Palliative Care Certification Requirements

Palliative Care Certification Program

Provision of Care, Treatment, and Services

PCPC.1

1. Patients know how to access and use the program’s care, treatment, and services.

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

Elements of Performance for PCPC.1

1. The program has a process to identify patients for whom palliative care services are indicated and communicates this to appropriate organization staff and interdisciplinary team members.

2. The program informs patients how to access care, treatment, and services during business hours.

3. The program informs patients how to contact staff in the case of an emergent situation during or after business hours.

4. The program informs patients about their rights and responsibilities while receiving care, treatment, or services from the palliative care program.

5. The program assists patients with accessing and using community resources that are available to meet their health care needs.

6. The program assists patients and families with accessing and using community resources that are available to meet their health care needs.

Note: Resources in the community may include, but are not limited to, community service providers, local school teachers, respite care providers, and spiritual leaders.

7. The program informs patients of their responsibility to provide information that is important to care, treatment, and services.

8. The program informs patients and families of their responsibility to provide information that is important to care, treatment, and services.

9. The program informs patients about their right to refuse any or all of the care, treatment, and services offered by the program.
7. The program informs patients and families about their right to refuse any or all of the care, treatment, and services offered by the program.

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.

**PCPC.2**

The program communicates with and involves patients in decision making.

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

**Elements of Performance for PCPC.2**

1. The program discusses with patients how they want to receive information, including the type and extent of information.

2. The patient's wishes about how he or she wants to receive information is communicated to staff across the care continuum who are involved in the patient's care.

3. The program respects the patient's right to and need for communication that meets their needs to stay informed about their care.

4. The program respects the patient's right to communication that meets his or her needs to stay informed about his or her care.

5. Patients receive information about the staff responsible for their delivery of care, treatment, or services.

6. The program educates patients on disease processes and prognosis so that they are able to make informed decisions about their care. (See also PCPC.3, EP 8)

7. The program educates patients and families on disease processes and prognosis so that they are able to make informed decisions about their care. (See also PCPC.3, EP 8)

8. The program informs the patient and family about benefits and burdens of care, treatment, and services.

9. The program involves patients in decisions about their clinical care.

10. The program involves the patient and family in decisions about his or her clinical care.

11. Patients and staff mutually agree upon goals of care.

12. Patients and staff mutually agree upon patient-centered goals of care.

13. The program promotes advance care planning and educates patients about it.
Palliative Care Certification Program

9. The interdisciplinary program team discusses, educates, and promotes advance care planning with the patient and family as appropriate to the patient's clinical status, based on the patient's expressed values, religious and spiritual beliefs, cultural practices, and preferences for care. This information is documented in the medical record.

10. If the patient has an advance directive, a copy is included in the patient’s medical record.

11. The interdisciplinary program team documents, in the patient's medical record, whether the patient has a designated surrogate decision-maker. In instances in which the patient has a surrogate decision-maker, the program documents the surrogate decision-maker's name and contact information in the medical record.

11. The interdisciplinary program team documents, in the patient’s medical record, whether the patient has a designated surrogate decision-maker. In instances in which the patient has a surrogate decision-maker, the program documents the surrogate decision-maker's name and contact information in the medical record. (For more information, refer to Standard PCPC.1)

12. The program has a process to provide surrogate decision makers with guidance on legal and ethical decision making, when needed.

13. If the patient has expressed preferences for treatment as their disease progresses, the program interdisciplinary team will document these preferences in the medical record.

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.

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.

PCPC.3
The program tailors care, treatment, and services to meet the patient’s lifestyle, needs, and values.

Elements of Performance for PCPC.3

1. The program’s staff demonstrate a compassionate presence with patients.

2. The documented plan of care is developed based on the patient’s assessed needs, strengths, limitations, and goals.

2. The documented plan of care is developed and updated by the program interdisciplinary team in collaboration with the patient and his or her family and health care providers involved in the care of the patient and family.

3. The plan of care is based on an understanding of the patient’s values and preferences.

3. The plan of care is based on the patient’s assessed needs in conjunction with the patient’s strengths, limitations, values, and goals.
4. The program delivers care, treatment, and services according to the patient’s individualized plan of care.

5. The program provides care, treatment, and services in a manner that meets the patient’s communication needs.

6. The program tries to accommodate the patient’s cultural preferences while providing care, treatment, and services.

   - While providing care, treatment and services, the program accommodates the patient’s and family’s cultural preferences and practices unless they are contraindicated or the accommodations affect the care of others.

7. The program communicates the plan of care to staff involved in the patient’s care. (See also PCPC.6, EP 1)

8. The program informs the patient about the outcomes of his or her care, treatment, and services, including unanticipated outcomes and sentinel events. (For more information, refer to Standard PCPI.4; see also PCPC.2, EP 5)

9. The program informs the patient and family about the outcomes of 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)

10. The program evaluates and revises the plan of care to meet the patient’s ongoing needs and documents the revisions in the patient’s medical record. (For more information, refer to Standard PCPC.4)

11. The program 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)

12. The plan of care includes the patient’s and family’s preferences for prevention and treatment of symptoms that may be experienced by the patient when death is imminent.

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**PCPC.4**

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

**Elements of Performance for PCPC.4**

1. The interdisciplinary program team performs an initial patient assessment, as defined by the program, and documents the assessment in the patient’s medical record. (For more information, refer to Standards PCIM.2 and PCPM.7)

2. The interdisciplinary program team performs a comprehensive initial patient assessment, as indicated by the patient’s needs and as defined by the program. The information gathered during the assessment is documented in the patient’s medical record. (For more information, refer to Standards PCPC.4, PCIM.2 and PCPM.7)
2. **The interdisciplinary program team obtains information about** cultural, spiritual, or religious beliefs and practices important to the patient that influence care, treatment, and services.

2. **As part of the comprehensive assessment, the interdisciplinary program team performs an assessment to identify** the cultural, spiritual, and religious beliefs and practices important to the patient and family that influence care, treatment, and services. **The information gathered during the assessment is documented in the patient’s medical record.**

3. The interdisciplinary program team assesses and documents the patient’s pain, dyspnea, constipation, and other symptoms and uses, when available, standardized scales.

3. **As part of the comprehensive assessment, the interdisciplinary program team assesses and documents the patient’s pain, dyspnea, constipation, and other symptoms and uses, when available, standardized scales.**

4. As part of the initial assessment, the interdisciplinary program team performs a functional assessment, as defined by the program, and documents the functional assessment in the patient’s medical record. (For more information, refer to Standard PCPM.7)

4. **As part of the comprehensive assessment, the interdisciplinary program team performs a functional assessment, as defined by the program. The information gathered during the assessment is documented in the patient’s medical record. (For more information, refer to Standard PCPM.7)**

5. As part of the initial assessment, the interdisciplinary program team performs a psychosocial assessment, as defined by the program, and documents the psychosocial assessment in the patient’s medical record. (For more information, refer to Standard PCPM.7)

5. **As part of the comprehensive assessment, the interdisciplinary program team performs a psychosocial assessment, as defined by the program. The information gathered during the assessment is documented in the patient’s medical record. (For more information, refer to Standard PCPM.7)**

6. The interdisciplinary program team assesses and documents the patient’s anxiety, stress, anticipatory grief, coping, and other psychological symptoms and uses, when available, standardized scales.

6. **As part of the comprehensive assessment, the interdisciplinary program team assesses the patient’s anxiety, stress, grief, coping, and other psychological symptoms, and uses, when available, standardized scales. The information gathered during the assessment is documented in the patient’s medical record.**

7. The interdisciplinary program team assesses and documents the need for grief and bereavement services for patients and family.

7. **The interdisciplinary program team assesses the need and documents the plan for post-death grief and bereavement services for the patient’s family.**

8. The interdisciplinary program team completes the assessment(s) within its defined time frame.

8. **The interdisciplinary program team completes the comprehensive assessment within its defined time frame.**

9. The interdisciplinary program team reassesses the patient as defined by the program and whenever there is a change in the patient’s condition or a change in the patient’s preferences. **The reassessment is documented in the patient’s medical record.**
9. The interdisciplinary program team reassesses the patient on a regular basis as defined by the program and whenever there is a change in the patient’s condition or a change in the patient’s and family’s goals or preferences. The reassessment is documented in the patient’s medical record.

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.

11. The interdisciplinary program team recognizes and documents the patient’s transition to the active dying phase.

12. The interdisciplinary program team recognizes and documents the patient’s transition from the pre-active dying phase to the active dying phase.

13. As part of the comprehensive assessment, the interdisciplinary program team performs a quality of life assessment with the patient. The information gathered during the assessment is documented in the patient’s medical record. Note: A quality of life assessment includes assessing the patient’s physical function, social interactions, psychological well-being, and spiritual concerns.

14. 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.

15. 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.

16. 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.

**PCPC.5**

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

**Elements of Performance for PCPC.5**

1. The program has a process to provide the patient with or refer the patient for emergency/urgent care.

2. The patient’s comfort and dignity are priorities.

3. The interdisciplinary program team provides compassionate care while preserving the patient’s comfort and dignity.

4. The patient’s physical symptoms are managed effectively according to the patient’s plan of care.
3. The interdisciplinary program team manages the patient’s physical symptoms according to the patient’s plan of care by utilizing pharmacological and/or non-pharmacological 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

4. The patient’s psychological symptoms, including anxiety, stress, anticipatory grief, and coping, are managed according to the patient’s plan of care.

5. The patient is monitored for the effects of medications.

6. The program makes spiritual care available through the organization’s pastoral care service and the patient’s own relationship(s) with clergy.

7. The program provides referrals for grief and bereavement services for patients, if indicated.

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.

9. The program provides education, training, and support to the patient, addressing the patient’s need for safe and suitable care.

10. The program provides education, training, and support to the patient and family, addressing the need to provide safe, patient-specific care.

11. The team informs the patient and family when the patient’s death is expected to be imminent.

12. The interdisciplinary program team informs the patient and family when the patient’s death is determined to be imminent.

13. The program educates the family about the signs and symptoms of imminent death in a way that the family can understand and in a way that respects the family’s culture.

14. After death, the program treats the patient’s body in a way that respects the patient’s and family’s cultural and religious practices and in accordance with local law.
13. The interdisciplinary program team assesses and then treats or refers patients with symptoms of psychiatric diagnoses such as depression, anxiety, and suicidal ideation.

14. The program has a process to provide or make referrals for respite care services for families of patients with serious, complex, life-threatening conditions.

**PCPC.6**

The patient's care is coordinated.

**Elements of Performance for PCPC.6**

1. Staff have the patient’s health information available for use in clinical decision making to provide care, treatment, and services. (For more information, refer to Standard PCIM.2; see also PCIM.1, EP 2 and PCPC.3, EP 7)

2. The program facilitates the exchanging of the patient’s health information among staff, both internal and external to the program, and other health care organizations involved in the patient’s care, to coordinate care. (For more information, refer to Standard PCIM.1)

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 the patient’s and staff’s ability to make decisions.

4. Patients’ co-occurring conditions, if present, are managed. Note: If the patient’s co-occurring conditions are managed by staff or a setting(s) outside the program, the information necessary for its management is communicated to staff and a setting(s) across the continuum of care. (For more information, refer to Standard PCIM.1)

5. The program conducts regular patient care conferences with members of the interdisciplinary program team to discuss goals of care, disease prognosis, and advance care planning, and to offer support.

5. The interdisciplinary program team conducts regular patient care conferences to provide support and discuss patient-centered goals of care, disease prognosis, and advance care planning. The frequency of these patient care conferences is defined by the program.

6. The leaders offer or provide staff access to ethics consultation or a process to address concerns and resolve ethical conflicts.

6. The program’s leaders either offer staff, patients, and families access to ethics consultation or provide the organization’s process to address concerns and resolve ethical conflicts that may occur in the provision of palliative care. 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.

7. The program assists the patient in collecting, organizing, and communicating important health information. (For more information, refer to Standard PCIM.2)
8. The program has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

9. At the time a patient is transferred to a different care setting, information about the patient’s goals, preferences, and values and the patient’s clinical condition are communicated to staff in the new setting.

Program Management

**PCPM.4**

The program identifies and minimizes risks to patients.

**Elements of Performance for PCPM.4**

1. The program identifies safety risks associated with the environment of care that include:
   - Equipment usage
   - Fire safety
   - Communication services
   - Utilities services
   - Preventing and controlling infection
   - Patient security

2. The program plans strategies to minimize the risk of disruption of care, treatment, and services.

3. The program plans strategies to minimize safety risks in the physical environment.

4. Staff know their roles and responsibilities relative to safety.

5. Staff implement activities for minimizing safety risks to patients.

6. Staff implement activities for preventing and controlling infection.

7. Staff implement activities for managing medications safely.

8. The program evaluates whether its activities for identifying and minimizing risks to patients meets its objectives. (See also PCPI.1, EP 2)

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, restricted access to pediatric patient area and protection from hazards such as stairs, cleaning supplies, storage rooms, access to medical equipment, and other patient areas.
### PCPM.5

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

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<th>Elements of Performance for PCPM.5</th>
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<tbody>
<tr>
<td>1. The program encourages patients to express any concerns or complaints about their care to staff.</td>
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<td>2. The program communicates its process for handling patients’ concerns or complaints about their care or the program to patients.</td>
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<tr>
<td>2. The program communicates its process for handling patients’ concerns or complaints about their care or the program to patients and their families.</td>
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<td>3. Staff are aware of how to handle patients’ concerns or complaints about their care or the program.</td>
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<td>4. Program leaders review and resolve complaints from patients and staff.</td>
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### PCPM.6

Program leaders are responsible for selecting, orienting, educating, retaining, and providing incentives for staff.

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<tbody>
<tr>
<td>1. Staff have education, experience, training, and/or certification consistent with the program’s philosophy and scope of care, treatment, and services.</td>
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<td>2. Program leaders, or designees, evaluate the qualifications, training, and experience of individuals who are considered for membership on the program team.</td>
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<td>3. Staff maintain a current professional license or certification, in accordance with law and regulation.</td>
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<td>3. Staff members maintain a current professional license or certification, in accordance with law and regulation.</td>
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<td>4. Program leaders assess staff competence to perform job responsibilities through observation within program-defined time frames. This assessment is documented.</td>
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<td>4. Program leaders assess each staff member’s competence to perform job responsibilities through observation within program-defined time frames. This assessment is documented.</td>
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<td>5. Orientation for the program team members includes information and training necessary to perform their responsibilities.</td>
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<tr>
<td>5. Orientation for the interdisciplinary program team members includes information and training necessary to perform their responsibilities.</td>
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6. The program leaders identify and respond to program team members' specific learning needs.

7. Leaders support staff participation in continuing education, including in-services, training, and other activities.

8. The program 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.

8. The program 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.

9. Program leaders provide clinical support and guidance to promote staff's confidence in their ability to provide palliative care for patients.

10. Leaders provide staff with emotional and psychological support. Note: Emotional and psychological support is especially important to support staff resilience.

10. The program provides for emotional support for leaders, members of the interdisciplinary program team, staff, and volunteers. Note: Emotional support is especially important in helping manage the stress of caring for seriously ill palliative care patients and their families.

11. Orientation and ongoing education for the interdisciplinary program team includes, but is 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

12. 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.
The program has an interdisciplinary team that includes individuals with expertise in and/or knowledge about the program’s specialized care, treatment, and services.

The program has an interdisciplinary team that includes health care professionals with 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

1. The core interdisciplinary program team is composed of the following:
   - Licensed independent practitioner(s)
   - Registered nurse(s)
   - Chaplain(s)
   - Social worker(s)

   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

2. Based on the care, treatment, and services provided, the population served, and the patient’s needs, the interdisciplinary program team also utilizes individuals from the following disciplines:
   - Child life services
   - Clinical pharmacy
   - Gerontology
   - Nutrition
   - Pediatrics
   - Psychology
   - Rehabilitative services
Based on the care, treatment, and services provided, the population served, and the patient’s and family’s needs, the interdisciplinary program team also utilizes individuals from other disciplines, including, but not limited to, the following:
- Child life services
- Clinical pharmacy
- Gerontology
- Nutrition
- Pediatrics
- Psychology
- Recreational therapy
- Rehabilitative services
- Supervised volunteers providing supportive services

3. The program defines in writing the interdisciplinary team members’ responsibilities.

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

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

PCPM.8

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

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

Elements of Performance for PCPM.8

1. The program and the organization promote and support a collaborative and trusting environment.

2. Program leaders facilitate communication among the interdisciplinary team members and other organization staff who are involved in the patient’s care.

3. The program demonstrates teamwork among the interdisciplinary team members and other organization staff who are involved in the patient’s care.

Performance Improvement

PCPI.3

The program analyzes and uses its data.

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

Elements of Performance for PCPI.3

1. The program analyzes its data.
2. The program uses statistical tools and techniques to analyze data.

3. The program identifies and evaluates variables that affect outcomes.

4. The program uses patient satisfaction data that is specific to the care, treatment, and services it provides.

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

5. The program uses its data analysis to improve and sustain its performance. (See also PCPM.1, EP 10; PCPM.3, EP 2; and PCPI.4, EP 6)