Palliative Care Consultation Service: Service Standards (SAMPLE)

Work Day

- The work day begins at 8:00 am and ends at 5:00 pm; staying beyond 5:00 pm for patient care duties is strongly discouraged.

- Team check-in rounds occur at 8:30 and 1:00 to review cases, plan for team member attendance at family meetings, ensure coverage of new consultations, and provide support to team members.

- Consultation requests are triaged into emergency, urgent, and elective categories; emergency consultations take priority and will be seen within 1 hour of the request Monday-Friday.

- New consultations are seen the day of the request; when not possible, the requesting clinician will be contacted and informed.

Consultation Processes

- A new palliative care consultation includes assessment of physical, social, psychological and spiritual dimensions. Requests by a referring clinician to limit consultation scope will be strongly discouraged.

- Complete symptom assessment data is recorded in the medical record on new consultations and repeated very 72 hours; symptom severity is recorded daily for moderate-severe symptoms.

- Whenever possible, all new consultations are staffed by both a palliative care physician and advanced practice nurse, either together or sequentially.

- All patients are seen by at least two different disciplines of the palliative care team; consultations concerning complex symptom management or complex medical decisions will be seen at a minimum by the palliative care physician and/or the advance practice nurse.

- Family meetings for goal of care discussions will be staffed by a palliative care physician and/or advance practice nurse.

- Family meetings will have a pre-meeting with the relevant care team members.

- Family meetings will be debriefed Immediately following the meeting to assess and support team members.

- Prior to hospital discharge, one team member will review the plan of care with a goal of ensuring smooth transition management: post-hospital clinician follow-up, family education, medication reconciliation, symptom control.

- Prior to discharge to a hospice program or other post-acute care service provider, one member of the palliative care team will contact a receiving clinician to review the plan of care.

- The team will consider “signing off” when there are no further issues relevant to the team’s Scope of Service.

Referring Clinician Relationship

- Prior to visiting the patient/family, the referring clinician will be contacted face-to-face or by telephone to obtain consultation information.
- The referring clinician or designated surrogate is contacted immediately following the consultation, face-to-face or by telephone, with consultation information/ recommendations
- Verbal or face-to-face contact with the referring clinician is made daily Monday-Friday.
- The referring and/or primary outpatient attending physician is invited to participate in family/goal-of-care meetings.
- The referring physician is contacted when the team is considering “signing off”.

Miscellaneous

- All patients will be encouraged to complete an advance care planning document naming a surrogate decision maker.
- Community DNR bracelets will be offered to all patients with DNR orders prior to discharge.
- Requests for information about community hospice providers will be referred to the appropriate hospital staff.
- Team physicians will not agree to take over inpatient attending responsibilities, if asked by the referring clinician, without consulting the full team.

Adapted From: Weissman DE Improving care during a time of crisis: the evolving role of specialty palliative care teams. J Pall Med 2015;18:204-207.