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Palliative Care Clinical Practice Guidelines (2018)

National Consensus Project for Quality Palliative Care

Reviewed and summarized by Medscape editors

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*The fourth edition of palliative care clinical practice guidelines from the National Consensus Project for Quality Palliative Care were released on October 31, 2018.*[[1](javascript:void(0);)]

Structure and Processes of Care

**Being holistic in nature, palliative care is provided by a team of physicians, advanced practice registered nurses, physician assistants, nurses, social workers, and chaplains.**

A comprehensive interdisciplinary assessment of the patient and family forms the basis for the development of an individualized patient and family palliative care plan.

In collaboration with the patient and family, the interdisciplinary team (IDT) develops, implements, and updates the care plan to anticipate, prevent, and treat physical, psychological, social, and spiritual needs.

Palliative care is provided in any care setting, including private residences, assisted living facilities, rehabilitation settings, skilled and intermediate care facilities, acute and long-term care hospitals, clinics, hospice residences, correctional facilities, and homeless shelters.

Physical Aspects of Care

**The IDT assesses physical symptoms and their impact on well-being, quality of life, and functional status.**

Interdisciplinary care plans are developed in the context of the patient's care goals, disease, prognosis, functional limitations, culture, and care setting.

Essential components of palliative care are ongoing management of physical symptoms, anticipation of health status changes, and monitoring of potential risk factors associated with the disease and with side effects resulting from treatment regimens.

The palliative care team provides written and verbal recommendations for monitoring and managing physical symptoms.

**Psychological and Psychiatric Aspects of Care**

The IDT includes a social worker with the ability and skill set to assess and support mental health issues, provide emotional support, and address emotional distress and quality of life for patients and families experiencing the expected responses to serious illness.

The IDT screens for and assesses psychological and psychiatric aspects of care based on the best available evidence, to maximize patient and family coping and quality of life.

The IDT manages and/or supports psychological and psychiatric aspects of patient and family care, including emotional or existential distress, related to the experience of serious illness, as well as identified mental health disorders.

Social Aspects of Care

The IDT screens for and assesses patient and family social supports, social relationships, resources, and care environment based on the best available evidence, to maximize coping and quality of life.

A palliative care plan addresses the ongoing social aspects of patient and family care in alignment with the goals of the patient and family and provides recommendations to all clinicians involved in ongoing care.

**Spiritual, Religious, and Existential Aspects of Care**

Patient and family spiritual beliefs and practices are assessed and respected. Palliative care professionals acknowledge their own spirituality as part of their professional role and are provided with education and support to address each patient's and family's spirituality.

The spiritual assessment process has three distinct components—spiritual screening, spiritual history, and a full spiritual assessment. Symptoms, such as spiritual distress, as well as spiritual strengths and resources, are identified and documented.

Patient and family spiritual care needs can change as the goals of care change or patients move across settings of care.

**Cultural Aspects of Care**

The IDT delivers care that respects patient and family cultural beliefs, values, traditional practices, language, and communication preferences and builds on the unique strengths of the patient and family.

The IDT ensures that the patient’s and family’s preferred language and style of communication are supported and facilitated in all interactions.

The IDT uses evidence-based practices when screening and assessing patient and family cultural preferences regarding healthcare practices, customs, beliefs and values, level of health literacy, and preferred language.

A culturally sensitive plan of care is developed and discussed with the patient and/or family. This plan reflects the degree to which patients and families wish to be included as partners in decision-making regarding their care.

**Care of the Patient Nearing the End of Life**

The IDT includes professionals with training in end-of-life care, including assessment and management of symptoms, communication with patients and families about signs and symptoms of approaching death, transitions of care, and grief and bereavement.

The IDT assesses physical, psychological, social, and spiritual needs as well as patient and family preferences regarding setting of care, treatment decisions, and wishes during and immediately following death.

In collaboration with the patient and family and other clinicians, the IDT develops, implements, and updates as needed a care plan to anticipate, prevent, and treat physical, psychological, social, and spiritual symptoms. All treatments are provided in a culturally and developmentally appropriate manner.

During the dying process, patient and family needs are respected and supported. Postdeath care is delivered in a manner that honors the patient’s and family’s cultural and spiritual beliefs, values, and practices.

Prepared in advance of the patient's death, a bereavement care plan for the family and care team is activated after the death of the patient and addresses immediate and longer-term needs.

**Ethical and Legal Aspects of Care**

The core ethical principles of autonomy, substituted judgment, beneficence, justice, and nonmaleficence underpin the provision of palliative care.

The provision of palliative care occurs in accordance with federal, state, and local regulations and laws, as well as with current accepted standards of care and professional practice.

The patient's preferences and goals for medical care are elicited using core ethical principles and are documented.

Within the limits of applicable state and federal laws, current accepted standards of medical care, and professional standards of practice, person-centered goals form the basis for the plan of care and decisions related to providing, forgoing, and discontinuing treatments.