Quality Palliative Care in Long-Term Care: Self-Assessment Checklist

This checklist has been developed to assess whether key structural, process, and outcome components are present in a given long-term care facility. This checklist can be used in conjunction with the *"Model for Quality Palliative Care in Long-Term Care"* to assist agencies to perform self-audits to monitor progress toward best practice in providing quality palliative care in long-term care facilities.

Description	Progress	Document or Evidence to Support
Organization Context		
Formalized palliative care program Description that includes:		
• Goals and objectives of the program	☐Yes ☐No ☐In Development	
• Definition of palliative care, end-of-life care, and care planning	☐Yes ☐No ☐In Development	
• List of services that are available within the palliative care program	☐Yes ☐No ☐In Development	
• There is a process in place to identify residents who would benefit from a palliative care approach.	☐Yes ☐No ☐In Development	
• Assessments specific to palliative care and end-of-life are listed (ie. Palliative Performance Scale)	☐Yes ☐No ☐In Development	
• Staff have a formal process of communicating the palliative care needs of a resident (shift to shift report, reporting on electronic charts)	☐Yes ☐No ☐In Development	
• There is pain and symptom management built within the program	☐Yes ☐No ☐In Development	
• Residents and Families are actively contributing and participating in the palliative care program development	☐Yes ☐No ☐In Development	
• Residents and families have access to palliative care education	☐Yes ☐No ☐In Development	
• Protocols are in place to support staff around grief and loss	☐Yes ☐No ☐In Development	
• There is a quality improvement strategy in place for palliative and end-of-life care initiatives (e.g. process mapping)	☐Yes ☐No ☐In Development	
• Evaluation of resident, family and staff satisfaction	☐Yes ☐No ☐In Development	
Formalized palliative care team that:		
• Is interprofessional and includes non-registered staff, volunteers	☐Yes ☐No ☐In Development	
• Provides leadership and mentorship to all staff and volunteers in implementing the process of care (communicate via huddles, staff meetings, committee, displays)	☐Yes ☐No ☐In Development	
• Develops and disseminate family and staff education resources on palliative and end-of-life care in long term care	☐Yes ☐No ☐In Development	
• Evaluates processes of care for ongoing quality improvement	☐Yes ☐No ☐In Development	
• Ensures resident and family perspectives are included	☐Yes ☐No ☐In Development	
• Ensures medical director and physicians are included as required	☐Yes ☐No ☐In Development	
Palliative care education that is:		
• Formalized plan in place to educate all direct care staff, families	☐Yes ☐No ☐In Development	
• Included in staff orientation	☐Yes ☐No ☐In Development	
• Included in your annual organizational education plan	☐Yes ☐No ☐In Development	
Community partnerships to support palliative care delivery include:		
• Hospice volunteers	☐Yes ☐No ☐In Development	
• Nurse led outreach teams (nurse practitioners)	☐Yes ☐No ☐In Development	
• Pain & symptom management consultants	☐Yes ☐No ☐In Development	
• Alzheimer's Society		
• Palliative care education initiatives	☐Yes ☐No ☐In Development	
• End-of-life care networks	☐Yes ☐No ☐In Development	
• Specialized consultants (oral care, wound care)	☐Yes ☐No ☐In Development	
• Cultural organizations	☐Yes ☐No ☐In Development	
• Spiritual organizations	☐Yes ☐No ☐In Development	

Description	Progress	Correlating Documents Indicate whether this component is Important (I), Somewhat Important (S), or Not Important (N)
Process of Care Delivery		
Advance Care Planning that:		
• Include conversations prior to admission and throughout long term care residency (ongoing)	☐Yes ☐No ☐In Development	
Assessment of palliative and end-of-life care needs :		
• Identification of residents who transition to palliative and end-of-life care:	☐Yes ☐No ☐In Development	
• Inclusion of palliative care planning in annual care conferences	☐Yes ☐No ☐In Development	
• Special care conferences organized at the time of transition into end-of-life care	☐Yes ☐No ☐In Development	
• Includes pain and symptom management, psychosocial and spiritual care plan	☐Yes ☐No ☐In Development	
• Special consideration of residents with dementia	☐Yes ☐No ☐In Development	
• Avoidance of hospital transfers whenever possible:	☐Yes ☐No ☐In Development	
• Manage physical environment to maximize privacy and dignity at end-of-life	☐Yes ☐No ☐In Development	
Documentation of care plan:		
• Needs are being recorded in the RAI	☐Yes ☐No ☐In Development	
• Needs are being identified in resident care plan	☐Yes ☐No ☐In Development	
• Needs are being recorded in the electronic record	☐Yes ☐No ☐In Development	
Delivery of care by an interprofessional team and family members:		
• Team includes staff from regulated and non-regulated professionals	☐Yes ☐No ☐In Development	
• Family members are included within the resident care team	☐Yes ☐No ☐In Development	
• Grief support for staff and families following deaths	☐Yes ☐No ☐In Development	
Engagement of community partners to support staff and families:		
• Spiritual Support	☐Yes ☐No ☐In Development	
• Cultural Support	☐Yes ☐No ☐In Development	
• Grief Support	☐Yes ☐No ☐In Development	
• Other types of support	☐Yes ☐No ☐In Development	
Process Components For Formalized Palliative Care Team:		
• Have regular team meeting	☐Yes ☐No ☐In Development	
• Have an identified chairperson and engage staff and other membership	☐Yes ☐No ☐In Development	
Process Components For Palliative Care Education:		
• Staff access education opportunities	☐Yes ☐No ☐In Development	
• Families are offered education in advance	☐Yes ☐No ☐In Development	
• Education is offered at a convenient time	☐Yes ☐No ☐In Development	
• Quality Improvement measures track # of sessions, # of family involvement, and suggestions for future family education topics	☐Yes ☐No ☐In Development	
Process Components For Community Partnerships to Support Palliative Care:		
• Community partners are engaged in the home	☐Yes ☐No ☐In Development	
• Protocols related to information sharing communication and confidentiality developed	☐Yes ☐No ☐In Development	

Description	Progress	Correlating Documents Indicate whether this component is Important (I), Somewhat Important (S), or Not Important (N)
Performance Measures		
Program Evaluation and Quality Improvement Measures		
• Process mapping that follows model of care	☐Yes ☐No ☐In Development	
• Promotional material that explains the palliative care team and program to residents, families, staff and community	☐Yes ☐No ☐In Development	
• Family satisfaction	☐Yes ☐No ☐In Development	
• Staff satisfaction	☐Yes ☐No ☐In Development	
• Pain and symptoms controlled	☐Yes ☐No ☐In Development	
• Residents die at home	☐Yes ☐No ☐In Development	
• Programs are in place to meet the social, spiritual, emotional, physical, functional, psychological , practical and grief support needs of residents and families.	☐Yes ☐No ☐In Development	
Active Palliative Care Team		
• Clearly defined roles for each discipline	☐Yes ☐No ☐In Development	
• Clearly stated team functions and objectives	☐Yes ☐No ☐In Development	
• Role of the team is clearly defined in the organization	☐Yes ☐No ☐In Development	
• Agendas and minutes of meetings	☐Yes ☐No ☐In Development	
Annual Education Plan		
• Summary documentation of staff participation in PC education	☐Yes ☐No ☐In Development	
• Copies of orientation training package	☐Yes ☐No ☐In Development	
• Copy of annual educational PC plans	☐Yes ☐No ☐In Development	
• Quality improvement measures-number of sessions, session attendance, written and verbal feedback	☐Yes ☐No ☐In Development	
Formalized Community Linkages		
• Referral forms	☐Yes ☐No ☐In Development	
• Memorandums of understanding	☐Yes ☐No ☐In Development	
• Role description of partner services and contact information readily available to staff and families	☐Yes ☐No ☐In Development	
• LTC home membership on community palliative care networks/committees	☐Yes ☐No ☐In Development	