

Original Article

Development of a Standard for Hospital-Based Palliative Care Consultation Teams Using a Modified Delphi Method

Tomoyo Sasahara, RN, PhD, Yoshiyuki Kizawa, MD, Tatsuya Morita, MD, Yuumi Iwamitsu, PhD, Junji Otaki, MD, DMedSc, Hitoshi Okamura, MD, PhD, Mikako Takahashi, RN, MS, Sayaka Takenouchi, RN, MPH, and Seiji Bito, MD
Institute of Nursing Science (T.S.), Institute of Clinical Medicine (Y.K.), Graduate School of Comprehensive Human Sciences, University of Tsukuba, Ibaraki; Department of Palliative and Supportive Care, Palliative Care Team and Seirei Hospice (T.M.), Seirei Mikatahara General Hospital, Shizuoka; Department of Medical Psychology (Y.I.), Graduate School of Medical Sciences, Kitasato University, Kanagawa; Department of General Medicine and Primary Care (J.O.), Tokyo Medical University Hospital, Tokyo; Psychosocial Rehabilitation Laboratory (H.O.), Graduate School of Health Sciences, Hiroshima University, Hiroshima; Palliative Care Unit (M.T.), St. Luke's International Hospital, Tokyo; Department of Biomedical Ethics (S.T.), Graduate School of Medicine, Kyoto University, Kyoto; and Division of Clinical Epidemiology (S.B.), National Hospital Organization, Tokyo Medical Center, Tokyo, Japan

Abstract

Although palliative care consultation teams are rapidly being disseminated throughout Japan as a result of government policy, the role of these teams has not been standardized. The aim of this study was to develop a hospital-based palliative care consultation team standard. We adopted a modified Delphi method to develop a standard. Twenty-seven multiprofessional panelists were selected according to two criteria: adequate experience as part of a palliative care consultation team and representative of 16 palliative care-related organizations. Panelists rated the appropriateness of 33 statements in a provisional standard, which was generated by the authors, using a nine-point Likert-type scale in a first-round survey. We set two criteria for agreement: the median value was 8 or more, and the difference between the minimum and maximum was 4 or less. There were 15 disagreements in the first-round survey. Based on discussions through e-mails and a panel meeting, these 15 statements were dealt with as follows: one was rejected, one was combined with another statement, three were unmodified, and 10 underwent minor revisions. Moreover, two statements that generated agreement were divided into two statements each. Consequently, the number of statements was 37. In a second-round survey, three statements engendered disagreement and were modified. At the end of the process, there were 37 statements in four areas: "philosophy and policy," "structure for care provision," "contents of activities," and "quality assurance and care improvements." This standard may be useful as a clinical

This work was supported by a Health and Labour Sciences Research Grant for Clinical Cancer Research.

Address correspondence to: Tomoyo Sasahara, RN, PhD, Institute of Nursing Science, Graduate School of

Comprehensive Human Sciences, University of Tsukuba, 1-1-1 Ten-nodai, Tsukuba, Ibaraki 305-8575, Japan. E-mail: tsasahara@md.tsukuba.ac.jp

Accepted for publication: February 19, 2009.

activity guide as well as a method to evaluate palliative care consultation teams. J Pain Symptom Manage 2009;38:496–504. © 2009 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

Key Words

Palliative care, palliative care consultation team, standard, modified Delphi method, cancer

Introduction

There is increasing awareness of the suffering of patients with pain, other physical symptoms, and psychosocial distress.^{1,2} As a result, specialized palliative care services have proliferated worldwide.^{3–6} In Japan, the Ministry of Health, Labour, and Welfare has strongly supported the dissemination of specialized palliative care as a part of the National Cancer Program. Since National Medical Insurance started to cover inpatient palliative care units (PCUs) for terminal cancer patients in 1990, PCUs have been a dominant palliative care service. However, more than 90% of cancer deaths occur in general wards,⁷ and it has been reported that the care of cancer patients is inadequate.^{8–10} With the consideration of this situation, palliative care consultation services have been covered by National Medical Insurance since 2002, and it became mandatory for Regional Cancer Centers to establish palliative care consultation teams. The number of Regional Cancer Centers is now 351.¹¹

In this way, palliative care consultation teams are being rapidly disseminated as a result of government policy. However, the role of such teams has not been standardized. The government released only six statements regarding the entity of the palliative care consultation team:¹² 1) a palliative care consultation team should include a palliative care physician and nurse and provide specialized palliative care for cancer patients; 2) specialized palliative care can be provided at outpatient clinics; 3) the palliative care consultation team holds care meetings to discuss patient symptom management at least once a week; 4) sufficient information is provided to cancer patients; 5) the attending physician, nurses, and the palliative care consultation team provide patients with information and education regarding palliative care before discharge, collaborating with their home care doctor; and 6) a palliative

care network with other hospitals and home care agencies in the same region is established. Although a standard for palliative care developed by Hospice Palliative Care Japan exists,¹³ it originally targeted the activity of PCUs and it is not detailed enough for new palliative care consultation teams to understand what they should do.

In Western countries, where palliative care consultation teams were developed from the early 1990s, palliative care standards comprising a wide range of palliative care services have been proposed.^{14–17} However, it is inappropriate to apply them directly to Japan because of a different social background and health care system. Thus, Japan needs its own standard specific to palliative care consultation teams.

“Consultation” has been practiced in Japan, and the general style is for consultants to play a more direct role in referrals. Palliative care consultation, in contrast, remains the primary responsibility of the referring team, which provides advice and gives recommendations.¹⁸ Moreover, emotional and educational support for the referring team is also an important role of the palliative care consultation team, in addition to the addressing of patients’ problems.^{19,20} Therefore, consultation by a palliative care team crucially differs from conventional consultation. For a new palliative care consultation team to function effectively and smoothly, we need to provide guidance, including the concrete step of consultation. The aim of this study was to develop a hospital-based palliative care consultation team standard.

Methods

We adopted a modified Delphi method²¹ to develop a palliative care consultation team standard.

Development of a Provisional Standard

To develop a provisional standard, we adopted the following procedures: First, the authors discussed the basic assumption of this standard and decided that it should be a fundamental standard, designed to show new palliative care consultation teams what to do at the very least. The subject was cancer patients because palliative care in Japan mostly targets such patients presently, and we have insufficient clinical experience of palliative care for non-cancer patients. The concept of the Donabedian model was applied because this standard was expected to be used for evaluation as well, and the framework of the standard was referred to existing standards and manuals on palliative care.^{13–15,17,22} Second, one author (T. S.) generated statements in line with the framework based on a literature review.^{6,13–15,17,22–29} Third, the authors discussed the appropriateness and coverage of the statements to reach a consensus regarding validity and then the provisional standard was formulated, consisting of four domains and 33 statements.

Expert Panel Selection

As there are no universally accepted criteria for the selection of experts using this method,³⁰ we selected expert panelists to create a multiprofessional panel based on the following criteria: 1) clinicians with adequate experience as part of a palliative care consultation team and 2) representatives of palliative care-related organizations.

Criterion 1. From the palliative care consultation team registration data of the Japanese Society for Palliative Medicine (December 2006) and the 2007 annual conference data of Hospice Palliative Care Japan, palliative care consultation teams that started their activity before April 2005 and received more than 80 referred patients per year were selected. Next, we contacted clinicians whose experience as part of a palliative care consultation team spanned over at least two years, and authors agreed that their activity levels were high within the palliative care consultation teams. One group of panelists comprised five physicians, two psychiatrists, and five nurses, showing diversity regarding hospital types

(cancer center, university hospital, and general hospital).

Criterion 2. We contacted 16 palliative care-related organizations (Table 1) by mail and asked them to participate in this study and recommend a panelist. As a condition to be a panelist, we proposed an extensive knowledge of palliative care and work experience within/with palliative care consultation teams. The total number of panelists was 27 experts (one panelist was recommended by two organizations).

Data Collection and Analysis

First, each panelist was asked to review 28 related reports.^{6,19,24,26–29,31–51} The reason why we asked the panelists to review these was to standardize their knowledge regarding the roles and activities of palliative care consultation teams, as such teams are relatively new in Japan, before study commencement.

Second, two months later, we implemented a first-round survey, mailing a questionnaire with the outline of a provisional standard to each panelist. Each member was asked to rate the appropriateness of each statement using a nine-point Likert-type scale (inappropriate 1–3, intermediate 4–6, and appropriate 7–9). In cases where panelists were unfamiliar with items due to their specialty, “incapable of rating” was also prepared. Panelists who rated a statement as less than 6 were asked to give the reason. We set two criteria for agreement:

Table 1
List of Palliative Care-Related Organizations Participating in This Study

Japanese Society for Palliative Medicine
Japan Psycho-Oncology Society
Japan Society of Clinical Oncology
Japanese Society of Medical Oncology
Japan Society of Pain Clinicians
Japanese Society for Therapeutic Radiology and Oncology
Japanese Society of Cancer Nursing
Japanese Nursing Association
Hospice Palliative Care Japan
Japanese Society for Pharmaceutical Palliative Care and Sciences
Japanese Society of Pharmaceutical Health Care and Sciences
Japanese Association of Social Workers in Health Services
The Japanese Psychological Association
The Association of Japanese Clinical Psychology
The Japanese Physical Therapy Association
Japanese Association of Occupational Therapists

the median value was 8 or more, and the difference between the minimum and maximum was 4 or less. A summary of the first-round survey was sent to each panelist and author, and disagreements were discussed by e-mail for two weeks. We asked the panelists, especially those who would not be able to attend a panel meeting, to give their opinions.

Third, after discussion by e-mail, an expert panel meeting was convened on January 19, 2008, in Tokyo to discuss statements causing disagreement face-to-face. At the meeting, a summary of the first-round survey and discussion through e-mail was distributed. After the panel meeting, a summary of the meeting and a revised version of the standard were sent to all panelists to confirm corrections or determine whether there were additional opinions.

Fourth, we implemented a second-round survey using the same method as in the first-round survey, and a revised version of the standard based on the expert panel meeting. For statements considered inappropriate, the relevant panelists were contacted by e-mail individually and we tried to reach a compromise.

This study was conducted from April 2007 to March 2008. The protocol was approved by the Institutional Review Board of the Graduate School of Comprehensive Human Sciences, University of Tsukuba. All statistical analyses were carried out using the statistical package SAS version 9.1 (SAS Institute, Inc., Cary, NC).

Results

The backgrounds of the panelists are summarized in Table 2. Of the 27 panelists, 25 had experience working as a member of a palliative care consultation team and the mean working period was 5.3 years.

All panelists responded to the first-round survey, and 17 (63%) participated in the panel meeting. In the first-round survey, 15 of 33 statements led to disagreements. We analyzed the reasons for the 15 disagreements and found that the minimum goal of a palliative care consultation team differs among the members, and the range of palliative care consultation team activities is not clear, whether for hospital inpatients or for the community. During the discussions by e-mail and in the panel meeting, the following were agreed: 1)

Table 2
Background of Panelists (n = 27)

Sex	
Male	15
Female	12
Specialty	
Physician	11
Psychiatrist	3
Nurse	7
Psychologist	2
Pharmacologist	1
Medical social worker	1
Occupational therapist	1
Physical therapist	1
Years of clinical experience (mean ± SD)	18.9 ± 6.1
Experience in PCT activity, yes	25
Years of PCT activity, n = 25 (mean ± SD)	5.3 ± 3.1

SD = standard deviation; PCT = palliative care team.

the standard should be achieved within five years, taking into account the wide-ranging skills of teams, not the minimal or lowest acceptable practices; 2) this standard should be applied to cancer patients first and then expanded to other diseases in the future; and 3) this standard should focus on consultation activities within a hospital.

According to the results of the first-round survey and discussion at the panel meeting, the 15 statements that produced disagreement were dealt with as follows: one was rejected, one was combined with another statement, three were unmodified on clarifying the basic assumption, and 10 underwent minor revision. Moreover, two other statements were divided into two statements each for explicitness. Consequently, the statements numbered 37.

In the second-round survey, all panelists responded. As a result, three of 37 statements produced disagreements. As disagreement was expressed by only one panelist for each statement and seems to have occurred from a misunderstanding of the statements, we contacted the panelists and gave more precise explanations. Subsequently, agreements were obtained from the panelists. For satisfactory statements that included some minor comments such as expressions, we revised them based on a discussion among authors. The final version of the standard is shown in the Appendix.

Discussion

We developed a palliative care consultation team standard using a modified Delphi

method and using a multiprofessional expert panel. The standard comprised 37 statements encompassing four areas: “philosophy and policy,” “structure for care provision,” “contents of activities,” and “quality assurance and care improvements.” It is important in terms of developing a standard to use a clear methodology. Furthermore, this standard would be of help to both new and existing palliative care consultation teams as a guideline. In addition, the activities of palliative care consultation teams could be evaluated based on this standard, which contributes to improvement in the quality of care.

In the first-round survey, 15 of 33 statements led to disagreement. This is a poor result compared with other studies using the Delphi method.^{52,53} The outcome suggests that what is viewed as the minimum of palliative care consultation team activities differs from person to person, as mentioned previously, and it might be difficult to achieve a common understanding of the role of palliative care consultation teams, not only for palliative care consultation team users^{54,55} but also for palliative care consultation team members themselves. The role of palliative care consultation teams became clearer using this standard. As a next step, we need to investigate to what extent the palliative care consultation team actually fulfills its role and how effective it is.

Given the lack of a clearly defined role, this standard was rather general. Common elements of palliative care, such as spiritual and bereavement care, were not included. Although spiritual and bereavement care have been acknowledged as essential elements in palliative care in Japan as well,¹³ it is difficult to actually provide these types of care as a part of daily practice in the acute setting^{20,56} and panelists might have believed that it would be difficult to achieve the goal within five years. Another possible reason would be that we tried to include the consultation steps in the standard, and thus, it made the standard a more general one that can be applied to any type of medical care.

Our study had several limitations. First, some statements were not precise enough because we intended the standard to be applied by both new and established palliative care consultation teams. Too precise a description would make it difficult for panelists to

reach an agreement. Second, panelists in this study consisted of diverse professionals, but the number of physicians was large. Thus, this standard might be biased to reflect physicians' opinions. Third, palliative care consultation teams cannot be directly evaluated with this standard. For actual evaluation, assessment criteria are needed. Fourth, the clinical effectiveness of this standard remains unclear, although it was developed by clinical experts.

In conclusion, we developed a palliative care consultation team standard consisting of 37 statements in four areas. Although this standard might not be precise, we believe that it is worthwhile in terms of developing a standard using a clear methodology. This standard is helpful both as a clinical activity guideline and as a method to evaluate palliative care consultation teams. As the next step, palliative care consultation team activities should be advanced with this standard, along with the development of criteria based on the standard, and the implementation of further evaluation.

Acknowledgments

The authors acknowledge the work of the members of the expert panel: Nobuya Akizuki, Koji Fujimoto, Takahiro Hashizume, Akitoshi Hayashi, Hitomi Higuchi, Minoru Hojo, Masako Iseki, Hitoshi Kasai, Shiro Katayama, Noritaka Kiyokawa, Makiko Koike, Mayumi Kondo, Fumie Kosako, Yukie Kurihara, Shigeko Matsuyama, Masato Murakami, Sachiko Mera, Keiichi Nakagawa, Masaru Narabayashi, Toru Okuyama, Iwao Osaka, Yoji Saito, Chizuko Takigawa, Miki Toya, Megumi Umeda, Mihoko Umenai, and Masahiro Yabe.

References

1. Emanuel EJ, Emanuel LL. The promise of a good death. *Lancet* 1998;351:21–29.
2. Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. *JAMA* 1999;281:163–168.
3. Morrison RS, Maroney-Galin C, Kralovec PD, Meier DE. The growth of palliative care programs in United States hospitals. *J Palliat Med* 2005;8:1127–1134.
4. The National Council for Palliative Care. MDS full report for the year 2006–2007. Available

- from http://www.ncpc.org.uk/download/mds/MDS_Full_Report_0607part.pdf. Accessed July 10, 2008.
5. Palliative Care Australia. State of the nation 1998, report of national census of palliative care services. Available from <http://www.palliativecare.org.au/Portals/46/reports/Census98.pdf>. Accessed July 10, 2008.
6. Kuin A, Courtens AM, Deliëns L, et al. Palliative care consultation in The Netherlands: a nationwide evaluation study. *J Pain Symptom Manage* 2004;27:53–60.
7. Ministry of Health, Labour and Welfare. Vital statistics of population 2003. [Japanese]. Available from http://www.dbtk.mhlw.go.jp/toukei/data/010/2003/toukeihyou/0004649/t0095927/JC050000_001.html. Accessed July 10, 2008.
8. Okuyama T, Wang XS, Akechi T, et al. Adequacy of cancer pain management in a Japanese cancer hospital. *Jpn J Clin Oncol* 2004;34:37–42.
9. Morita T, Akechi T, Ikenaga M, et al. Late referrals to specialized palliative care service in Japan. *J Clin Oncol* 2005;23:2637–2644.
10. Morita T, Akechi T, Ikenaga M, et al. Communication about the ending of anticancer treatment and transition to palliative care. *Ann Oncol* 2004;15:1551–1557.
11. Ministry of Health, Labour and Welfare. The list of regional cancer centers. [Japanese]. Available from <http://www.mhlw.go.jp/bunya/kenkou/gan04/index.html>. Accessed July 10, 2008.
12. Ministry of Health, Labour and Welfare. The guideline for developing regional cancer centers. [Japanese]. Available from <http://www.mhlw.go.jp/topics/2006/02/tp0201-2.html>. Accessed June 10, 2008.
13. Hospice Palliative Care Japan. Standard for hospice palliative care. [Japanese]. Available from http://www.hpcj.org/what/gd_kijyun.html. Accessed November 25, 2008.
14. Department of Health. Manual for cancer services 2004. Available from http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Cancer/DH_4135595. Accessed July 10, 2008.
15. Palliative Care Australia. Standards for providing quality palliative care for all Australians. Available from <http://www.palliativecare.org.au/portals/46/resources/StandardsBrochure.pdf>. Accessed July 10, 2008.
16. National Consensus Project. Clinical practice guidelines for quality palliative care. Available from <http://www.nationalconsensusproject.org/Guideline.pdf>. Accessed November 25, 2008.
17. Clinical Standards Board for Scotland. Clinical standards specialist palliative care. Edinburgh, UK: Clinical Standards Board for Scotland, 2002.
18. Salisbury C. Models of palliative care. In: Bosanquet N, Salisbury C, eds. *Providing a palliative care service*. Oxford, UK: Oxford University Press, 1999: 57–68.
19. Carter H, McKinlay E, Scott I, Wise D, MacLeod R. Impact of a hospital palliative care service: perspective of the hospital staff. *J Palliat Care* 2002;18:160–167.
20. Sasahara T, Umeda M, Higuchi H, et al. What kind of support does hospital-based palliative care team provide in a university hospital?: a result from participant-observation approach. [Japanese]. *J Jpn Soc Cancer Nurs* 2008;22:12–22.
21. Fitch K, Bernstein SJ, Aguilar MD, et al. The Rand/UCLA appropriateness method user's manual. Santa Monica, CA: RAND, 2001.
22. Center to Advance Palliative Care. Crosswalk of JCAHO standards and palliative care-policies, procedures and assessment tools. March 2007. Available from http://www.capc.org/support-from-capc/capc_publications/JCAHO-crosswalk-new.pdf. Accessed July 10, 2008.
23. Hunt J, Keeley VL, Cobb M, Ahmedzai SH. A new quality assurance package for hospital palliative care teams: the Trent Hospice Audit Group model. *Br J Cancer* 2004;91:248–253.
24. Manfredi PL, Morrison RS, Morris J, et al. Palliative care consultations: how do they impact the care of hospitalized patients? *J Pain Symptom Manage* 2000;20:166–173.
25. Zhukovsky DS. A model of palliative care: the palliative medicine program of the Cleveland Clinic Foundation. A WHO demonstrations project. *Support Care Cancer* 2000;8:268–277.
26. O'Mahony S, Blank AE, Zallman L, Selwyn PA. The benefits of a hospital-based inpatient palliative care consultation service: preliminary outcome data. *J Palliat Med* 2005;8:1033–1039.
27. Morita T, Fujimoto K, Tei Y. Palliative care team: the first year audit in Japan. *J Pain Symptom Manage* 2005;29:458–465.
28. Homsy J, Walsh D, Nelson KA, et al. The impact of a palliative medicine consultation service in medical oncology. *Support Care Cancer* 2002;10:337–342.
29. Vernooij-Dassen MJ, Groot MM, van den Berg J, et al. Consultation in palliative care: the relevance of clarification of problems. *Eur J Cancer* 2007;43:316–322.
30. Keeney S, Hasson F, McKenna H. Consulting the oracle: ten lessons from using the Delphi technique in nursing research. *J Adv Nurs* 2006;53:205–212.
31. Fischberg D, Meier DE. Palliative care in hospitals. *Clin Geriatr Med* 2004;20:735–751.
32. Hanks GW, Robbins M, Sharp D, et al. The imPaCT study: a randomised controlled trial to

- evaluate a hospital palliative care team. *Br J Cancer* 2002;87:733–739.
33. Higginson IJ, Finlay I, Goodwin DM, et al. Do hospital-based palliative teams improve care for patients or families at the end of life? *J Pain Symptom Manage* 2002;23:96–106.
34. Groot MM, Vernooij-Dassen MJ, Courtens AM, et al. Requests from professional care providers for consultation with palliative care consultation teams. *Support Care Cancer* 2005;13:920–928.
35. Morita T, Fujimoto K, Imura C, et al. Self-reported practice, confidence, and knowledge about palliative care of nurses in a Japanese regional cancer center: longitudinal study after 1-year activity of palliative care team. *Am J Hosp Palliat Care* 2006;23:385–391.
36. Virik K, Glare P. Profile and evaluation of a palliative medicine consultation service within a tertiary teaching hospital in Sydney, Australia. *J Pain Symptom Manage* 2002;23:17–25.
37. Miyashita M, Sasahara T. Clinical audit for palliative care team. [Japanese]. *Jpn J Palliat Med* 2006;8(2):111–118.
38. Akechi T. The role of a psychiatrist in a palliative care team. [Japanese]. *Clinical Psychiatry* 2007;49:907–913.
39. Gwyther LP, Altilio T, Blacker S, et al. Social work competencies in palliative and end-of-life care. *J Soc Work End Life Palliat Care* 2005;1(1):87–120.
40. Omatsu S, Yokokawa M, Ideshita N. Palliative care team and the medical linkage. [Japanese]. *Symptom Management in Cancer Patients* 2004;15(2):34–38.
41. Gilbar P, Stefaniuk K. The role of the pharmacist in palliative care: results of a survey conducted in Australia and Canada. *J Palliat Care* 2002;18:287–292.
42. Kuratsuji Y, Shiokawa M. A role of pharmacologist in palliative care team. [Japanese]. *J Jpn Soc Hosp Pharm* 2006;42:1027–1030.
43. Kanbayashi Y, Konishi Y, Nishii H. The roles of pharmacist in the pain treatment and palliative care unit. [Japanese]. *Journal of Kyoto Prefectural University of Medicine* 2006;115:201–209.
44. Payne S, Haines R. The contribution of psychologists to specialist palliative care. *Int J Palliat Nurs* 2002;8:401–406.
45. Kurihara Y. The role of clinical psychologist. [Japanese]. *Jpn J Clin Nurs* 2005;31:1057–1061.
46. Santiago-Palma J, Payne R. Palliative care and rehabilitation. *Cancer* 2001;92(4 Suppl):1049–1052.
47. Imai S, Suzuki A, Murata J, Taguchi N. The activity of palliative care support team and physical therapist. [Japanese]. *Kokuritsudaigakuhojin Rehabilitation co-medical Gakujutsu-taikaishi* 2007;28:72–75.
48. Masuda Y, Tajiri H, Tsuji T. The role of physical therapist and occupational therapist. [Japanese]. *Sogo Rehabil* 2003;31:953–959.
49. Noguchi W, Matsushima E. The role of psychiatrist as a “coordinator” and “breakwater” in palliative care team. [Japanese]. *Clinical Psychiatry* 2007;49:915–919.
50. Akizuki N. From the viewpoint of a psychiatrist: analysis of the questionnaire to the participants for the palliative care team workshop. [Japanese]. *Clinical Psychiatry* 2007;49:901–905.
51. Salerno SM, Hurst FP, Halvorson S, Mercado DL. Principles of effective consultation: an update for the 21st-century consultant. *Arch Intern Med* 2007;167:271–275.
52. Smith KL, Soriano TA, Boal J. Brief communication: national quality-of-care standards in home-based primary care. *Ann Intern Med* 2007;146:188–192.
53. Miyashita M, Nakamura A, Morita T, Bito S. Identification of quality indicators of end-of-life cancer care from medical chart review using a modified Delphi method in Japan. *Am J Hosp Palliat Care* 2008;25:33–38.
54. Oakley C, Pennington K, Mulford P. Perceptions of the role of the hospital palliative care team. *Nurs Times* 2005;101:38–42.
55. Mytton EJ, Adams A. Do clinical nurse specialists in palliative care de-skill or empower general ward nurses? *Int J Palliat Nurs* 2003;9:64–72.
56. Miyashita M, Nishida S, Koyama Y, et al. The current status of palliative care teams in Japanese university hospitals: a nationwide questionnaire survey. *Support Care Cancer* 2007;15:801–806.

Appendix

Hospital-Based Palliative Care Consultation Team Standard

This standard was developed to define the goal of hospital-based palliative care consultation teams working in hospitals.

Palliative care is administered for all patients with life-threatening diseases. This standard has been devised mainly for palliative care consultation teams for cancer patients, as most patients receiving palliative care in Japan suffer from cancer. However, it can also be applied by palliative care consultation teams to non-cancer patients.

This standard only refers to the activities of the palliative care consultation team in a hospital and does not mention activities in the local community, for the following two reasons: 1) palliative care consultation in the local community is not common in Japan, and there are few authorities on this, although it is expected to become more common in the future, and 2) the activities of palliative care consultation teams in hospitals and local communities are markedly different; thus, it would be difficult to devise a standard covering both activities.

Definition of the Terms Used in This Standard

Palliative Care. An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual (the World Health Organization definition).

Palliative Care Consultation. Support to enable health care professionals to efficiently deal with difficult issues regarding palliative care.

Direct Care. Medical intervention and care provided by a palliative care consultation team directly to patients and family.

Structure

I. Philosophy and Policy

1. Philosophy. Palliative care consultation teams educate and support health care professionals and provide direct care for patients and their families by providing clinical knowledge and skills to improve the quality of life of both parties.

2. Policy. The palliative care consultation team should:

- a. Consult with health care professionals working in hospitals.
- b. Provide direct care for patients and their families when necessary, after consensus with the referring health care professionals.
- c. Work according to the needs of the referring health care professionals as well as patients and their families.
- d. Have discussions with the referring health care professionals and decide on the care plan for patients and their families.

II. Structure for Care Provision

1. Occupational Structure. It is desirable for palliative care consultation teams to include the human resources mentioned below or for the teams to have access to such professionals whenever needed:

- a. Physician who is skilled in the palliation of physical symptoms.
- b. Physician who is skilled in the palliation of psychiatric symptoms.

- c. Nurse who is qualified as a certified nurse specialist/certified expert nurse in palliative care.
- d. Pharmacologist who is skilled in palliative care.
- e. A medical social worker.
- f. A psychotherapist.
- g. Health care professionals involved in rehabilitation (physical, occupational, speech therapists, etc.)
- h. A registered dietitian.
- i. Other professionals who contribute to improve patients' and their families' quality of life.

2. Structure of Activity. The palliative care consultation team should:

- a. Be clearly positioned within the organization of the hospital.
- b. Specify its philosophy and policy to the hospital.
- c. Inform health care professionals in the hospital, patients, and their families about the team framework (position in the hospital, members, working hours, and contents of activities).
- d. Inform health care professionals in the hospital of who has access to the team (staff who can request referral and the process involved).
- e. Establish a referral system that facilitates prompt action.

Process

III. Contents of Activities

1. Clinical Activities. The palliative care consultation team should:

- a. Provide patients with symptom management, emotional support, support for decision making, a place of care, and support for terminal problems, as well as support for the families and health care professionals.
- b. Carry out a comprehensive assessment of patients and their families based on information from referring staff, physical examinations of patients, discussions with the family, medical charts, and the results of other examinations and provide recommendations and direct care.
- c. Make an assessment using a standardized tool whenever possible.
- d. Provide recommendations and direct care based on existing clinical practice guidelines if possible, taking the individual situations/conditions of patients into consideration.
- e. Record the contents of assessments/recommendations and direct care on medical charts.
- f. Review and follow up the results of recommendations and direct care.
- g. Inform patients and their families about the contents of direct care and obtain consent.
- h. Hold conferences with the referring health care professionals if needed.
- i. Facilitate communication within the palliative care consultation team through regular meetings, etc.

2. Organizing Resources. The palliative care consultation team should:

- a. Allocate a palliative care link nurse to a ward or outpatient division as needed.
- b. Facilitate a guideline for palliative care in the hospital.
- c. Promote a cooperative relationship with facilities related to palliative care (e.g., palliative care units, clinics, home-visiting nursing stations, and pharmacies) in the local community.

3. Educational Activities. The palliative care consultation team should:

- a. Educate health care professionals in hospitals through their daily activities.
- b. Give regular lectures on palliative care to health care professionals.
- c. Provide regular study sessions and lectures to educate inpatients/outpatients and their families.

IV. Quality Assurance and Care Improvements

The palliative care consultation team should:

- a. Evaluate and improve activities by holding regular case reviews and conferences.
- b. Evaluate activities by collecting and analyzing information on the referred patients and activities of the team (e.g., diagnosis, the reason for referral, and number of referrals).
- c. Make maximum efforts to obtain up-to-date information on palliative care.