A GUIDE TO HELP PALLIATIVE CARE PROGRAMS SUCCESSFULLY COMPLETE **THE JOINT COMMISSION (TJC) CERTIFICATION PROCESS**

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INFORMATION MANAGEMENT STANDARDS

STANDARD	EXAMPLE	COMMENTS
PCIM.1 Privacy and Security of Health Information (8 elements)		Check hospital policies
PCIM.2 Complete and Accurate Medical Records (5 elements)		Check hospital policies
PCIM.3 Continuity of Information (4 elements)		Check hospital policies

PALLIATIVE CARE STANDARDS

PCPC.1 ACCESS & USE OF THE PALLIATIVE CARE PROGRAM'S CARE/SERVICES	EXAMPLE	COMMENTS
1. Process to identify for whom services are indicated and communicate this to organization staff and interdisciplinary team members.	Pocket card with referral criteria. Pager information for new consultations.	
2. Informs patients how to access care/services during business hours	Program brochure.	
3. Informs patients how to contact staff for emergencies after hours	Program brochure; program website.	
4. Informs patients about their rights & responsibilities		Check hospital policies
5. Assists patients to access and use community resources needed to meet health care needs.	Psycho/social/spiritual (PSS) assessment; community resources patient education materials.	
6. Informs patients of their responsibility to provide information that is important to care/treatment/services.		Check hospital policies
7. Informs patients of right to refuse care/treatment/services.		Check hospital policies

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PCPC.2 PROGRAM COMMUNICATES WITH AND INVOLVES PATIENTS IN DECISION MAKING	EXAMPLE	COMMENTS
1. Discusses with patients how they wish to recieve information.	Initial patient assessment.	
2. Patient wishes regarding how they want to recieve information is communicated to staff across care continuum.	Interdisciplinary team rounds.	
3. The program respects patients right to, and need for, communication that meets their need to stay informed.	Palliative care initial and daily assessment.	
4. Patients receive information about the staff responsible for their care.	Palliative care brochure/business cards.	
5. Program educates patients on disease processes and prognosis.	Palliative care daily rounds; family meetings.	
6. Program informs patients about benefits and burdens of care/ treatments.	Palliative care daily rounds; family meetings.	
7. Program involves patients in decisions about their care.	Palliative care daily rounds; family meetings.	
8. Patients and staff agree upon goals of care.	Palliative care daily rounds; family meetings.	
9. Program promotes advance care planning and provides education.	Palliative care daily rounds; family meetings; psycho/social/spiritual (PSS) assessment/plan.	
10. Advance Directive is placed in medical record.	Initial palliative care assessment; PSS assessment/plan.	
11. Documents surrogate decision maker and contact information.	Initial palliative care assessment; PSS assessment.	

PCPC.3 TAILORED TO MEET PATIENT NEEDS/VALUES	EXAMPLE	COMMENTS
1. Palliative care staff demonstrates compassionate presence with patients.	Palliative care daily rounds.	
2. Care plan is developed based on patient's needs/goals.	Initial palliative care assessment; interdisciplinary team rounds	
3. Plan of Care (POC) is based on understanding patient's values.	Initial palliative care assessment; family meeting.	
4. Program delivers care according to individual patient POC.	Palliative care daily rounds.	

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5. Program provides care that meets patient's communicaton needs.	Palliative care initial assessment.	
6. Tries to accommodate patient's cultural preferences.	Initial palliative care assessment; psycho/social/ spiritual (PSS) assessment.	
7. Program communicates POC to staff involved in patient care.	Medical record documentation; daily rounds.	
8. Program informs patient about treatment outcomes including sentinel events.		Check hospital policies.
9. Evaluates, revises POC based on changes in patient's needs; documents changes.	Palliative care daily rounds; interdisciplinary team rounds.	
PCPC.4 INTERDISCIPLINARY TEAM ASSESSES AND REASSESSES THE PATIENT'S NEEDS	**EXAMPLE**	**COMMENTS**
1. Interdisciplinary team (IDT) completes initial assessment; documents assessment.	Initial palliative care assessment; IDT rounds records.	
2. IDT obtains cultural/spiritual/relicious information.	Initial assessment; PSS assessment.	
3. IDT assessment of pain, other physical symptoms and uses standardized scales.	Initial assessment template.	
4. IDT does/documents functional assessment.	Initial assessment template.	
5. Program monitors effects of medications.	Daily rounds template.	
6. Spiritual care available from organization's pastoral care department and/or clergy.	PSS assessment/plan.	
7. Provides grief/bereavement (G/B) referral.	PSS assessment/plan.	
8. IDT completes assessments within defined timeframes.	Service standards; hospital standards.	Check hospital policies regarding consultant policies
9. IDT reassesses the patient with change in condition or patient preference; reassessment is documented.	Daily rounds/progress notes.	
10. Documents patient wishes about care across settings, including site of death.		

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11. IDT recognizes transition to iminent death.		
PCPC.5 PROGRAM PROVIDES CARE, TREATMENT OR SERVICES ACCORDING TO THE PLAN OF CARE (POC)	**EXAMPLE**	**COMMENTS**
1. Program has process to provide/refer for emergency/urgent care.		
2. Patient's comfort and dignity are priorities.	Initial assessment; daily rounds.	
3. Physical symptoms are managed according to POC.	Daily rounds; medical record documentation.	
4. Psychological symptoms are managed according to POC.	Daily rounds; medical record documentation.	
5. Monitor effects of medications.	Daily rounds; medical record documentation.	
6. Spiritual care made available.	Psycho/social/spiritual (PSS) assessment/plan.	
7. Referrals made for grief/bereavement if indicated.	PSS assessment/plan.	
8. Process to identify patients at high risk for complicated grief/ bereavement and provide referrals.	PSS assessment/plan.	
9. Provides education/support regarding patient's need for safe/ suitable care.	PSS assessment/plan; family meeting.	
10. Informs patient/family regarding iminent death.	Initial assessment; daily rounds.	
11. Educates family regarding signs/symptoms of imminent death.	Initial assessment; daily rounds' family meeting; education brochures.	
12. Treats body with respect after death.		
PCPC.6 THE PATIENT'S CARE IS COORDINATED	**EXAMPLE**	**COMMENTS**
1. Patient health information is available for decision making.		Check hospital policy.
2. Medical information is available for internal/external sharing to coordinate care.		Check hospital policy.

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3. Program asssts staff in obtaining knowledge-based information for patient care and self management and patient/ staff ability to make decisions.	Fast Facts placed on chart; patient/family educational material	
4. Co-occurring conditions are managed.	Progress notes.	
5. Interdisciplinary Team (IDT) holds regular team meetings to discuss goals of care, prognosis, advanced care planning.	Program Service Standards	
6. Ethics consults are available.		Check hospital policy.
7. Program assists patients in collecting health information.	Psycho/social/spiritual (PSS) assessments/plans	
8. Process exists to address patients need for continuing care after discharge.	PSS assessment/plans	
9. Upon transfer to new care setting; patient goals, preferences/ values are communicated.	PSS assessment/plans; medical record documentation	

PERFORMANCE IMPROVEMENT STANDARDS

PCPI 1. ORGANIZED APPROACH TO PERFORMANCE IMPROVEMENT (PI)	EXAMPLE	COMMENTS
1. Program has written PI plan.	Sample PI Plan	
2. Program leader/staff participate in evaluation of provision of care/treatment/services.	Sample PI Plan (PCPI 1.1)	
3. Patients are involved in evaluation of care provision..	Patient/Family Satisfaction Data	
4. Program sets PI priorities and describes how priorities are adjusted in response to urgent events.	Sample PI plan (PCPI 1.1); strategic plan.	
5. PI activities include multiple disciplines and/or settings.	Sample PI Plan (PCPI 1.1)	
6. Program implements its PI plan.	Provide PI Plan Data	
7. If requested, provides public with information about commitment to PI.	Patient Satisfaction Data	Check hospital policy.

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PCP1 2. COLLECTS DATA	EXAMPLE	COMMENTS
1. Collects data to improve processes/outcomes.	Sample Performance Improvement Plan (PCPI 1.1)	
2. Uses consistent data sets, codes and terminology.	Sample PI Plan (PCPI 1.1)	
3. Data collection is timely, accurate, relevant.	Sample PI Plan (PCPI 1.1)	
4. Valid, reliable PI measures are selected.	CAPC Metrics (NQF When Available)	
5. Process and outcome measures at the level of the individual patient are collected.	CAPC Metrics	
6. Patient satisfaction data is collected.	Annual PI Report	
7. Program monitors the quality of data collected.	Sample PI Plan (PCPI 1.1)	Check hospital policies
PCP1 3. PROGRAM ANALYZES & USES DATA	**EXAMPLE**	**COMMENTS**
1. Program analyzes/uses its data	Annual Performance Improvement Report	
2. Program uses statistical tool/techniques to analyze data	Sample PI Plan (PCPI 1.1)	
3. Identifies variables that impact outcomes.	Sample PI Plan (PCPI 1.1); Annual PI Report	
4. Uses patient satisfaction data specific to the care it provides.	Sample PI Plan (PCPI 1.1)	
5. Uses data analysis to improve and sustain its performance.	Sample PI Plan (PCPI 1.1)	
PCP1 4. ADDRESSES SENTINEL EVENTS	**EXAMPLE**	**COMMENTS**
1. Process for reviewing sentinel events.		Check hospital policies
2. Process for identifying and reporting sentinal events through established channels, internally and externally.		Check hospital policies

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3. Process for analyzing sentinel events.		Check hospital policies
4. Implements a process to conduct analysis of sentinel events.		Check hospital policies
5. Documents its analysis of sentinel events.		Check hospital policies
6. Implements changes based on findings of sentinel event analysis.		Check hospital policies

PERFORMANCE MANAGEMENT STANDARDS

PCPM 1.PROGRAM LEARDERS (PL) SECURE SUPPORT FROM THE ORGANIZATION	EXAMPLE	COMMENTS
1. Program leaders describe program philosophy that guides provision of care; philosophy is aligned with organizational mission.	Program mission statement; business or strategic plan.	
2. PL and organization leaders (OL) work together to formulate program goals.	Business or strategic plan.	
3. PL are empowered by OL to provide care.	Strategic plan/annual report.	
4. PL communicate with OL to obtain recognition/support.	Strategic plan/annual report.	
5. PL secure resources from OL to meet the services it provides.	Business or strategic plan/annual report.	
6. PL evaluates care provided via contractual arrangements to ascertain if care is consistently provided.	Contractual agency review.	
7. Program makes staff throughout organization aware of program objectives and method for patient referral.	Program brochure; marketing tools.	
8. PL integrate their care with those of the organization.	Business or strategic plan/annual report.	
9. PL create opportunities for staff to participate in the design of care provided.	Staff surveys; QI/PI activities that interface with palliative care activities.	

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10. Program performance improvement plan is communicated at least annually to OL.	Annual Report	
PCPM 2. PROGRAM DEFINES ITS LEADERSHIP ROLES	**EXAMPLE**	**COMMENTS**
1. Program has dedicated leadership and staff necessary to meet the scope of care it provides.	Job descriptions; operational data report.	
2. Program defines its leader's accountabilities.	Job descriptions.	
3. Program defines its scope of care/services.	Program brochure; Service Standards.	
4. Program leaders have opportunities to share best practices with leaders of other similar programs.	Time for attendance at national meetings; audio-conference.	
5. Program complies with laws/regulations.		Check hospital policies
PCPM 3. CARE PROVIDED IN ACCORDANCE WITH NATIONAL GUIDELINES OR EXPERT CONSENSUS	**EXAMPLE**	**COMMENTS**
1. Program has policies/procedues that support its clinical practices.	Clinical Care Policies (e.g. sq opiod policy)	
2. Program reviews its clinical practices in response to changes in evidence-based guidelines/consensus or performance-improvement activities.	Method of clinical care update review (e.g. monthly business meeting/Journal Club).	
PCPM 4. Identifies and Minimizes Patient Risk (8 elements)		Check hospital policies
PCPM 5. Program has Process to Address Concerns/Complaints from Patients (4 elements)		Check hospital policies
PCPM 6. Leaders Selecting, Orienting, Educating, Retaining and Providing Incentives for Staff		Check hospital policies
1. Staff have education and training that is consistent with the program's philosophy and scope of care.	New palliative care staff orientation/training manual.	Check hospital policies
2. Program leaders evaluate qualifications, training individuals considered for membership in the program.	Palliative care credentialing form.	Check hospital policies

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3. Staff maintain a current license/certification in accordance with law and regulation.		Check hospital policies
4. Program leaders assess staff competence to perform job through observation…		Check hospital policies
5. Orientation includes information and training necessary to perform their responsibilities.	New palliative care staff orientation/training manual.	Check hospital policies
6. The program leaders identify and respond to team members' specific learning needs.	Strategic plan; individual staff annual review.	
7. Leaders support staff participation in continuing education.	Strategic plan; individual staff annual review.	
8. Program coaches staff to improve care.	Individual staff annual review.	
9. Program leaders provide clinical support to promote staff and confidence to provide palliative care.	Individual staff annual review.	
10. Leaders provide staff with emotional and psychological support.	Description of team health activities (e.g. quarterly retreat, team-building workshops).	
PCPM 7. PROGRAM HAS INTERDISCIPLINARY TEAM (IDT) WITH EXPERTISE/KNOWLEDGE ABOUT THE PROGRAM'S CARE/SERVICES	**EXAMPLE**	**COMMENTS**
1. Core IDT has: • Licensed Independent Practitioner • RN • Chaplain • SW ***Note:*** *Program demonstrates effort to have all of the above with palliative care specialty training or BC/RE.*	Job descriptions; annual program report.	
IDT also utilizes (in accordance with program services): • Child Life • Gerontology • Pediatrics • Rehabilitation Services • Pharmacy • Nutrition • Psychology	Business or strategic plan; annual program report; job descriptions; service standards.	

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3. IDT members responsibilities are in writing.	Job descriptions.	
PCPM 8. PROGRAM PROMOTES INTERDEPENDENCE AMONG PROGRAM STAFF INVOLVED WITH PATIENT CARE	**EXAMPLE**	**COMMENTS**
1. Program and organization support a collaborative environment.		Check hospital policies
2. Program leaders facilitate team communication.	Service Standards	
3. Program demonstrates teamwork among interdisciplinary team members and other organization staff who are involved in the patient's care.	Service Standards	

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