



# Implementing the New Commission on Cancer Standard on Palliative Care Services

Oncology nurses know that improving quality of life is essential for patients with cancer. Optimizing quality of life requires excellence in symptom management, such as relief from physical symptoms (e.g., pain), as well as addressing the psychosocial and spiritual needs of patients and their families. Improving quality of life and relieving suffering are priorities across the disease spectrum from diagnosis, treatment, survivorship, and end-of-life care to bereavement support for families. Interdisciplinary teams are needed to address the multiple dimensions of physical, psychological, and spiritual care. Nurses are integral members of cancer care teams, and their inclusion in the new accreditation standards for cancer centers highlights the contributions of the profession and the specialties of oncology nursing and palliative care. Different approaches to implementing the new standard for palliative care services are described in the next two articles. Each article explores the roles of oncology nurses and advanced practice nurses (APRNs) on palliative care teams. The articles describe how oncology nurses, by virtue of their education and clinical expertise, need to be involved in the Commission on Cancer (CoC) standard implementation regarding palliative care across hospital and community settings.

## Background

The term *palliative care* is used to describe the provision of care to patients and their families that maximizes quality of life by anticipating, preventing, and treating suffering (National Quality Forum [NQF], 2012). The American Medical Association Institute for Medical Ethics ([AMA-IME], 1999) developed an educational model that integrated curative

and palliative care, including the physical, psychological, and spiritual care of patients and their families (AMA-IME, 1999), which was adapted by the World Health Organization (2007). In 2007, the Oncology Nursing Society (ONS) and the Association of Oncology Social Work released a joint position statement on palliative and end-of-life care, which was updated in 2010 (ONS, 2010). The joint statement reflects the importance of beginning palliative care at the time of diagnosis and continuing care across the disease trajectory and through bereavement. In 2012, the NQF endorsed 22 cancer-specific measures, including palliative and end-of-life care (visit [www.qualityforum.org/News\\_And\\_Resources/Press\\_Releases/2012/NQF\\_Endorses\\_Cancer\\_Measures.aspx](http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Cancer_Measures.aspx) to see the measures). Finally, in 2012, the American College of Surgeons (ACOS) CoC developed accreditation standards that included palliative care services (visit [www.facs.org/cancer/coc/programstandards2012.pdf](http://www.facs.org/cancer/coc/programstandards2012.pdf) to see the standards).

## Commission on Cancer

In 1913, ACOS focused on improving the care of surgical patients. At that time, surgery was the only treatment available for cancer, but the focus later expanded to all forms of cancer treatment. ACOS formed the Committee on the Treatment of Malignant Disease in 1922 and later changed the name to the CoC. In 1933, the committee developed the first standards for cancer clinic performance. Today, more than 1,500 cancer programs are accredited by the CoC; these programs provide almost 70% of care to patients newly diagnosed with cancer in the United States and Puerto Rico (ACOS, 2013).

The CoC is a consortium of professional organizations dedicated to improving survival and quality of life for people with cancer (ACOS, 2012). Since 2004, the CoC has worked with the NQF and other professional organizations, including ONS, the American Academy of Hospice and Palliative Medicine, and the American Psychosocial Oncology Society, to develop key quality measures and implement national standards of cancer care (ACOS, 2012).

The new CoC accreditation standards (CoC, 2012) encompass the full spectrum of care from screening to end-of-life care. The newest standards were released in 2012 and included new patient-centered functions and performance criteria, including quality measurement and outcomes. Cancer centers seeking accreditation will be required to comply with the new standards by 2015. One new CoC standard, Standard 2.4: Palliative Care Services, specifies that cancer centers seeking accreditation must have the availability of on-site palliative care services or have referral to palliative care services available for their patients (CoC, 2012). Standard 2.4 requires that the palliative care services team include at least one physician, preferably board-certified in palliative medicine, and one nonphysician member. The nonphysician member may be a nurse, preferably with specialty training or certification in hospice and palliative nursing. However, the nonphysician member also may come from another discipline such as pharmacy, social work, mental health, or spiritual care.

## Section III Overview

Given that nurses spend the most time with patients, an oncology nurse or APRN should be the second member of the

palliative care team. Other professions such as pharmacy, social work, and pastoral care also play vital roles in improving quality of life and relieving suffering in patients with cancer and their families. As a team, oncology nurses and APRNs work with colleagues from other disciplines to provide high-quality palliative care. In the article, "Working Together: Including Palliative Care With Oncology Care," Mary Kazanowski, PhD, APRN, BC, ACHPN®, and I discuss the role of the oncology nurse on the palliative care services team in the hospital and as a provider of hospice care in the community (Kazanowski & Kennedy Sheldon, 2014). With the increasing fragmentation and complexity of cancer care, the authors note that nurses can help bridge the gaps and improve continuity of care. Kazanowski and I advocate for training and certification in palliative care for team members, including physicians and nurses. Finally, the authors support the introduction of palliative care at the time of diagnosis to decrease patient suffering and improve quality of life across the disease trajectory.

In the next article, "The Role of the Acute Care Nurse Practitioner in the Implementation of the Commission on Cancer's Standard on Palliative Care," Kristin Fox, MS, APRN, BC, AOCN®, describes the importance of APRNs in acute care settings in palliative care programs (Fox, 2014). First, she generally describes the benefits of palliative care programs, including rapid treatment of burdensome symptoms, ready access to specialists, improved patient satisfaction, and decreased use of resources. Fox, an acute care nurse practitioner, discusses how APRNs in hospital settings can provide palliative care services such as pharmacologic and nonpharmacologic treatment for symptoms (depending on the state regulations and privileges at the institution); make referrals to specialists, social work, and pastoral care; and provide navigation services for patients and families. In addition, she describes how APRNs coordinate services among providers such as specialists in oncology care, hospitalists (who provide specialized acute care for inpatients), and primary care providers, ensuring smooth transitions across settings and along the disease trajectory. Finally, Fox discusses the role of APRNs in providing education

to other healthcare providers and in the community to increase understanding about the difference between palliative care and hospice and end-of-life care.

## Implications for Oncology Nursing

Oncology nurses are key members of the oncology and palliative care teams. Whether working with medicine, nursing, pharmacy, social work, or other departments, oncology nurses bring their education and expertise to improve quality of life for patients and families. In addition, oncology nurses develop and maintain relationships with patients and families over time, and often are best at understanding their changing needs and priorities. After reading the two articles in this section, examine the different roles of oncology nurses and APRNs in your practice setting.

- Do they provide cancer care to patients and their families from the time of diagnosis and through survivorship or end-of-life care and bereavement?
  - Do they address the physical, psychological, and spiritual concerns of their patients and families?
  - Do they perform navigation, coordination of care, and facilitation of communication among providers?
  - Do they participate in organizational committees to develop standards of care? Are they voting members on cancer committees? Do they have specialty certification?
  - Do they improve the quality of life for people with cancer and their families?
- If you answered "yes" to more than two questions, your oncology nurses already are providing palliative care as part of their professional roles. Explore and develop the role of oncology nurses and APRNs in palliative care services in your healthcare setting. Advocate for more involvement by oncology nurses on policy committees (e.g., cancer committees) at your cancer center when the center imple-

ments the new CoC standards. Be the voice for palliative care and the role of oncology nursing in making a difference in quality of life for your patients!

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