



Oncology Nursing Society and Association of Oncology Social Work Joint Position on Palliative and End-of-Life Care

Despite the clear benefits of hospice care, too many patients die in settings that do not support an optimal death experience (Teno et al., 2004). Technical advances in healthcare have, in some cases, prolonged suffering. A proactive and integrated approach to palliative and end-of-life care will improve quality of life across the care continuum. The National Quality Forum (2006) affirmed the necessity of integrating timely and appropriate palliative care practices across the illness trajectory. That care involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice.

It is the Position of ONS and the Association of Oncology Social Work That

Patient and Family Rights

- Patients and families understand and evaluate the benefits and burdens of potential treatment options as well as accompanying financial costs.
- Patients and families consider hospice care when patients are likely to die within a year or the reintroduction of hospice as patients decline.
- Assistance in adapting to altered goals of treatment and role responsibilities as well as other difficult decision-making circumstances is provided to patients and families.
- Families and significant others are included in the unit of care as evidenced by patient and family care conferences with appropriate members of the interdisciplinary team.
- Designated surrogates and decision makers are documented in accordance with state law.
- Patients and families have access to ethics committees or ethics consultation across care settings.
- A bereavement care plan is implemented after patients' deaths.

Skilled Palliative Care

- A timely care plan is based on a comprehensive interdisciplinary assessment of values, preferences, goals, and needs of patients and families.
- Psychological symptoms, including anxiety, depression, delirium, and behavioral disturbances, are

measured comprehensively and documented using available standardized scales.

- Pain, dyspnea, constipation, and other symptoms are measured comprehensively and documented using available standardized scales.
- Physical and psychological symptoms are assessed, managed, and reassessed in a timely, safe, and effective manner to a level that is acceptable to patients and families.
- Therapies traditionally considered part of active care are provided if they improve patients' symptoms and enhance quality of life.
- A comprehensive social care plan addresses the social, practical, and legal needs of patients and caregivers.
- Sensitive and appropriate spiritual care issues are assessed and integrated into the care plan to promote adequate coping for patients, families, and significant others.
- Professional interpreter services and culturally sensitive materials are provided in patients' and families' preferred languages.
- Clinical and behavioral research related to the care of patients who are near the end of life are strengthened and support evidence-based practice and improved patient outcomes.

Interdisciplinary Team

- Healthcare providers receive adequate training in palliative care at undergraduate and graduate levels and in required continuing education programs.
- Interdisciplinary team members are credentialed or certified in their areas of expertise.

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- The interdisciplinary team includes adequate numbers of physicians, nurses, social workers, pharmacists, nursing aides, spiritual care professionals, bioethicists, volunteers, and allied personnel who are all skilled in the essentials of palliative care pertinent to their positions.
- The interdisciplinary team values shared decision making and supports culturally competent practice (i.e., the ability to respectfully inform patients and families about prognosis, interventions, and outcomes in the context of differing value systems).
- Interdisciplinary team members are informed and updated as necessary on values, preferences, goals, and needs of patients and families.

Integrated Care Systems

- Healthcare systems adopt the Physician Orders for Life Sustaining Treatment paradigm (Oregon Health and Science University, 2005) to ensure respect for do-not-resuscitate orders when terminally ill patients change sites of care.
- Acute, critical care, outpatient, emergency department, home health, and long-term care services incorporate palliative care principles and provide timely and appropriate care to patients and families 24 hours a day, seven days a week.
- Communication about patients (especially when transitioning between healthcare facilities or providers)

includes (a) patients' values, goals, preferences, and needs; (b) physical and psychosocial issues; (c) current treatment interventions and requirements; (d) potential complications; and (e) expected outcomes across sites of care.

Public Advocacy

- Public and professional education regarding the preparation of advanced healthcare directives and the right of each individual to excellent end-of-life care is increased.
- Skilled advocacy in collaboration with national and regional policy makers, consumer groups, and licensing and regulatory agencies focuses on equal and affordable access to end-of-life care and the elimination of prescribing laws that impede adequate relief of pain.

References

- National Quality Forum. (2006). *A national framework and preferred practices for palliative and hospice care quality: A consensus report*. Washington, DC: Author.
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- Teno, J.M., Clarridge, B.R., Casey, V., Welch, L.C., Wetle, T., Shield, R., et al. (2004). Family perspectives on end-of-life care at the last place of care. *JAMA*, 291, 88–93.

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