Acknowledgements

On behalf of Palliative Care Australia, I would like to congratulate the many people involved in this pilot National Standards Assessment Program Collaborative Improvement Project, that was funded by the Australian Government Department of Health and Ageing.

In particular I would like to thank: members of the Expert Reference Panel who provided leadership, the knowledge base for the project, and assisted in the development of the change package; NSAP governance group for supporting the project; CareSearch¹ who provided support through assistance with the literature review as well as the platform for the web based forum; the project team who managed the project so ably and effectively; the participants from the 20 specialist palliative care services, and the palliative care patients, carers, families and friends who provided constructive feedback to staff involved in this project and for whom our work is ultimately for.

I would like to acknowledge the project leads, for continuing despite all the challenges, as without them the Project would not have been possible. Their energy and contribution have been invaluable in testing the viability of this methodology in the palliative care sector. The outcomes of the Collaborative Improvement Project will help to shape how NSAP can provide support for specialist palliative care services in the future. Thus, ultimately build capacity and capability within these services to empower them to make sustainable changes for the improvement of patient care and meeting the National Palliative Care Standards.

I commend this report to you and hope that for the participants it is a record of your involvement, and for others, that it is a guide of how to undertake change in the provision of improved care for palliative care patients and their families.

Dr Scott Blackwell
President
Palliative Care Australia
May 2012

Executive Summary

The National Standards Assessment Program (NSAP) is a national framework for continuous quality improvement built on the *Standards for providing quality palliative care for all Australians – 4th Edition* (the National Palliative Care Standards) for specialist palliative care services and is funded by the Australian Government Department of Health and Ageing. As part of the NSAP cycle services undertake evidence based self assessment in order to consider how consistently they achieve the quality elements for each of the National Palliative Care Standards; identify opportunities for future improvement activities; and develop a quality improvement action plan.

The National Standards Assessment Program Collaborative Improvement: Assessment and Care Planning Project (the Project) was commenced in January 2011. The goals of the Project were to enhance staff skills in continuous quality improvement and to improve the assessment and care planning for palliative care patients; these areas were chosen based on the results of the National Standards Assessment Program self assessments to June 2010. The IHI Breakthrough Series was adopted for the NSAP Collaborative Improvement Project. This methodology is known to produce the rapid sharing and spread of ideas for a specified topic across multiple sites in a short time.

The two Project aims were:

1. All patients will have an assessment that is patient centred and holistic
2. All patients will have care planning which is holistic, current and demonstrates patient involvement.

NSAP recruited 20 specialist palliative care services and they had various models of care delivery that included inpatient, community, consultative, and both community and consultative. These covered both adult and paediatric services, as well as direct care, consultative and shared models of care. They commenced in May 2011 and the Project concluded in December 2011.

The evaluation of the Project has demonstrated that the Collaborative Improvement BTS Model builds skill development in continuous quality improvement. Participants improved skills, knowledge and confidence in the use of quality improvement techniques. There has also been a transformation in attitude and increased motivation which are both needed to make changes in practice. This was despite the limitations of the short time frame and a broad and complex topic.

This Project was conducted to improve the quality and relevance of care for people towards the end of their life. By using the Collaborative Improvement BTS Model the participating specialist palliative care services have made changes to improve processes involved in the assessment and care planning for palliative care patients. Patients’ perspective would further enhance our understanding of the outcomes of these process improvements. These changes resulted in overall improvements in the performance measures, and there was significant reduction in the variation for each of the performance measures. The performance data identified strengths of where the objective of this Project was achieved, such as patient involvement and having care plans that reflect the holistic assessment. The objective of the Project was to improve patient centred assessment and care planning, and ensure that it is holistic, coordinated, ongoing and responsive to the changing needs and wishes of the patient, their caregiver/s and family using a collaborative improvement methodology. This Project supports the argument that the Collaborative Improvement BTS model should be the preferred approach for future projects aiming to improve care across several services.

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2. Palliative Care Australia (2005) *The Standards for providing quality palliative care for all Australians*, 4th edn, Canberra: Palliative Care Australia
3. Palliative Care Australia (2011) *NSAP National Quality Report December 2010* Canberra: Palliative Care Australia
5. Palliative Care Australia (2005) *The Standards for providing quality palliative care for all Australians*, 4th edn, Canberra: Palliative Care Australia
Introduction

The National Standards Assessment Program (NSAP) is a national framework for continuous quality improvement built on the Standards for providing quality palliative care for all Australians – 4th Edition\(^6\) (the National Palliative Care Standards).

As part of the NSAP cycle services undertake evidence based self assessment in order to consider how consistently they achieve the quality elements for each of the National Palliative Care Standards; identify opportunities for future improvement activities; and develop a quality improvement action plan. NSAP provides tools to support services to independently study, plan and implement improvement actions. A summary of this improvement effort is provided and incorporated into an annual NSAP National Quality Report. It is from this submitted summary information that the NSAP team identify opportunities to inform the ongoing development of well targeted quality improvement programs. The challenge for NSAP was finding a methodology that could be used nationally across a variety of clinical settings with varied clinical needs that ensured effective use of resources whilst building capacity and capability of the services to provide sustainable improvements in patient care. The collaborative improvement method was identified as one approach for supporting sustainable improvements in care.

The National Standards Assessment Program (NSAP) uses the plan-do-study-act (PDSA) cycle\(^7\) to support improvement effort. The Breakthrough Series (BTS) collaborative model developed by the Institute for Healthcare Improvement (IHI)\(^8\) also uses the PDSA cycle to get organisations to test and introduce change. In essence the PDSA cycle is an inductive learning model – the growth of knowledge through making changes and then reflecting on the consequences of those changes. Drawing on experience from the literature\(^9\), experts and congruence in the use of the PDSA cycle a method based on the IHI Breakthrough Series was adopted for the NSAP collaborative improvement project. This methodology is known to produce the rapid sharing and spread of ideas for a specified topic across multiple sites, in a short time\(^10\).

The analysis of 69 submitted quality improvement action plans from services that had completed their NSAP self assessment prior to June 30, 2010\(^11\), including reports from the pilot study program, identified key priorities for improvement. The areas were skill development in continuous quality improvement and assessment and care planning.

These key priorities were addressed through the NSAP Collaborative Improvement Project: Assessment and Care Planning (the Project). The goals were to:

1. Pilot the collaborative improvement methodology in the palliative care sector in Australia to determine if this methodology was feasible as an approach that could be maintained and managed by the NSAP team for implementation of sustainable improvements across the sector to meet the National Palliative Care Standards.
2. Support the specialist palliative care sector in Australia using an improvement methodology on the topic of assessment and care planning for palliative care patient and/or family/carers.

The Project commenced in January 2011 with the planning and preparation taking place initially up to April 2011. The participating specialist palliative care services commenced in May 2011 and the Project concluded in December 2011.

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\(^6\) Palliative Care Australia (2005) The Standards for providing quality palliative care for all Australians, 4th edn, Canberra: Palliative Care Australia


\(^11\) Palliative Care Australia (2011) NSAP National Quality Report December 2010 Canberra: Palliative Care Australia
CHAPTER 1

1. Collaborative Improvement Breakthrough Series Model

Evidence from the fields of change management and quality improvement have provided multiple strategies, tools and resources that can be utilised to improve patient care. The difficulty for clinical staff is finding and knowing how to use these tools and techniques correctly to identify and resolve problems as quickly and as cost-effectively as possible whilst ensuring that any improvements in patient care are sustained. It also should be recognised that the work involved for a project team to initiate and sustain improvement in health care is complex and demanding.

The objective of clinical improvement is simply to spread innovation in order to improve a particular process or outcome, through changing the processes within the current system for that care12. Berwick13 indicates that every system is perfectly designed to achieve the results and outcome that it achieves. This important so-called ‘central law of improvement’ advocates that unless you change and improve the system there will not be an improvement in outcomes. The process of change to make the improvement needs to be selected carefully and one dimension to this is the underlying change theory that drives the work14.

The Breakthrough Series (BTS) model was developed by IHI in response to the knowledge that breakthrough change could not happen in a traditional didactic setting15. Telling people about change strategies did not necessarily result in implementation of improvement focused activities. The NSAP team also experienced this in their Action Plan Workshops conducted throughout 2010. These singular workshops focused on teaching the theoretical components of continuous quality improvement. Clinicians reported that they found it hard to translate the theory into practical application to improve clinical care.

The BTS model is a learning system that brings together a large number of teams from different services to seek improvement in a focused topic area over a defined period of time14. Its strength is the relatively efficient use of experts and peers and the exchange of best practices to facilitate and guide improvement by rapidly spreading new ideas and best practice in health care16. This is achieved by leading teams from different services to share ideas and work toward systematically trialling, testing, evaluating and improving processes of care to achieve the desired outcome.

Quality improvement collaboratives based on the BTS model are being used increasingly in the United States, Canada, Australia, and European countries. The BTS model has been used in a palliative care setting in the United States where substantial gains were made in familiarity with continuous quality improvement (CQI) techniques and in building palliative care programs and networks17. NSAP decided to adopt this methodology for the NSAP Collaborative Improvement Project pilot in the palliative care setting in Australia on the basis that:

• This model has credibility
• Participants learn from experts about evidence, concepts of change, practical changes
• There are measurable targets and data is collected18
• The model utilises principles of collaboration through bringing services together to learn
• The model encourages staff to develop skills in continuous quality improvement through participation in the project. These skills can then be used for other improvements in their services.

“ The whole process has been very valuable with significant impact on other related areas ”

The key elements for the BTS Collaborative Improvement model include topic selection (this was stated in the objective), experts to lead, model for improvement (includes the performance measures), participants and process. These are shown in figure 1 below.

Figure 1 Breakthrough Series Collaborative Improvement model

The application of these elements for the Project is described in chapter 2. As it was a pilot project with limited funding the action period of the Project was conducted over a shorter time of 6 months compared to the usual 12 to 24 months.


Above: All the participating specialist palliative care services
CHAPTER 2

2. NSAP Collaborative Improvement Project: Assessment and Care Planning methodology

2.1. Objective and aims

The objective of this Project was to improve patient centred assessment and care planning, and ensure that it is holistic, coordinated, ongoing and responsive to the changing needs and wishes of the patient, their caregiver/s and family20 using a collaborative improvement methodology.

To achieve this objective by December 2011 there were two project aims:

1. All patients will have an assessment that is patient centred and holistic
2. All patients will have care planning, which is holistic, current and demonstrates patient involvement.

2.2. Structure and personnel to lead the project

The NSAP Collaborative Improvement Project management team was responsible for the development, implementation and evaluation of the Project.

The Project team comprised of:

- Dr Jan Davies – Independent Consultant
- Miss Claudia Giugni – NSAP Manager
- Dr Amanda Henderson – Consultant
- Mrs Helen Vaz – NSAP Quality Coordinator
- Clinical Lead – Expert Reference Panel
- Collaborative Improvement Advisor
- Project Manager
- Collaborative Improvement Evaluator
- Project Officer

Above: The Project Team

20 Palliative Care Australia (2005) The Standards for providing quality palliative care for all Australians, 4th edn, Canberra: Palliative Care Australia
An Expert Reference Panel (ERP) (Appendix 1) was convened to develop the change package and provide support as required to the Project either by attending the learning sessions or teleconferences.

2.3. Expert process to develop the change package

A change package\(^{21}\) contains a vision for ideal care in the topic area and specific changes that, when applied locally, will improve significantly the system's performance. The change package (Appendix 2) for this Project contained the overarching principles to drive system wide improvement and strategies for meeting the standards for assessment and care planning. This was developed through the combination of a literature search and expert opinion. The change package did not contain any assessment or care plan tools.

2.3.1. Literature on assessment and care planning

A review of the healthcare literature was undertaken to identify potential change strategies and measurements used to improve assessment and care planning.

NSAP would like acknowledge that the literature search was been completed by CareSearch\(^{22}\). Medline, PubMed, Scopus, Embase, CINAHL, the Cochrane Library, Informit (for Australian health content), Bandolier, TRIP, Cochrane Effective Practice: Organisation of Care Group, American Nurses Association resources, and Google Scholar were searched.

The search terms used included:

Patient care planning OR care plan/plans/planning OR case management OR Critical pathways or goals combined with (using AND) each of the following:

- Standards
- Documentation OR Medical records or Nursing records or Patient records
- Patient care team OR Multidisciplinary team or Interdisciplinary Communication or Continuity of Patient Care
- Outcome and Process Assessment (Health Care) or Quality Assurance, Health Care or Program evaluation or Nursing audit
- Professional Family Relations or Family or Communication Or Family Centred care
- Patient Centred Care.

These terms were trialled both on their own and in combination with “palliative care or terminal care or hospice care”. The results were also combined with “chronic disease” to remove some of the acute care references. The removal of “acute” to try and identify relevance to palliative care may have narrowed the search as outside the palliative care setting there are thousands of results for each combination. The results mostly relate to diabetes. There is also quite a focus on care planning in aged care. A date range limit was not used though limited to English.

This search yielded 112 articles. Abstracts of the potentially relevant articles were reviewed and those articles that appeared not to be relevant were discarded. The full articles of those potentially relevant were retrieved. The reference list of the articles are included as Appendix 3.

Key points from the literature review identified the following:

- The majority of the literature addressed nursing aspects of assessment, care and documentation.
- There was scant evidence about multidisciplinary care and documentation in the literature.
- Literature sources were predominately from Scandinavian countries (ie a different context) and not specific to palliative care.
- The care planning process and tools used within the processes to improve care both work together and are important. This was indicated by the assessment and care planning processes being initially reviewed and changed to be more standardised. Then once the new processes were in place the tools were changed in response to support these\(^{23}\). An association between improved provision and outcome of care and care planning was shown\(^{24}\) but it is not known whether the change was due to the care planning process by the team work and/or the tool of a multidisciplinary care plan.


The results of the review of the healthcare literature were grouped according to the following themes relevant to assessment and care planning:

- **Care planning**
  - There were no clearly successful methods on the development of evidence based care plan tools. There were some examples of how assessment is linked to care planning.
  - The provision of coordinated multidisciplinary care is promoted with examples of tools that can be used.

- **Clinical pathways.** These can, and have been, used in the palliative care setting.
- **Documentation.** This is an important component in assessment and care planning.
- **End of life care.** There are some “lessons learnt” and implementation strategies used for end of life care that can be applied to care planning.

No specific measurements or indicators for monitoring improvements in either the assessment or care planning process, or outcomes for patients were found in the literature.

### 2.3.2. Expert reference panel meeting: deliberations on change strategies

On the 22nd March 2011 in Sydney a meeting was convened with a multi professional group of experts who shared an interest in improving the assessment and care planning of palliative care patients and their families/carers in Australia. The aims of this meeting were to identify barriers and solutions to be used in the development of the change package. The Project literature review was provided to the ERP at this point in the process.

The attendees were national clinical peer and academic experts in palliative care and chronic care (see Appendix 1 for ERP membership). The meeting was conducted by the Project team. Ms Bernie Harrison (NSW Clinical Excellence Commission) facilitated brainstorming and nominal group technique sessions to identify:

- Barriers to:
  - Assessment
  - Care Planning
- Prioritise the barriers
- Identify possible solutions to address the barriers.

The prioritised barriers and the key themes of the solutions identified in response to these barriers are listed below:

### Prioritised barriers: Assessment

#### Process
- The lack of formalised assessment culture within services
- There is poor information sharing between services leading to duplication of assessments/care plans
- Multiple assessments are used by multiple agencies
- The same tools are not being used across services
- There is an unclear ownership of process
- Staff do not recognise assessment and care planning is a process
- Multiple assessments are not being connected.

#### Communication
- A lack of input from patient/family
- The communication between teams where multiple teams are involved
- Lack of empowerment of client and support system by informing them proactively about their care
- Unclear goals of care – clinically focused rather than patient focused.

#### Staffing
- The lack of consultation with patient and families
- The level of clinical skills in completing holistic assessment and providing a person centred approach
- The level of clinical skill to complete physical assessments. This is particularly relevant in rural/remote areas
- There are assumptions by health care professionals regarding what patients need
- The challenges of creating integrated multidisciplinary teams (MDT).
Prioritised barriers: Care planning

Process
• The lack of clarity in the goals
• The confusion about the ownership of care plans
• The care plan is not a living document with current information
• Lack of clear linkage between assessment and care plan
• Separate care planning by disciplines with no shared overall plan.

Staffing
• Role delineation within service e.g. primary needs versus speciality needs
• A lack of interdisciplinary planning
• Appropriate use of roles mindful of skill sets within palliative care
• Lack of pre-planning work with families/patients (if need an interpreter etc.)
• Difficulty getting MDT together due to time, distance, etc.

Several solution strategies were identified to address these barriers to assessment and care planning. These were organised into the following themes:
• Goals of care/linkage/tool work and process
• MDT process/support (includes telehealth options)
• Role delineation and up skilling of staff
• Executive support/formal agreement/guidelines for staff
• Case management/coordinator
• Centralised documentation
• Family/patient involvement.

These solution strategies were used to develop the change package (see Appendix 2).

2.4. Key performance measures

Central to the collaborative improvement methodology is measurement. It is not possible to know whether changes are an improvement without measurement. It was clear from the literature that there are no standard or validated indicators for monitoring improvements in assessment and care planning processes. The Project team and ERP developed the following suite of indicators, based on the literature search and their expert knowledge, for the Project:

1. Percentage of assessments with evidence of patient and/or family/carer involvement.
2. Percentage of assessments with evidence of a first assessment completed within 48 hours of admission to the inpatient setting or face to face visit.
3a. Percentage of patients with a holistic assessment.
3b. Percentage of patients with a holistic care plan informed by the holistic assessment.
4. Percentage of care plans that reflect the most recent assessment by any member of the MDT.
5. Patient perspective about their involvement in the assessment and planning of their care (This was optional and measured using focus groups/interviews with patients).

Data for performance measures 1 to 4 were collected monthly by the 20 participating specialist palliative care services using the measurement strategies as detailed in Appendix 4. Data was collected using medical record audit. This data was submitted to the Project team each month using a data report template provided by the Project team.

2.5. Participants and the breakthrough collaborative process

Recruitment to the pilot was through an expression of interest process to all specialist palliative care services that had completed their NSAP self assessment by December 2010. Based on available resources, the Project was limited to 20 services. In April 2011, 20 specialist palliative care services from across Australia committed to participation by signing an agreement. The 20 specialist palliative care services had various models of care delivery that included inpatient, community, consultative, and both community and consultative. These covered both adult and paediatric services, as well as direct care, consultative and shared models of care.
<table>
<thead>
<tr>
<th>Service</th>
<th>State</th>
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<tbody>
<tr>
<td>Banksia Palliative Care Service</td>
<td>VIC</td>
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<td>Bethesda Hospital Palliative Care Unit</td>
<td>WA</td>
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<td>Canterbury Hospital Telopea ward</td>
<td>NSW</td>
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<td>Cessnock Singleton Palliative Care Service</td>
<td>NSW</td>
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<tr>
<td>Claire Holland House</td>
<td>ACT</td>
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<td>David Berry Hospital (Shoalhaven Palliative Care Service)</td>
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<td>Hammond Care North Palliative Care Service</td>
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<tr>
<td>Mercy Health Albury Palliative Care</td>
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<td>QLD</td>
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<td>Sacred Heart Palliative Care – St Vincent’s Hospital</td>
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<tr>
<td>West Gippsland Healthcare group</td>
<td>VIC</td>
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Table 1: Participating specialist palliative care services

In the agreement the participating specialist palliative care services committed to conducting PDSA cycles to test the change strategies in the change package, with the specific objective of improving patient centred assessment and care planning. The strategies tested were different for each service based on their specific needs with the focus always being on the overall Project objective. The change package consisted of strategies and did not include any assessment or care plan tool. Each specialist palliative care service agreed to establish a local project team with executive support and provide the monthly data. There was agreed participation in the monthly teleconferences and learning sessions. The Project team agreed to provide support and reports on the monthly data.

What did you like most about the Learning sessions?

“Reports from different kinds of palliative care services. Useful to hear that other teams faced similar challenges, and how they approached overcoming them”
As previously mentioned the IHI Model was the methodology employed for this Project. Figure 2 shows the key components of the Project model.

**Figure 2: The key components of the Project model**

**Learning Sessions (LS1 – 3):** The team members from the 20 specialist palliative care services across Australia came together for three learning sessions in May 2011 (in Melbourne), August and November 2011 (both in Sydney) to learn skills in the improvement methods, to share ideas, discuss their interventions, gain support from peers and clinical leaders and network with colleagues from across the country.

- **LS1** occurred over 2 days (see Appendix 5 for the program) and the focus was preparation for the project with the distribution of some tools for the participants to use. These included
  - the change package (Appendix 2),
  - project planning document,
  - Plan-Do-Study-Act (PDSA) worksheet,
  - Barrier Analysis tool.
- **LS2** was an one day session (see Appendix 6 for the program), where half of the participants presented their project stories focusing on their progress and challenges. Sustainable strategies were discussed using a worksheet and checklist.
- **LS3** was also an one day session (see Appendix 7 for the program), where the other half of the participants presented their project stories focusing on their outcomes. Participants completed plans for maintaining and enhancing improvements.

**What did you like most about the Learning sessions?**

“Hearing and comparing ways of managing changes with like organisations”

**Action Periods (AP):** In between the learning sessions, the teams worked on their own projects, applying their new knowledge and skills, testing the effectiveness of the changes using the PDSA cycle repeatedly, learning how to apply key change ideas to their services and completing the monthly data performance measures. The PDSA cycle is underpinned by three important questions:

- What are we trying to accomplish? (aim)
- How we will know that change is an improvement? (measure)
- What changes could be made that might lead to an improvement? (change)

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**The Project team support:** A number of communication strategies were implemented to support the teams throughout the Project:

- A web based forum through CareSearch[^26] allowed services to access and store their shared resources. Discussion and the subsequent sharing of information occurred via this web based forum in between the learning sessions and teleconferences. The Project monthly reports were located on this web based forum. Services were able to use the Project monthly reports to track their individual progress in comparison with the overall project.

- Monthly group teleconferences on relevant topics, led by either a topic expert or the Project team. These were recorded for those who were unable to attend and provide a point of reference for attendees. Teleconferences also provided an additional opportunity for support to services and sharing of information between services.

- Individual contact with the specialist palliative care services and a site visit to all the specialist palliative care services from the Project team. The site visit gave the services the opportunity for the whole team to discuss their specific local progress and challenges with the Project team.

CHAPTER 3

3. Project Evaluation

NSAP commissioned an independent evaluation of the Project to assess the impact of participation in the Project on staff skills, knowledge and confidence in use of improvement techniques; and assess the effectiveness of the Collaborative Improvement Project in improving assessment and care planning in palliative care. The summative Project evaluation sought to evaluate generic outcomes across the participating services and included two components:

Part A: The assessment of the usefulness of the Collaborative Improvement Breakthrough Series (BTS) Model in improving assessment and care planning in palliative care.

Part B: The achievements of the specialist palliative care service projects in improving assessment and care planning.

The full Evaluation Report details the methods used including: setting, sample, performance measures, data collection, data analysis, limitations, findings and discussion of the findings for the Project. Extracts related to the findings and recommendations from the Evaluation Report are included below. This report is available from the NSAP website (nsap.palliativecare.org.au).

Part A: Collaborative Improvement Breakthrough Series Model

A mixed methods approach was used to complete the evaluation of the Collaborative Improvement BTS Model. The evaluation questions for this model were agreed by the NSAP Project team and based on the Project aims and purpose. The seven evaluation questions were:

1. Does participation in an improvement collaborative (e.g., learning sessions, communication outside the service team) help specialist palliative care services facilitate improvement in assessment and planning of care for palliative care patients and their families/carers?
2. What is the service’s perspective on the lessons learnt from participating in an improvement collaborative?
3. What is the service’s perspective on the benefits from participating in an improvement collaborative?
4. Did all participating services implement the PDSA rapid cycles of improvement?
5. What are the barriers to adopting the PDSA rapid cycles of improvement?
6. Did all participating services complete their project?
7. Did all participating services meet NSAP’s requirements for the Project (e.g., attendance at learning sessions, submission of data and reports)?

The details and results for each of the seven evaluation questions are presented in Appendix B and the evaluation report. A summary of the Part A evaluation findings and recommendations is listed below.

Evaluation findings of the Project

1. The majority of collaborative participants agreed that participation in a national program improves the acceptance of the Project and the service changes.
2. The NSAP team provided appropriate leadership and communication to support the participating projects.
3. The executives of participating services responded to project requirements.
4. The collaborative improvement model facilitated the sharing of ideas and networking across participating services.
5. The collaborative experience motivated staff to improve care planning.
6. The majority of collaborative participants agreed that the project outcomes were sustainable.
7. Participants were able to explain the PDSA cycles and identify gaps in service delivery.
8. The collaborative improvement process is effective and supports the review and improvement of services.
9. The education resources were appropriate and helpful for the collaborative improvement projects.
10. The data criteria and collection requirements to measure project outcomes were appropriate.
11. The data was helpful to demonstrate care delivery improvements.
12. Learning sessions facilitated individual project development and implementation.
13. Learning sessions were critical for networking and sharing of information between services.
14. The communication processes in the collaborative improvement project were appropriate.
15. Project participants learnt new skills and gained knowledge about continuous quality improvement activities during the collaborative improvement project.

16. Participants (97.5%) would like to participate in a future collaborative improvement project.

17. The Project performance measures have shown where improvements were achieved.

18. The administrative and reporting requirements of the Project were appropriate.

**Recommendations for a future Palliative Care Collaborative Improvement Project**

1. Projects need to be carefully scoped to ensure that outcomes are achievable within the defined project timeframe.

2. A collaborative participation requirement package needs to be provided to participants prior to commencement of the Project.

3. A project strategy should include the development and support of the multidisciplinary team.

4. The structure of the teleconferences should be reviewed for a future collaborative improvement project.

5. Human resources need to be allocated at each site to undertake a collaborative improvement project.

6. Project leaders need dedicated time to manage and implement collaborative improvement projects.

7. Executive support is needed to endorse the implementation of PDSA cycles.

8. Executive support is needed to facilitate a culture of change management.

9. Executive support is needed to facilitate policy and documentation approvals related to PDSA requirements.

10. Dedicated training should be provided regarding the PDSA cycle at project commencement for staff implementing the cycles.

The findings supported the use of the Collaborative Improvement Model to improve the assessment and care planning for palliative care patients. Recommendations for a future project are concentrated on having suitable human resources to conduct the project and executive support of the project, scoping projects appropriately and having reasonable timeframes to conduct the work.

**PART B: Specialist Palliative Care Service Projects**

Part B of the Project evaluation was undertaken to determine if the aims of the Project 1: All patients will have an assessment that is patient centred and holistic; and 2: All patients will have care planning, which is holistic, current and demonstrates patient involvement were achieved by the participating specialist palliative care services. The evaluation questions and performance measures for Part B were agreed with the NSAP team and the Expert Reference Group. Table 1 shows the questions and performance measures used for the Project.

“Thanks to NSAP team especially Helen for their support guidance and feedback. This project has provided a great foundation to continue to improve our practice within strong framework. Even though it has been a struggle at times we have seen direct positives in patient care. This is what makes getting out of bed to go to work for each day worthwhile.”
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Performance Measure</th>
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<tbody>
<tr>
<td>Question 1: Do palliative care assessments evidence patient and/or family/carer involvement in the process?</td>
<td>P1: Percentage of assessments with evidence of patient and/or family/carer involvement (relative to the individual project percentage results)</td>
</tr>
<tr>
<td>Question 2: Are palliative care assessments completed within 48 hours of admission to the inpatient setting or a face to face visit?</td>
<td>P2: Percentage of assessments with evidence of assessments completed within 48 hours of admission to the inpatient setting or a face to face visit (relative to the individual project results)</td>
</tr>
<tr>
<td>Question 3A: Are palliative care assessments holistic?</td>
<td>P3A: Percentage of assessments with evidence of assessments that show a holistic assessment (relative to the individual project results)</td>
</tr>
<tr>
<td>Question 3B: Do palliative care plans reflect the holistic assessment?</td>
<td>P3B: Percentage of assessments with evidence of patients with a holistic care plan informed by the holistic assessment (relative to the individual project results)</td>
</tr>
<tr>
<td>Question 4: Do palliative care plans reflect the most recent assessment by any member of the multidisciplinary team?</td>
<td>P4: Percentage of assessments with evidence that palliative care plans reflect the most recent assessment by any member of the multidisciplinary team (relative to the individual project results)</td>
</tr>
<tr>
<td>Question 5: What is the patient perspective about their involvement in the assessment and planning of their care?</td>
<td>A qualitative design using focus groups or face to face interviews with palliative care patients was required to explore this question. This question was not compulsory due to the amount of resources needed to complete the data collection within the constraints of the short Project time of just 6 months. It was not completed by enough services to include in the summative evaluation.</td>
</tr>
</tbody>
</table>

Table 2: Evaluation questions and performance measures

*Above: Doing some table work at learning session*
While all services should aim for 100% across all measures (1 – 4), it was acknowledged that achievable targets should be set for a Project lasting only 6 months. The Project goal set for all the quantitative performance measures was therefore 80%. The evaluation was based on group data for performance measures collected from all 20 participating services. Data was collected using medical record audit. Some services met the 80% target at their baseline measure for performance measures 1 and 2 but remained in the Project as there was still opportunity to improve to 100%. Also they did not meet the target for the other performance measures and the focus of their changes was to meet the target on those performance measures.

Summary results in figure 3 show that the assessment and planning of care for palliative care patients improved from the baseline data set.

![Figure 3: Summary of average percentage results for each performance measure](image)

Performance measures P1 and P2 both showed strong results from Project commencement. The variation in the range of the data improved for both measures. At Project completion 90% of services had achieved the Project goal (80%).

Performance measure P3A was the weakest result area of the Project. However, it showed a continual improvement over the PDSA reporting periods. This performance measure was the only measure that required a number of criteria to be fulfilled to obtain a positive audit result. Five audit criteria to be evidenced were: physical, emotional, social, cultural and spiritual assessments. The five criteria used for P3A were critical to this measure and the improvement of the "cultural" and "spiritual" criteria supported the achievements over the Project period. At Project completion only 35% of services had achieved the Project goal (80%) suggesting that ongoing work is required to improve the assessment process. However, a positive P3A outcome was strongly linked with a positive P3B (Percentage of assessments with evidence of patients with a holistic care plan informed by the holistic assessment) result. 80% of services, that positively reported P3A, reached or exceeded the 80% target for P3B at Project completion.

Performance measure P4 showed steady improvement over the Project period and the percentage of assessments with evidence that palliative care plans reflect the most recent assessment by any member of the multidisciplinary team reached 85% at project completion. At Project completion only 68% of services had achieved Project goal (80%), hence there were still a number of services addressing this measure.

The results for each of the performance measures are presented in Appendix 9 and the evaluation report. A summary of the Part B evaluation findings and recommendations is listed below:
**Project strengths: Quantitative measures**

1. The percentage of palliative care assessments with patient and/or family/carer involvement in the process evidenced improvement.
2. The percentage of palliative care assessments completed within 48 hours of admission to the inpatient setting or a face to face visit evidenced improvement.
3. The percentage of holistic care assessments, for palliative care patients, evidenced improvement.
4. The percentage of palliative care plans that reflected a holistic assessment evidenced improvement.
5. The percentage of palliative care plans reflecting the most recent assessment by any member of the multidisciplinary team evidenced improvement.

**Recommendations for developing the key performance measures for the assessment and planning of care for palliative care patients**

1. Project areas (and settings) need to be more defined in future Projects to support a more valid and reliable comparison between project groups.
2. The validity of the four quantitative measures needs to be more extensively researched before the measures can be used in the wider palliative care setting.
3. Inter-rater reliability of performance data needs to be completed in future projects.
4. The inclusion of a qualitative question in a future collaborative improvement project should be managed and conducted by NSAP as a separate Project evaluation. Participating services/projects would agree to facilitate access for an NSAP evaluator to conduct this work.

The evaluation of the achievements of the specialist palliative care service projects in improving assessment and care planning has evidenced improvements across all quantitative performance measures. Unfortunately the qualitative measure was not completed by 18 of the services; therefore the “patient perspective” on assessment and planning of their care is not reported. Recommendations for a future Project are focused on the reliability and validity of the quantitative measures.
CHAPTER 4

4. Project Stories

Each of the 20 specialist palliative care services completed a project summary to provide details of their experience at the completion of their individual project journey. It was to include a record of their progress and to potentially provide advice to inform future learning projects for both the individual service and the broader palliative care sector. The executive for each of the special palliative care services provided written endorsement so that the project summary could be used in publications related to the Project.

The project summaries addressed the following ten questions:

1. Why did you want to participate in the NSAP Collaborative Improvement Project: Assessment and Care Planning (CIP: A&CP) project? What was your evidence that your assessment and care planning need improvement?
2. What were the key areas/problems you were trying to address in the NSAP CIP: A&CP project?
3. What was the aim of your project?
4. What change(s)/intervention(s) were implemented in your project using the PDSA cycles?
5. What are the key results of your project?
6. What measures/data are used to demonstrate your project results?
7. What were the challenges/barriers to changing practice and how did you overcome them?
8. What sustainability strategies have you in place?
9. What are 3 key things that you have learnt from participation in the collaborative improvement project?
10. What is your message for someone who is commencing a collaborative improvement project?

The full stories, addressing these ten questions, from each of the 20 specialist palliative care services are in a booklet called 'Project Stories' available from the NSAP website (nsap.palliativecare.org.au).

“Participation in the collaborative provided us structure, skills and impetus to complete a project that we had wanted to do for a long time, but had never started as they were not sure exactly how to go about it. The experience motivated staff to improve care planning.”

There were some key themes emerging from the specialist palliative care service project summaries:

- Reasons for participation and evidence that their assessment and care planning needed improvement
  - The evidence used by services in their NSAP self assessment had identified that assessment and care planning was an opportunity for improvement for most of the specialist palliative care services.
  - Some services recognised that participation in this Project would provide them with a methodology to make the changes required.
  - There were others who saw the Project as a chance to network across Australia and learn from other services.

- Challenges/barriers to changing practice experienced and how they were overcome
  - Staff availability and turnover was a common challenge for the services. This was managed through having flexibility in the meeting structure, working with key people and constant provision of feedback to all staff to keep the project progressing.
  - Change fatigue and resistance were managed by identifying champions and giving positive feedback and demonstrating how the changes were benefiting the patients.
  - The time required to conduct the Project provided a challenge. Some services were able to appoint a project officer or organise for relief to cover the project lead doing project work.
• Some of the sustainability strategies put into place
  – The relevant procedure was updated with the new changes or new procedures developed to ensure regular practice reflected the successful interventions from the project.
  – Continue with the regular audits to monitor that the improvements gained remain as part of regular practice and have these reported at meetings by being a regular agenda item.
  – Continue with a champion concept with the topic being included in some staff member’s portfolio to make it role dependant rather than person dependant.

• Some key things that have been learnt from participation in the collaborative improvement project
  – Making changes using this methodology and learning about PDSA provided a good framework to improve patient care.
  – The significance of starting off small to make it feasible. Building small increments can result in a bigger change.
  – The importance of having the appropriate engagement from leadership to support the changes.

• Message for someone who is commencing a collaborative improvement project
  – Participation provides a good opportunity to work collaboratively with other services to learn and share in the successes as well as the challenges to assist with the motivation to continue.
  – Keep it simple and take small steps.
  – Planning is important for the success of the project.

See Appendix 10 for the details of these points from the perspective of each of the individual 20 specialist palliative care services.
CHAPTER 5

5. Discussion

The Project evaluation and services’ project summaries provide both data and experiences of the Collaborative Improvement BTS model in the specialist palliative care sector. This model has been applied to make changes to the assessment and care planning of palliative care patients and their families/carers. There are some strengths and limitations of the Project using this model.

Collaborative Improvement Breakthrough Series Model

One of the strengths of the Collaborative Improvement BTS model was the networking across the participating services and provision of a national perspective. The learning sessions were critical for this to occur and supported by the teleconferences and web forum during the action periods. Ideas and experiences were shared. Building motivation is about developing confidence of participants in their ability to make improvements. This occurred both through sharing examples of change and seeing the data provide the evidence of improvements.

Learning quality improvement theory and techniques, as a component of the Collaborative Improvement BTS model, is extremely important for the participants. At the start of the Project each specialist palliative care service project team had staff with differing levels of experience in utilising the quality improvement skills and understanding the requirements of the collaborative improvement method. The evaluation identified that participants learnt new skills and gained knowledge about continuous quality improvement activities and were able to explain the PDSA cycles. The services introduced different changes through the PDSA cycles and used the data to monitor the impact of these changes. This method provided ownership of the changes and influenced engagement with implementing them. Getting staff to feel engaged and to own the changes are significant for increasing the likelihood of the changes being sustained.

Several resources were provided to the participants to assist them making the changes. These included the change package, PDSA workbook, barrier analysis, sustainability checklist, etc. It was hard to measure how these were used and resulted in the changes or if just the participation and sharing of ideas between the services was enough for participations to know how to introduce the changes.

The Project had limited funding so was conducted over a relatively short time. This impacted on the both the preparation time and completion of their projects for the specialist palliative care services. This also restricted the time to collect data to 6 months compared to the usual 12 to 24 months.

There were only 3 weeks between expression of interest and the first workshop. This resulted in the specialist palliative care services not able to collect baseline data prior to attendance at learning session 1. This limited their ability to have meaningful data to utilise during the practices at this learning session and understand the requirements to participate. This meant that they were not prepared to hit the ground running at the first meeting, which is a factor for an effective improvement collaborative. This also delayed some services completing their preparation in establishing their local project teams, collect the baseline data and then review the data to identify the interventions that required for the PDSA cycles. Research has shown that as part of collaborative improvement projects it is important for teams to be supported to deal with data and change challenges. Throughout the Project the participants learnt to understand the role and importance of the data to demonstrate care delivery improvements.

The services understood the importance of considering sustainable strategies throughout the Project. Those who had completed their project felt it was too early to demonstrate the sustainability of the changes made. These can only occur in the future. The short length of time of the project meant that only 43% services were able to complete their project. The sustainability of the improvements needs to be measured at least one year later to be able to demonstrate that the improvements were not temporary. All services had completed their planning and considered sustainable strategies, some of which were already in place.

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Learning session 2 included the consideration of sustainability strategies through the use of a worksheet and checklist. Each service was able to use this information to assess what strategies needed to be employed to ensure the long term success of their project. This was an important strategy to include as it increases the chance of successful spread of the quality improvement. Plus the Project team learnt from research\(^1\) which has shown that many collaboratives and teams did not make time to learn about and plan how to sustain improvements, but including the focus on sustainability strategies at this learning session.

Due to the different service structure and staffing at each specialist palliative care service the availability of a multidisciplinary team to participate in the Project varied greatly, with some services not getting any engagement from some members of the multidisciplinary team. These services struggled at times during the Project. Preparation time could have given these services the opportunity to form their multidisciplinary team and start to get engagement with the staff before they attended learning session 1 and thus be ready to hit the ground running.

Support from senior management was crucial for the sustainability of any changes made.\(^2\) The senior management need to know exactly what support is required and how it can be given\(^3\) to facilitate the sustainable changes. The evaluation highlighted some of the roles that the executive support need to be aware of such as facilitation of a culture of change management, endorsement of the implementation of the PDSA cycles and facilitation of policy and documentation approval related to the PDSA requirements. The importance of getting senior management support and establishing communication strategies with them was highlighted at the learning session 1 and also included in the change package. This message was repeated a few times through the project. The agreement also identified the roles of the executive support and project teams.

There needs to be sufficient allocation of human resources to undertake the Project. The time required for this was often hard for the project leaders to fit within their other tasks. The evaluation highlighted that project leaders need dedicated protected time to manage and implement collaborative improvement projects. This was managed by some executive supports through the appointment of project officers who could have dedicated time for the project. This involves costs. Data was not collected on the cost benefit for this model so it is difficult to demonstrate this. The cost of the staff resources is hard to define. This relates to both the service local project teams and the Project team. It is often hard to measure benefits in terms of motivation, application of the skills and improved patient assessments. The costs related to the learning sessions are easier to measure.

The choice of topic is a critical determinant of how successful a collaborative improvement project would be\(^4\) and there needs to be evidence of effective interventions and measurements. It is questionable how effective collaborative improvement projects can be for broad subjects\(^5\). Assessment and Care planning is a broad topic and no specific measurements or indicators for monitoring improvements in either the assessment or care planning process or outcomes for patients were found in the literature. The Project highlights the complexities in specifying performance measures that can robustly measure the practices associated with the assessment and planning of care for palliative care patients.

A common challenge mentioned by the services was “project creep” and how to ensure that they kept within project scope and focused on their aim. Each specialist palliative care service was required to complete their own project plan which included details of scope and aim for their own service. Initially the Project team did not request copies of these completed project plan. However, during the course of the Project it became evident that this limited the Project team’s understanding of the scope, aim and individual planning for each service. This is turn impacted on the ability to provide specific, relevant advice when providing support to each service. These project plans were then requested later in project, but often too late to assist with the planning. The evaluation identified that projects need to be carefully scoped to ensure that outcomes are achievable within the defined project timeframe.


The communication plan included the monthly teleconferences and the web forum. Due to the short preparation time the web forum was only set up after learning session 1. This delay in having it ready meant that the services were not familiar with using it from the beginning of the Project and were used to alternative communication methods, and the resources were not available initially. The participating specialist palliative care services felt the communication and leadership from the NSAP team was appropriate. However, the communication via the monthly teleconference was not optimal and some participants felt they had limited benefit from these. This was due to the timing of the teleconference and unpredictability of clinical care meant that some services were unable to participate, with the maximum attendance at 65%.

Some of the services had the problem of not having a satisfactory holistic assessment tool at the beginning of the Project. This meant that they focused on the development of an assessment tool, rather than specific components of improving assessment and care planning. This did not identify the focus on a particular aspect of care that could be improved such as spiritual care. This encouraged the development of local assessment and care planning tools rather than the use of validated assessment tools.

**Assessment and Care Planning**

The significant improvement was in the reduction of the variation for each of the performance measures. This was particularly relevant for P1 and P2, although not all services met the target for all the performance measures.

Definitions of the performance measures were given (see Appendix 4) for the data collection. However, during the Project it became clear through discussion at the teleconferences and learning sessions that there was still opportunity for different interpretation within the different specialist service settings and the holistic components. This was particularly relevant for the definition of cultural and spirituality criteria and how these were measured.

There are different resources and skills required to collect qualitative data from the patients. It involved specific planning for the specialist palliative care services and in some instances getting ethical approval. Each service needed to manage the collection of this data individually and then send it to the Project team for the overall Project. A significant barrier was determining who should conduct the interview. It needed to be someone who was independent from those who provided the patient care. Also the shorter time period to complete the Project provided another barrier to the completion of this data collection.
## Overall requirements

The Project was planned to deliver the following requirements:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Test/Check/Review</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of an ERP to inform model for improvement and change package</td>
<td>Attendance record and minutes of ERP meeting held. Sign off on model and package</td>
<td>ERP met on March 22nd 2011 in Sydney and had change package and model for improvement ready for first Learning Session 4th and 5th May 2011</td>
</tr>
<tr>
<td>Model for improvement implemented by 80% of participants</td>
<td>Have 80% of data from PDSA cycles at the end of each action period</td>
<td>Each month had &gt;80% of services submitting data</td>
</tr>
<tr>
<td>Deliver learning sessions as per Project schedule</td>
<td>Dates of the learning sessions and attendance records</td>
<td>All 20 specialist palliative care services attended the 3 learning sessions</td>
</tr>
<tr>
<td>Participation in the collaborative improvement project is sustained</td>
<td>Percentage of participation throughout the Project remains above 80%</td>
<td>There was 100% participation with all 20 specialist palliative care services remaining part of the Project</td>
</tr>
<tr>
<td>80% of participants are satisfied with the collaborative improvement model used</td>
<td>Evaluation data</td>
<td>95% of the participants would like to participate in a future collaborative improvement project. There was enhancement in the participant’s skills, knowledge and confidence in the use of the quality improvement techniques.</td>
</tr>
</tbody>
</table>

“It was a great initiative, and I personally really appreciated the opportunity to take part in something which allowed such unique networking and communication”
CHAPTER 6

6. Recommendations

Collaborative Improvement Breakthrough Series Model

This model is a valuable and relevant approach to building sector understanding of quality improvement and change management and could be repeated in the palliative care sector. The recommendations for a future Project are concentrated on having adequate preparation time, suitable human resources to conduct the project with associated costs and executive support of the project, scoping projects appropriately and having reasonable timeframes to conduct the work.

1. Recommendation: Increase the length of the Project to include more preparation time and data collecting periods.

Pre work is part of the Collaborative Improvement BTS model. This is part of the preparation which also includes the establishment of an ERP, development of a change package and setting the measures. There was no time for services to do the pre work and this meant they did not feel well equipped to start. This was highlighted in the evaluation with the identification that a collaborative participation requirement package needs to be provided to participants prior to commencement of the Project. Plus dedicated training should be provided regarding the PDSA cycle at project commencement for staff implementing the cycles. Some collaboratives have included a Learning session zero or orientation session for the preliminary work.34

2. Recommendation: Ensure both the project team and the executive support completely understand the role of the executive support.

The support provided by the executive management varied across the services. Some executive supports participated in the learning sessions and local team meetings. It is important that they engage with the project and provide time and attention. The identification of who fulfils this role is also important to ensure that the executive support is the person who makes decisions for the service and not too senior and removed from the operational components of the service. Plus, the project team members need to engage with the executive support and recognise when to escalate any issues that is preventing the project progressing.

3. Recommendation: To establish the overall cost include a commitment analysis as part of the evaluation.

The time required to undertake a collaborative improvement project was often hard for the project leaders to fit within their other tasks. The management in some services appointed project officers who could have dedicated time for the project.

4. Recommendation: Revise the structure of the workshops from National to State based to reduce the costs and increase the number of services able to participate.

There are high costs related to a National Project which involves the flights and accommodation associated with the delivery of the workshops. This limited the number of services who could participate. The services were not requested to pay for participation. Their costs related to the local human resources and any equipment used.

5. Recommendation: Ensure services submit their local project plan to the Project team, so that the team can ensure the projects are scoped appropriately with an achievable aim.

Projects need to be carefully scoped to ensure that outcomes are achievable within the defined project timeframe. Each specialist palliative care service was required to complete their own project plan which included details of scope and aim for their own service. The Project team needs to be able to provide appropriate support and direction to assist participating services to clearly define the scope and aim for project. This helps in supporting the services utilise validated tools as part of the changes introduced.

6. Recommendation: Review the teleconference structure.

7. Recommendation: Establish the web forum during the preparation for the Project so that it is ready to use at learning session 1.

Attendance at the teleconference was part of the project agreement and was a forum for providing education about different topics as well as services sharing information as part of the support and networking. The low attendance and participants reporting that they felt they had limited benefit, highlighted that the structure of the teleconferences should be reviewed for a future collaborative improvement project. The web forum had limited use.

8. Recommendation: Develop a list of validated tools for services to use.

There were a variety of assessment and care planning tools used. Some of the specialist palliative care services developed their own and others used validated assessment and care plan tools.

“Thanks for everything – I’ve learnt about professional project management quality improvement, palliative care practices, and documentation plus so much more. Thanks again. It’s been an honour and privilege to be part of the collaborative”

Assessment and Care Planning

Recommendations for developing the key performance measures for the assessment and planning of care for palliative care patients are related to having validated quantitative measures and qualitative data.

9. Recommendation: Validate the four quantitative measures and complete the inter-rater reliability.

The interpretation of the criteria for holistic care could have been different between the services. The evaluation identified that the validity of the four quantitative measures needs to be more extensively researched before the measures can be used in the wider palliative care setting. Also the inter-rater reliability of performance data needs to be completed in future projects.

10. Recommendation: Make collection of qualitative data compulsory to gain the patient perspective.

It is important to get patient perspective on the changes in patient care for some outcome data. The difficulties expressed by those who completed the qualitative data, and the fact that majority of the specialist palliative care services did not collect this data, suggests that the inclusion of a qualitative question in a future collaborative improvement project should be managed and conducted by NSAP as a separate Project evaluation. This would mean that the services would not need to use their own resources. Participating services/projects would agree to facilitate access for an NSAP evaluator to conduct this work.
CHAPTER 7

7. Conclusion

The pilot Project has shown that there has been some success with the Collaborative Improvement BTS Model to build skill development in continuous quality improvement. This is demonstrated by the Project participants’ improved skills, knowledge and confidence in the use of quality improvement techniques. There has also been a transformation in attitude and increased motivation which are both needed to make changes in practice. This was despite the limitations of the short time frame and a broad and complex topic.

By using the Collaborative Improvement BTS Model the participating specialist palliative care services have made changes to improve processes involved in the assessment and care planning for palliative care patients. Without the patients’ perspective it is not possible to know the outcomes of these process improvements. The performance data identified strengths of where the objective of this Project was achieved, such as patient involvement and having care plans that reflect the holistic assessment. The objective of the Project was to improve patient-centred assessment and care planning, and ensure that it is holistic, coordinated, ongoing and responsive to the changing needs and wishes of the patient, their caregiver/s and family35 using a collaborative improvement methodology.

NSAP team were pleased with the results of the pilot Project and feel that the Collaborative Improvement BTS model is a viable methodology to use in the palliative care sector to make improvements in patient care. The recommendations will be incorporated in future planning to support specialist palliative care services with their continuous quality improvement activities.

35 Palliative Care Australia (2005) The Standards for providing quality palliative care for all Australians, 4th edn, Canberra: Palliative Care Australia
CHAPTER 8

8. Next steps

These findings and recommendations were taken to the NSAP Steering Committee for discussion about the next steps of rolling out the pilot project into the NSAP model. The Committee is eager for these lessons learnt to be spread wider across the palliative care sector and more specialist palliative care service staff to improve their skills, knowledge and confidence in the use of quality improvement techniques.

The component of the collaborative improvement methodology of the participants having the opportunity to practise the quality improvement skills learnt through a focused topic and having the support was the determining factor.

Due to the success of the pilot it has been decided to implement this strategy and embed this workshop model into NSAP. This will be called the NSAP Continuous Quality Improvement (CQI) collaborative workshops and will take place over 20 months. The recommendations from this report will be included in the new structure. This will include 4 months of preparation time for the services and 12 months of data collection. The project team would be able to set up a web forum and reporting structure during this time, in addition to the establishment of an ERP for the development of the change package and setting the indicators, similar to what occurred for the pilot Project. This time would also include the preparation for setting up the gathering of qualitative data, so that all the services complete getting this data. Collection of this data would be highly recommended as it is important to get patient’s feedback to be able to know the effectiveness of the interventions introduced to improve the care. The workshops to be state based instead of national so that more specialist palliative care services could be involved. The cost component of conducting the pilot project from the perspective of human resources was not completed and so a commitment analysis would need to be part of the evaluation, to establish the overall cost.
# Appendix 1: Expert Reference Panel Members

<table>
<thead>
<tr>
<th>Name and place of work</th>
<th>Position</th>
<th>Name of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan Davies</td>
<td>Advisor – Experience: Director of National Emergency Department and Organ Donation Collaboratives</td>
<td>Independent Consultant</td>
</tr>
<tr>
<td>Bernie Harrison</td>
<td>Director, Organisation Development and Education – Experience: Director of Blood Transfusion Improvement Collaborative</td>
<td>Clinical Excellence Commission, NSW</td>
</tr>
<tr>
<td>Melanie Benson</td>
<td>Palliative Medicine Physician</td>
<td>Alfred Health, Victoria</td>
</tr>
<tr>
<td>Scott Blackwell</td>
<td>General Practitioner President</td>
<td>Silver Chain Hospice Care Service, WA</td>
</tr>
<tr>
<td>Philip Lee</td>
<td>Senior Staff Specialist Palliative Care</td>
<td>Westmead Cancer Care Centre, NSW</td>
</tr>
<tr>
<td>Ghauri Aggarwal</td>
<td>Head Department Palliative Care</td>
<td>Concord Hospital, SLHN, NSW</td>
</tr>
<tr>
<td>Frank Brennan</td>
<td>Palliative Care Physician</td>
<td>St George Hospital / Calvary Hospital, NSW</td>
</tr>
<tr>
<td>Sharon Wiley</td>
<td>Clinical Nurse Consultant</td>
<td>Sacred Heart Palliative Care, NSW</td>
</tr>
<tr>
<td>Fran Gore</td>
<td>Acting Manager</td>
<td>Mercy Palliative Care, Victoria</td>
</tr>
<tr>
<td>Helen Wearne</td>
<td>Chief Executive Officer</td>
<td>South East Palliative Care, Victoria</td>
</tr>
<tr>
<td>Andrew Allsop</td>
<td>Support Manager - Psychosocial and Spiritual Service</td>
<td>Silver Chain Hospice Care Service, WA</td>
</tr>
<tr>
<td>Sue Hearne</td>
<td>Manager Social Work / Bereavement Coordinator</td>
<td>HammondCare Greenwich, NSW</td>
</tr>
<tr>
<td>Kim Hobbs</td>
<td>Social Worker</td>
<td>Westmead Centre for Gynaecological Cancer, NSW</td>
</tr>
<tr>
<td>Mary Santos</td>
<td>Physiotherapist Neuroscience</td>
<td>Physiotherapy, Prince of Wales Hospital, NSW</td>
</tr>
<tr>
<td>Helen Tassell</td>
<td>Senior Physiotherapist Neurosciences and ENT</td>
<td>Physiotherapy, Prince of Wales Hospital, NSW</td>
</tr>
<tr>
<td>Jane Phillips</td>
<td>Professor of Palliative Nursing</td>
<td>Cunningham Palliative Care centre, Sacred Heart, NSW</td>
</tr>
<tr>
<td>Trish Davidson</td>
<td>Professor of Cardiovascular Nursing Research, St Vincents and Mater Health</td>
<td>Curtin Health Innovation Research Institute, NSW</td>
</tr>
<tr>
<td>Peter Jenkins</td>
<td>Clinical Practice Consultant</td>
<td>Southern Adelaide Palliative Services</td>
</tr>
<tr>
<td>Patsy Yates</td>
<td>Professor of Palliative Care A/Director Centre for Palliative Care Research and Education</td>
<td>School of Nursing &amp; Midwifery, Queensland University of Technology</td>
</tr>
<tr>
<td>Jen Tieman</td>
<td>CareSearch Director</td>
<td>Flinders University</td>
</tr>
<tr>
<td>Maree Banfield</td>
<td>National Palliative Care Outcomes Collaboration Quality and Education Manager</td>
<td>University of Wollongong</td>
</tr>
<tr>
<td>John Stubbs</td>
<td>Chief Executive Officer</td>
<td>Cancer Voices Australia</td>
</tr>
</tbody>
</table>
Appendix 2: Change Package

Overarching principles to drive system wide improvement

1. Focus on results through reviewing, changing and improving practice

Palliative Care services are accountable for maintaining a rigorous focus on patient centred assessment and care planning, that it is holistic, coordinated, ongoing and responsive to the changing needs and wishes of the patient, their caregiver/s and family. This requires developing and maintaining informed, trained staff who work together in a culture of excellence.

2. Person centred care

The holistic needs of the patient, their caregiver/s and family are acknowledged in the assessment and care planning processes, and strategies are developed to address those needs, in line with their wishes. (refer National Palliative Care Standard 2).

3. Health professionals with appropriate skills

The service employs and develops health professionals with the appropriate qualifications, credentialing and experience to meet the physical, psychological and spiritual needs of both patients and families. (refer NSAP quality element 12.1).

CHANGE PACKAGE PRIMER

Four strategies for meeting the standards for assessment and care planning

1. Involve clinical and organisational leaders to get results
2. Focus on the needs of the patient, their family and carer/s
3. Link the assessment to care planning and delivery
4. Ensure that roles and responsibilities are understood, accepted and supported.
STRATEGY ONE

Involvë clinical and organisational leaders to get results

Senior leaders, both clinical and managerial, actively support the teams through a well-defined assessment and care planning process that is patient centred.

Key change concepts

1. Use service data as the basis for improvement
2. Identify an organisational champion or executive sponsor.

Action items

Secure the commitment

• Hospital executive and clinical leaders are prepared to play a constructive role to support change and improvements
• Clinical staff know how to engage senior leadership to facilitate the process of making assessment and care planning routine
• Make patient focused assessment and care planning “organisational priorities”.

Establish the underlying process

• Clear roles and responsibilities: everyone knows who does what, everyone acknowledges and respects the roles of others
• The multidisciplinary approach to assessment, care planning, referral and care delivery is supported by the senior leaders
• Possible barriers to patient centred assessment and care planning are identified and appropriate action by senior leaders is planned
• Communication channels with senior leaders are established
• The organisation is committed to, and endorses clear policies and procedures regarding, assessment and care planning.

STRATEGY TWO

Focus on the needs of the patient, their family and carer

The assessment involves the process of understanding what is relevant to the patient, their family and carer at key moments in the patient’s journey.

Key change concepts

1. The assessment of the patient and family expectations includes preferences for the type and place of care (refer NSAP quality element 2.3)
2. The patient assessment is reviewed and updated on a regular basis based on patient condition and need (refer NSAP quality element 2.4) and informs the development of a current care plan.

Action items/ Ideas for change

• Develop a process for patient/family to record their agreement with assessment/plan
• Develop an assessment process checklist that includes assessment completed, assessment sent to required people, date of next assessment
• Develop and use a standard form or checklist for content to ensure that all patient needs are met
• At a minimum, involve the family/carer by conducting family meetings at the initial assessment, when there is a Karnovsky score 60, and at the terminal phase
• Ask the patient and carer to identify the three issues of most concern to them
• Place patient goals at the top of the assessment sheet
• Develop/ implement easy to use flow diagrams that address steps, decision points and triggers for action.
STRATEGY THREE

Link the assessment to care planning and delivery

Assessment and care planning tools are linked by triggers in the assessment process, and lead to negotiated goals/objectives and measurable outcomes for each dimension: bio/psycho/social/spiritual.

Key change concepts

1. Use triggers from the assessment process to determine care planning and delivery
2. Use a multidisciplinary approach to assessment, care planning and delivery.

Action items/ideas for change

• Develop and introduce assessment tools and triggers to ensure 100% compliance with linking the assessment to the care plan
• Ensure that identified issues discovered at assessment become care planning issues with prompts ‘have you entered a care plan issue?’ e.g. anxiety depression score 6 – 10/10, pain scores of 7-10/10
• Develop assessment processes and documentation with a formal pathway that integrates prompts and includes a section for multidisciplinary team (MDT) and patient/carer sign off
• Use common validated assessment tools and protocols with monitoring stages Palliative Care Outcomes Collaboration (PCOC)
• Develop efficient processes for conducting MDT meetings
• Use multidisciplinary meeting tools with evidence of assessment and outcomes for each patient.

STRATEGY FOUR

Ensure that roles and responsibilities are understood, accepted and supported

Ensure the understanding of role and responsibilities of those involved in completing the assessment and care planning.

Key change concepts

1. Appoint an identified care coordinator (e.g. Lead agency or clinician) who takes responsibility for overall plan of care (refer NSAP quality element 4.4).

Action items/Ideas for change

• Appoint a case manager/coordinator to organise/facilitate and arrange patient care with all relevant agencies
• Appoint a case manager/care coordinator to be responsible for communication with the team and formulate one care plan
• Appoint a case manager/coordinator to be responsible for planning family conferences; checklist/protocol, who needs to be informed/involved etc.
• Appoint a case manager/care coordinator to manage complex cases and have regular communication between the MDT and patient/carer
• Arrange processes for regular communication between MDT and patient/carer etc.
• Arrange patient and family conferencing as a routine part of the assessment process
• Arrange set times in the patient/family journey when family meetings are routinely held e.g. entry to service, functional decline, terminal phase and use the family conference guidelines to set up and conduct them
• Include clear review dates and who is responsible for what on the assessment and care plan.
Appendix 3: Reference list of the Literature on Assessment and Care planning

Care planning (29)


Clinical Pathways (3)


Documentation (17)


End of Life (6)


Health Records


Quality Improvement


### Appendix 4: Performance measures

#### Measurement strategies:

1: Do palliative care assessments evidence patient and/or family/carer involvement in the process?

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome measure</td>
<td>% of assessments with evidence of patient and/or family/carer involvement</td>
</tr>
<tr>
<td>Definition</td>
<td>Assessments with evidence of patient involvement of all patients and/or family/carer</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of assessments with evidence of patient and/or family/carer involvement</td>
</tr>
<tr>
<td>Denominator</td>
<td>The last 20 patients admitted to the service in the current month (if less than 20 patients are admitted within the month then a census is used)</td>
</tr>
<tr>
<td>Goal</td>
<td>80% of assessments with evidence of patient and/or family/carer involvement</td>
</tr>
</tbody>
</table>

**Data source**
- Patient record audit to identify:
  - Evidence of patient and/or family/carer involvement in the record (please specify), or
  - Patient/carer signature, or
  - Other (please specify)

2: Are palliative care assessments completed within 48 hours of admission to the inpatient setting or first face to face visit?

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome measure</td>
<td>% of assessments with evidence of a first assessment completed within 48 hours of admission to the inpatient setting or face to face visit</td>
</tr>
<tr>
<td>Definition</td>
<td>Patients with a first assessment completed within 48 hours of admission to the inpatient setting or, face to face visit of all patients</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients with a first assessment completed within 48 hours of admission to the inpatient setting or face to face visit</td>
</tr>
<tr>
<td>Denominator</td>
<td>The last 20 patients admitted to the service in the current month (if less than 20 patients are admitted within the month then a census is used)</td>
</tr>
<tr>
<td>Goal</td>
<td>80% of first assessments completed within 48 hours of admission to the inpatient setting or first face to face visit</td>
</tr>
</tbody>
</table>

**Data source**
- Patient record audit to identify an assessment of the patient’s needs within 48 hours of admission to the inpatient setting or first face to face visit
3A: Are palliative care assessments holistic?

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome measure</td>
<td>% of patients with a holistic assessment</td>
</tr>
<tr>
<td>Definition</td>
<td>Patients with a holistic assessment as a percentage of all patients</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of patients with a holistic assessment</td>
</tr>
<tr>
<td>Denominator</td>
<td>The last 20 patients admitted to the service in the current month (if less than 20 patients are admitted within the month then a census is used)</td>
</tr>
<tr>
<td>Goal</td>
<td>80% of patients have a holistic assessment</td>
</tr>
<tr>
<td>Data source</td>
<td>Patient record audit to identify ALL the following determinants in the holistic assessment: physical, social, emotional, cultural, spiritual</td>
</tr>
</tbody>
</table>

3B: Do palliative care plans reflect the holistic assessment?

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome measure</td>
<td>% of these patients with a holistic care plan informed by the holistic assessment</td>
</tr>
<tr>
<td>Definition</td>
<td>Patients with a holistic care plan informed by the holistic assessment as a percentage of all patients with a holistic assessment</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of records where the care plan appropriately includes the issues identified in the holistic assessment</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number of records with a holistic assessment identified in (3A)</td>
</tr>
<tr>
<td>Goal</td>
<td>80% of patients have a holistic care plan informed by the holistic assessment</td>
</tr>
<tr>
<td>Data source</td>
<td>Patient record audit to identify a care plan that appropriately includes care related to the holistic assessment (3A)</td>
</tr>
</tbody>
</table>

4: Do palliative care plans reflect the most recent assessment by any members of the multidisciplinary team?

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome measure</td>
<td>% of care plans that reflect the most recent assessment by any member of the multidisciplinary team (MDT)</td>
</tr>
<tr>
<td>Definition</td>
<td>Frequency of care plan review</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of care plans that reflect the most recent assessment by a MDT member</td>
</tr>
<tr>
<td>Denominator</td>
<td>The last 20 patients admitted to the service in the current month (if less than 20 patients are admitted within the month then a census is used)</td>
</tr>
<tr>
<td>Goal</td>
<td>80% of care plans reflect the most recent MDT member assessment</td>
</tr>
<tr>
<td>Data source</td>
<td>Patient record audit</td>
</tr>
</tbody>
</table>

The overarching key principles to drive system wide improvement for palliative care assessment and care planning are provided within the Project change package.
Glossary

**Advance care planning**

The process of preparing for likely scenarios near the end of life that usually includes assessment of, and discussion about, a person's understanding of their medical condition and prognosis, values, preferences and personal and family resources. Respecting Patient Choices is one of many programs that supports advance care planning. Advance care planning supports patients in communicating their wishes about their end of life.

**Assessment (context for this Project)**

The conducting of an assessment of a patient to identify their needs. This can be through the use of assessment tools with validated tools available for use (eg Symptom Assessment Score – SAS).

**Care planning (context for this Project)**

The provision of clinical management for care delivery.

**Care plan**

A care plan is a written, comprehensive, and longitudinal plan of action that sets out the health care needs of a patient and the type of services and supports needed to meet those needs.

**Holistic**

Holistic is a whole made up of interdependent parts. You are most likely to hear these parts referred to as the mind/body connection: mind/body/spirit, or physical/mental/emotional/spiritual aspects. When this meaning is applied to the treatment of illness, it is called holistic medicine and includes a number of factors, such as dealing with the root cause of an illness, increasing patient involvement and considering both conventional and complementary therapies.

The principles of palliative care are framed around holistic care and the interdependent physical, social, emotional, cultural and spiritual aspects.

**Multidisciplinary team**

A multidisciplinary team consists of a mix of health care disciplines. Team members share common goals, collaborate and work together in planning and delivery of care. Members of a multidisciplinary team might include GPs, surgeons, medical or radiation oncologists, palliative care specialists, pastoral care workers, nurses, social workers, occupational therapists, physiotherapists, dieticians, volunteers, pharmacists or care assistants.

**References**

Appendix 5: Program for Learning Session 1

NSAP Collaborative improvement project: Assessment and Care planning
Mantra Tullamarine Hotel Cnr Melrose Drive and Trade Park Drive Tullamarine VIC I Ph: 03 9093 6594

Patient Centred Palliative Care

Learning Session 1
Monday 2nd May 2011 9:00 - 17:00 + networking dinner

Presenters
Mr Andrew Allsop, Expert Reference Group
Dr Scott Blackwell, PCA President
Dr Jan Davies, Collaborative Advisor
Miss Claudia Giugni, NSAP Manager
Mr Fran Gore, Expert Reference Group
Dr Amanda Henderson, Collaborative Evaluator
Mrs Helen Vaz, NSAP Quality Coordinator

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Registration and coffee / tea</td>
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</tr>
<tr>
<td>9:00</td>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Introductions - housekeeping</td>
<td>Claudia Giugni</td>
</tr>
<tr>
<td></td>
<td>2. Welcome</td>
<td>Scott Blackwell</td>
</tr>
<tr>
<td></td>
<td>Success story: ‘Care planning improving clinical practice’</td>
<td>Fran Gore</td>
</tr>
<tr>
<td>10:00</td>
<td>MORNING TEA</td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td>The Improvement method</td>
<td>Jan Davies</td>
</tr>
<tr>
<td>12:30</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>13:30</td>
<td>Success story: ‘Now for something not so medical’</td>
<td>Andrew Allsop</td>
</tr>
<tr>
<td></td>
<td>The collaborative process</td>
<td>Helen Vaz</td>
</tr>
<tr>
<td></td>
<td>The change package</td>
<td>Helen Vaz and Claudia Giugni</td>
</tr>
<tr>
<td>15:30</td>
<td>AFTERNOON TEA</td>
<td></td>
</tr>
<tr>
<td>16:00</td>
<td>‘So what’s changed?’ Collaborative Evaluation</td>
<td>Amanda Henderson</td>
</tr>
<tr>
<td></td>
<td>Discussion and questions</td>
<td>Helen Vaz and Claudia Giugni</td>
</tr>
<tr>
<td>17:00</td>
<td>Closing remarks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- pre dinner canapés 18:00</td>
<td>Scott Blackwell</td>
</tr>
<tr>
<td></td>
<td>- dinner 18:30</td>
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</table>
NSAP Collaborative Improvement Project: Assessment and Care Planning

Mantra Tullamarine Hotel Cnr Melrose Drive and Trade Park Drive Tullamarine VIC Ph: 03 9093 6594

Patient Centred Palliative Care

Learning Session 1

Tuesday 3rd May 2011 8:30 - 16:00

Presenters

Dr Melanie Benson, Expert Reference Group
Dr Jan Davies, Collaborative Advisor
Miss Claudia Giugni, NSAP Manager
Dr Amanda Henderson, Collaborative Evaluator
Mrs Helen Vaz, NSAP Quality Coordinator

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
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<td>8:00</td>
<td>Registration and coffee / tea</td>
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<td>8:30</td>
<td>Experiences from the field as an agent of change</td>
<td>Melanie Benson</td>
</tr>
<tr>
<td></td>
<td>Barrier analysis</td>
<td>Jan Davies</td>
</tr>
<tr>
<td></td>
<td>Measuring success and reporting</td>
<td>Amanda Henderson</td>
</tr>
<tr>
<td>10:30</td>
<td>MORNING TEA</td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td>Panel for performance measures</td>
<td>Jan Davies, Claudia Giugni, Amanda Henderson, Helen Vaz</td>
</tr>
<tr>
<td>11:30</td>
<td>Project planning (table work)</td>
<td>Jan Davies</td>
</tr>
<tr>
<td>12:15</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>13:00</td>
<td>Project planning continued (table work)</td>
<td>Jan Davies</td>
</tr>
<tr>
<td>15:00</td>
<td>AFTERNOON TEA</td>
<td></td>
</tr>
<tr>
<td>15:15</td>
<td>Discussion and next steps</td>
<td>Helen Vaz and Claudia Giugni</td>
</tr>
<tr>
<td>16:00</td>
<td>Close of workshop</td>
<td></td>
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</table>
Appendix 6: Program for Learning Session 2

NSAP Collaborative improvement project: Assessment and Care planning
Mercure Sydney Airport 20 Levey Street, Wolli Creek, NSW, Tel: 02 9518 2000

Patient Centred Palliative Care
Learning Session 2
Friday 12th August 2011 9:30 - 17:00

Presenters
Dr Melanie Benson, Clinical Lead NSAP Expert Reference Group
Dr Jan Davies, Collaborative Advisor
Miss Claudia Giugni, NSAP Manager
Dr Amanda Henderson, Collaborative Evaluator
Mrs Helen Vaz, NSAP Quality Coordinator

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>9.00</td>
<td>Registration and coffee/tea</td>
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</tr>
<tr>
<td>9.30</td>
<td>Introduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Introduction – housekeeping</td>
<td>Claudia Giugni</td>
</tr>
<tr>
<td></td>
<td>2. Welcome</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project stories – powerpoint</td>
<td>4 services/ Melanie Benson</td>
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<tr>
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<tr>
<td>11.10</td>
<td>Skill development: Running focus groups</td>
<td>Amanda Henderson</td>
</tr>
<tr>
<td>12.20</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>13.00</td>
<td>Project stories – table top</td>
<td>6 services/Helen Vaz</td>
</tr>
<tr>
<td></td>
<td>Sustainability – avoiding the improvement evaporation syndrome</td>
<td>Jan Davies</td>
</tr>
<tr>
<td>15.30</td>
<td>AFTERNOON TEA</td>
<td></td>
</tr>
<tr>
<td>15.45</td>
<td>Project stories – table top</td>
<td>6 services/ Helen Vaz</td>
</tr>
<tr>
<td></td>
<td>Feedback, discussion, questions and next steps</td>
<td>Helen Vaz</td>
</tr>
<tr>
<td>17.00</td>
<td>Closing remarks</td>
<td>Claudia Giugni</td>
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</table>
Appendix 7: Program for Learning Session 3

NSAP Collaborative improvement project: Assessment and Care planning
Mercure Sydney Airport 20 Levey Street, Wolli Creek, NSW, Tel: 02 9518 2000

Patient Centred Palliative Care

Learning Session 3
Friday 25th November 2011 9:30 - 17:00

Presenters
Dr Melanie Benson, Clinical Lead NSAP Expert Reference Group
Dr Scott Blackwell, PCA President
Dr Jan Davies, Collaborative Advisor
Miss Claudia Giugni, NSAP Manager
Dr Amanda Henderson, Collaborative Evaluator
Dr Karen Luxford, Director, Patient Based Care, Clinical Excellence Commission
Mrs Helen Vaz, NSAP Quality Coordinator

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter</th>
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<tbody>
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<td>9:30</td>
<td>Introduction</td>
<td>Claudia Giugni</td>
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<tr>
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<td>1. Introductions - housekeeping</td>
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<tr>
<td></td>
<td>2. Welcome</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project stories</td>
<td>4 Services/ Melanie Benson</td>
</tr>
<tr>
<td>11:00</td>
<td>MORNING TEA</td>
<td></td>
</tr>
<tr>
<td>11:15</td>
<td>Skill development: working data</td>
<td>Amanda Henderson</td>
</tr>
<tr>
<td></td>
<td>Project stories</td>
<td>3 services/ Helen Vaz</td>
</tr>
<tr>
<td>13:00</td>
<td>LUNCH</td>
<td></td>
</tr>
<tr>
<td>13:40</td>
<td>Patient Centred Care—How to make this a reality</td>
<td>Karen Luxford</td>
</tr>
<tr>
<td></td>
<td>Project stories</td>
<td>3 Services/ Melanie Benson</td>
</tr>
<tr>
<td>15:20</td>
<td>AFTERNOON TEA</td>
<td></td>
</tr>
<tr>
<td>15:45</td>
<td>Skill development: Keeping the momentum</td>
<td>Jan Davies/ Melanie Benson</td>
</tr>
<tr>
<td></td>
<td>What now: Feedback, discussion, questions</td>
<td>Helen Vaz/ Claudia Giugni</td>
</tr>
<tr>
<td></td>
<td>Final wrap up</td>
<td>Scott Blackwell</td>
</tr>
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</table>
Appendix 8: Results of the Collaborative Improvement Model evaluation

Findings
The survey results are presented below using the following topic headings: Response rate, demographics, agreement statements (questions 1-3), question 4, question 5, question 6 and question 7. Project strengths and recommendations are made for each topic area as appropriate.

Response rate
Forty participants (out of a possible 43) completed the survey giving a response rate of 93%.

Demographics
Professional group: The majority of participants (85%) were nurses. Doctors represented only 2.5% of participants (n=1) and the “other” category for professional group represented 12.5% of participants. The “other” category included a social worker (2), counsellor, occupational therapist and quality improvement coordinator.

Service type based on PCA role and capability model: The majority of participants were from a level 3 service model, 30% were from a level 2 service model and 25% were from a level 1 service model.

Geographical area: The majority of participants (75%) were from metropolitan hospitals. 17.5% of participants were from regional hospitals and three participants (7.5%) identified “other” as a response option.

Agreement statements (Questions 1-3)
The in-text discussion includes summary tables by survey theme area. The green shading in these tables is used to identify survey statements that the majority of participants agreed with the respective statements (> 50% in total for the agree and strongly agree categories of the five point agreement scale). The blue shading in the tables is used to identify survey statements where the majority of participants have not agreed with the respective statements (>50% in total for the disagree, strongly disagree and neither agree nor disagree categories of the five point agreement scale). The category “neither agree nor disagree” is included in this grouping because participants have not committed to an “agree” response. The results were very strong for the majority of the statements. Given the high results achieved recommendations are made for any response less than 70%. Project strengths are also stated on the basis of the statement results.

Theme: National perspective
The “National perspective” statement responses show that 95% agreed with the survey statement. The data are summarised in Table 3.

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in a national program improves the acceptance of the project and the service change</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.0%</td>
<td>52.5%</td>
<td>42.5%</td>
</tr>
</tbody>
</table>

Table 3: National perspective and exposure statement results

Theme: NSAP/project support
The “NSAP/project support” statement responses show strong agreement for the leadership and communication survey statements. Interaction with the NSAP team was agreed to be important for the successful implementation of the project. The data are summarised in Table 4.
Survey Statement/s | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree
---|---|---|---|---|---
NSAP team provided the appropriate leadership and support to the local project team (n= 39) | 0.0% | 0.0% | 2.6% | 48.7% | 48.7%
Communication with the NSAP team was helpful for the project | 0.0% | 0.0% | 7.5% | 45.0% | 47.5%
Interaction with the NSAP team was vital for the successful implementation of the project | 0.0% | 2.5% | 10.0% | 35.0% | 52.5%

Project Strength
• The NSAP team provided appropriate leadership and communication to support the participating projects.

Table 4: NSAP/project support statement results

**Theme: Executive support**

The “executive support” statement responses show that 77.5% of respondents agreed that the executive responded to identified project requirements. The data are summarised in Table 5.

Survey Statement/s | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree
---|---|---|---|---|---
Our executive has responded to identified project requirements | 0.0% | 5.0% | 17.5% | 37.5% | 40.0%

Project Strength
• The executives of participating services responded to project requirements.

Table 5: Executive support statement results

**Theme: Sharing/networking**

The “Sharing/networking” statement responses show that respondents agreed that the collaborative supported sharing of ideas and networking. The data are summarised in Table 6.

Survey Statement/s | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree
---|---|---|---|---|---
Participation in the collaborative enabled sharing of ideas | 0.0% | 0.0% | 2.5% | 30.0% | 67.5%
Participation in the collaborative facilitated a strong network between participants | 0.0% | 0.0% | 15.0% | 50.0% | 35.0%

Project Strength
• The collaborative improvement model facilitated the sharing of ideas and networking across participating services.

Table 6: Sharing/networking statement results

**Theme: Motivation**

The “Motivation” statement responses show that 100% of respondents agreed that the collaborative experience was motivating to improve care planning. The data are summarised in Table 7.
The collaborative experience was motivating to improve care planning.

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The collaborative experience was motivating to improve care planning</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>37.5%</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

**Project Strength**
- The collaborative experience motivated staff to improve care planning.

**Theme: Sustainability**

The “Sustainability” statement responses show that 82.5% of respondents supported that project outcomes are sustainable. The data are summarised in Table 8.

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The project outcomes are sustainable</td>
<td>0.0%</td>
<td>0.0%</td>
<td>17.5%</td>
<td>55.0%</td>
<td>27.5%</td>
</tr>
</tbody>
</table>

**Project Strength**
- The majority of collaborative participants agreed that the project outcomes were sustainable.

**Theme: Quality improvement/structure/tools**

The “quality improvement” statement responses support that participants could explain the PDSA improvement cycle and identify gaps in service. 61.5% of participants indicated that “project creep” was difficult to avoid. The data are summarised in Table 9.

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I could fully explain the PDSA rapid improvement cycle and describe each step</td>
<td>0.0%</td>
<td>0.0%</td>
<td>22.5%</td>
<td>55.0%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Project creep was difficult to avoid (n = 39)</td>
<td>2.6%</td>
<td>20.5%</td>
<td>15.4%</td>
<td>33.3%</td>
<td>28.2%</td>
</tr>
<tr>
<td>The project identified gaps in the service delivery</td>
<td>0.0%</td>
<td>5.0%</td>
<td>0.0%</td>
<td>42.5%</td>
<td>52.5%</td>
</tr>
</tbody>
</table>

**Project Strength**
- Participants were able to explain the PDSA cycles and identify gaps in service delivery.

**Recommendation**
- Projects need to be carefully scoped to ensure that outcomes are achievable within the defined project timeframe.

**Theme: Collaborative improvement**

The “Collaborative improvement” statement responses show that the majority of respondents agreed that the collaborative process is effective and supports the review and improvement of services. While the collaborative requirements were supported to be clear prior to commencement, the percentage agreeing was less than other statements in the theme (70%). The data are summarised in Table 10.
Survey Statement/s  | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree
---|---|---|---|---|---
The collaborative participation requirements were clear prior to commencement | 0.0% | 17.5% | 12.5% | 45.0% | 25.0%
The collaborative process was structured appropriately | 0.0% | 0.0% | 7.5% | 52.5% | 40.0%
Participation in a collaborative is a catalyst to review and improve services | 0.0% | 0.0% | 0.0% | 47.5% | 52.5%
The collaborative experience has increased my confidence in conducting quality activities | 0.0% | 2.5% | 10.0% | 55.0% | 32.5%
The collaborative process is credible | 0.0% | 0.0% | 5.0% | 57.5% | 37.5%

Project Strength
- The collaborative improvement process is effective and supports the review and improvement of services.

Recommendation
- A collaborative participation requirement package needs to be provided to participants prior to commencement of the Project.

Table 10: Collaborative process statement results

Theme: Education resources

The “Education resources” statement responses show that the majority of respondents agreed the education resources were helpful. The data are summarised in Table 11.

Survey Statement/s  | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree
---|---|---|---|---|---
The collaborative resources were helpful (n= 39) | 0.0% | 0.0% | 7.7% | 51.3% | 41.0%
Sufficient collaborative resources were provided | 0.0% | 2.5% | 5.0% | 55.0% | 37.5%
The collaborative web forum site was user-friendly (n= 38) | 0.0% | 5.3% | 13.3% | 52.6% | 28.9%

Project Strength
- The education resources were appropriate and helpful for the collaborative improvement projects.

Table 11: Education resources statement results

Theme: Data

The “data” statement responses show that the majority of respondents agreed with the data statements. The data are summarised in Table 12.
Table 12: Data statement results

**Theme: Learning sessions**

The “Learning session” statement responses show that the majority of respondents supported that these sessions are an important aspect of the collaborative process and for the successful implementation of projects. The data are summarised in Table 13.

Table 13: Learning session statement results

**Theme: Teleconference**

The “Teleconference” statement responses show that the majority of respondents agreed that teleconferences were useful. However, the data (56.7 %) were not as strong for this theme when compared with other theme results. The data are summarised in Table 14.
Survey Statement/s Strongly Disagree Disagree Neither Agree nor Disagree Agree Strongly Agree
I found the teleconferences useful (n=37) 0.0% 6.0% 27.0% 37.8% 18.9%

Project recommendation
• The structure of the teleconferences should be reviewed for a future collaborative improvement project.

Table 14: Teleconference statement results

Theme: Communication
The "Communication" statement responses show that the majority of respondents agreed that communication was appropriate. The data are summarised in Table 15.

Survey Statement/s Strongly Disagree Disagree Neither Agree nor Disagree Agree Strongly Agree
Communication (emails, teleconferences) with the NSAP team were about right (n=38) 2.6% 0.0% 15.8% 55.3% 26.3%

Project strength
• The communication processes in the collaborative improvement project were appropriate.

Table 15: Communication statement results

Theme: Education and learning
The “Education and learning” statement responses show that the majority of respondents agreed that new skills were acquired and knowledge was gained about quality activities during the project. The data are summarised in Table 16.

Survey Statement/s Strongly Disagree Disagree Neither Agree nor Disagree Agree Strongly Agree
I learnt new skills during the collaborative (n=39) 0.0% 5.1% 7.7% 48.7% 38.5%
My knowledge on quality activities was enhanced as a result of participating in the collaborative (n=39) 0.0% 2.6% 7.7% 53.8% 35.9%
Professional reflection has been facilitated in the collaborative experience 0.0% 2.5% 5.0% 52.5% 40.0%

Project strength
• Project participants learnt new skills and gained knowledge about continuous quality improvement activities during the collaborative improvement project.

Table 16: Education and learning statement results

Theme: Human resources/time
The “human resources/time” statement responses show that the majority (53.9%) of respondents disagreed that resources were adequate for the project. The majority (94.8%) also supported that the project leader needed quarantined time to undertake the project. The data are summarised in Table 17.
The human resources allocated for the local project were adequate for the work to be completed (n=39)

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The human resources allocated for the local project were adequate for the work to be completed (n=39)</td>
<td>2.6%</td>
<td>35.9%</td>
<td>15.4%</td>
<td>38.5%</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

The project leader required “quarantined time” for the project (n=38)

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The project leader required “quarantined time” for the project (n=38)</td>
<td>0.0%</td>
<td>5.3%</td>
<td>0.0%</td>
<td>39.5%</td>
<td>55.3%</td>
</tr>
</tbody>
</table>

Recommendation
- Human resources need to be allocated at each site to undertake a collaborative improvement project.
- Project leaders need dedicated time to manage and implement collaborative improvement projects.

Table 17: Human resources/time

**Theme: Future participation/expectations**

The “future participation” statement responses show that 97.5% of respondents would like to participate in a future collaborative improvement project. The data are summarised in Table 18.

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like to participate in a future collaborative</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.5%</td>
<td>32.5%</td>
<td>65.0%</td>
</tr>
</tbody>
</table>

Project strength
- Participants (97.5%) would like to participate in a future collaborative improvement project.

Table 18: Future participation/expectations statement results

**Theme: Outcomes**

The “Outcomes” statement responses show that 95% respondents agreed that performance measures used have shown where improvements have been achieved. The data are summarised in Table 19.

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The performance measures have shown where improvements have been achieved</td>
<td>0.0%</td>
<td>2.5%</td>
<td>2.5%</td>
<td>50.0%</td>
<td>45.0%</td>
</tr>
</tbody>
</table>

Project strength
- The project performance measures have shown where improvements were achieved.

Table 19: Outcomes statement results

**Theme: Workplace focus/Team work**

The “Workplace focus/team work” statement responses show that the majority (67.5%) of respondents agreed that multidisciplinary team members were supportive of the project. 61.5% of respondents supported that team building was enhanced by the project. While these results show overall agreement they are not as strong as the results for other themes. The data are summarised in Table 20.
NSAP Collaborative Improvement Project: Assessment and Care Planning May 2012

<table>
<thead>
<tr>
<th>Survey Statement/s</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Agree nor Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary team members, not directly included in the project team, were supportive of changes to the service</td>
<td>5.0%</td>
<td>7.5%</td>
<td>20.0%</td>
<td>42.5%</td>
<td>25%</td>
</tr>
<tr>
<td>The project has facilitated team building and improved the function of the team in the assessment and planning of patient care (n=39)</td>
<td>0.0%</td>
<td>10.3%</td>
<td>28.2%</td>
<td>35.9%</td>
<td>25.6%</td>
</tr>
</tbody>
</table>

Recommendations
- A project strategy should include the development and support of the multidisciplinary team.

Table 20: Workplace focus/team work statement results

**Question 4: Did all participating services implement the PDSA rapid cycles of improvement?**

All projects were required to use the PDSA rapid cycles of improvement, which is a key process of the collaborative improvement model. All participants answered this survey question. The survey data shows that all services completed the PDSA cycles. The minimum number of PDSAs completed for a project was one and the maximum number completed was 24 cycles. The average number of PDSA cycles conducted by projects was seven, the median was six cycles and the most common number (mode) of PDSA completed for projects was seven.

PDSAs that had the most impact on individual projects had six focus areas: care plan; assessment process/tools; multidisciplinary teams; training/education; cultural/spiritual determinants; terminology. Example PDSAs, drawn from the survey responses, are shown for each focus area:

**Care plan**
- Holistic care plan/pain
- Reorganising files to make the care plans easily accessible
- Changing the layout of patient files to have care plans
- Trial of care plan
- Intervention plan.

**Assessment process/tools**
- Streamlining combined assessment tools
- Review of assessment process
- Development of assessment documentation
- Retesting an early assessment form
- Development of assessment form
- Standardising and formatting of the tool
- Review of assessment process and development of documentation tool
- Trialling new form and feedback.

**Multidisciplinary team (MDT)**
- Implementation of multidisciplinary assessment form
- Changing the format of the MDT Meeting
- Cycles around the MDT gaps
- Formalising uniform format for MDT documentation with prompts to discuss the 5 areas of holistic care.

**Training/education**
- Training needs assessment
- Face to face raising staff awareness
- Initial: to highlight areas of improvement
- Training form and getting feedback, educational sessions
- Education.
Spirituality/cultural determinants
- Spiritual care and introduction of teams and referrals to chaplains and social workers
- The spirituality focused PDSA
- Cultural
- Spirituality.

Terminology
- Standardising the terminology.

**Question 5: What are the barriers to adopting the PDSA rapid cycles of improvement?**

All participants answered this survey question. Eight barrier areas emerged from the responses to this question: project management, workplace culture, scope of the project, resources, multidisciplinary team/clinical commitment, the PDSA process, organisational policy and procedures and data collection. Examples of responses, below, are grouped by barrier area.

**Project management**
- Executive had good understanding of the project however community …team understanding and interest varied
- Project leader not having a great buy-in or a quality background
- Senior managers not involved, getting management to be involved
- Competing projects
- Would approach another collaborative differently with increased sponsor support
- Communication
- Change fatigue
- Staff engagement, staff buy in
- Paper based care plans: required to visit homes, increase workload.

**Recommendation**
- Executive support is needed to endorse the implementation of PDSA cycles.

**Workplace culture**
- Culture: busy staff at the bedside who see change as a negative reflection on them not an opportunity to improve, staff culture resistance to change
- Change management
- Being worried about doing it right
- Staff (not) seeing a need for change, staff engagement
- To clearly identify cultural issues with the change and implement appropriate support for NSAP team
- Identify clarity around people’s concerns, practical versus cultural and providing support.

**Recommendation**
- Executive support is needed to facilitate a culture of change management.

**Scope of the project**
- Breadth of original plan; required refinement.
Recommendation
• Projects need to be carefully scoped to ensure that outcomes are achievable within the defined project timeframe.

Resources
• Resources
• Time available for staff to complete the PDSAs
• The organisation did not realise how much time the clinicians would need to do this project. Otherwise they may not have supported this in the first place.
• Staff movements, staff changes
• Workload, workload, clinical load
• Staff shortages, reduced staffing, reduced staffing levels
• Busy workloads prevented completion of PDSA cycles some weeks.

Recommendation
• Human resources need to be allocated to undertake a collaborative improvement project.

Multidisciplinary team/clinical commitment
• Having relevant participants all available together to work on the project
• Access to clinical staff
• Access to and involvement of MDT
• Involvement from MDT and medical clinicians, both time restraints and care factor
• MDT: time and unwillingness to commit
• Clinicians: time restraints, lack of interest
• Lack of quality team member.

Recommendation
• A project strategy should include the development and support of the multidisciplinary team.

The PDSA process
• Gap identification
• Understanding the process, initially overwhelming but then as collaborative progressed increased understanding
• Staff knowledge of PDSA at grass roots level
• Educating part time staff.

Recommendation
• Dedicated training should be provided regarding the PDSA cycle at project commencement for staff implementing the cycles.

Organisational policy and procedures
• Organisational policy and documentation approvals.

Recommendation
• Executive support is needed to facilitate policy and documentation approvals related to PDSA requirements.

Data collection
• The need to separate the role of auditor from visiting RN
• Documentation deficits: having data on 2 databases (actually 3).
Question 6: Did all participating services complete their project?

Thirty five participants answered this survey question. 57.1% (n=20) of participants indicated that their projects were complete; 42.9% (n=15) indicated that their projects were not finalised. Examples of comments from participants who answered "no" to this question were:

- Almost
- Reached 92% instead of 100% achieved – too ambitious to start with but keep motivation high
- No. Timelines were blown out in the …of a comprehensive assessment tool
- No there is more work to do
- Still on-going and evolving
- No, a number of changes identified a new issue to work on
- Completed 2 elements of original plan. Aims proved to be too resource demanding and groups needed to narrow project aims to be more realistic
- No, our project will require a further 6 months to develop care plan to trial phase
- No, will be on-going for a long time
- No, but it has helped identify that we have only just begun and need to continue …on holistic assessment and care-planning
- It will never be completed, initial project well underway
- No, on-going development of assessment and care planning pathway.

Examples of comments from participants who answered “yes” to this question were:

- Yes, with difficulty, don’t know if we could commit to this again
- Yes, but still have work in progress
- Project completed but highlighted further areas of need
- Yes, marked improvement, but sustainability is important
- Yes, we still have other projects that are on the go that will continue to improve the areas we weren’t able to address as part of the collaborative
- Yes, on-going process, other projects related to initial project running side by side to be implemented in next 2/12.

Introduction of another initiative after Christmas to continue to reinforce models and change culture of ward staff.

The initial scoping of projects and determining realistic project timelines is a skill that develops with on-going project experience. The NSAP CIP: A&CP was only six months in duration; this was likely to impact the results if projects weren’t skillfully scoped.

Recommendation

- Projects need to be carefully scoped to ensure that outcomes are achievable within the defined project timeframe.
**Question 7: Did all participating services meet NSAP’s requirements for the project?**

This question was included to determine if the 20 participating hospitals fulfilled the administrative requirements of participation in the Project. The administrative requirements of the Project were substantially achieved except for teleconference participation rate. The following administration and reporting activities were undertaken:

**Learning sessions**

Three learning sessions were completed during the Project. These were conducted at project commencement (2nd and 3rd May 2011), mid Project (12th August 2011), and at Project completion (25th November 2011). All 20 services (100%) were represented at all three learning sessions.

**Teleconferences**

Seven teleconferences were conducted during the Project period. Service representation and participation in these teleconferences was between 20% -65%. Figure 4 shows the service participation in the monthly teleconferences.

![Figure 4: Teleconference participation](image)

- Baseline and monthly data reports
  - Each service was required to submit seven data reports including a baseline report and six project reports. Only eight of the 140 reports across the project were not submitted. Detail regarding these reports is discussed in 3.2 Results performance measures of assessment care planning.

**Project strength**

- The administrative and reporting requirements of the Project were appropriate.

**Recommendation**

- The structure of the teleconferences should be reviewed for a future collaborative improvement project.
Appendix 9: Data Results of the Performance Measures

Quantitative performance measures

Performance measures were analysed using descriptive statistics.

Graph Format: A common graphical format is used to display the results for the performance markers. The following diagram describes the conventions used in this display.

Figure 5: Notes on the common format

- Results are not usually “normally” distributed between the maximum and minimum reported results. The blue vertical line simply depicts the spread of results.
- Q1, median and Q3 will usually be stacked in this way, however, when results are heavily biased towards 100% it would be normal to find Q3 and the median overlapping.
- Where the average trend-line sits compared to the median trend-line gives some perspective on the weight of the higher or lower performing results. In this case the average trend-line is below the median trend-line.

Results

The key findings by question and performance measure are discussed below.

Question 1: Do palliative care assessments evidence patient and/or family/carer involvement in the process?

Performance measure (P1)
Percentage of assessments with evidence of patient and/or family/carer involvement (relative to the individual project percentage results)

The average monthly result for this measure improved from the baseline data (78%) and then remained reasonably consistent for the remainder of the Project (89%-93%).

The more relevant improvement in this measure, across the Project, was the decrease in the range between the minimum and maximum monthly results. The range reduced and the minimum result achieved by any project for the last three months was 65%-70%. This decrease in variance was due to the performance improvement of the lower quartile performers. Overall, this performance measure met the Project goal from June 2011.

Figure 6 shows performance across the Project for performance measure P1.
Percentage of projects reaching the project goal

The percentage calculated reflects the percentage of projects that met or exceeded the Project goal from those that submitted data. The percentage of projects meeting the project goal increased over the six-month project period from 74% to 90%. Table 21 summarizes these results.

<table>
<thead>
<tr>
<th>Performance Measure (2011)</th>
<th>Baseline</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1: Percentage of palliative care assessments evidence patient and/or family/carer involvement in the process</td>
<td>74% (14/19)</td>
<td>79% (15/19)</td>
<td>79% (15/19)</td>
<td>81% (15/19)</td>
<td>81% (13/16)</td>
<td>90% (18/20)</td>
<td>90% (18/20)</td>
</tr>
</tbody>
</table>

Table 21: Summary of percentage of projects meeting the Project goal

Percentages split by project focus: 1) inpatient projects and 2) community projects

The community projects consistently performed better than inpatient projects in this measure and met the Project goal from the baseline data. The inpatient projects improved over the project improving from 59% at baseline to an average of 88% over the last three months. The difference between the inpatient and community focus projects was significant (Chi square test had a p value result < 0.05) in the baseline, June, September and November data reporting periods. During these periods the inpatient focus projects had a less than expected number of records showing patient and or family/care involvement in the assessment. The community focus projects had a more than expected number of records showing evidence of patient and or family/care involvement in the assessment. This significance may be related to different processes and care assessment protocols used by community and inpatient services. Table 22 shows the percentage results split by project focus.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Baseline</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>59%</td>
<td>72%</td>
<td>83%</td>
<td>83%</td>
<td>89%</td>
<td>91%</td>
<td>85%</td>
</tr>
<tr>
<td>Community</td>
<td>96%</td>
<td>99%</td>
<td>98%</td>
<td>95%</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Table 22: Average percentage of palliative care assessments that evidence patient and/or family/carer involvement in the process split by project focus (P1)

Comment

The results for this measure show that patient and/or family/carer involvement in the assessment process was already strong at Project commencement. Community projects performed better in this measure, however caution...
in interpreting this data is needed because the setting differences may have influenced the “definition of assessment” and “requirements of the assessment”.

**Question 2: Are palliative care assessments completed within 48 hours of admission to the inpatient setting or a face to face visit?**

**Performance Measure (P2)**

Percentage of assessments with evidence of assessments completed within 48 hours of admission to the inpatient setting or a face to face visit (relative to the individual project results)

The average monthly result for this measure improved from the baseline data (81%) and then remained strong for the remainder of the Project (92-94%).

Across the Project there was a decrease in the range of the minimum and maximum monthly results. The range in these results reduced and the minimum result achieved across the Project by any project for the last three months was 57%-65%. Once again, this decrease in variance was due to the performance improvement of the lower quartile performers. Overall, this performance measure met the Project goal from the baseline data 2011.

Figure 7 shows performance across the Project for performance measure P2.

![Performance Measure P2 Chart](image)

**Figure 7: Percentage of palliative care assessments completed within 48 hours of admission to the inpatient setting or first face-to-face visit (P2)**

**Percentage of projects reaching the project goal**

The percentage calculated reflects the percentage of projects that met or exceeded the project goal from those that submitted data. The percentage of projects meeting the project goal increased over the six-month project period from 74% to 90% (The July result was 95%). Table 23 summaries these results.
**Table 23: Summary of percentage of projects meeting the Project goal**

Percentages split by project focus for: 1) inpatient projects and 2) community projects

The community projects consistently performed better than inpatient projects in this measure and met the Project goal from the baseline data. The inpatient projects did show improvement over the project improving from 72% at baseline. The inpatient results across the project fluctuated from 84% to 93% over the six-month project. The difference between the inpatient and community focus projects was significant (Chi square test had a p value result < 0.05) in all the reporting periods except for July and October. During these periods the inpatient focus projects had a less than expected number of records assessments completed within 48 hours of admission to the inpatient setting or a face to face visit. The community focus projects had a more than expected number of records showing assessments completed within 48 hours of admission to the inpatient setting or a face to face visit. Again, this significance may be related to different processes and care assessment protocols used by community and inpatient services. Table 24 shows the percentage results split by project focus.

**Table 24: Average percentage of palliative care assessments completed within 48 hours of admission to the inpatient setting or first face to face visit split by project focus (P2)**

Comment

The results for this measure also suggest that the measure for palliative care assessments completed within 48 hours of admission to the inpatient setting or first face to face visit was strong at Project commencement. This performance measure was at the Project goal from the baseline data.

**Question 3A: Are palliative care assessments holistic?**

This performance measure was the only measure that required a number of criteria to be fulfilled to obtain a positive audit result. Five audit criteria to be evidenced were: physical, emotional, social, cultural and spiritual assessments. The baseline data showed an average of 42% across the projects. The result dropped in the first project period to 35%. Initial teleconference discussions about this measure suggested that ambiguity and rigour in the interpretation of the performance measure potentially caused this decrease. Teleconference discussions also highlighted that many PDSAs were conducted around the criteria of this measure. This work was reflected in a gradual increase in the results over the six-month project.

When the results are examined by quartiles, it shows that project results in the lower quartile (Q1) impacted the overall results, but also that these projects gradually improved showing an overall upward trend. The top quartile performing projects increased steadily and the 50th percentile results across the project were similar to the project averages. There was an overall upward trend in the results and while the Project goal (80%) was not achieved the results were positive increasing to 69% in November in 2011.

Figure 8 shows performance across the Project for performance measure P3A.
Holistic assessment criteria

As discussed above the determinants of a holistic assessment included: physical, social, emotional, cultural, and spiritual criteria. For an audit of a patient record to be successful all criteria had to be identified in the documented assessment. This measure was introduced in June 2011 following the baseline data period to try and better understand where improvement in the holistic assessment was needed.

The physical assessment criterion was strong (90%-100%) in the holistic assessment. Social assessment criterion were the second strongest (June 81%, end of project 92%). Emotional assessment criterion improved over the Project period (June 66%, end of project 82%). Physical, social and emotional criteria all met the Project goal (80%) early in the project.

The two lowest results for assessment criteria were “cultural” (June: 42%) and “spirituality” (June: 55%). The result for “cultural” in July (91%) should be considered with caution because the interpretation of the criterion may have influenced the result. Work on these two criteria resulted in improvements, but still the criteria did not meet the Project goal (80%). These two criteria were likely to impact the overall performance results for P3A. However, it should be emphasised that the PDSAs related to these criteria could take several months to address. Therefore, in the timeframes of this project, the results have shown very positive improvements.
The average percentage results are shown in figure 9 below:

Figure 9: Average percentages for holistic assessment criteria

Percentage of projects meeting the Project goal

The percentage calculated reflects the percentage of projects that met or exceeded the project goal from those that submitted data. The percentage of projects meeting the project goal (80%) ranged between 11% and 47%. Given the overall P3A results this was not unexpected. Table 25 summarizes these results.

<table>
<thead>
<tr>
<th>Performance Measure (2011)</th>
<th>Baseline</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>P3A: Percentage of palliative care assessments that are holistic</td>
<td>26% (5/19)</td>
<td>11% (2/19)</td>
<td>21% (4/19)</td>
<td>26% (5/19)</td>
<td>47% (7/15)</td>
<td>40% (8/20)</td>
<td>35% (7/20)</td>
</tr>
</tbody>
</table>

Table 25: Summary of percentage of projects meeting the Project goal

Percentages split by project focus for: 1) inpatient projects and 2) community projects

The community projects performed better than inpatient projects but neither group met the Project goal. Chi square results are not conducted for P3A and P3B. A successful patient record audit for P3A required all the following criteria in the holistic assessment to be completed: physical, social, emotional, cultural, spiritual. The interpretation of these criteria (validity) cannot be confirmed across different services. This measurement issue makes comparing inpatient and community projects inappropriate. Table 26 shows the percentage results split by project focus.

<table>
<thead>
<tr>
<th>Performance Measure/ Month 2011</th>
<th>Baseline</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>32%</td>
<td>10%</td>
<td>16%</td>
<td>28%</td>
<td>40%</td>
<td>49%</td>
<td>56%</td>
</tr>
<tr>
<td>Community</td>
<td>60%</td>
<td>53%</td>
<td>60%</td>
<td>78%</td>
<td>82%</td>
<td>78%</td>
<td>77%</td>
</tr>
</tbody>
</table>

Table 26: Average percentage of palliative care assessments that are holistic split by project focus (P3A)
Comment
This performance measure is critical to understanding the “holistic assessment”. The complexities of a holistic assessment were illuminated both in data results and teleconference discussions. One of the difficulties with this measure is that the assessment of the five criteria may not have been consistent across services. Some services may have used “yes” or “no” categories for a criterion and others may have used more comprehensive approaches. However, assuming that the same organisations used the same specifications for criteria during the project the results do show improvement. This measure requires further criteria specification for future work.

Question 3B. Do palliative care plans reflect the holistic assessment?

Performance measure (P3B)
Percentage of assessments with evidence of patients with a holistic care plan informed by the holistic assessment (relative to the individual project results)

This performance measure reviewed the care plan with respect to a successful holistic assessment audit. (The denominator for this measure was the number of records with a holistic assessment identified in 3A). While performance measure P3A identified the difficulties in achieving a successful “holistic assessment” the care planning associated with the assessment was more positive. The results of this performance measure improved from a baseline result (58%) to meet the goal (80%) from July 2011. When the results are examined by quartiles, it shows that project results in all quartiles continually improved.

Figure 10 shows the performance across the Project for performance measure 3B.

Figure 10: Percentage of palliative care plans that reflect the holistic assessment (P3B)

Percentage of projects meeting the Project goal
The percentage calculated reflects the percentage of projects that met or exceeded the project goal from those that submitted data. The percentage of projects meeting the project goal increased over the six-month project period from 38% to 80%. Table 27 summaries these results.

<table>
<thead>
<tr>
<th>Performance Measure (2011)</th>
<th>Baseline</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>P3B: Percentage of palliative care plans that reflect the holistic assessment</td>
<td>38% (5/13)</td>
<td>69% (9/13)</td>
<td>71% (12/17)</td>
<td>71% (12/17)</td>
<td>62% (8/13)</td>
<td>67% (12/18)</td>
<td>80% (16/20)</td>
</tr>
</tbody>
</table>

Table 27: Summary of percentage of projects meeting the Project goal
Percentages split by project focus for: 1) inpatient projects and 2) community projects
Both the community and inpatient projects increased from 58% and 59% respectively to achieve the Project goal. Table 28 shows the percentage results split by project focus.

Table 28: Average percentage of palliative care plans that reflect the holistic assessment split by project focus (P3B)

<table>
<thead>
<tr>
<th>Performance Measure/ Month 2011</th>
<th>Baseline</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>59%</td>
<td>100%</td>
<td>96%</td>
<td>82%</td>
<td>91%</td>
<td>89%</td>
<td>81%</td>
</tr>
<tr>
<td>Community</td>
<td>58%</td>
<td>86%</td>
<td>82%</td>
<td>89%</td>
<td>81%</td>
<td>92%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Comment
This performance measure showed a steady improvement for both the community and inpatient projects to achieve the Project goal.

**Question 4. Do palliative care plans reflect the most recent assessment by any member of the multidisciplinary team?**

**Performance measure (P4)**
Percentage of assessments with evidence that palliative care plans reflect the most recent assessment by any member of the multidisciplinary team (relative to the individual project results)

The average monthly result for this measure showed strong improvement from the baseline data (52%) and met the project goal by August 2011. There was a decrease in the range of the minimum and maximum results from the last four months of the project. When the results are examined by quartiles, it shows that this decrease in this variance was due to the performance improvement of the lower quartile performers.

Figure 11 shows performance across the Project for performance measure P4.

![Percentage of palliative care plans that reflect the most recent assessment by any member of the multidisciplinary team (P4)](image)

Figure 11: Percentage of palliative care plans that reflect the most recent assessment by any member of the multidisciplinary team (P4)
Percentage of projects meeting the Project goal
The percentage calculated reflects the percentage of projects that met or exceeded the project goal from those that submitted data. The percentage of projects meeting the project goal increased from 39% at outset to an average of 72% over the September-November Project period. Seven projects achieved 100% in November. These higher performing projects drove up the average summated data for this performance measure to 85% in November. Table 29 summarizes these results.

<table>
<thead>
<tr>
<th>Performance Measure (2011)</th>
<th>Baseline</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4: Percentage of palliative care plans that reflect the most recent assessment by any member of the multidisciplinary team</td>
<td>39% (7/18)</td>
<td>47% (9/19)</td>
<td>71% (12/17)</td>
<td>67% (12/18)</td>
<td>73% (11/15)</td>
<td>74% (14/19)</td>
<td>68% (13/19)</td>
</tr>
</tbody>
</table>

Table 29: Summary of percentage of projects meeting the Project goal

Percentages split by project focus for: 1) inpatient projects and 2) community projects
Both the community and inpatient projects increased from 46% and 60% respectively to achieve the Project goal by mid Project. The difference between the inpatient and community focus projects was significant (Chi square test had a $p$ value result < 0.05) in July and October. However, these results were marginal (July $p$ value result = 0.034, October $p$ value result = 0.045) and may not reflect true significance. During these periods the inpatient focus projects had a more than expected number of plans reflecting the most recent assessment by any member of the multidisciplinary team. The community focus projects had a less than expected number of plans reflecting the most recent assessment by any member of the multidisciplinary team. This significance may be related to different processes and protocols used by community and inpatient services. Table 30 shows the percentage results split by project focus.

<table>
<thead>
<tr>
<th>Performance Measure/ Month 201</th>
<th>Baseline</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>60%</td>
<td>69%</td>
<td>84%</td>
<td>85%</td>
<td>85%</td>
<td>91%</td>
<td>90%</td>
</tr>
<tr>
<td>Community</td>
<td>46%</td>
<td>54%</td>
<td>77%</td>
<td>87%</td>
<td>87%</td>
<td>88%</td>
<td>87%</td>
</tr>
</tbody>
</table>

Table 30: Average percentage of palliative care plans that reflect the most recent assessment by any member of the multidisciplinary team split by project focus (P4)
Comment
This performance measure showed a steady improvement across the project period. However, as discussed above, six projects did not meet the 80% target.
Appendix 10: Project stories

Banksia Palliative Care Service

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

Banksia Palliative Care Service provides home-based palliative care by multidisciplinary team that consists of nursing, social work/counsellors and complementary therapies. In 2010 as part of our move toward an interdisciplinary model of care we attempted to introduce a psychosocial assessment tool in addition to an existing clinical assessment tool that had been in use for many years. Nursing staff felt that there was too much duplication across the two tools and questioned the need for additional information. The NSAP Collaborative Improvement Project provided the ideal opportunity to review our assessment tools in the context of a holistic assessment as defined by the PCA Standards.

2 What were the challenges/barriers to changing practice and how did you overcome them?

The different lenses that each discipline brings to the interdisciplinary team impacts on how they ask questions and how they collect assessment data. This has become particularly evident trying to establish the questions or prompts related to the psychosocial aspects of assessment. Nursing may be limited to psychosocial screening rather than a comprehensive assessment. Develop nursing skill set in interviewing and containment techniques as part of the assessment process.

3 What sustainability strategies have you in place?

Sustainability following implementation will be reliant on ongoing education, audit and feedback.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

That different disciplines hold different worldviews and that this project has provided an opportunity to explore these differences. That interdisciplinary teams need to work toward establishing a shared language and assessment is a good place to start. Having national standards and clearly defined measurable outcomes has helped to contain and direct this project.

5 What is your message for someone who is commencing a collaborative improvement project?

Respect the differences between the different disciplines whilst working toward a common goal.

Bethesda Hospital Palliative Care Unit

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

Care planning and assessment were rated as a medium priority during our NSAP self assessment last year, which in hindsight we feel was a under ranking. Care plans were sometimes poorly recognised, documented on and often not updated after the admission. Even though the care plan we had was intended to be an interdisciplinary document, some of the Doctors were not aware that it existed. The care plan was tucked away at the back of the bed side charts, while interestingly the medication chart always sat on top of the bedside charts. We also wanted to join the collaborative because of the opportunity to benchmark our service; to tap into the support and expertise provided; and meet with services across Australia with similar concerns that would assist in helping us identify opportunities for improvement. We were also hoping to develop a care plan that was best practice and met industry standards. Lastly being part of the collaborative would give us the opportunity to promote assessment and care planning and its importance in the clinical handover of care.

2 What were the challenges/barriers to changing practice and how did you overcome them?

Change fatigue/resistance: The project team was passionate and enthusiastic. Where possible we found out of hours champions. Also played on the PCU pride “we are a level three tertiary service, so we should have a care plan that reflects this”. Getting an interdisciplinary approach: The project team included the Senior Consultant, an Allied Health person Junior and Senior Nurses and the Chaplain. We also gave regular feedback of audit results and PDSA cycles.

Access to staff, lots of part timers and casuals: Talks at the MDT meeting, at handover, as well as many one on ones. Taking time to talk to the night staff.
Getting people to document care delivered, particularly the non physical domains of care: Education (one on one)
Prompts on care plans and examples of specific documentation for specific issues and domains. Feedback from
audits, lots of praise. A competition for best care plan (bottle of wine for prizes and a small ceremony).

3 What sustainability strategies have you in place?
Care planning and assessment are to be included as part of the orientation for new nurses, Doctors and Allied
Health staff. Also to be included is an overview of the National Standards. Assessment and Care Planning will be
part of the regular cycle of audit, and feedback to the team. A portfolio holder for assessment and care planning
with succession planning.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?
Change in practice is possible, but needs to be planned, small increments towards an overall goal, find champions,
and give regular feedback and encouragement to the team. Many other services share similar issues, and have the
same problems and concerns. While the project has been about the broadly about assessment and care planning,
it has given us as a team opportunities to discuss the importance of acknowledging cultural and spiritual issues.

5 What is your message for someone who is commencing a collaborative improvement project?

Canterbury Hospital Telopea ward

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care
planning need improvement?
Telopea ward participated in the NSAP project as a follow on from the outcomes of the NSAP self assessment
survey that we had previously participated in. This project gave us the support needed to improve on our wards
ability to meet the national standards in palliative care. The NSAP self assessment highlighted to us that we were
not currently meeting standard 2

2 What were the challenges/barriers to changing practice and how did you overcome them?
Ensuring all members of the team were involved in the project, particularly when arranging meetings with the
MDT team, this was difficult to manage, with annual leave, workload, sick leave and people being time poor.

3 What sustainability strategies have you in place?
Integration of holistic assessment into our weekly MDT ward rounds. Integration of the SPECS acronym into the
nursing education plus the inclusion of the SPECS prompt lanyard.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?
Aim for small manageable, but beneficial changes. Use a small number of patients to trial the project on,
then incorporate change on a larger scale. How beneficial it is to work on a project with a wide variety of
colleagues nationally, I was able to draw inspiration through work that others have/are doing, I found this to be
the most valuable aspect of the collaborative. As well as the ongoing support from Helen Vaz with the actual
improvement project

5 What is your message for someone who is commencing a collaborative improvement project?
Ensure you pick the team carefully, utilise the resources that are available and start small.

Cessnock Singleton Palliative Care Unit

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care
planning need improvement?
It was an opportunity to be involved in a project that guided change in a formalised way with clear guidelines and
involved continuous quality improvement.

It was identified during Cycle 1 of NSAP self-assessment that our pain assessment tool did not allow for the variety
of ways that patients and families perceive and describe pain.
2 What were the challenges/barriers to changing practice and how did you overcome them?

Research time to find pain tools that use patient language that would be appropriate for our service- negotiated with manager. Development and introduction of charts/tools- brainstorming, meetings, PDSA cycles. Staff engagement- discussed at Peer Review meetings, gave feedback on outcome of results, acknowledgement of work well done. Reduced staff levels due to holiday, long service and sick leave- worked with the dedicated few.

3 What sustainability strategies have you in place?

Incorporation of tool is in every-day use and associated patient language is used daily as a means of communicating between staff, patients, families and the medical fraternity. Through ongoing monitoring and feedback from staff about the project there are parts of the tool that all agree needs to be revised again. There is further review of where to keep the assessment in the medical record. There is a need for further education for new staff re the pain tool. PDSA cycles will be used for these changes.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

Change is ongoing and challenging and it is necessary to have continuous analysis and give feedback to staff. There needs to be a lead clinician/ champion. Acknowledge staff efforts and give praise where praise is due.

5 What is your message for someone who is commencing a collaborative improvement project?

Be as inclusive as possible. Start small, grow slowly, be patient. Most staff support change if they see the benefits for patients, the recalcitrant will grudgingly follow. We all need to constantly review what we do so it can be “the best possible” and to do this we need processes to sustain such change. This process makes us stop and think about our processes and everyday practices.

Claire Holland House

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

In December 2010 Clare Holland House (CHH) participated in the NSAP National Standards Assessment Program. Two key issues identified during this process were the lack of a multidisciplinary holistic patient assessment tool and poor multidisciplinary care planning. Although CHH had a number of patient assessment tools these were not integrated, patients were being asked the same questions multiple times and other important information was being lost in the body of the patient record and therefore not easily accessible to all members of the multidisciplinary team. Patient care planning was discipline specific and as a consequence did not appear to be holistic and patient centred.

2 What were the challenges/barriers to changing practice and how did you overcome them?

The main challenge has been freeing clinical staff from their normal duties to undertake the project. It was very apparent that the staff needed to be away from the clinical area in order to put the concerted effort needed into this project for success.

3 What sustainability strategies have you in place?

In order to ensure sustainability of the project a number of strategies have been implemented. Firstly a policy and procedure have been developed in relation to the “Palliative Care Holistic Assessment Form” and the “Palliative Care Assessment Chart”. The second strategy is to check the form has been completed each day during the MDT meeting; those forms that are incomplete are given to the staff on duty for completion. The final strategy is auditing the forms and presenting the results back to the team on a monthly basis through the general staff meetings and the Quality Risk & Safety meetings.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

The most significant thing we learnt was that CHH was not alone in having not already addressed such a significant aspect of care (holistic assessment and care planning). Somehow this made it easier to share ideas however out of “left field” they may be. The staff all learnt about the PDSA cycle and how easy and useful this tool is when trying to make a significant change involving a large group of people who at times had competing interests. Working in a collaborative group provided CHH with an opportunity to learn from others and share some good ideas with other palliative care organisations.
5 What is your message for someone who is commencing a collaborative improvement project?

This is a great way to undertake a project, the collaboration works well providing opportunity to share triumphs and failings, having others involved gives the project team impetus to continue as there is a shared goal at the end. For sustainable results all key stakeholders need to be involved from the start of the project and time must be set aside in order to plan, develop, implement and evaluate the project. Having Executive endorsement from the beginning is essential as there will be costs associated with the project, and it would be completely demoralising to complete a project and then find there is not the Executive support to implement change.

David Berry Hospital (Shoalhaven Palliative Care Service)

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

The NSAP pilot study highlighted for David Berry Hospital and its staff that we needed to make some improvements in Standards 1, 2, 10, and why we gave these areas a high priority for action.

2 What were the challenges/barriers to changing practice and how did you overcome them?

Change and new forms are challenging, continuous reminders of the need and benefits of the new assessment form were and will continue to be provided. The continued use of a non palliative care assessment form in the notes, discussions with nursing staff.

3 What sustainability strategies have you in place?

Ongoing Education Introduction of Spirituality and Cultural elements to staff and their impact in patient care. Continue 2nd monthly audits to continue the momentum.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

Small changes can make large significant changes. Networking opportunities. The usefulness of testings forms and interventions before introducing them.

5 What is your message for someone who is commencing a collaborative improvement project?

Understand that the process of change can be difficult for some, not everyone will share your enthusiasm however once staff become involved in the process they begin to understand the benefits and join you in your enthusiasm and make the changes.

Fairfield Community Palliative Care Service

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

NSAP self-assessment highlighted that, following initial assessment, documentation was fragmented and difficult to locate. Care planning was spread over home-based records, palliative care sub-files and community files located in two separate Community Health Centres. There was no integrated care plan readily accessible for review.

2 What were the challenges/barriers to changing practice and how did you overcome them?

Staff changes – 2 of original project team rotated out during course of project; changes in front-line managers with different people acting in positions. Palliative Care nurses work with two CHN teams – only 2 CHNs from one team involved in project. The other CHN team not able to participate due to too many other commitments. Community Health senior management aware of project but not involved – project peripheral to normal Community Health business. (Executive Sponsor situated in Area Palliative Care Service, not part of Community Health Service). Presentation of project to Community Health DON and senior managers postponed then cancelled due to restructure of AHS. Community Health documentation undergoing separate review. CHN teams trialling “case review sticker” not including SPECS domains. How to integrate holistic assessment and care planning for palliative care clients into normal Community Health practice.

3 What sustainability strategies have you in place?

Continue PDSA cycles to further streamline care plan documentation. Gain support of Community Health management in new LHD structure for integration of palliative care assessment and care planning into revised Community Health documentation. Long-term strategy to include palliative care plan in EMR.
4 **What are 3 key things that you have learnt from participation in the collaborative improvement project?**

Small changes can result in significant improvements. Be realistic about what can be achieved. Management support is essential for effective implementation.

5 **What is your message for someone who is commencing a collaborative improvement project?**

Small steps. Involve managers with direct responsibility for implementing changes. Regular feedback – celebrate improvements.

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**Hammond Care North Palliative Care Service**

1 **Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?**

NSAP self assessment identified that the HammondCare community palliative care services did not have an ongoing assessment / care planning tool.

2 **What were the challenges/barriers to changing practice and how did you overcome them?**

Conflicting priorities: unstable staffing, clinical load, and three teams situated over a large geographical area and organisational structural changes. Project team meet regularly with staff. No quality team member. Updates cc to quality officer. During the transition of changing to one initial assessment form varying versions were used in the three sectors. Project team identified inconsistencies and emailed CNC/coordinators.

3 **What sustainability strategies have you in place?**

NSAP updates are standing agenda items at all palliative care meetings. Email communication between the project leader and executive sponsors demonstrates commitment to the project. Use of innovative marketing – tags, prompts strategically positioned. Project team considering rotating membership to include all disciplines and inclusion of a member of the quality team.

4 **What are 3 key things that you have learnt from participation in the collaborative improvement project?**

The value of testing the interventions. The value of PDSA cycles – follow through process. Learning from other specialist services and the entire collaborative project.

5 **What is your message for someone who is commencing a collaborative improvement project?**

Ensure you have administration support and an involved quality team member.

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**Mercy Health Albury Palliative Care**

1 **Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?**

We wanted to improve the provision of holistic care to our patients and families with the particular area of focus being bereavement. Requests for bereavement follow up from families after their bereavement episode was completed where pre death bereavement risks were identified but not recorded on the assessment form was also evidence as well as the 3 monthly audits showing incomplete bereavement risk forms. This prompted us to review our bereavement risk assessment processes to be in line to provide more holistic care. This involved the need to develop a more user friendly tool as well as looking at our MDT meeting and how the information was communicated to the team.

2 **What were the challenges/barriers to changing practice and how did you overcome them?**

Reluctance of staff to change longstanding documentation practices in bereavement – meeting and including them in change processes. Asking nurses to complete a running sheet – the way in which it would improve the meeting process was explained and this meant it was readily accepted.

3 **What sustainability strategies have you in place?**

Giving ownership to the grade three nursing staff to chair the meeting. Integration of the PCOC data and language into the team meeting processes. Bereavement documentation physically easier to manage. Starting on a smaller scale allowed to be transferred to other teams with buy in from management team.
What are 3 key things that you have learnt from participation in the collaborative improvement project?

It is beneficial to start with small changes when trying to achieve a larger result. Sharing with other services is invaluable in learning ways in which your service can improve. Sometimes one change can lead to another – drill down the problem to find the source – it may be different from what you initially think and this happen in the case of this project.

What is your message for someone who is commencing a collaborative improvement project?

Use the opportunity to drive that quality improvement that seems too big to tackle!!!

Mercy Palliative Care – Sunshine

Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

The decision to participate in the project was made following our NSAP peer review and because staff were spending a lot of time writing in progress notes. It was also seen as being a way to review our documentation. Staff were spending a lot of time in handover and case review and saw a need to reduce this time in order to see patients in order to reach targets in patient contacts.

What were the challenges/barriers to changing practice and how did you overcome them?

We are still having challenges and trying to overcome them. Requires monitoring on a regular basis.

What sustainability strategies have you in place?

Development of procedures. Ensuring the documentation is user friendly with input from the staff

Engagement of the staff. Information board to be put up to provide information to visitors and staff.

What are 3 key things that you have learnt from participation in the collaborative improvement project?

Go slowly and small PDSA cycles – think small and develop gradually. Need to have the time to devote to the collaborative. Staff are busy and change can be difficult to implement.

What is your message for someone who is commencing a collaborative improvement project?

Ensure you have the capacity to participate. Engage staff identify people who will champion the cause. Don’t think big – take small steps. Provide chocolate and cake.

Modbury Palliative Care – Northern Adelaide

Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

We knew that we had a problem in this area post our self assessment against the standards. We were keen to be part of the collaborative as we wanted to make a difference to the bigger picture in regard to this area of care.

What were the challenges/barriers to changing practice and how did you overcome them?

Change resistance, busy clinicians that were not initially enthused by what the project team were selling. We needed to engage the interested ones and nurture their development. This did create some peer pressure. There is still some way to go to completely convince everyone (we may not even get there).

What sustainability strategies have you in place?

We have an application in with the DoH to participate in the team STEPPS program from next year. This will reinforce the framework and culture around change and patient centred care all while empowering the team to be responsible for the patient and not individuals.
4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

Be consistent, take things slowly i.e. don’t bite off more than you can chew and keep in mind the 80/20 rule (you can’t please everyone).

5 What is your message for someone who is commencing a collaborative improvement project?

That the collaborative won’t help you to solve ALL the problems but will provide the team with the tools to continue to work on quality improvement. It is fantastic to be part of a collaborative as many of the challenges and lessons learnt are magnified leading to a can do culture.

Royal Children’s Hospital Palliative Care Service

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

All patients to have an assessment that could be located easily by the key providers in the child’s care. All patient have a care plan that addresses the NSAP self assessment objectives/palliative care standards.

2 What were the challenges/barriers to changing practice and how did you overcome them?

Lack of understanding and support for the need to improve practice. – revisiting the NSAP self assessment outcomes, re-examining the standards, education around the collaborative and the ideal outcomes. No patient charts therefore nothing to audit easily – enlisted administration assistance. Time to create the ‘summary’ sheet – allocated to key team people who sit in the initial meetings with the family ie nurse practitioner or registrar.

3 What sustainability strategies have you in place?

Sustainable strategies include: address NSAP needs as an agenda item to 6 weekly palliative care meeting. Audits are collated and stored on common computer drive. Portfolio of NSAP needs to be built into nursing role in PPCS. Progressing a quality manager role in the team.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

Appreciating the strengths and challenges for your own team – some are unique and others are very common to others in this area. Learning to thin outside the square to approach as barrier – being reassured that there are many different well recognised ways to deal with barriers. Maintaining focus on what is to be achieved and that even if patient numbers are small this can allow clarify in any changes in practice which do occur.

5 What is your message for someone who is commencing a collaborative improvement project?

Take the time to appreciate that it is not a competition but an opportunity to keep motivated and learn from others. It will feel overwhelming initially. Dedicated time to project needs to be protected. Listen to what others are doing even if their team works differently – you may be able to adapt the situation to suit.

Sacred Heart Palliative Care – St Vincent’s Hospital

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

Sacred Heart NSAP self assessment and two patient carer surveys identified care planning as areas for improvement. The surveys specifically highlighted the symptom of pain as an area requiring further exploration

2 What were the challenges/barriers to changing practice and how did you overcome them?

To identify clarity around people’s concerns. Practical verses cultural.

To encourage and clearly identify practical issues people had with the change and implement appropriate support. To clearly identify cultural issues with the change and implement appropriate support for NSAP collaborative team and colleagues through referring to executive and managers.

3 What sustainability strategies have you in place?

The establishment of a process of how to consistently use the Electronic referral system-Web Delacy. Template for Multidisciplinary team meeting has been trialled and now in place. Plan to meet with executive and managers to discuss strategies and guidelines for current strategies to ensure consistency and sustainability post collaborative improvement project.
What are 3 key things that you have learnt from participation in the collaborative improvement project?

1. Importance of executive leadership.
2. Ensure you have the capacity to follow up with colleagues regularly.
3. Culture is much stronger than systems.

What is your message for someone who is commencing a collaborative improvement project?

Ensure the executive endorse the project and communicate their expectations and support with all staff at the start of the project and throughout.

Engaging staff from the beginning

Start with small incremental change consolidate and build consistently and maintain the passion and commitment to continue to improve.

Silver Chain Hospice Care Service

Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

Silver Chain has a well-developed electronic information management system and paper-based assessment and care planning tool. However, evidence from regular internal audits of client notes indicated that assessment and care planning was not sufficiently holistic and there was insufficient evidence to demonstrate a dynamic link between the care plan and the assessment.

What were the challenges/barriers to changing practice and how did you overcome them?

Changeover of staff within the team - overcome by the targeted nature of the education module and the support of the CNCM and case coordinator. The absence of an electronic assessment and care planning tool – overcome by the use of the variance sheet – although this still required home visits to be undertaken. The impact of the additional home visits in terms of travel and staff time. The need to separate the role of auditor from that of a visiting RN.

What sustainability strategies have you in place?

Ongoing education. Rolling the initiative out to another 2 clinical teams. Regular and timely feedback to the participating clinical teams. Using the PDSA cycle – keeping the focus on “small scale” and “achievable”.

What are 3 key things that you have learnt from participation in the collaborative improvement project?

Learning from other people’s ideas. Networking opportunities. The effectiveness of using the continuous PDSA cycles as elements to achieve a broader aim and significant continuous improvement.

What is your message for someone who is commencing a collaborative improvement project?

The significance of early preparation at the “grassroots” level. Constant and consistent involvement of the study participants. Feedback.

St John of God Murdoch Community Hospice

Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

Care Planning was identified as a key improvement during ACHS Organisation Wide survey in October 2009. Assessment and care planning was highlighted as a service development priority during our second cycle of NSAP self assessment (April 2011). Feedback from our patient and carer surveys indicated a need for enhanced patient and carer involvement in care planning. As a service, we are involved in the Palliative Care Outcomes Collaboration (PCOC). However, there was recognition that although we were actively involved in data collection, there was a need to integrate these evidence base assessment tools into everyday practice.

What were the challenges/barriers to changing practice and how did you overcome them?

The NSAP CIP; A&CP has enabled change in the way our service delivers care, by prompting us to explore assumptions about our service and act on these. It has also given us a framework to address the variation in the level of “experience” within our staff as all members of staff, regardless of their numbers of years experience, are new to this project and therefore NSAP CIP;A&CP has created an even playing field.
3 What sustainability strategies have you in place?

It has become obvious that completion of the work associated with the NSAP CIP; A&CP will not be the end of our commitment to quality improvement within our service. Going forward, we plan to:

- Continue to develop the Nursing Assessment and Care Planning document.
- Include PCOC and NSAP in the orientation of new staff.
- Develop the role of the AHT through its working party.
- Work with PCOC QIF to improve our utilisation of the Problem Severity Score.
- Review the Medical Admission Assessment form.

St John of God Subiaco

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

Collaboration with similar services. Compliance with national standards to improve holistic care of the patient. Learning opportunities. NSAP self assessment indicated an area for improvement being multidisciplinary team involvement in care planning. Providing structure to improvement project.

2 What were the challenges/barriers to changing practice and how did you overcome them?

MDT availability and timeliness of referral has been a challenge for us. We do not have a dedicated multidisciplinary team and rely on resources from within the hospital, most of whom are not trained/specialised in the area of palliative care, to assist with assessment and care planning. Whilst the motivation and enthusiasm is obvious for these members of the team, it is sometimes difficult for referrals to be seen or discussed. This has however improved with the revised processes for our weekly MDT meeting. Understanding the framework of the project and the collaborative approach has sometimes proved to be difficult particularly for the caregivers outside the palliative care team. As with all organisations, resources and man-power was at times an issue as well as maintaining motivation and energy. Consistency in assessment of culture and spirituality was a problem with most of the groups within the collaborative and we were no exception. However, education and informal discussion with caregivers is seeing an improved appreciation for what is meant by these areas.

3 What sustainability strategies have you in place?

Ongoing education/communication: The consultative service relies on developing strong credible relationships with disciplines outside palliative care. It is essential that we continue to grow these relationships through conversation in order to educate caregivers regarding the value of holistic assessment, reflective care planning and involving the patient and the family in decision-making. The team has some structured study days and also less formal sessions throughout the year and education is a both a medical and nursing priority. Maintain relationships with MDT. Regular audits/monitoring: The service will continue to audit case notes on a quarterly basis using the same audit tool used for the collaborative. Given the issues around the context of care, some of the results may not be as relevant, as such we will continue to use an annual family and patient satisfaction survey to measure outcomes for patients and families. Commitment to quality improvement through standard organisational processes and ongoing involvement with NSAP evaluations. Executive/organisational support: We have a very strong executive support and understanding of the philosophy of palliative care and participation in projects such as the collaborative will continue to be encouraged.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

Is the context of care always considered?. The issue of palliative care definition has been raised within our project team. Is ‘care’ or goals of care’ the same for each setting-community, inpatient/hospice and acute care? Are we considering the ever changing needs of palliative patients and their families? Is there enough consideration for patient choices at the end of life or are we keeping it too narrow? Practicality of the implementation of the standard? Are we all talking the same language? Discussion within our project team has raised the issue of whether or not the National Palliative Care Standards require review and do they adequately reflect the changing needs of palliative patients and their families? Evaluation: Participation in the collaborative has highlighted the need for ongoing and consistent evaluation of our processes. It has motivated our team to ‘keep things simple when looking for a better way’. 
**South East Palliative Care**

1. **Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?**

   We wished to participate in the project to respond to the opportunity to work collaboratively with other palliative care services, in the area of care planning. Although we had an existing care planning tool, it was often used sub-optimally and was not always clear enough to accurately guide care planning. Evidence to support this claim included the not infrequent duplication of care plan items by multiple staff members, and the not uncommon occurrence of care issues being documented in progress notes only.

2. **What were the challenges/barriers to changing practice and how did you overcome them?**

   We were in the fortunate position that the majority of our clinical staff were open to change at the time that the project commenced. We enhanced their engagement by asking for their input into the terminology, and by giving regular updates on the progress of the project. We also highlighted to the staff when any particular staff member made a particular effort to embrace the changes.

3. **What sustainability strategies have you in place?**

   To ensure sustainability, we plan to keep monitoring compliance with the terminology and to keep giving regular updates to staff.

4. **What are 3 key things that you have learnt from participation in the collaborative improvement project?**

   The key lessons that we learnt from participation in the project were that we need to start small, ensure staff involvement and buy-in, and that without executive support, the project would not have been possible.

5. **What is your message for someone who is commencing a collaborative improvement project?**

   We would encourage anyone considering commencing a collaborative improvement project to go ahead with it, and enjoy the journey.

**St Vincent’s Hospital Brisbane Palliative Care**

1. **Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?**

   We wanted to participate in the NSAP project to develop a patient focused multidisciplinary care plan and assessment tool. Each discipline used its own pathway and the team thought a complete multidisciplinary plan would be a more effective tool to share with the primary health care providers.

2. **What were the challenges/barriers to changing practice and how did you overcome them?**

   Change can be challenging. The whole service is going through a time of change and was partly the reason to change care assessment plans at the same time. There was some difficulty in engaging senior medical staff and continues to be an ongoing challenge. The new model of care encourages the initial face to face visit within 48hrs of referral, the definitive referral date is still been discussed but the bench mark will be reached.

3. **What sustainability strategies have you in place?**

   Improve the care pathway so staffs take increased ownership. Maintain multidisciplinary patient focused care pathway within the community service. Maintain linkage with primary health care givers.

4. **What are 3 key things that you have learnt from participation in the collaborative improvement project?**

   Sometimes too much input can be delaying as too little. Maintain your goal despite all the changes around you. Take even the smallest success as a positive.

5. **What is your message for someone who is commencing a collaborative improvement project?**

   Keep it really simple.
Townsville Hospital Palliative Care Service

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

Outreach Palliative Care at The Townsville Cancer Centre, The Townsville Hospital signed with NSAP on 4/6/09 and completed Self assessment and an Action Plan 1/12/09. The Action Plan included Standard 2.6 (there are arrangements in place that support Level 1 and 2 service to achieve improved outcomes for patients and carers) with a Priority B. During 2010 Quality improvement strategies had improved the arrangements in place and a Palliative management plan for the patient was developed and approved in December 2010.

2 What were the challenges/barriers to changing practice and how did you overcome them?

The challenges / barriers to changing practice were time and documentation processes. The availability of adequate time to dedicate to the project was due to key persons on leave or committed to other projects at the same time. The service primarily uses an electronic record and this causes difficulty when referred patients have a paper based record. Documentation audits were complicated by the fact that some data was on either record but also highlighted the urgency of integration of health records for the organisation.

3 What sustainability strategies have you in place?

The sustainability strategies in place are executive and clinical leadership, a staff training plan for new and present staff in addition to a documentation policy, procedure and work place instructions for assessment and care planning. The credibility of the benefits of assessment and care planning is evident in the acceptance of change by staff. Assessment and care planning are agenda items on all service meetings and during performance appraisals of nursing staff. An electronic journey board for all patients is being developed at present and due for implementation in 2012. This will further integrate assessment and care planning as an ongoing practice in the outreach and inpatient service.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

A communication plan is paramount to ensure key persons are included in decision making and kept up to date at all times. When anything went right or wrong it was due to communication. Team work is essential. The project team within the service, the NSAP team, the collaborative and the patient and families are all essential for the project to be a success. Each member has something to contribute and no one is more important than anyone else. Each person being aware of their role and responsibilities is essential to prevent role confusion, duplication or delays. The PDSA cycles encourage reflective practice among the team throughout the duration of the project. As a result of this reflective practice, a number of systems and processes were refined and redesigned to ensure the sustainability of the assessment and care planning process.

5 What is your message for someone who is commencing a collaborative improvement project?

Any service commencing a collaborative improvement project requires time to plan, as does any project. The time taken to plan is an investment and helps to identify extra resources needed, possible barriers and the sustainability requirements. Clear identification of the scope of the project and a communication plan are a top priority. The project result for patients, their family and the service is worth the effort.

West Gippsland Healthcare group

1 Why did you want to participate in the NSAP CIP: A&CP project? What was your evidence that your assessment and care planning need improvement?

Our organisation recognised this as an opportunity to; review current practice, identify opportunities for improvement using the NSAP Collaborative and PDSA framework that has been recognised by WGHG in ensuring sustainability and meeting the 13 National Palliative Care Standards, develop quality improvement action strategies that enabled us to redevelop our assessment and care planning pathway to include documentation from all multidisciplinary team (MDT) members for use cross all setting, monitor and evaluate outcomes using small test PDSA cycles.
2 What were the challenges/barriers to changing practice and how did you overcome them?

There was variation in the level of understanding by staff members within the organisation about the project. Education sessions were provided and well attended with positive feedback. Visual display boards in the community and acute sector also informed of progress. Staff were able to comment on individual components of care plan. Time constraints and conflicting time frames with other projects/obligations within the organisation. Review of length of PDSA cycles. Dependence on other MDT members to report back to working party in a timely manner. Perseverance, reminders, emails, phone calls. Planned targeting of stakeholders to reduce time commitment in attending meetings.

3 What sustainability strategies have you in place?

Monthly working party meetings of key NSAP members. Appointment and engagement of key person to continue specific components of the care plan such re-development of assessment, spirituality tools. Continued funding allocation for project worker until June 20121. Continued organisational support. The national palliative care standards remain on the palliative Care Committee as a standing agenda item. This will ensure all stakeholders remain informed of progress.

4 What are 3 key things that you have learnt from participation in the collaborative improvement project?

It is a team effort. Change takes time. The importance of perseverance and the importance of engaging key persons to assist with the project.

5 What is your message for someone who is commencing a collaborative improvement project?

A journey of a thousand miles must begin with a single step. Keep the goal in sight. Small cycles for change to realise the bigger picture.