- C 6. The ~~program's~~ leaders ~~offer or provide~~ inform staff, ~~access to ethics consultation or a~~ patients, and families about the organization's process to address concerns and resolve ethical conflicts that may occur in the provision of palliative care. (For more information, refer to Standard RI.01.07.01)

**Note:** *Examples of ethical concerns that may occur in palliative care include, but are not limited to, withholding or withdrawing treatments, conflict with advance directives including "do not resuscitate" (DNR) orders, and use of sedation and pain medications. (See also LD.04.02.03, EP1)*

#### Performance Improvement (PCPI)

Standard PCPI.3  
The program analyzes and uses its data to identify opportunities for performance improvement.

#### Element of Performance for PCPI.3

- C 4. The program uses patient satisfaction data that is specific to the care, treatment, and services it provides in order to improve care of patients and families.

#### Program Management (PCPM)

Standard PCPM.4  
The program identifies and minimizes risks to patients.

#### Element of Performance for PCPM.4

- A 9. **For palliative care programs that provide care for pediatric patients:** The special safety needs of pediatric patients are addressed in the physical environment. **Note:** *Examples of pediatric safety needs in the physical environment include, but are not limited to, the following: controlled access to the pediatric patient area; protection from hazards such as cleaning supplies or medical equipment; restricted access to other patient areas, storage rooms, or stairwells.*

Standard PCPM.5  
The program has a process to address concerns or complaints patients have about the care, treatment, and services it provides.

#### Elements of Performance for PCPM.5

- C 2. The program communicates its ~~to~~ patients and their families the process for handling patients' concerns or complaints about the program or their care ~~or the program to patients.~~
- A 3. ~~Staff~~ Program staff are aware of how to handle patients' or families' concerns or complaints about the program or their care ~~or the program.~~

Standard PCPM.6  
Program leaders are responsible for selecting, orienting, educating, and retaining, ~~and providing incentives for~~ staff.

#### Elements of Performance for PCPM.6

- A 3. ~~Staff~~ Program staff maintain a current professional license or certification, in accordance with law and regulation. <sup>A</sup>
- A 4. <sup>D</sup> Program leaders assess each program staff member's competence to perform job responsibilities through observation within program-defined time frames. This assessment is documented.
- A 5. <sup>D</sup> ~~Orientation for the program~~ The program provides or facilitates access to orientation for the interdisciplinary team members, program staff, and volunteers. The orientation plan and specific content are defined by the

program leaders and includes information and training necessary to perform their responsibilities, but are not limited to, the following areas:

- The domains of palliative care
- Assessment and management of pain and other physical symptoms
- Assessment and management of psychological symptoms and psychiatric diagnoses
- Communication skills
- Cross-cultural knowledge and skills
- Information on specific population(s) served
- Grief and bereavement
- Ethical principles that guide provision of palliative care
- Community resources for patients and families
- Hospice care

**Note:** *Orientation may be provided over a period of time and in a variety of methods, including live and video presentations; electronic or written materials; clinical experience with a preceptor or mentor; or education at a seminar or other organization.*

C 7.6. Leaders Organization and program leaders support staff participation in continuing education, including in-services, training, and other activities by providing or facilitating access to ongoing continuing education in palliative care for the interdisciplinary team members and program staff.

C 6.7. The program Program leaders identify and respond to program team members the specific learning needs of the interdisciplinary team and program staff. This includes determining education topics and number of hours of continuing education.

C 8. The program leaders coaches and mentors staff in order to improve their ability to provide care, treatment, and services in a manner that builds mutual trust with the patient and family.

C 10. Leaders The program provides for staff with emotional and psychological support for leaders, members of the interdisciplinary team, staff, and volunteers.

**Note:** *Emotional and psychological support is especially important to support staff resilience in helping manage the stress of caring for seriously ill palliative care patients and their families.*

C 11. **For palliative care programs that provide care for pediatric patients:** The program provides access to pediatric-specific orientation and ongoing education for the interdisciplinary team members, staff, and volunteers that provide care for pediatric patients.

Standard PCPM.7

The program has an interdisciplinary team that includes individuals health care professionals with expertise in and/or knowledge about the education and experience to provide the program's specialized care, treatment, and services that meet the needs of the patient and family.

**Elements of Performance for PCPM.7**

A 1. The core interdisciplinary program team is composed comprised of the following: <sup>Δ</sup>

- ~~—Licensed independent practitioner(s)~~
- Physician(s) (doctor of medicine or osteopathy) who has specialized training in palliative care or clinical experience in palliative medicine, or is board-certified or board-eligible for certification in Hospice and Palliative Medicine
- Registered nurse(s) or advanced practice nurse(s) who has palliative care training or clinical experience in hospice or palliative care, or one who has, or is eligible for, palliative care certification
- Chaplain(s) who has palliative care training or experience in hospice or palliative care, or one who has or is eligible for board certification; or, a spiritual care professional(s) \* who has palliative care training or experience in hospice or palliative care
- Social worker(s) who has palliative care training or experience in hospice or palliative care, or one who has, or is eligible for, palliative care certification

\* Spiritual care professionals are recognized as specialists who provide spiritual counseling. **Source:** Dahlin, C., editor. *The National Consensus Project for Quality Palliative Care Clinical Practice Guidelines for Quality Palliative Care*, 3rd edition, 2013, p. 26.

**Note:** *The program demonstrates effort to include at least one of each of the following:*

- ~~—Licensed independent practitioner who has palliative care specialty training or one who is board-certified or board-eligible~~
- ~~—Registered nurse who has palliative care specialty training or one who has or is eligible for palliative care certification~~
- ~~—Chaplain with palliative care specialty training~~
- ~~—Social worker with palliative care specialty training~~

A 2. Based on the care, treatment, and services provided, the population served, and the patient's and family's needs, the interdisciplinary program team also may utilizes additional individuals from the following disciplines including, but not limited, to the following:

- ~~—Child life services~~
- ~~—Clinical pharmacy~~

- Gerontology
- Nutrition
- Pediatrics
- Psychology
- Rehabilitative services
- Additional physicians to support members of the core interdisciplinary team
- Additional nursing staff to support members of the core interdisciplinary team
- Case managers
- Child life service providers
- Clinical pharmacists
- Gerontologists
- Dietitians
- Pediatricians and neonatologists
- Psychiatrists
- Psychologists
- Recreational therapists
- Respiratory therapists
- Rehabilitation therapists, including physical, occupational, and speech therapists
- Supervised volunteers providing supportive services

A 4. **For palliative care programs that provide care for pediatric patients:** Members of the interdisciplinary team have expertise in providing care for children.

C 5. **For palliative care programs that provide care for pediatric patients:** The interdisciplinary team provides family-centered care for the child and family.

Standard PCPM.8

The program promotes ~~interdependence~~ collaboration among program staff and with the organization's staff who are involved in the patient's care.