

QUALITY STANDARD PLACEMAT FOR Palliative Care

This document is a resource for health care providers and patients and synthesizes content from the [Palliative Care quality standard](#).



Adults with a Progressive, Life-Limiting Illness

Quality Statement (QS)* 1: Identification and Assessment of Needs

As early as from time of diagnosis, perform and document a comprehensive, holistic assessment of your patients with a progressive, life-limiting illness to determine whether they would benefit from palliative care.

*The quality statements are provided in full on page 2.

QS 2: Timely Access to Palliative Care Support

Ensure that people with identified palliative care needs have access to palliative care support 24 hours a day, 7 days a week, as needed.

Advance Care Planning and Goals of Care

QS 3: Advance Care Planning—Substitute Decision-Maker (SDM)

Ensure that your patients know whom the law considers to be their SDM(s) and how they can appoint someone else if they wish. Encourage patients to think about their values, wishes, and beliefs and to share those with their family and their SDM.

QS 4: Goals of Care Discussions and Consent

Talk to your patients about their illness, prognosis, goals of care, and treatment options to ensure that their values, beliefs, and wishes are aligned with the care provided. Assess the patient's understanding of their illness and give information to help them or their SDM in providing informed consent.

Management of Palliative Care Needs

QS 5: Individualized, Person-Centred Care Plan

Collaborate with patients and their caregivers to create, document, and regularly update a care plan that reflects their individual values, wishes, and goals of care.

QS 6: Management of Pain and Other Symptoms

Assess patients for pain and other symptoms such as agitation, anxiety, respiratory changes, constipation, dehydration, delirium,

depression, diarrhea, fatigue, nausea, and poor appetite. Ensure the timely delivery of high-quality management of pain and other symptoms.

QS 7: Psychosocial Aspects of Care

Assess patients' overall psychosocial well-being and incorporate their mental, emotional, social, cultural, and spiritual needs into the care plan. Ensure the timely delivery of high-quality care to address these needs.

Education and Support for Patients, SDMs, Families, and Caregivers

QS 8: Education for Patients, SDMs, Families, and Caregivers

Provide education about palliative care to patients, their families, and their caregivers, and offer information about available resources and supports.

QS 9: Caregiver Support

Offer assessment and appropriate support to the family and caregivers of people with identified palliative care needs. Provide access to resources, respite care, and grief and bereavement supports and services, consistent with their preferences.

Transitions and Settings of Care

QS 10: Transitions in Care

Ensure people moving between care settings or care providers experience coordinated and seamless transitions by involving the patient, their family, and caregivers in the transition plan, facilitating timely and effective communication between providers, and identifying a member of the care team to be accountable for care coordination.

QS 11: Setting of Care and Place of Death

Provide information about options for the setting of care and place of death to people with identified palliative care needs, their family, and their caregivers.

Team-Based Care and Education for Health Care Providers and Volunteers

QS 12: Interdisciplinary Team-Based Care

Collaborate with other health care providers, volunteers, and people's family members and caregivers to meet the needs of people receiving palliative care.

QS 13: Education for Health Care Providers and Volunteers

Engage in competency-based education, tailored to your role, to obtain the necessary knowledge and skills to effectively provide high-quality care for people with a progressive, life-limiting illness.

Palliative Care Quality Statements

Quality Statement 1: Identification and Assessment of Needs

People with a progressive, life-limiting illness have their palliative care needs identified early through a comprehensive and holistic assessment.

Quality Statement 2: Timely Access to Palliative Care Support

People with identified palliative care needs have access to palliative care support 24 hours a day, 7 days a week.

Quality Statement 3: Advance Care Planning—Substitute Decision-Maker

People with a progressive, life-limiting illness know who their future substitute decision-maker is. They engage in ongoing communication with their substitute decision-maker about their wishes, values, and beliefs, so that the substitute decision-maker is empowered to participate in the health care consent process if required.

Quality Statement 4: Goals of Care Discussions and Consent

People with identified palliative care needs or their substitute decision-makers have discussions with their interdisciplinary health care team about their goals of care to help inform their health care decisions. These values-based discussions focus on ensuring an accurate understanding of both the illness and treatment options so the person or their substitute decision-maker has the information they need to give or refuse consent to treatment.

Quality Statement 5: Individualized, Person-Centred Care Plan

People with identified palliative care needs collaborate with their primary care provider and other health care professionals to develop an individualized, person-centred care plan that is reviewed and updated regularly.

Quality Statement 6: Management of Pain and Other Symptoms

People with identified palliative care needs have their pain and other symptoms managed effectively, in a timely manner.

Note: This resource can be used to support health care providers in the provision of care. It does not override the responsibility of health care providers to make decisions with patients, after considering each patient's unique circumstances. Grouping/directionality of statements may not be applicable for every patient, and clinical judgment should be used.

Quality Statement 7: Psychosocial Aspects of Care

People with identified palliative care needs receive timely psychosocial support to address their mental, emotional, social, cultural, and spiritual needs.

Quality Statement 8: Education for Patients, Substitute Decision-Makers, Families, and Caregivers

People with a progressive, life-limiting illness, their future substitute decision-maker, their family, and their caregivers are offered education about palliative care and information about available resources and supports.

Quality Statement 9: Caregiver Support

Families and caregivers of people with identified palliative care needs are offered ongoing assessment of their needs, and are given access to resources, respite care, and grief and bereavement support, consistent with their preferences.

Quality Statement 10: Transitions in Care

People with identified palliative care needs experience seamless transitions in care that are coordinated effectively among settings and health care providers.

Quality Statement 11: Setting of Care and Place of Death

People with identified palliative care needs, their substitute decision-maker, their family, and their caregivers have ongoing discussions with their health care professionals about their preferred setting of care and place of death.

Quality Statement 12: Interdisciplinary Team-Based Care

People with identified palliative care needs receive integrated care from an interdisciplinary team, which includes volunteers.

Quality Statement 13: Education for Health Care Providers and Volunteers

People receive palliative care from health care providers and volunteers who possess the appropriate knowledge and skills to deliver high-quality palliative care.

Resources

- [Palliative Care Quality Standard and Patient Guide](https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/palliative-care)
<https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/palliative-care>
- [Palliative Care Toolkit](https://www.ontariopalliativecarenetwork.ca/resources/palliative-care-toolkit)
<https://www.ontariopalliativecarenetwork.ca/resources/palliative-care-toolkit>
- [Palliative Care Health Services Delivery Framework](https://www.ontariopalliativecarenetwork.ca/resources/health-services-delivery-framework)
<https://www.ontariopalliativecarenetwork.ca/resources/health-services-delivery-framework>
- [Ontario Palliative Care Competency Framework](https://www.ontariopalliativecarenetwork.ca/resources/palliative-care-competency-framework)
<https://www.ontariopalliativecarenetwork.ca/resources/palliative-care-competency-framework>
- [Speak Up Ontario](https://www.speakupontario.ca)
<https://www.speakupontario.ca>
- [thehealthline.ca](https://www.thehealthline.ca)
<https://www.thehealthline.ca>
- [Palliative Care Quality Improvement Implementation Community of Practice](https://quorum.hqontario.ca/en/Home/Community/Groups/Activity/groupid/112)
<https://quorum.hqontario.ca/en/Home/Community/Groups/Activity/groupid/112>
- [Quality Standards in Other Palliative Care Topics](https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards)
<https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards>