

National Standards Assessment Program

Improving quality in palliative care



NSAP Continuous Quality Improvement Collaborative Project:

Support for Carers

Project Stories 2014



Australian Government
Department of Health



PalliativeCare
AUSTRALIA

This project is funded by the Australian Government Department of Health

Contents

Introduction.....	3
Barwon Health Palliative Care Program, VIC.....	4
Bethesda Hospital, WA.....	6
Calvary Mater Newcastle Palliative Care, NSW	7
Cessnock Kurri Kurri Singleton Palliative Care Service, NSW	9
Cittamani Hospice Service, QLD.....	11
Glengarry Private Hospital, WA	13
Gold Coast Health Palliative Care Service, QLD	15
Goulburn Valley Hospice Care Service, VIC	16
Melbourne City Mission Palliative Care, VIC	18
Mercy Health Community Palliative Care, VIC	20
Mercy Health Hospital Palliative Care Service, VIC.....	22
Mercy Health Mackay Mater Hospital, QLD	24
Midwest Regional Palliative Care Service, WA	26
Portland District Health: Community Palliative Care Service, VIC.....	28
Rockhampton Hospital Cancer & Specialist Palliative Care, QLD	30
Royal Children’s Hospital Paediatric Palliative Care Service,QLD	32
Sacred Heart Supportive and Palliative Care Service, NSW	34
St John of God Murdoch Community Hospice, WA	36
St John of God Subiaco Palliative Care, WA	37
St Vincent’s Hospital Brisbane, QLD.....	39
St Vincent’s Hospital Melbourne, VIC	41
South East Regional Community Health Service, SA.....	43
South West Specialist Palliative Care Service, WA	45
Sunshine Coast Specialist Palliative Care Service, QLD	47
Tamworth Palliative Care, NSW.....	49
Tasmanian Southern Community Palliative Care Service, TAS.....	51
Territory Palliative Care, Central Australia, NT.....	53
Territory Palliative Care, Top End, NT	55
Western District Health Services, VIC	57
West Gippsland Healthcare Group, VIC	58
Yorke and Lower North Health Service, SA	60

Introduction

This document is a collection of stories completed by 31 of the 35 specialist palliative care services who finished the NSAP Continuous Quality Improvement Collaborative Project: Support for Carers from May 2013 to March 2014.

Each of the specialist palliative care services completed a project story to provide a summary of their experience at the conclusion 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 story could be used in publications related to the Project.

The project stories addressed the following eleven questions:

1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?
2. What were the key issues that you were trying to address in the project?
3. What was the aim of your project?
4. What change(s) were implemented in your project using the PDSA cycles?
5. What are the key results of your project?
6. What measures demonstrated your project results?
7. What worked well to make the changes in practice?
8. What were the challenges to changing practice and how did you overcome them?
9. What sustainability strategies do you have in place?
10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?
11. In moving forward what are your next steps?

Barwon Health Palliative Care Program

Author/s: Julie Jones, Manager Palliative Care & Jacqui White, Manager Palliative Care

Email contact: julie.jones@barwonhealth.org.au

1. What evidence was used in your NSAP self-assessment that identified Support for Carers as an area for improvement?

- Barwon Health Palliative Care program provides palliative care services across a number of settings including home based and inpatient palliative care settings. Care is provided by an interdisciplinary team, which consists of nursing, medical and supportive care. The need to enhance the palliative care service to ensure that 'care is co-ordinated to minimise the patient, caregivers and family' has been consistently identified over a number of years as an area requiring improvement by Barwon Health via NSAP and Department of Health Strategic Directions self-assessment processes, as well as results from the Victorian Palliative Care Satisfaction Survey.

2. What were the key issues that you were trying to address in the project?

- Carer feedback indicating that they required further support and guidance about their role.
- A lack of specific strategies identified or implemented to meet carers needs as per Standard 5.
- A lack of strong procedures and systems responses to address the needs of carers as demonstrated during the NSAP self-assessment.

3. What was the aim of your project?

- To develop and implement a procedure which outlines the carer needs assessment process and the expectations of staff to complete and follow up.
- To introduce into clinical practice an agreed carer needs assessment tool (procured via existing tools available) to assess the needs of all Palliative Care carers.
- To develop and implement an education package and schedule for ongoing staff training.
- To develop a web based Resource Toolkit for patients, carers and staff to use when addressing identified carer needs.

4. What change(s) were implemented in your project using the PDSA cycles?

- Identification of the Carers Support Needs Assessment Tool (CSNAT) as an appropriate tool to utilise in assessing the needs of carers both within home based and inpatient palliative care settings.
- Trial of CSNAT to ensure the process of assessment was appropriate and sustainable.
- Introduction of the CSNAT to all carers within the Community Palliative Care Program at the point of initial assessment.
- Introduction of the CSNAT to all carers of patients within the Palliative Care Unit (PCU) within the first 72 hours of admission to the PCU.
- Education for staff across community and inpatient settings on the use of the CSNAT and the subsequent implementation of an action plan based upon the needs identified by the carers.
- Development and implementation of a formal procedure to direct and guide staff on the use of the CSNAT
- Continuous monitoring to ensure the tool was used consistently and effectively.

5. What are the key results of your project?

- A multi-disciplinary working group was established.
- Education has been provided to staff across the community and inpatient settings.
- The CSNAT has been trialled and formally implemented.
- A procedure guiding the use of CSNAT has been developed, and is currently going through the final approval processes within the Barwon Health organisation.
- A comprehensive electronic Carer Resources Toolkit is currently in development. Once finalised, the toolkit will be promoted on the Barwon Health website with clear links from the Palliative Care page.

6. What measures demonstrated your project results?

- Ad hoc audits during the trial period.
- Continuous monitoring, which has been recently implemented, will demonstrate the tool is now being used consistently by staff across the Palliative Care program to assess carer needs.
- It is anticipated that the Victorian Palliative Care Satisfaction Survey 2014 will show an improvement on 2013 results.

7. What worked well to make the changes in practice?

- Identifying key champions within the Palliative Care Unit and the Community Palliative Care Team assisted in:
 - Having a 'go to' person in each area for questions and issues.
 - Ability to advice regarding what was possible and what was not when developing the procedure.
 - Monitoring the implementation of the CSNAT and addressing any issues as and when they occurred without further reference to the working group.

8. What were the challenges to changing practice and how did you overcome them?

- Moderate resistance from the team – whilst they were supportive of the principles, they felt they did not have enough time to implement this tool in the context of their work with clients at the point of initial assessment within CPC or admission to PCU.
- Maintaining momentum during the trial has been particularly challenging. This may have been resultant of a perspective that the use of the CSNAT was optional rather than mandatory.
- Christmas and New Year leave meant that staffing levels were sub optimal and subsequently workloads were higher than would normally be expected. During this period, it was noted there was a considerable decline in CSNATs completed.
- Strategies to address these included discussion with the team on how best to manage; consultation and feedback regarding the procedure; a robust monitoring process to ensure the CSNAT is being used to assess the needs of carers.

9. What sustainability strategies do you have in place?

- Sustainability of these changes to practice will be reliant on a number of strategies including the formal procedure for the implementation and use of the CSNAT within palliative care, ongoing education for staff, inclusion within the palliative care audit schedule and continuous monitoring within the context of clinical supervision to ensure carer's needs are being appropriately assessed and responded to.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- The importance of continuous monitoring of staff within the clinical supervision setting to ensure that the assessment of carers needs is being completed as directed. We have learnt, for our particular program, this is just as important as developing the guiding procedures and educating staff regarding the use of the assessment tool. If regular (i.e. weekly or fortnightly) monitoring, including audits, is not taking place, the tendency is for the use of the CSNAT to slip down the list of priorities.

11. In moving forward what are your next steps?

- The Carers Resource Toolkit remains in development with assistance from the Communications and Marketing team at Barwon Health.
- The continued use of the CSNAT in both the CPC and PCU settings.
- The continuation of monthly audits with the inclusion of the audit on the Palliative Care audit schedule. It is anticipated that initially monthly audits will continue to ensure the CSNAT is embedded within practice with an eventual transition to a quarterly audit schedule.

Bethesda Hospital

Author/s: Ed Gaudoin ,Clinical Nurse Consultant & Alison Brodie, Clinical Nurse Consultant

Email contact: egaudoin@bethesda.asn.au

- 1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?**
 - Scored 0% on initial review regards to Carer assessment as per domains of data collection, which was the number of patient records with evidence that the patient has identified their carer (s).
- 2. What were the key issues that you were trying to address in the project?**
 - No documentation on who the primary carer was.
 - No documentation that they agreed to the role and needs assessed with a corresponding plan based on the initial project.
- 3. What was the aim of your project?**
 - Identify and document who the primary carer is in 60% of audited files monthly for 1 year.
- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - Document changes on:
 - Referral form.
 - Admission form.
 - Family meeting summary.
- 5. What are the key results of your project?**
 - 60% improvement on identifying carer and assessment of their needs.
- 6. What measures demonstrated your project results?**
 - Measuring the identification of carer in the medical records.
 - Measuring documentation of carers needs being assessed.
- 7. What worked well to make the changes in practice?**
 - Good staff support.
 - Medical records – Liaison with the medical records officer discussing the changes we wished to make to the admission document/ referral form/ family meeting form.
 - Involve social worker in all of our discussions around carer and needs assessment.
- 8. What were the challenges to changing practice and how did you overcome them?**
 - New medical director – settling into role, wanting more time to review service and documentation.
 - A lot of new staff – not experienced in palliative care requiring training and development in assessment role.
 - Introduction of Liverpool care pathway – competing with resources that were available to us. Staff overwhelmed with documentation changes.
- 9. What sustainability strategies do you have in place?**
 - Every Tuesday at Team meeting re enforced need for completion of Data- and completed at that time and discussed if needed.
- 10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?**
 - Aware we discuss carer's needs but not necessarily complete documentation re plans in place.
- 11. In moving forward what are your next steps?**
 - Continue with Reviewing/Auditing every month- 15 patient files. Anyone from the multidisciplinary team (MDT) can review and complete integrated notes/assessment.
 - Review documentation every Tuesday with staff at MDT meeting that carer identified and needs assessment completed.
 - Every quarter review/audit notes to check compliance and educate if needed.

Calvary Mater Newcastle Palliative Care

Author/s: John Cavenagh, Staff Specialist & Jessica Cain Acting Nurse Unit Manager and
Barbara Bagley, Physiotherapist

Email contact: Jessica.Cain@calvarymater.org.au

1. What evidence was used in your NSAP self-assessment that identified Support for Carers as an area for improvement?

- Identified in carer-based projects (FAMCARE in 2004) with regards to carer based needs assessments and formalised support

2. What were the key issues that you were trying to address in this project?

- Identify the support needs of primary caregivers.
- What works within our current service provision to support the needs for carers and identify any gap.
- Improve the process of identification and needs assessment of primary caregivers.

3. What were the aims of your project?

- All patients to have an identified primary carer.
- All patients will have discussed the role with a health professional and agreed to be the patient's primary caregiver.
- All primary caregivers will have a needs assessment completed and a documented plan of action.

4. What changes were implemented in your project using PDSA cycles?

- Identification and Documentation of Primary Caregiver

Plan:

- Multidisciplinary team formed to review current practices and identify opportunities for improvement; Scope and aims of project identified.

Do:

- Liaised with ARIA project manager to add "Primary Caregiver" as a demographic field; Developed a "How To" information sheet for staff; Education provided at various MDT forums.

Study:

- 20 chart reviews each month; Ongoing agenda item at MDT meetings to ascertain informal feedback to change.

Act:

- Ongoing MDT review and discussion; Project feedback added to agenda at MDT and Department Manager's meetings.

- Identification of Primary Caregiver NEEDS assessment

Plan:

- Reviewed recommended guidelines of project and available literature; Developed executive briefing to communicate scope of CQI; MDT with consumer rep to review needs assessment options available; Selection of CS-NAT as assessment tool.

Do

- Obtained permission from authors of CS-NAT and signed licensing agreement; Developed information sheet and process flow chart to support change; Engaged with MDT to identify roles in practice change.

Study:

- 20 chart review each month; Data analysis of all CS-NATs undertaken to determine priorities for Primary Caregivers; Review of available CS-NATs at MDT weekly meeting to engage staff with review and promote action plans from information provided.

Act:

- Ongoing communication with working party via email and in person meetings; Add progress to agenda items at CQI and departmental meetings; Ongoing education with staff.

- Development & Documentation of a Primary Caregiver SUPPORT PLAN

Plan:

- Reviewed recommended guidelines of project and available literature; MDT with consumer rep to review needs assessment options available; Development of a documentation tool to clearly identify interventions for carers once assessed

Do

- Developed information sheet and process of change introduction; Engaged with MDT to identify roles in practice change; Caregiver Support Plan drafted and to be scanned into ARIA when completed.

Study:

- 20 chart review each month; Data analysis of all CS-NATs undertaken to determine priorities for carers; Review of available CS-NATs at MDT weekly meeting to engage staff with review and promote action plans from information provided.

Act:

- Ongoing communication with working party via email and in person meetings; Add progress to agenda items at CQI and departmental meeting; Ongoing education with staff.

5. What are the key results of your project?

- Three top identified needs of caregivers when initially presenting to community service: *Knowing what to expect; Who to contact; Understanding relative's illness.*
- Implementation of CS-NAT.
- Improved identification of Primary caregiver in ARIA.

6. What worked well to make the changes?

- Multidisciplinary collaboration.

7. What were the challenges to changing practice and how did you overcome them?

- Caregivers undertaking needs assessment – frontline staff involved in planning process of implementation.

8. What sustainability strategies do you have in place?

- Multidisciplinary team meetings to review CS-NATs when identifying patients and caregivers with complex needs; Ongoing VMO input at weekly meetings.

9. What is your take home message?

- Work out roles ASAP for each team member; Plan PDSA's early with collaboration of team; find champions in MDT to assist with their discipline's role in implementation.

10. Next steps?

- Work towards cycle 3 self-assessment to assess carer's feedback. Develop the logistics to enable a CARER SUPPORT PLAN to be used by Team particularly using ARIA (IT electronic records).

Cessnock Kurri Kurri Singleton Palliative Care Service

Author/s: Caroline Short, Clinical Nurse Consultant & Kate Stuart, Clinical Nurse Specialist

Email contact: caroline.short@hnehealth.nsw.gov.au kate.stuart@hnehealth.nsw.gov.au

- 1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?**
 - During self assessment Standard 5.1 to 5.3 highlighted that carers and their role is not always clarified and their needs are often confused with patients' needs.
 - A carer survey further highlighted this issue.
- 2. What were the key issues that you were trying to address in the project?**
 - Sustainable improved support for carers.
 - Evidence to identify where change is required and introduce those changes utilising quality improvement practices.
 - Improve staff skills in supporting carers.
- 3. What was the aim of your project?**
 - All patients identify a carer at initial assessment.
 - The carer identifies their caring role at initial assessment after discussion with staff.
 - To identify carer assessed needs.
 - To source and introduce an evidence based tool to assess and support carers ongoing needs.
- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - Alteration to Initial Assessment to include carer data collection as per aims.
 - Introduction and implementation of Carer Support Needs Assessment Tool (CSNAT).
- 5. What are the key results of your project?**
 - Improved identification of carer, their role and their holistic needs at initial assessment.
 - An initial carer specific plan of care with actions agreed by carer and then implemented.
 - Ongoing carer needs assessment through use of CSNAT.
- 6. What measures demonstrated your project results?**
 - Monthly medical records audits.
 - Staff incorporating carers needs discussion into daily clinical handover.
 - Weekly peer review highlighting carers needs using CSNAT.
- 7. What worked well to make the changes in practice?**
 - Altering our initial assessment form so:
 - carer and their role is identified at the start of an initial assessment
 - carers own needs are now included
 - there is a specific section to develop a carer action plan.
 - Brain storming sessions using De Bono's "six thinking hats for change" to educate, inform, create interest in and introduce the CSNAT.
 - Ongoing education and training at meetings and opportunistically.
 - Agenda item at business meetings, peer review re when, where to use CSNAT forms and how to follow up.
- 8. What were the challenges to changing practice and how did you overcome them?**
 - Staff concern, if carer completes CSNAT becomes 2 clients/ medical records therefore more workload issues.
 - Staff reassured that carer assessment is underpinned by national palliative care standards and is integral to holistic patient care.
 - Confusion re where to file CSNAT form and whether form should be used only once or more often.
 - Clarification at meeting re where to file CSNAT form. Consensus to review Carer needs regularly via PCOC assessment and use CSNAT as required for any ongoing issues.
 - CSNAT only partially embedded in practice.
 - Ongoing CSNAT education, results of De Bono's brainstorming sessions using butchers paper pinned to office walls as reminders.

- Remind staff CSNAT becomes useful in situations where it is difficult for carers to talk and it gives legitimacy to carers needs.

9. What sustainability strategies do you have in place?

- Initial assessment identifying carers their roles and a carer plan of support has been embedded in our practice.
- CSNAT is now routine in daily handover, weekly peer review and agenda item at business meetings.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- Involve staff every step of the way with appropriate responsibilities accepted by team members and give regular feedback re outcomes.
- Don't change the goal posts every few days when introducing change.
- Discuss staff confusion and concerns, don't ignore them, and regularly refer back to project objectives.

11. In moving forward what are your next steps?

- Further Carer feedback surveys.
- Continue to review use of CSNAT.

Cittamani Hospice Service

Author/s: Karen Ristuccia, Registered Nurse & Loretta Chakley, Registered Nurse

Email contact: cittamanihospice@powerup.com.au

Background

Cittamani offers professional home based palliative care to people who are dying and to their families, by honouring individual choices and providing compassionate care. Cittamani provides 24 hour support via a pager system. One of our 6 RNs is always on call 24/7. This allows us to respond to our clients and carers as issues arise for them. It offers a great deal of support to our carers.

Our Social Work team offers emotional support for carers, clients, and families; including, support with, financial legal and culturally specific documentation. In this way Cittamani seeks to demonstrate a deep respect for the individual and their choices.

We have a comprehensive range of equipment to loan to families free of charge. This allows changing needs to be attended to immediately.

Our dedicated Volunteer coordinator trains, supports, and manages a diverse team of volunteers able to offer in home respite to our carers.

Cittamani provides a very comprehensive bereavement program. This program grows in flexibility according to the needs ages etc of the bereaved clients. We offer group sessions, one on one sessions, and phone support. Recently a young 'widows' group started up due to demand and we have also developed a facebook/internet support program for younger bereaved clients. Our belief is that this service is best provided in a healthy and supportive community where death, dying and bereavement is openly discussed and accepted.

Our vision springs from a Buddhist value base, which includes: - The value and dignity of all life, compassionate service and empowerment of our clients' carers and families.

Evidence

As part of our cycles of NSAP self-assessment, our MDT team identified that our documentation around carer assessment/needs needed improvement. The evidence we used for NSAP self assessment process included client file, carer satisfaction survey, bereavement notes and complaints system.

Key Issues

The key issues for our project were to provide written evidence for our carer; assessment, care planning and support measures. We are a small team with a verbal culture, and as such we rely on verbal handovers. Information shared in this way, can mean that written evidence can at times be hard to find.

Aim

The aim of our project was to provide comprehensive written evidence, for our carer assessment and carer planning. In doing this we were cognisant not to overuse validated assessment tools but rely more on our conversations with carers enabling them to feel secure to identify their needs.

Changes using PDSA cycles

The PDSA cycles we used revolved around team meetings and fine-tuning our assessment documents to enable nurses to document the essence of our conversations with the carer and the client.

The main benefit for our practice has been the increased awareness amongst team members regarding documenting evidence, not just discussing the findings issues etc. Our written assessment now more fully records the conversations we have with the carer around how they perceive the role, the problems they encounter and being able to ask for help.

We created a new audit tool to incorporate ongoing internal assessment of our documentation; specifically around recording key issues etc for the carer and family. This new audit tool has been trialled and the results presented at our team meeting. This process allows for ongoing increased awareness of the importance of written evidence in a verbal workplace. A changing of our cultural practice 'bad habits' whatever we call it a 'change' it remains.

Challenges

The main difficulty in having the staff at large, embrace the project, was our innate verbal culture. Our aim was to translate that verbal nature to a written one. The selling point we believe is slogging away at it, knowing that we are providing a lasting record of what we do for our clients, carers and families.

At Cittamani we aim to; Come from a place of compassion and love; Walk the journey with our clients and carers; Draw out what is important/meaningful to them; and Empower carers to find the answers for themselves.

As an organisation, we need to treat our team members as we aspire to treat clients/carers. Trust is very important, but also respect and kindness– for family, clients, fellow practitioners in our team and others.

Next steps

Our ongoing commitment, within the team, is to understand that in documenting the carers' conversations and providing that evidence enables this service to continue to provide cares in our unique way. Our resistance to using validated assessment tools, per se, must be offset by our determination to record the essence of our assessment style in its entirety.

To quote Dame Cecily Saunders (1996) 'If we can come not only in our professional capacity, but in our common vulnerable humanity there may be no needs of words on our part, only of concerned listening.'

Glengarry Private Hospital

Author/s: Sarah Greeshaw, Social Work & Tracy Robinson, Clinical Nurse Consultant

Email contact: RobinsonTracy@ramsayhealth.com.au

- 1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?**
 - Data/information from patient integrated notes identified carers' needs as being assessed "sometimes". The original assessment documentation failed to capture identified carers' and their needs.
 - Organisational policies and procedures failed to capture identified carers' and their needs.
- 2. What were the key issues that you were trying to address in the project?**
 - We were not always identifying carer/s.
 - We were not clearly and thoroughly identifying the needs of carer/s.
- 3. What was the aim of your project?**
 - All patients will identify a carer.
 - All carers will discuss their specific needs with the palliative care team.
 - All carers will have a documented plan of action.
- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - Initial nursing admission assessment revised to include identification of carer/s.
 - Chaplaincy documentation commenced in patient record.
 - "Social Work Initial Assessment and Recommendation Report" implemented.
 - Further modification of the "Social Work Initial Assessment and Recommendation Report" to include a discussion with the identified carer to ascertain the carers role on the ward and their level of involvement in the patients care during the inpatient stay.
- 5. What are the key results of your project?**
 - Patients' carer/s were identified and their needs discussed/assessed; an action plan was formulated where required.
 - Clearer understanding of the carer role by the patient which impacts on future care-planning; Future care-planning and recommendations were made easier as needs were identified from the beginning.
 - Referrals to agencies increased where the need was identified, as the question(s) were not previously asked. Similarly, information/resources given to carer(s) increased due to a more diverse range of needs were identified.
 - Improved documentation.
 - Increased communication within the Palliative Care team.
 - The importance of the multi-disciplinary team approach to assessment and care-planning was highlighted.
 - Staff sought further education/understanding of the standards and their correlation to the care delivered.
- 6. What measures demonstrated your project results?**
 - Data from monthly documentation audit.
- 7. What worked well to make the changes in practice?**
 - Supportive executive sponsorship with active participation and encouragement; no resistance to proposed changes.
 - Supportive organisation: accessing monthly patient records; formatting assessment forms in a timely manner; effective communication within a small team.
- 8. What were the challenges to changing practice and how did you overcome them?**
 - Staffing issues: no or minimal cover when annual leave taken. To overcome leave cover issues: a detailed handover was given to the locum social worker along with a guide to completing the form.
 - Completion of audits, etc became challenging as our organisation wide accreditation survey is in October, producing increased work levels. Executive prioritised endorsement of draft forms, changes and reprinting required.
 - Communication between project team members required clear planning and scheduling due to part time contracts and team members working on different days. Presentations and education to staff had to be

repeated many times to capture all staff in our team. Challenges were overcome with the staff being flexible and being willing to prioritise education sessions.

- Not every patient is able to identify or requires a carer due to the health status on admission. A thorough psycho-social assessment by the team identified a carer/s where appropriate and developed an action plan.

9. What sustainability strategies do you have in place?

- Include the audit in the unit yearly audit template/calendar; feedback results to team; celebrate positive results/relevance.
- Ongoing training and education; include in unit orientation.
- Update unit policies and procedures.
- Update unit documentation.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- The project reinforced the diverse roles of the palliative care team members and their individual value in contributing to the holistic approach to patient assessments and care planning.
- Educating team members and receiving feedback from them lead to valuable changes and positive outcomes.
- Keep on track with timelines and meeting dates.
- We are now more mindful of the diverse and changing needs of carers; things are far less assumed.
- Be proud of small accomplishments.
- The importance of advocating for leave cover.

11. In moving forward what are your next steps?

- Implement sustainability strategies as mentioned above.
- Plan and implement the next NSAP cycle.

Gold Coast Health Palliative Care Service

Author/s: Lois Lawler, Social Worker
Email contact: lois_lawler@health.qld.gov.au

Background:

- The Supportive and Palliative Care Service on the Gold Coast identified the need for quality improvement in the delivery of support for carers of palliative care patients in the self-assessment process in 2012.
- There was a lack of evidence for the kind of support that the Service was providing to carers of our patients.
- The key issue to be addressed was documentation of how the Service was supporting carers of patients and in the process, focusing on improving the care provided.

Aim:

- To improve documentation of frontline workers (nurses and social workers in the Palliative Care Unit) about how they were addressing the needs of carers of palliative care patients.

Changes Implemented:

- Formation of the Multidisciplinary Improvement Project Team (MDIPT) including consumer representatives.
- Introduction of a carer sticker to be completed on the nursing admission form.
- Introduction of carer specific information on the social worker psychosocial assessment template.
- Implementation of Carer Support Needs Assessment Tool (CSNAT) and process for use.
- Implementation of a carer consent form accompanying the CSNAT.
- The formulation of audit guidelines.

Results:

- Gradual improvement of documentation of assessment of carers and their needs evidenced by the audit results over time. This was a slow process which will continue beyond the life of the formal improvement project.

Challenges:

- The difficulty of engaging all key stakeholders due to competing demands and Hospital and Health Service restructure. This was allowed to play out in the fullness of time and needed patience and persistence of the project participants.
- Commitment of time needed to drive the project was underestimated by the project lead. Colleagues in the service were engaged to assist when needed.

Sustainability Strategies:

- Incorporation of new processes in the day to day work practices of coal face workers including ongoing in services to staff about these work practices and the importance of addressing the needs of carers.
- Continuation of regular audits and reporting back to senior leadership team and frontline staff.
- Explore the possibility of the continued use of the CSNAT tool.

Take Home Messages:

- The importance of having audit guidelines at the outset of the project.
- The value of including consumer representatives in quality improvement projects.
- The usefulness of making time to stop and reflect at regular phases of the quality improvement project.
- The importance of having change champions to continue to drive the project.
- The value of being part of a nation-wide project to enable the sharing of ideas and other service's wisdoms.

Goulburn Valley Hospice Care Service

Author/s: Annette Cudmore, Clinical Nurse Consultant

Email contact: annettec@hospice.shepparton.net.au

Background:

Goulburn Valley Hospice Care Service is a Level 2 stand-alone community-based palliative care service in regional Victoria. The Service participates in the Palliative Care Outcome Collaboration (PCOC) and has an electronic healthcare record Palcare. The Organisation completed Cycle 2 of the National Standards Assessment Program in June 2012 and is in the process of commencing Cycle 3.

Evidence Supporting Project Participation:

Two priority A ratings against Standard 3 “On-going and comprehensive assessment and care planning are undertaken to meet the needs and wishes of the patient, their caregiver’s and family” and Standard 5 “The primary caregiver’s is provided with information, support and guidance about their role according to their needs and wishes” were identified. These were:

1. Development and implementation of a carer assessment process that informs care planning and information provision.
2. Development and implementation of a ‘My Care Diary’ for the patient and carer.

The later priority was a suggested outcome from previous local carer research “Exploring information needs of family caregivers in rural community-based palliative care” completed in November 2012. The other evidence utilised to support the need for continued development of carer support was demonstrated in the January-June 2013 PCOC report. It was identified during cycle 2 peer mentor visit that the problem severity of carers was higher in the unstable and deteriorating phase (44.1-68.8% with moderate levels of distress), offering opportunity to increase carer support during phase changes.

Project Aims:

1. A concise audit tool and process is utilised to improve validity of monthly audit data.
2. A carer policy, that supports carer assessment and carer care planning, underpins the Organisation’s approach to meeting the needs of carers.
3. Carer needs will be assessed utilising the Carer Support Needs Assessment Tool as a guide.
4. The needs of carers, based on assessment, are documented in a carer care plan within the Palcare electronic healthcare record.
5. A workplace culture with carer needs assessment embedded as routine practice.

These aims were developed at the very beginning of the project, and retrospectively, do not clearly reflect where the project has ventured over the nine months.

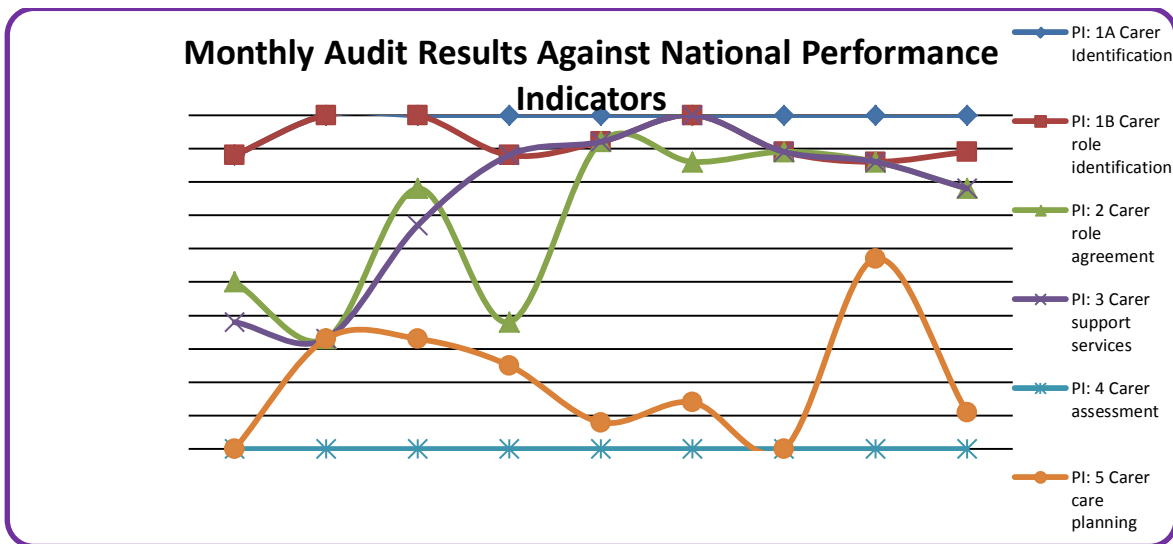
Quality Improvement utilising PDSA Cycles:

Three PDSA cycles were implemented with review of one twice following unsuccessful implementation outcomes. These included:

1. Development of a concise audit tool validated through a check audit process by the Quality & Risk Coordinator.
2. Development of a common process for documenting the needs of carers. This cycle remains an on-going quality improvement activity based on monthly audit results.
3. Introduction of carer assessment using the Carer Support Needs Assessment (CSNAT). This cycle is currently in its second pilot period with a focus on implementing a sustainable and on-going process. Evaluation of carer assessment will include carer feedback combined with routine evaluation methodologies.

Key Project Results:

Success criteria for this project were based on the five performance indicators for the National Project.



Goulburn Valley Hospice Care Service aimed to have an 80% achievement record against PI: 1A, 1B, 2 and 3, with a 40% achievement against PI: 4 and 5. Quality improvement activity against PI: 4 and 5 is now the main focus of activity.

Successes and Challenges/Barriers:

- Ability to have an inclusive project approach due to small workforce.
- Project inclusion in monthly Quality Improvement meetings.
- Improved staff awareness of the importance of carer needs and carer support.
- Access to comprehensive electronic record process that is inclusive of carer needs.
- Lack of staffing capacity to implement new processes, such as carer assessment.
- Consideration of the development of a new role-Family Support Worker.
- Implementation of carer information afternoons.
- Development and completion of 'My Caring Companion'. A specific booklet aimed at supporting carers and offering them general information about the physical, psychological and social aspects of caring, as well as a reflective journaling process.
- Development of a Trigger Discussion/Referral tool that compliments the CSNAT process.

Moving Forward: Continuing to sustain progress and improvement:

Completion of a pilot project based on utilising the Carer Support Needs Assessment tool to support carer care planning is underway. Evaluation of this will inform a sustainable process for a carer specific visit, inclusive of carer assessment and needs care planning. Auditing against the key PI will continue, although may be reduced to bi-monthly. Exploration of a carer specific support visit during unstable and deteriorating phases will also be explored.

Conclusion/Take-Home Message:

In conclusion, outcomes from this project have not been substantial, but awareness of carer needs has been heightened, with development of sustainable strategies to improve carer support being implemented. Our take-home messages may sound simple, but are worth on-going consideration:

- Don't make processes too complex.
- Involve everyone, including your carers.
- Measure outcomes-if processes are not making a positive difference to the carer then consider why you are doing them.
- Finally, this is about empowering carers to care at a very stressful time in their lives, always keep this in mind.

Melbourne City Mission Palliative Care

Author/s: Jeanne Chase Social Worker, Sally Brown Counsellor/ Quality Coordinator

Email contact: sbrown@mcm.org.au

Background:

Melbourne City Mission Palliative Care (MCMPC) is a community based organisation servicing clients who live in the Melbourne LGAs of Hume, Darebin, Moreland and Yarra. MCMPC uses a holistic approach to care, recognizing that the illness affects the whole person and their family/carers in many ways - spiritually, emotionally, socially and physically. With an interdisciplinary team of specialist nurses, counsellors, spiritual care workers, palliative care doctors, bereavement counsellors, trained volunteers and other allied health support, MCMPC provides a holistic rather than a medical model approach to care, which identifies and responds to the changing needs of clients and carers.

1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?

- Although we found that carers were being identified and assessed more routinely than in the past, there was still room for improvement.
- Documentation audits of the electronic client record system - PalCare – indicated that the carer screens (Family Profile, Complicated Bereavement Risk Assessment Tool and Genogram) were not being used as consistently as they should.

2. What were the key issues that you were trying to address in the project?

- Confusion around the terms and roles of 'caregivers' and 'next of kin'.
- For the team to have a clear and agreed understanding of the definition of the term 'carer'.
- Need to have standardised documentation.
- Need for written evidence as a mandatory Care Plan item.

3. What was the aim of your project?

- To initiate a conversation at assessment as to whom the client identifies as their caregiver, and what is understood about the role of caregiver and what it involves.
- To identify and link appropriate supports from this intervention.
- To document the discussion at assessment, and for this to be a mandatory Care Plan item.

4. What change(s) were implemented in your project using the PDSA cycles?

- Presented the project and its aims to the multidisciplinary team at the weekly client review meetings.
- Created a standardised definition of what a carer is; shared this with the team and encouraged them to use this term.
- Demonstrated documentation to be written in the Care Plan.
- Discussion with management and appropriate working party re additional mandatory Care Plan item.
- Education of new staff, and continuing discussions with current staff.
- Continuing review and discussion at monthly audit meetings.

5. What are the key results of your project?

- Now have Identification of Carer as a mandatory Care Plan item for all clients which includes discussion re caregivers role when appropriate.
- Clearer understanding of who the client has identified as their caregiver.
- Assisted with opening up the conversations for further discussion with the client and their family.
- Development of a good working definition of caregiver and their role.

6. What measures demonstrated your project results?

- 80% of client records include a care plan item that indicates a discussion has been held with the client, who has identified their caregiver and has had a discussion of what a caregivers role involves.
- Increased allied care involvement with the caregiver and increased referrals to support services.
- Anecdotal evidence that allied care counsellors and nursing staff had richer conversations, especially regarding Advance care Planning and linking clients and caregivers to support services in a timely manner.

7. What worked well to make the changes in practice?

- Having the mandatory Care Plan item and continued discussions at weekly client review meetings.
- All clinicians having a hard copy on the current task of how to question the client and carer, as well as the process of documentation.
- Written document on the definition of a caregiver for the purpose of this project for all staff.
- Support from the management team.
- Remaining in the scope of the project.
- Keeping the process simple and doable.

8. What were the challenges to changing practice and how did you overcome them?

- Diminishing project team due to staff resignations, workload and time constraints.
- Standard analysis of data between team members.
- Maintaining staff enthusiasm in the face of conflicting work load issues.

9. What sustainability strategies do you have in place?

- Mandatory Care Plan item.
- Incorporated into allied care and nursing protocols.
- Development of consistent approach to documentation.
- Weekly discussion re client identified caregiver at client review
- Change of mindset on assumption re next of kin as caregiver.
- Include this element in future documentation audits.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- Encourage more ownership of project by organisation and staff.
- Keep it simple and manageable! Keep the higher outcome in sight.
- The smaller the change . . . the more sustainable.
- Feedback, feedback, feedback.

11. In moving forward what are your next steps?

- To identify a team or individual to keep the issues for caregivers on the agenda.
- Formalise discussion at weekly client review.

Mercy Health Community Palliative Care

Author/s: Deanne Layton, Clinical Nurse Consultant – Education and Quality

Email contact: dlayton@mercy.com.au

- 1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?**
 - Carers were not receiving a holistic assessment.
 - There was little evidence that carers were receiving information about their role.
- 2. What were the key issues that you were trying to address in the project?**
 - The key issue identified was the lack of a formal assessment of the carer by an Allied Health Professional
- 3. What was the aim of your project?**
 - To identify carers.
 - To implement a model where all carers receive a needs assessment and have a documented plan of care.
- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - Initial project audit – no real evidence of carer assessment and identification of carer.
 - Project discussion at staff meeting and identification of carer as opposed to NOK. Initial assessment form altered to reflect this.
 - Meeting with Allied Health team and Manager of Volunteers to discuss development of a carer assessment tool.
 - Tool developed and reviewed by the team – changes to content and format.
 - Established process of allocation of carer support phone calls and process for documentation.
 - Slight changes to form and process to avoid calls being repeated when Allied Health involved.
 - Identified situation where no carers exist and education by Allied Health staff at team meetings re differences between EPOA and NOK and carer.
 - Review of process of which member of the Allied Health team make the calls to carers to identify the most appropriate team member.
- 5. What are the key results of your project?**
 - Improved identification of carers.
 - Improved assessment of carers and their need.
 - Documented plan of action for carers.
- 6. What measures demonstrated your project results?**
 - Improvements in identification of carers in audits of 20 histories measure increased from 20% to 70% in Jan 2014.
 - Improvements in the carers receiving a needs assessment overall looking at each of the domains.
 - Improvement in documented plan of actions for carers from 5% to 70%.
- 7. What worked well to make the changes in practice?**
 - Engaging the staff in the process and using them as a resource to develop the assessment tool.
 - Continuing the sharing of the results and information provided during the project.
- 8. What were the challenges to changing practice and how did you overcome them?**
 - Encouraging the staff to realise this is an important part of their job and valued.
 - Time management – trialled multiple models of allocating the calls to the team until most appropriate model was established.
- 9. What sustainability strategies do you have in place?**
 - All carers are contacted two weeks after admission to the service.
 - Allocation of staff member to complete the calls and time scheduled to do this.
 - Discussion at weekly referral meeting to avoid duplication of calls to carers.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- Small changes can lead to big improvements.
- Engage the staff in change will lead to sustainability.

11. In moving forward what are your next steps?

- Continue to audit for ongoing sustainability.
- Identify areas of assessment which require further work to improve ie spiritual and cultural components.

Mercy Health Hospital Palliative Care Service

Author/s: Leanne Mackay, Associate Nurse Unit Manager

Email contact: lmackay@mercy.com.au

- 1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?**
 - The self assessment process identified whilst patients were being assessed this was not the case for carers.
- 2. What were the key issues that you were trying to address in the project?**
 - There was not a consistent approach to address the need for carers and how the carer assessment was attended so staff did not always know what to do. This resulted in carers needs being missed.
- 3. What was the aim of your project?**
 - All patients will have an identified carer.
 - All carers will have a need assessment completed and a documented plan of care.
- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - An existing form was used with another column added for the assessment of carers.
 - Initially the form was trialled by nurses admitting patients on the unit for one week.
 - Position of the form in the folder to improve compliance.
 - Discussion with staff re barriers to completing a holistic assessment.
 - Meeting with Social Work to discuss effect on workload – continued monitoring.
 - Review of form and layout is continuing.
- 5. What are the key results of your project?**
 - Increased identification of need for referral of carer to social work.
 - Increased contact from social work for carers.
- 6. What measures demonstrated your project results?**
 - Audit of completed carer assessments-Identification of the Carer improved from 31% to 69% since implementation of the audit tool.
 - Regular audits were carried out to assess the impact of the tool on the use of allied health services.
 - Review of the impact on the number of social work referrals. Social work referrals increased from 18% to 82%.
- 7. What worked well to make the changes in practice?**
 - Ongoing encouragement and education.
 - Engaging the staff in the change process by asking for their feedback and making changes accordingly.
- 8. What were the challenges to changing practice and how did you overcome them?**
 - During the process ensuring staff adherence to completing the tool proved to be challenging, however with regular education on the tool and encouragement from clinical leadership, staff compliance has improved. Feedback was also provided at the team meeting.
- 9. What sustainability strategies do you have in place?**
 - Encouragement from not only leadership, but, also colleagues.
 - Ongoing education and including this in the orientation of new staff.
 - Ensuring that resources are available to provide carers with support eg present statistics for increased social work time in the palliative care unit.
 - Regular feedback in the ward meeting.
- 10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?**
 - After being a part of this project the emphasis on a holistic approach is paramount, when assessing not only the Patient but also the Carer.

11. In moving forward what are your next steps?

- To work towards ensuring that adequate resources remain available so the identification of carer needs and the implementation of support for carers continue.
- Results will be presented at the staff meeting and possibly the program meeting for subacute services.

Mercy Health Mackay Mater Hospital

Author/s: Catherine Chamberlain, Nurse Unit Manager & Dorothy Oates, Enrolled Nurse

Email contact: cchamberlain@mercyqcq.com

- 1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?**
 - Two years ago when we undertook the NSAP self assessment survey it revealed a lack of support for carers. As a palliative care unit it's important to give our patients the best care possible. As the NSAP self assessment results have shown, care for the carer has been lacking so by taking part in this project we are expecting to improve our support for carers.

- 2. What were the key issues that you were trying to address in the project?**
 - The key issues that we were trying to address were to support Standard 5 of the national palliative care standards for providing quality palliative care for all Australians. This Standard states that "The primary caregiver/s is provided with information, support, and guidance about their role according to their needs and wishes". It was our hope that by implementing a revised and improved carers assessment tool we would provide this care.

- 3. What was the aim of your project?**
 - There were three main aims to our project. The first aim was to identify a carer of all patients. The second aim was then to have evidence that a health professional had discussed the caring role with the patient and their carer and thirdly we aimed to have a needs assessment completed so we could put in place an action plan to support the carers.

- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - We already had a carers assessment tool but although it identified the primary carer it did not ask the questions we needed answers to for the project so we put together a PDSA to try to achieve the identity of the carer and that the patient and the carer both understood and agreed to the role. It was suggested that the information be documented in the patients progress notes on admission. This was only moderately successful so we made another PDSA where we made changes to the carers assessment tool by putting in some tick boxes to show we had obtained the information. This was more successful. We then realised there were a few new staff coming on board so we did another PDSA where we made sure new staff were educated about our project and to ensure the continuation of data collection.

- 5. What are the key results of your project?**
 - The key results of our project so far is that we have a better carers assessment tool. We are able to gather the relevant information from the patient and carer easily on admission which tells us immediately what we need to know. If there is any problem we are able to refer to the carers assessment tool and find the information we need making it easier to address the issue.

- 6. What measures demonstrated your project results?**
 - By reviewing our data used for the project we are able to identify where we've been able to improve our identification of the needs of the carer. More completed carers assessment tools are also an indicator of the staff making a more concerted attempt to gather the information.

- 7. What worked well to make the changes in practice?**
 - Educating the staff about the need to show to the carer helped with the changes. A good explanation of the carer support assessment tool encouraged the staff to ensure the tool was filled out completely and making small changes to the tool made the gathering of information easier as well as easier to access when needed as it was all in one place.

- 8. What were the challenges to changing practice and how did you overcome them?**
 - Motivating the staff has been very difficult. Trying to get the message across to the staff that this was important wasn't easy. We brought it up at staff meetings, mentioned it in the communication book, put the carers assessment tool in the admission package so it was hard to ignore and even put reminder posters up on the wall in the handover room so it was always in their face.

9. What sustainability strategies do you have in place?

- Having a carers assessment form that the carer and patient fill out on admission is part of our sustainability strategy.
- Ongoing education to staff regarding the importance of obtaining this information and making new staff aware of the need for carer information.
- We continue to press the staff to make every effort to obtain the carer information on admission. When this is not done it tends to get put on the back burner and sometimes is never obtained.
- We have added extra tick boxes to the carers assessment form that asks the question about the carers role and whether the nursing staff have discussed the role with the patient and the carer. This is a very effective method of obtaining the information.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- The take home message seems to be that although changes have been implemented there is an ongoing need to review the changes to ensure they are still working and to continue to encourage the people involved in collecting data to keep collecting. There is a tendency to ignore it if not reminded regularly.
- Ongoing assessment of data collected is important to ensure that we continue to ask the questions and document in the appropriate place so that the information is easy to access when required and that the correct information has been gathered. At the end of the day if the project is going to be successful we need to keep reminding the staff, asking the questions of the patients and carers and above all never give up.

11. In moving forward what are your next steps?

- At this stage we are still only managing small changes towards our assessment of the carers needs and our ability to support them in their role. We are trying to hand out carers packages with information relevant to their needs but at the end of the day we're still not quite achieving full compliance with the palliative care standard that states "The primary caregiver is provided with information, support and guidance about their role according to their needs and wishes". This is a work in progress that will require continual effort to keep us on track.

Midwest Regional Palliative Care Service

Author/s: Robyn Ellis, Clinical Nurse Coordinator & Kris Dwyer, Social Worker

Email contact: Robyn.Ellis@health.wa.gov.au

1. What evidence was used in your NSAP self-assessment that identified support for carers as an area for improvement?

- A number of patients had identified a next of kin on documentation not necessarily as the carer. This person may not have been their recognised carer and no assessment of supports for this carer was undertaken.

2. What were the key issues that you were trying to address in the project?

- Formal admission of Carers is absent from patient admission process (including consent from carers for service involvement).
- Formal assessment of Carers Needs does not currently occur.
- Care planning for support to carers is not currently documented.
- Improved collaborative practice with other health and welfare services is required to better support carers.

3. What was the aim of your project?

- 80% of patient records with evidence that the patient had identified their carer(s) and the carers' role.
- 80% of records with evidence that a health care professional had discussed the caring role with the carer(s) and that the carer(s) had agreed to the role.
- 80% of records with evidence that the carer(s) was aware of palliative care and other services and resources that is available to support their role.

4. What changes were implemented in your project using the PDSA cycle

- Trial of a new patient admission form identifying each patient's carer and the carer's role.
- Trial of a new carer admission form, independently admitting the carer to our service and assessing their needs.
- Introduction of a carer consent form.
- Trial of Carers Care Plan documentation to formally identify individual carer's needs and to develop a plan of support to best meet these need.
- License approval for the Carer Support Needs Assessment Tool (CSNAT).

5. What are the key results of your project?

- 89% of patients identified their carer (s).
- 71% of patients identified the carer's role.
- 67% of carers have discussed the caring role with a health care professional and have agreed to the role.
- 84% of carers who were aware of services and resources to support their caring role.
- 24% of carers with a recorded assessment of their identified needs (CSNAT introduced Nov).

6. What measures demonstrated your project results?

Base line audit from May 2013 – February 2014 focusing on identified KPIs:

1. Number of records with evidence that the carer(s) is aware of palliative care and other services and resources that are available to support their role.
2. Number of patient records demonstrating assessment of the carer(s) needs?
3. Number of records with evidence that the carer(s) is aware of palliative care and other services and resources that are available to support their role.
4. Number of patient records demonstrating assessment of the carer(s) needs?

7. What worked well to make the changes in practice?

- Close collaboration between Midwest and South West Palliative Care Teams.
- Being a direct care service enabled direct implementation of new documentation and assessment processes for patients and their carer(s).
- Realisation that the NOK is not necessarily the carer.
- Development and implementation of carer admission forms separate from patient admission forms.
- Introduction of the CSNAT Tool as a clear and simple means of assessing carer need.
- Distinct care planning for carers post CSNAT assessment.

8. What were the challenges to changing practice and how did you overcome them?

Challenges

- Staff acceptance of change in admission documentation and practice processes.
- Restricted participation at the initial workshop with one attendance from the Care Plan Project team. This initially made the scope and vision of the project difficult to relay to other team members.
- Electronic recording of patient and carer documentation was erratic which resulted in some auditing difficulties.
- Fluctuating work load and staffing pressures.

Solutions

- Ongoing education and mentoring.
- The Care Plan project remained a standard agenda item on team meetings and education sessions.
- Regular communication and collaboration with the South West Palliative Care team.
- Support from senior management for second person to attend the second NSAP workshop.
- Auditing processes reviewed both electronic and hard copy patient records.
- Identifying a team key coordinator for each new admission process.

9. What sustainability strategies do you have in place?

- NSAP Carers Project to remain an integral part of the Midwest & Southwest trial documentation project through ongoing NSAP self-assessment processes prioritising the role of carers in our service (Palliative Care Standard 5).
- Continued targeted use of existing team based and external resources to support carers through more thorough assessment, care planning and referral processes (using recently developed tools and documentation processes).
- Carer initiatives to become a standing item at team meetings, education sessions and executive briefings.

10. What is your take home message (something that you have learnt as being part of this collaborative project?)

- An identified NOK is not the same as an identified carer(s).
- An informal carer does not necessarily equate with the willingness of a carer to formally assume the caring role in its entirety.
- Ongoing support to carers is key to holistic patient care in a Palliative Care Setting.
- Assumptions about a carers needs is not the same as specifically assessed need using formal assessment tools (CSNAT) and practices.

11. In moving forward what are your steps?

- Trial of patient/carer documentation project to continue within the Midwest & Southwest Palliative Care Services with a view to formally assessing the effectiveness of this documentation in April 2014.
- Ongoing work towards WA state wide formal implementation of patient/carer documentation in Palliative Care Services.
- Formal State Wide licencing of CSNAT tool.
- Ongoing education within the Midwest region about formal identification, assessment and support to carers.

Portland District Health: Community Palliative Care Service

Author/s: JoAnna Spurge, Nursing Unit Manager & Clinical Nurse Consultant,
Nicole Evans, Clinical Nurse Consultant

Email contact: JMSpurge.PDH@swarh.vic.gov.au, NMEvans.PDH@swarh.vic.gov.au

- 1. What evidence was used in your NSAP self-assessment that identified Support for Carers as an area for improvement?**
 - National Standards Assessment Program (NSAP) cycle 2 highlighted we were not adequately meeting standards 1, 3, 5 & 8 with regard to support for caregivers. Although often it was determined carers were supported in an ad hoc and informal way there was little evidence available to determine consistency and assessment of all assessment determinants. We also determined we were not utilising of care plans.
 - The Clinical Practice Guidelines for the Psychosocial and Bereavement Support of Family Caregivers of Palliative Care Patients standards 7 and 8 and the National Standards 11 and 12 indicated need to improve caregiver assessment and care planning.

- 2. What were the key issues that you were trying to address in the project?**
 - There were inadequacies in our Patient Electronic Record Management (PERM) in capturing and reporting data on carer identification and role, and the caregiver assessment determinants for performance measure P4 (psychological, physical, social, spiritual, cultural, financial, death preparation, bereavement).

- 3. What was the aim of your project?**
 - To have all caregivers complete an assessment within 14 days of admission.

- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - Sought and reviewed three different caregiver assessment tools (C-NAT, NAT-C & CSNAT) for their capability to address all eight determinants in caregiver assessment.
 - We determined the CSNAT was the most appropriate tool covering more domains than the other two tools reviewed.
 - The CSNAT was trialled by offering the tool to all current client caregivers to complete.
 - Audits evidenced that the tool worked well with implementation to follow.
 - Nurses educated on how to deliver the CSNAT to caregivers. CSNAT given to all caregivers with 14 days of admission and collected within 14 days.
 - Audit of the Bereavement Risk Assessment Tool showed inconsistent use.
 - Bereavement Risk Assessment Tool completed on admission.
 - Reviewed our service admission checklist; added carer support information.

- 5. What are the key results of your project?**
 - All caregivers are identified and their role is determined.
 - All caregivers complete a CSNAT within 14 days of admission.
 - Inclusion of CSNAT on PERM.

- 6. What measures demonstrated your project results?**
 - May 2013 100% caregivers were identified. While submitting June's data we identified that we were in fact discussing the caring role and that the carer has agreed to this role and that we were documenting it. In September we reviewed PERM data and discovered social needs were addressed and documented. In September to December we audited the three assessment tools and trialled the CSNAT and in January 100% of our clients evidence records audited evidenced an assessment of caregivers needs using all 8 determinants (P4). In December we also implemented consistent use of the bereavement assessment tool (BRAT), again discovering that PERM does address assessment of the caregiver's financial needs.
 - PERM captures caregiver status and role.

- 7. What worked well to make the changes in practice?**
 - Keeping the project within the domain of community palliative care.
 - The CPC team has 2 dedicated members who both shared the same vision.
 - Having a small team enabled weekly discussion optimising communication and focus.
 - Monthly team meetings with the executive sponsor coinciding with data submissions.

- Monthly meetings with Acute and Sub-Acute NUMs kept them up to date with project progress. It is expected that the CSNAT will be implemented into inpatient palliative care in 2015.

8. What were the challenges to changing practice and how did you overcome them?

- Challenges included executive level staff changes and need to familiarise new staff with project purpose, part time work status of team members, annual leave, sick leave, work load, time constraints and availability.

9. What sustainability strategies do you have in place?

- Monthly auditing of caregiver identification, role and support needs comprehensive assessment aligning with P4.
- Inclusion of CSNAT and BRAT as part of admission procedure.
- Future NSAP cycles provide opportunity to review evidence in meeting standards specific to caregiver identification, role, assessment, and support provision.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- Keep it simple.
- Utilise PDSA cycles, aim for small achievements.
- Involve management and other relevant departments- seek champions.
- Feedback regularly.
- Celebrate small achievements.

11. In moving forward what are your next steps?

- Continue to follow up and liaise with PERM software developers regarding incorporation of the CSNAT into PERM.
- Caregiver care plan to be considered as a further addition to the PERM program.
- Develop supporting policy.

Rockhampton Hospital Cancer & Specialist Palliative Care Service

Author/s: Roslyn Belz

Email contact: Roslyn.Belz@health.qld.gov.au

Brief introduction of our Service:

- 10 bed Specialist Palliative Care Inpatient Unit.
- 7 day/wk (0700-1530) Palliative Care Community Liaison Service.
- 6 chair Day Therapy Unit (Mon – Fri).
- Supportive Clinics- Haematology, Medical Oncology, Specialist Palliative Care & Radiation Oncology.
- Formal linkages & consultations to Chronic Disease Program, Residential Aged Care Facilities, Rural Hospitals, Hospital inpatients, GP's & Community agencies.
- Model of Care remains an Integrated Service Model – Cancer & Specialist Palliative Care.
- Point of entry into Service can be via clinic, inpatient admission or community visit. Palliative care patients – under one Specialist Palliative Care Consultant & MDT, one hospital UR chart/patient medical record.
- Signed up with NSAP mid 2012 - started Cycle 1 September 2012.
- Reported results back in January 2013. [Got there in the end!]
- Started work to formulate a MDT 1st Assessment Form to be used on all new patients into service.

1. Evidence from NSAP self assessment that identified improvement for Support for Carers was needed

Two Key areas were highlighted from Unit Record (UR) chart audits & general discussions:

- Information sought was being recorded in many areas of patient UR chart & community notes. As a 'whole service', we were actually identifying carers & other patient information at a high percentage. However, this information had to be searched for (involving reading not only current admission notes, but also clinic reviews, community notes as well as previous admission notes), which was obviously time consuming & not beneficial.
- Information that was recorded generally identified the carer, but did not reflect the carers needs – appeared questions were often asked, but not always recorded.

2. Key issues to address

- Assessment of Carer/s needs is where we failed – almost never achieved all 8 criteria (as per project).
- Needed more clear & structured documentation to capture both patient & carer information – needed to be easily identifiable regardless of ongoing points of contact within the Service.

3. Aim of project

- To develop a 'fluid' patient assessment form to be utilised by all members of the MDT within our Service.
- To include the 8 criteria required for carers assessment into this new MDT 1st Assessment Form.
- To ensure that the 8 criteria are included to have a more comprehensive assessment & planning for carers needs.
- To assist in identifying any potential problems before they occur & make appropriate referrals as indicated.

4. Changes implemented using the PDSA cycle

2 main changes we have been working on using PDSA cycles:

- Development of a Specialist Palliative Care Baseline Assessment Tool for patients, to incorporate not only desired information about our patients, but also include assessment of their designated carer. Decision to 'add to' what was already being developed rather than doing something completely separate for the carers.
- Included 'refinement' of a Patient Folder already in use – to include specific information & resources for carers.

5. Key results from project

Use of the Baseline Assessment Tool has 'rolled out' since January 2014, & audits are now showing a noticeable improvement in % of patient records with evidence of assessment of carer's needs:

- Information addressing all 8 carers criteria is documented on the Baseline Assessment form.
- The Baseline Assessment form is kept in a plastic sleeve, placed into the Palliative Care section of UR chart. This is now easily identifiable & accessible for all staff, regardless of where the point of contact within the Service is happening. (The Community have a copy of this form with the patient's community notes.)
- Carers risk factors are identified & relevant introduction/referral to other supports is able to be actioned earlier.

6. Demonstration of projects results

- The Specialist Palliative Care Baseline Assessment Tool has been developed & introduced. Has involved input from MDT members, & initial trialling of completing this form by staff when seeing patients & their carers in the clinic & community settings.
- Auditing of form use shows increasing compliance for completion.
- The 8 criteria of the carer's assessment are easily identifiable.

7. What worked well to change practice

- We were already formulating a MDT form as part of initial NSAP self assessment, so it was easy to add the carers project to this... why invent yet another assessment tool!
- The clinic & community nurses were very accommodating & felt comfortable in asking carers the required information during consults.
- Community staff have now taken on the 'ownership' of the MDT form & keep it updated. They attend beside consults with inpatients prior to discharge & update the form during this discussion. They also update the form as required when attending home visits.

8. Challenges to changing practice

- A lot of changes have already been ongoing due to 'redevelopment' at the Rockhampton Hospital, which involves the facilities & set up of our service, therefore our aim was to keep things as simple as possible.
- We needed to look at the role of MDT staff. Staff concern re an increase to their already very busy workloads, but we needed someone to take 'ownership' for the form, otherwise completion of the form probably would not happen (recognising not always done in 'one sitting', plus need to indicate changes).
- Community nursing staff agreed to accept ownership for the form & change their work practice - now joining the morning bedside handover, & 'catches up' with patients &/ carers prior to discharge & completes/ updates the form.
- Housing of the form - our Medical Records Dpt was agreeable for the form to be housed in a plastic sleeve behind the Palliative Care divider in the UR chart.
- Staff usage of the form – the form has been shown at 2 ward meetings. Inpatient staff feedback so far has been positive. They find the form easy to find, easy to read, good content of information & like that they are not responsible to update it!

9. Sustainability Strategies

- Monthly audits of UR charts for evidence of initial completion of form & that it is being updated as required.
- To incorporate use of the form as part of both the inpatient & community MDT meetings.
- Review of the content & format of the form at NSAP meetings. Make changes as required.
- Include information re the form in the Medical & Nursing Orientation folders & the Services' Standard Operating Procedures.

10. Take home message from project

- Never assume carer is the NOK.
- Keep things simple. Look at what you already have & what you are already doing. You may only need some small adjustments to forms & processes to have a big effect.
- Have input from all the staff, not just the NSAP team. Floor staff will certainly let you know if something won't work & not sustainable.

11. What next????

- Peer Mentor visit, & ensuring readiness for our move into Bigger, Better, Brighter Facilities

Royal Children's Hospital, Paediatric Palliative Care Service

Author/s: Lee-anne Pedersen, Nurse Practitioner – Paediatric palliative care service

Email contact: Lee-anne.Pedersen@health.qld.gov.au

1. Evidence used

The Paediatric Palliative Care Service (PPCS) summary sheets of new admissions to the service were evaluated at the end of each month and showed there were gaps in the identification of the carer.

2. Key issues

Needing more accurate identification of the child's carer for a variety of reasons including: providing appropriate support to the right person/ people, privacy and legal issues i.e. Department of child safety, custody orders, assist accurate bereavement follow up with various surnames, addresses and key people.

3. Aim

To clearly identify the carer and have that information documented in the assessment sheet and medical records as appropriate, ensure appropriate information to carers identified and ensure standard resources provided – and same documented.

4. Changes through PDSA cycles

- Exploration of how parent / carer information is populated to initial admission sheet in medical notes, understanding that this was a very informal process and that the information there was not always 100% accurate for the purpose of providing palliative care.
- Additional prompts to assessment sheet to record legal carer details, correct surnames of divorces parents etc, identify who is legal guardian.
- Prompt to identify any other significant decision makers who should be included into the family/ child discussions with PPCS e.g. matriarch of Maori family unit, tribal elder etc.
- Additional prompts about specific carer needs – post natal care, mental health plan, vaccination needs.
- Discussion with the Multi disciplinary team regarding the value of correctly identifying and documenting carers details.

5. Key results

- The changes to the assessment sheet has led to more accurate identification and follow up for the 'correct' people needed in the palliative care context.
- Inclusion of prompted documentation (as tick boxes on summary sheet) to recognise when additional supports for a particular family acknowledged and demonstrates attention to specific needs of a family or individual involved in the care of the child i.e. post natal care – dates and times of clinic can be records, a good reason to connect with local GP etc.

6. Measures

- Ongoing audits of the PPCS summary sheets to ensure ongoing consistency with practice and documentation changes.

7. What worked well?

- Multidisciplinary team (MDT) discussions generated valid issues
- Visual PDSA cycles (cut out and put on the walls)
- Assistance by administration staff to reset format of assessment sheet.

8. What were the challenges?

- Newer members of the team not understanding the role of NSAP, the standards and how this created quality improvement. MDT discussion assisted as well as including this concepts in the team orientation package given to incoming members.
- Support from the social work team to progress project further. Used some time of the social worker student and also piggybacked into social work project already being established.

9. Sustainable strategies:

- Standards addressed at staff orientation to the service.
- Permanent changes to prompts in assessment sheet.
- Audit allocation each 3 months (working with quality person).

10. Take home message?

- The value of being part of a larger project is very motivating.
- Change and all of the challenges is better done as a group and there needs to be 'by in' from the necessary people to make it sustainable.

11. Moving forward?

- To be sure that future project participation is carefully considered – who will be key lead, resource allocation and value added to service at that point of time.
- Look forward to next self assessing with NSAP process against the national palliative care standards.

Sacred Heart Supportive and Palliative Care Service

Author/s: Kate Weyman, Clinical Nurse Consultant & Sandra Sullivan, Clinical Nurse Consultant

Email contact: kweyman@stvincents.com.au , ssullivan2@stvincents.com.au

- 1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?**
 - Monthly audits of electronic medical record (EMR) for community patients.
 - Brain storming session with project team.
- 2. What were the key issues that you were trying to address in the project?**
 - All patients are asked to identify if they have a carer, and if more than one, who is the main carer.
 - A health professional will discuss with all carers the caring role and whether they agree to be the patient's carer.
 - All carers will be offered a needs assessment.
- 3. What was the aim of your project?**
 - 80% of all patients referred to SHSPC community team will have documented evidence of a primary carer, or lack thereof including evidence of discussion related to their caring role.
- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - Development of an audit tool to ensure consistency in auditing by different project team members.
 - Identifying barriers to carer information.
 - Determining strategies to assess carer needs.
 - Identification of carer assessment forms currently in use cross LHN.
 - Development of guidelines for use of Carer Assessment Form.
 - Trial of Carer Assessment Form.
 - Modification of carer assessment tool to suit the needs of a community palliative care team (comments from team members, brain storming & comments from project team members).
 - Development of a process for scanning and uploading tool to the EMR for easy access for the whole multidisciplinary team.
 - Audit of completed Carer Assessment Forms to inform modification of the assessment form and education to the community team.
- 5. What are the key results of your project?**
 - Improved documentation of carer needs following the introduction of a structured Carer Assessment Form, however to date the project deliverables have not been met.
 - Table 1 shows raw data of the percentage of eligible referrals with a completed Carer Assessment Form.

					Implementation of carer form							
	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Carer Form					8	18	9	13	11			
New referrals in scope for project	39	38	43	36	56	41	46	30	37			
Percentage					14.20%	44%	19.50%	43.30%	30%			

Table 1

- 6. What measures demonstrated your project results?**
 - Monthly audits of carer documentation in the EMR.
 - Evaluation of completed Carer Assessment Form.
- 7. What worked well to make the changes in practice?**
 - CNC Community liaising with the community team nurses to initiate and complete the Carer Assessment Form.
 - Engagement from key team members (not on project team) in uptake and use of the form.

8. What were the challenges to changing practice and how did you overcome them?

- Although assessment of carers was seen as important, implementation of a new assessment form was attempted during a time of change for the team and for the service as a whole. The service changes resulted in major disruptions to the project team. New members were recruited to the team.
- Engaging team to prioritise formal assessment of the carer within the time constraints of a multidisciplinary home visit. This remained a challenge throughout the project.
- Resistance to having another 'form' to complete. This improved during the project with support of the project team. Feedback from the community team was encouraged and suggested changes to the Carer Assessment Form were implemented.
- There was inconsistent use of the assessment form by team members.
- Agreement on ideal timing to complete the assessment form- often not appropriate on first visits. This was addressed by consultation with the community team and reaching agreement the assessment form could be completed within the first 2 weeks of an initial assessment.

9. What sustainability strategies do you have in place?

- Integrating carer questions (identification of carer) into an initial assessment tool as suggested by community team.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- It is hard to maintain the enthusiasm from a workshop environment with like-minded people when back in the workplace where the project is impacted by major service and staffing changes.
- Don't assume everyone will understand the purpose of the project. Regular feedback to the key stakeholders is essential to get buy in. Structured education prior to the implementation of any new process enables consistency in use and application of tools.
- Recruit a project team who are enthusiastic and available to participate for the duration of the project.
- The Project team members have clear role delineation and responsibilities.

11. In moving forward what are your next steps?

- Analyse results from the project and present to the community team and service managers.
- Implement sustainability initiative.

St John of God Murdoch Community Hospice

Author/s: Sheelagh Purdie, Clinical Nurse Specialist & Glenys Joplin, Operations Manager

Email contact: sheelagh.purdie@sjog.org.au, glenys.joplin@sjog.org.au

1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?

Through auditing the current admission documentation used within the Hospice against the Clinical Practice Guidelines for the Psychological and Bereavement Support of Family Caregivers of Palliative Care Patients (2010), it was identified that Support for Carers was an area that required improvement. NSAP Self-Assessment also identified that carer support was an area for improvement.

2. What were the key issues that you were trying to address in the project?

Two key issues were addressed within our project. To ensure that the patient's nominated main carer was identified and that those carers who received support from others was also documented (often the **nominated** main carer was not the person undertaking the main caring role and support from other family members was significant to the degree that the identified main carer would not have been able to continue in that role without the additional support)

3. What was the aim of your project?

Our aims were to identify and record the details of every in-patients nominated main carer and, to assess and record the carer's needs within the current documentation.

4. What change(s) were implemented in your project using the PDSA cycles?

PDSA improvement cycles were carried out within the first 4 months of the project. Changes were made to the documentation and the Carers Support Needs Assessment Tool (CSNAT) tool was introduced. Staff training was provided and data continued to be collected.

5. What are the key results of your project?

February 2014, 90% of in-patients had identified their main carer. The CSNAT tool is currently being used within the admission documentation and its use will continue to be monitored.

6. What measures demonstrated your project results?

Each month, 20 in-patients records were audited for the required criteria which demonstrated our projects results and all CSNAT tools were reviewed by the multi-disciplinary team and actioned by the most appropriate member of that team.

7. What worked well to make the changes in practice?

PDSA cycles were used continually throughout the project.

8. What were the challenges to changing practice and how did you overcome them?

The challenges included staff, carer and patient participation, adherence to the new documentation, data collection for patients with no main carer and overall data collection. These challenges were overcome by perseverance, motivation to continue with PDSA improvement cycles as well as informing those involved of results and improved percentages.

9. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

Our take home messages from this project are: PDSA improvement cycles are an extremely useful and quick way to implement change without being over-complicated and easy to complete and by implementing one change can often highlight other related quality improvements that can be implemented at a future time.

10. In moving forward what are your next steps?

In moving forward, our next step is to continue using the CSNAT tool within the current in-patient documentation with a plan to improve rates of carer participation as well as increasing involvement from other members of the multi-disciplinary team in its use.

St John of God Subiaco Palliative Care

Author/s: Louise Angus, Clinical Nurse Consultant & Sunette Odendal, Clinical Nurse

Email contact: Louise.Angus@sjog.org.au/sunette.odendal@sjog.org.au

Background:

We are based at St John of God Hospital Subiaco and are part of the Consultative Palliative Care team. Our team consist of a 2x Palliative Care Consultants, Clinical Nurse Consultant, Clinical Nurse, and 1x RMO. The Multidisciplinary team (MDT) consists of Pharmacist, Ward rep, OT, Physiotherapist, CM, Social worker, Dietician, Clinical Psych, Pastoral Care.

1. What evidence was used that identified Support for Carers as an area of improvement?

- 2nd NSAP self-assessment indicated Standard 5 gaps for the carer needs.
- Patient notes, repeat admissions due to lack of community support.
- No dedicated discussion to address the carer or the carer's needs at MDT meeting.

2. Key issues we were trying to address in the project

- Identifying carer as early as possible.
- Have a standard approach across the hospital to address the carer's needs.
- Ensure that all carers of PC patients with a pending discharge have a documented plan.
- Discharge is not actioned until the carer's needs are address.

3. The aim of our project was

- All patients will identify a carer.
- All carers will discuss their specific needs with the palliative care team.
- All carers will have a documented plan of action.

4. What change(s) were implemented?

- Initial assessment by Palliative Care team included identification of carer.
- The carer's name would clearly be documented in patient record.
- A carer needs discussed and documented at the meeting.
- Family meeting for each patient.
- Family meeting outcomes documented clearly in notes.
- Commenced CSNAT.

5. The key results of the project

- Carer were identified and their needs discussed/assessed routinely on admissions.
- An action plan was formulated where required and followed up on repeat admissions and documented by Case Management and Social Work.
- The role and impact on the carer discussed.
- Improved documentation and communication.
- Realistic time frames set for discharge.

6. What measures demonstrated the project results?

- Audit of patient notes and using the data collected regarding the patients carer's needs on a monthly basis showed either an improvement in the areas addressed or where we needed to focus on more.

7. What worked well to make the changes in practice?

- Weekly MDT meetings – involving MDT in project goals (Social worker and Case Manager).
- Support from medical team.
- Support from Executive.
- Individual MDT documentation – highlighted gaps/needs of carer and plan for support.
- Communicating strategic plan for overall improvement.

8. Challenges to changing practice and how did we overcome them?

- Patient perception doesn't always reflect actual circumstance.
- Demands for Patient beds (push to get patient out).
- Time constraints with competing responsibilities.

- Keeping the enthusiasm.
- Boundaries blurred regarding the role of Palliative Care.

9. What sustainable strategies have you put in place?

- Involve carer at point of referral to Palliative Care. Phone to organise family meeting or at initial assessment establish acceptance of role.
- Continue with weekly MDT meetings and record attendance, document appropriate MDT member referral
- Clear and thorough documentation of communication with carer/s, regarding needs identified and action plans.
- Ongoing CSNAT – awaiting approval to use the same assessment tool used by Silver Chain Hospice Care Service (SCHCS). Aim to have same State/National wide standard in assessing the carer’s needs.

10. What is your take home message from something that you have learnt as being part of this project?

- The importance of keeping on track with action plans and meeting dates.
- Clear documentation and communication of the carer/s needs.
- Acknowledge and being mindful of changing needs of carers; and adjusting your action plans accordingly

11. In moving forward our next steps would be:

- Acknowledge the diverse roles of the Multi-disciplinary team members and their individual contribution to the holistic approach to assessing the carer/s needs in including them in the care planning and action plans
- Continue with MDT meetings.
- Continue initiating family meetings.
- CSNAT – Identifying the carer’s needs concerns and issues at the point of referral. Develop a relationship and build trust. Adjust according the changing needs of the patient as well as the carer.

St Vincent's Hospital Brisbane

Author/s: Russell Richard, Staff Specialist

Email contact: Russell.Richard@svha.org.au

1. What evidence was used in your NSAP self-assessment that identified Support for Carers as an area for improvement?

- We had no prior evidence that identified "Support for Carers" as an area for improvement.
- We had no full understanding of which carer's needs were causing most distress.
- Information concerning carers was in several places in the medical record. Primary Carer was often not clearly identified. Some confusion over Carer and Next of Kin.
- Service had limited understanding of which support were valuable for carers during the different phases of patient's illness.
- Bereavement needs of carers were not fully addressed prior to death of patient.
- We gained insight into Carer needs through discussion with Palliative Care staff, workshops, literature review and *Clinical Practice Guidelines for the Psychosocial Support and Bereavement Support of Family Caregivers of Palliative Care Patients (2010)*.

2. What were the key issues that you were trying to address in the project?

- To identify if a Carer or Carers were involved in care of patient.
- To establish if that Carer was willing to accept that role.
- To ensure that Carers needs are identified, discussed and a plan instituted to address these problems, and to ensure that plan for carer support is reviewed through the illness and into bereavement.
- To ensure bereavement needs of the carers are addressed on presentation and following the death of the patient.

3. What was the aim of your project?

- Improving carer support, with *targeted* support, guided by their needs.
- To improve understanding of carers needs and concerns by end of project.
- To develop tools, to enable easy collection and review, throughout admission of patient, by end of project
- To develop check list of problems so that needs can be addressed and not forgotten after initial contact. Check list to be used by majority of carers by end of project.
- To develop and use a Carer Action Plan, following assessment, in majority of carers by end of project.
- To enable ability to review carer needs, to ensure that needs identified on first review are addressed on subsequent contacts, in majority of carers by end of project.
- To continue carer support beyond end of project. Measured by 6 monthly audits.

4. What change(s) were implemented in your project using the PDSA cycles?

- Development of a comprehensive Carer Assessment Tools
 - Carer Stress Thermometer
 - Trial of CSNAT (Carer Support Needs Assessment)
 - Carer Action Plan to identify and review carer needs during course of service contact with patient and carer and into bereavement.
- Carer Assessment Tool to be filed in chart in a new section: Carer Support/Bereavement.

5. What are the key results of your project?

- Introduced comprehensive assessment of carer needs for all patients admitted to Community Palliative Care Service. Development and implementation of Carer Assessment Tool incorporating a carer distress thermometer and Carer Support Needs Assessment Tool (CSNAT).
- Developed and now implementing a carer action plan for all community patients.
- All patients now seen in the community have a carer assessment done on admission, and reviewed at the initial MDT meeting. Carer action plan to be reviewed at subsequent patient contacts.
- Identification of carers and identification of needs have improved by at least 50% since initiation of project
- Most importantly, the team has gained a better understanding of carer needs and conversely have become more aware of wider needs of patients who lack a competent carer. Acknowledging that care is a major factor influencing patients' ability to remain independent in their community.

6. What measures demonstrated your project results?

- Monthly data collection.
- We plan to perform audit, looking at the number of carers with Carer Assessment and Care Plan, at three months following end of project.

7. What worked well to make the changes in practice?

- Introduction of a simple, easily completed Carer Assessment Tool.
- Placing Tool with the initial patient assessment forms, so that carer issues become a standard part of clinical assessment.
- Planning time during every community consultation and structuring interviews differently.
- Discussion with and encouragement of medical staff to complete Carer Assessment Form.
- Using the Carer Assessment at MDT meetings to assess and plan further carer support.
- Seeing value in collection of carer details and concerns to further support and plan for patient.

8. What were the challenges to changing practice and how did you overcome them?

- Encouraging staff to use the tool to collect and record Carer stressors and needs.
- Showing data collected and showing improved data.
- Developing an understanding of what constitutes cultural and spiritual needs.
- Having education on spiritual and cultural aspects of care.

NB Yet to see an improvement in practical terms on management of the patient.

9. What sustainability strategies do you have in place?

- Six monthly audits to ensure improvements remain.
- Keep Carer Assessment as part of holistic assessment.
- File Carer Assessment next to Bereavement section of medical chart to aid in later bereavement follow up.
- If demonstrating quality of patient care improves with Carer Assessment, palliative medical and nursing staff will see value in continuing Carer Assessments and Plans. Will need to measure quality. Preferred Place of death could show link between Carer support and Death at Home.

10. What is your take home message?

- Maintain enthusiasm.
- Encourage staff to make changes.
- Be aware that any change takes time and encouragement.

11. In moving forward what are your next steps?

- Introduce Carer Assessment to In Patient Unit palliative care patients within 6 months.
- Full audit within 6 months.
- Possibly expand data and experience into a peer review article.

St Vincent's Hospital Melbourne

Author/s: Tom Whelan, Nurse Practitioner Candidate

Email contact: Tom.WHELAN@svhm.org.au

1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement and key issues trying to address in the project?

- Palliative Care services at St Vincent's have undergone quality improvement initiatives with NSAP in the past including self-assessment snapshots against the National Standards for Palliative Care and development of improvement plans.
- These snapshots have highlighted deficits in identification and the provision of supports to families and carers of palliative care patients. These deficits were identified as being medium and high priorities for action by our service.
- This NSAP project offered an opportunity to progress these actions in a collaborative manner with similar services.

2. What was the aim of your project?

- The ultimate aim of our project is to identify the carer and ensure the carer is aware of their role and how this may change as a patient's condition changes.

3. What change(s) were implemented in your project using the PDSA cycles?

- PDSA cycles were completed in relation to education sessions for staff, and changes to documentation to incorporate criteria around carer identification.
- Preliminary meetings have been held in relation to changing the nursing care-plan to incorporate a carers section, this work is ongoing.

4. What are the key results of your project?

- Engagement of senior nursing staff in highlighting carers needs.
- A much greater awareness of the needs of carers and families by the multidisciplinary team.

5. What measures demonstrated your project results?

- The results of the monthly medical notes audit showed improvement across areas audited
 - Carer identification.
 - Carer role identification.
 - Carers discussing role with healthcare professional.

6. What worked well to make the changes in practice?

- Targeted education sessions for key staff (social workers, pastoral care, nursing staff) who were involved in supporting carers.
- Support from executive sponsor.
- Giving ownership of practice changes to the staff who developed and implemented them.

7. What were the challenges to changing practice and how did you overcome them?

- Project was run over two geographically different sites.
- Different skill mix.
- Different patient acuity.
- Different cultural mix of patients.
- One site more acute than the other.
- Different paperwork.
- Acknowledgement that we cannot change everything, (that was not the remit either).
- Utilised key staff in both units to move the project forward.

8. What sustainability strategies do you have in place?

- Added as an agenda item to Quality meeting.
- Ongoing education to new Nursing and medical staff as they rotate through the unit.
- Ongoing educational updates for regular staff.
- Continued audit of medical records (using same audit tool) on a 2-3 monthly timescale to identify any areas that need further education.

9. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- The importance of networking and learning from others.
- Ensure changes are manageable.
- Allocate sufficient time.
- Change can be challenging to some.

10. In moving forward what are your next steps?

- There is currently a review of the nursing documentation within the in-patient nursing units. Access to this process via our executive sponsor has enabled us to table our proposed carers section in the notes as a priority.
- When this change is implemented it will enable us to look further at implementation of *“The Clinical Practice Guidelines for the Psychosocial and Bereavement Support of Family Caregivers of Palliative Care Patients”*.

South East Regional Community Health Service

Author/s: Elizabeth Fallas, Nurse Practitioner Candidate

Email contact: liz.fallas@health.sa.gov.au

- 1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?**
 - Working party around Standards identified potential gains in Standards 1.1, 1.2, 1.6, 5.2, 11.4 and 12.1.
 - The service had also undertaken the PCOC carers' survey in July 2010 and was keen to further explore how to measure and improve the response to needs of carers.
 - A previous documentation audit revealed a low percentage of psycho-social assessments routinely been conducted on clients and their carers.

- 2. What were the key issues that you were trying to address in the project?**
 - That we currently did not have a systematic approach to how we identified carers and assessed the need of carers.
 - We also did not have a systematic approach to how we planned the delivery of support for carers, which team member should respond and how and when we monitored the ongoing pathway for carers as needs and disease trajectories changed.

- 3. What was the aim of your project?**
 - All patients are asked to identify a carer, and be measured on audit by a goal by the end of the first assessment with an audit goal of 80%.
 - All carers will discuss the caring role with a health professional and agree to be the patient's carer, measured on audit to be 80%.
 - All carers will have a needs assessment completed and a documented plan of action by their 3rd assessment, measured on audit to be 80%.

- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - PDSA cycle one:
 - Triage process to identify carer, and to start influencing the State wide clinical network to have it included in state-wide standardised referral form which was under development.
 - Joint initial assessment with two disciplines, this is arranged at our weekly interdisciplinary meeting or on a day to day basis with one of the disciplines focusing on the needs of the carer.
 - Weekly clinical practice improvement meetings to keep us motivated and keep as on track during life of project.
 - Trial of a carer needs and care pathway document.
 - PDSA cycle two:
 - Carer information folders which include CSNAT tool, information about palliative care, caring and resources available.
 - CSNAT tool to be distributed at each assessment and then returned forms to be raised and discussed at IDT meetings.
 - Use of mind map to explore network of carers, and supports for client.
 - Use of reflection tool of client's death using framework suggested by Hudson (2010), "*Clinical Practice Guidelines for the Psychosocial and Bereavement Support of Family Caregivers of Palliative Care Patients*" (guideline 20) to follow up on the quality of death, bereavement risk of carer and determine ongoing follow up.
 - Systematic approach to auditing shared amongst all team members.
 - PDSA cycle three:
 - Carer pathway developed using PCOC tools as prompts for discussion at team members when carer needs are changed.
 - CSNAT has not worked the way we thought, but it provides a discussion point.
 - Redevelopment of client list to streamline interdisciplinary meeting minutes and recording of different actions of team members.
 - Carer needs and care plan document not working.
 - PDSA cycle four:
 - What are we going to do about the Carer needs and care pan document, where to from here?

5. What are the key results of your project?

- Culture change of Next of Kin (NOK) versus carer, the shift has changed from engaging with a decision maker to collaborating with a care giver.
- 80% of first assessments are joint visits by two members of the interdisciplinary team (usually a nurse and social worker) to address both the needs of the client and carer.
- State wide triage form reflects identified carer as item to consider at triage.

6. What measures demonstrated your project results?

- Number of patient records that had identified carers.
- Number of patient records with evidence that the patient had identified the carer's role.
- Number of patient records with evidence that a health care professional has discussed the caring role.
- Number of patient records with evidence that the carer is aware of palliative care services and other resources to support their role.

7. What worked well to make the changes in practice?

- Meeting weekly as a team with both a clinical practice meeting followed by a client discussion meeting
- Identifying the carer in documentation and introduction of a separate carer information folder, promoted lots of discussion around the role and support of the carer.
- The reflection of client death tool to discuss bereavement risk for carers as well as other opportunities for changes to clinical practice that can support carers.

8. What were the challenges to changing practice and how did you overcome them?

- Staff engagement – ensuring all team members on the “one page” and progressing the project which was overcome by weekly clinical practice improvement meetings and using their collective wisdom and knowledge of how to problem solve through PDSA cycles.
- Monitoring of carers – developing a pathway that informed us of when we may need to intervene using PCOC measures.

9. What sustainability strategies do you have in place?

- Good monitoring processes with validated tools (PCOC) to monitor progress
- Excellent team work, with a diverse skill set, with an attitude of engagement “can do” and a culture of continuing improvement.
- Strong organisational support and the fact that the learnings of this project can be transferred across many other areas of the organisation and will be translated into policy.
- Developing partnerships with external organisations such as Carers SA around supporting carers.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- Don't get disheartened by audit results, reflect on the quantitative, but also reflect on the qualitative, because good stuff is happening.
- Harness the passion of your team.

11. In moving forward what are your next steps?

- Continue our weekly clinical practice improvement meeting, “keep the eye on the ball”.
- Revisit how will can continue to audit and measure some of the measurable aims of this project.
- Translate our learnings into policy and procedure.

South West Specialist Palliative Care Service

Author/s: Paula Vink, Nurse Manager & Pippa Blackburn, Senior Social Worker

Email contact: paula.vink@health.wa.gov.au

- 1. What evidence was used in your NSAP self-assessment that identified for carers as an area for improvement?**
 - No evidence existed. Palliative Care in the region was provided by Non-Government Service providers.
 - Our service commenced in April 2010 and after mapping the region and doing our first NSAP self-assessment our key improvement area's identified the need for documentation and information to support carers and to capture evidence around activity.

- 2. What were the key issues that you were trying to address in the project?**
 - Holistic assessment for carers not being conducted consistently.
 - Responses not always timely and referrals of carer's needs not being completed consistently.
 - Limited documentation and evidence around carer activity existed.
 - Limited transparency with carers and patients around information recorded of assessments and needs, promoting collaborative relationships with patients and carer's and families.

- 3. What was the aim of your project?**
 - All patients are asked to identify a carer.
 - All carers will discuss the caring role with a health professional and agree to be the patient's carer.
 - All carers will have a needs assessment completed and a documented plan of action.

- 4. What changes were implemented in your project using the PDSA cycles?**
 - Carers assessment and care-planning embedded in patient documentation - carer assessment information extracted from patient care-plans and made as stand alone documents (2 PDSA cycles).
 - Development of carer consent form and amended to comply with WACHS guidelines and procedures (3 PDSA cycles).
 - Education of staff (3 PDSA cycles).
 - Formal admission of carers as separate clients this includes development of admission form (3 PDSA cycles).
 - Developed informational flyer about carer support for new admissions to the services (2 PDSA cycles).
 - Screening of carer needs using a formal assessment tool (2 PDSA cycles).
 - Pre-implementation survey of existing palliative care patients and carers to obtain baseline data of carer experience (2 PDSA cycles).
 - Crisis meeting and development of briefing notes to inform business cases of the need for increased FTE (2 PDSA cycles).

- 5. What are the key results of your project?**
 - The many PDSA cycles have refined and embedded the project to ensure sustainability.
 - Nursing Staff recognized and acknowledged the importance of Carer assessment and evidencing carer support through documentation.
 - Enabled the regional team to advocate for increased FTE through evidence the project provided.

- 6. What measures demonstrated your project results?**
 - Variable based on services capacities. Most successful months were August 2013 where we met 75% to 100% of KPI's and January 2014 where we met 100% of KPI's. PCOC Carer Experience survey provided baseline data identifying areas for improvement and this will enable us to demonstrate if carer and patients' outcomes are improved, through follow-up survey In October 2014.

- 7. What worked well to make the changes in practice?**
 - Collaborative project work with the Mid-west Palliative care service.
 - Already established large scale CQI-documentation project which included carer and family information so we didn't have to start from scratch.

- 8. What were the challenges to changing practice and how did you overcome them?**
 - Resourcing of FTE and this was already identified in our planning document. Solution: Crisis meetings – Planning and processes commenced to increase FTE.

- Changing practice for nurses relating to admitting, assessing and documenting Carer Support Solution: Ongoing education and mentoring.
- Being a consultative and not a direct care service, with limited capacity to undertake audits throughout a whole region impacted on the audit collection. Solution: ongoing.

9. What sustainability strategies do you have in place?

- NSAP Carers project to remain an integral part of the South west and Midwest trial documentation project.
- Documentation trial working towards the implementation of a standardised West Australian Country Health Services (WACHS) patient/carer documentation process for Palliative care Services.
- Ongoing focus of carer initiatives at team meetings and education sessions.

10. What is your take home message (something that you have learnt as being part of this collaborative project?)

- Documenting mini PDSA cycles to demonstrate the work you have done – when you feel like you haven't achieved much, this provides visual evidence of what you have actually achieved!
- Having staff workshop and contribute in the development of the initiatives gets buy-in and ownership which increases motivation.
- Looking at the future, this is just the beginning and the carer project is here to stay.
- NOK, Carer, and nominated family spokesperson are not necessarily the same person.

11. In moving forward what are your steps?

- In October 2014 a follow up Carer Experience Survey will be conducted to ascertain if carer outcomes are actually improved.
- Ongoing trial of patient/carer documentation project within the Southwest and the Midwest Palliative care services.
- Ongoing work towards WA state wide formal implementation of patient/carer documentation in Palliative Care services.
- Formal State Wide licensing of CSNAT tool with WACHS.
- Ongoing education within the South west region about formal identification, assessment and support to carers.
- Ongoing development of formal Bereavement support process for carers and family members.

Sunshine Coast Specialist Palliative Care Service

Author/s: Suzanne Robson, Nursing Unit Manager & Julie Pook, Social Worker

Email contact: suzanne.robson@health.qld.gov.au

1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?

The SCHHS Specialist Palliative care service has participated in the 2010 and 2012 NSAP self assessment reviews, cycle 1 and cycle 2, where enhanced support for carers was identified as a service priority. The service results for each were sometimes and a Medium priority for the service. Carer stress has also been identified as a main cause of admission to hospital which could have been prevented following evidence from Clinical redesign project PALLiAPP commenced by the service.

2. What were the key issues that you were trying to address in the project?

The key issue for the project was to improve the assessment, planning and delivery of support to meet the needs of carers of palliative care clients on the Sunshine coast using a collaborative improvement methodology.

3. What was the aim of your project?

The project aim was that by April 2014 all new patients attending palliative care outpatients clinics will be asked to identify a carer, all carers will discuss the carer role with a health professional and agree to be the client's carer, and all carers will have a needs assessment completed and a documented plan of action.

4. What change(s) were implemented in your project using the PDSA cycles?

Changes implemented in the project using the PDSA cycles included a Carer Support Plan being completed for new patients and their carers referred to the specialist palliative care outreach service, and attending the outpatient's clinic at Nambour General Hospital. A member of the allied health outreach team would attend the outpatient's clinics on Tuesdays and Thursdays to meet with new patients and their carers, and commence the Carer Support Plan. Follow-up would occur via a telephone call or a home visit as required.

5. What are the key results of your project?

The key results of the project are that on average 60 % more carers of patients first met through our palliative care outpatients clinic, are now having their needs assessed at the earliest point and a specific care plan developed (in consultation with them) – to help meet their needs.

6. What measures demonstrated your project results?

Our project results have been demonstrated from the monthly 20 randomly selected clinical chart audits (from May 2013 to the time of completing this document) for new patients and their carers referred to the outreach specialist palliative care team.

7. What worked well to make the changes in practice?

Changes to practice occurred by having excellent team support for the project via our team leaders and clinical director, having a dedicated multidisciplinary project team with a current carer as a key member, and having the project being very well complimented by another in –service quality initiative the Palliative Admission Prevention Program (where increased carer support was also identified as a major need for service improvement).

8. What were the challenges to changing practice and how did you overcome them?

Challenges to changing practice included the re-design of the way in which social work and psychology support would be offered to carers of new patients through an early intervention model operating via the outpatient's clinic setting. Initially the sitting in on a full first clinic consultation, with the associated waiting for people to arrive for appointments etc., was not considered an efficient use of the allied health staff time (particularly for the psychologist). This was overcome through working the PDSA process as a project team, and scheduling all new patient appointments early in the morning, deciding only the social workers would sit in on the clinic consultations, and that the social workers would commence the Carer Support Plan where possible by a phone call to the carer prior to the clinic meeting. Another challenge has been the time it has taken to complete the Carer Support Plan – particularly covering the domains of the carer assessment. Again through the PDSA process, it has been decided that the Carer Support Plan can be completed as accurate and relevant for the

carer at that initial point in time, and that it will be considered a document to be readily updated as new information is obtained.

9. What sustainability strategies do you have in place?

The sustainability strategies we have developed are:

- Planning to expand the use of the Carer Support Plan to be used in all the specialist palliative care outpatients clinics across the district, for use by the allied health team with the carers of new patients referred to the service.
- Embedding carer assessment and care planning via the use of Carer Support Plan into core business for the service - and having this reflected in a work practice instruction, planned internal education for staff, a standing team meeting agenda item, and continuing the Carer Support Project Team meetings several times a year.
- Future planning for a service evaluation seeking direct client and carer feedback as to the usefulness of the Carer Support Plans and early intervention model for carer support.
- Continued periodic chart audits similar to those used during the project, may be considered.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

Key learning's as a result of being part of this collaborative improvement project have been the usefulness of using a very clear and comprehensive project planning document from the start, strategically thinking through how changes are best introduced and implemented within the team's culture, and then using the PDSA cycle to think through what is working and how improvements can be made to the project operations.

11. In moving forward what are your next steps?

Our next steps in moving forward are to:

- Organize education sessions with the social worker and occupational therapist at the Dove Palliative Unit (inpatient arm of the service) who will be starting to implement the Carer Support Plan within their setting. Change of Clinic days to be actioned with dedicated room for Allied health member.
- Organize education sessions to the whole of service as to the proposed sustainability plans for the enhanced carer assessment and care planning processes.
- Continue to discuss carer support issues within team meetings as a standing agenda item, and planning continued meetings for the Carer Support Project Team.
- The Carer Support Project team will have as one of its future goals to develop a means to evaluate the use of the Carer Support Plan and resource packs via direct local patient and carer feedback.

Tamworth Palliative Care

Author/s: Jonathon Gourlay, Clinical Nurse Consultant

Email contact: Jonathan.Gourlay@hnehealth.nsw.gov.au

1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?

Qualitative discussion during the NSAP self-assessment process indicated that as a service we felt we were identifying carers and including them into our practice but this was inconsistent and not well documented. This was confirmed when we completed the baseline data collection for the project, which indicated that we had virtually no recorded evidence that we were identifying a patients carers and supporting these carers needs.

2. What were the key issues that you were trying to address in the project?

The key issues were how as a service we could; with limited staffing resources provide a consistent and sustainable approach in identifying and supporting patient's carers.

3. What was the aim of your project?

Our key project deliverables were to:

- Make changes to existing referral process to ensure that the presence of Carers is identified at point of referral and this document in Community Health Information Management Enterprise (CHIME).
- To ensure initial assessment documentation on CHIME includes the carer, carer role and any identified carer issues.
- Development of a Community carer's resource package that contains information on local palliative care services and other resources that are available to support their role as a carer.
- Development of a home visit resources folder for health professional to provide written practical information to support carers throughout the journey, i.e. managing breathlessness, how to safely provide personal care, what to expect in the last few days, and what is a syringe driver etc.

4. What change(s) were implemented in your project using the PDSA cycles?

The following changes have been implemented as part of this project:

- **Referral system:** referral process was reviewed; all referrals now need to have a completed written referral form, which includes the identification of carer (if present) and acknowledgement that the carer is aware of and consenting to Palliative care referrals. Intake process now involves providing the carer with an introduction letter regarding the Tamworth palliative care service, contacting the carer via phone to acknowledge referral and the carer being identified as the prime carer in CHIME.
- **Documentation:** Data indicates that there has been a significant improvement in initial assessment documentation, to include the carer, carer role and identified carer issues. No procedure changes have occurred to ensure this is sustainable, but as this has been the prime quality activity for this service over the last 12 months, the new culture of asking these questions from initial assessment has been evident. The development of a standardised Palliative care initial assessment form, which would include carer assessment, would assist with this becoming sustainable.
- **Examination of local available resources** and then consistently providing carers with this information. For example our services has significantly increased in the amount of referrals been made to the Commonwealth respite and care link centres for support of carer needs. The service is currently in the final stages of developing community carer's package that will be provided to all carers.

5. What are the key results of your project?

The key results are that the carer's are now on the Tamworth community Palliative care service agenda. The services monthly audit indicates an improvement in the service identifying the patient's carer, the carer role been discussed with the carer and the carer being aware of available local services.

6. What measures demonstrated your project results?

- We have had mixed results with achieving success criteria for our project. Some of the results that we hoped we would be able to achieve have not been met, but others have and some we are hoping will happen in the future. Changes to the Palliative Care referral process to include the identification of the presence of the carer at the point of referral and this is being documented in CHIME.
- The first success criteria result was that we were able to complete a carer's resource package and that we would have correct use of same. At this stage we are very close to having this completed but haven't yet completed it.

- We were hoping to have provided 80% of our carers with a carer's package and discussed Palliative Care resources that are available. Even though we haven't been able to give out a carer's package yet, we have discussed and given out other resources to support their role in 72% of our records. We had an 80% target.
- Evidence in our records that health professionals had discussed the caring role with carers and carers have agreed to this role was achieved with 81% of our notes having this evidence. Our target was 80%. At commencement of our project in May 2013 we were achieving 40% and this increased to 100% in recent months.
- We achieved 64% of patient's records that had evidence that the patient had identified their carer and the carer's roles. Our success criteria target was 80%. However our documentation had been improving each month and was up to 92% for January's statistics.

7. What worked well to make the changes in practice?

What has worked well to make the changes in practice has been firstly recognising the importance of the carers and then including the questions aimed at the carers as a standard procedure with the initial Palliative care assessment.

8. What worked well to make the changes in practice?

The main challenge was a shifting of mind sets and attitudes to not just be focusing on the patients but also the carers. These mind sets and attitudes have changed over time as a better understanding of the necessity of the carer has occurred. The implementation of changes and the development of resources have also been hindered by staff vacancies and limited time available for clinicians to focus on service improvement due to limited staff and a high clinical load. To address this project we incorporated into weekly case management agenda. Use of email to communicate and review changes was beneficial rather than just having one meeting a week.

9. What sustainability strategies do you have in place?

- Further work is required to ensure these results are sustainable. For example whilst the current staff are now performing well with documentation of carers, a policy will need to be completed to ensure the practice will continue into the future.
- The community carer resources package home visit resource folder remains uncompleted and is ongoing. Strategies have been discussed regarding the sustainability of both the Community carer resource package and the home visit support resource folder. The service feels that this is financially secure as the service has a good relationship with a group called "Friends of Nioka" who are a support group for the Palliative Care service in the Peel cluster who have made a commitment to support the Palliative Care service in this project and beyond.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

Key take home messages: KISS principle: Keep it simple, small services with limited staff that are time poor cannot make massive changes immediately, small steps, one at a time. i.e. we addressed areas that were easy to change and saw immediate improvement.

11. In moving forward what are your next steps?

Support for carers needs to remain a high priority quality improvement agenda item for this service as we have not yet met all of our project deliverables or begun to address NSAP CQI projects objective of all carers having a needs assessment completed and documented plan of action to support the carers needs.

Tasmanian Southern Community Palliative Care Service

Author/s: Angela Kosmeyer, Acting Nursing Unit Manager

Email contact: Angela.Kosmeyer@dhhs.tas.gov.au

National focus is on two key areas:

- Skill development in continuous quality improvement.
- Support for carers.

Aim:

- To improve the assessment, planning and delivery of support to meet the needs of carers of community based palliative care patients using a collaborative improvement methodology.
- The measureable project objectives for the Service are:
 - A process exists to guide the identification of carers and discussion about the caring role.
 - All carers have an assessment of their needs and wishes and have a documented plan of action.
 - All carers receive information and referrals as appropriate.
 - All carers have their needs assessed on an ongoing basis.
 - A process is embedded that provides for routine and consistent support for carers.
- KPI 80% of records audited with evidence:
 - of a documented plan of action to support carers needs
 - of an assessment of the carers needs and wishes on admission
 - of ongoing assessment of carers needs and wishes as required
 - that a health care professional has discussed the caring role with the carer/s and that the carer/s has agreed to the role
 - that the carer has been provided relevant information that was identified in the assessment of needs and wishes on admission and throughout the episode of care
 - that appropriate referrals have been made that were identified in the assessment of carer needs and wishes
 - that the patient has identified their carer/s and the carer/s role in relation to their individual care requirements.

Audits will include 20 random medical records each month until April 2014.

Outputs:

- A process is developed and documented that guides the identification of carers and discussion about the caring role. This includes receiving appropriate information and referrals. This process is updated and reviewed annually, and as needed.
- An assessment tool is developed that facilitates the assessment and documentation of an action plan of the carers needs and wishes.
- The carer assessment and action plan is evaluated to ensure processes are embedded into practice. Evaluation will be undertaken through clinical review and the review of client and carer feedback.

Learnings and feedback:

- Audit process using 1 month old data means that a client is with the Service ¼ of clients between 5-6 weeks, ¼ 4-5 weeks, ¼ 3-4 weeks, ¼ 2-3 weeks. There is insufficient time for some of these discussions to occur e.g. death preparation and bereavement talk does not usually occur when a patient is admitted to the Service. 1 or 2 contacts may have been completed during this time and it is inappropriate for most to have these discussions when introducing the Service.
- The focus of the team according to the medical record is physical symptoms and goals of care and describes a medical model.
- The KPIs chosen were not achieved i.e. 80% compliance not achieved in any criteria.
- The Service does not have any specific tools to support the assessment for carers.
- Communication to carers by other services is not documented routinely by the Service. Process needed to support this i.e. Include relevant carer specific service information in introductory pack.
- Regular feedback to the team provided. Some staff have started to include audit items in the patient documentation.
- Criteria for auditing not defined and 4 different auditors were involved throughout the audit period leading to potential inconsistency in data.
- Quality of documentation is variable throughout this process e.g. inclusion of clients admitted directly to level 2 following a consult visit should be excluded, and whether a carer assessment was undertaken and

not documented fully, and busy days and/or lower resource days impacted on the standard of documentation.

- The Carer satisfaction survey undertaken by the Service this year provides positive feedback from carers.

Next Steps:

- Ongoing education for staff identified to include the rationale and benefits of a comprehensive assessment of the carer.
- A dedicated assessment tool to support the assessment of the carer is required and is under development.
- Regular Documentation audits to include carer information.
- Carer specific service information to be provided in the introductory pack.

Territory Palliative Care, Central Australia

Author/s: Susan Grant, Social Worker

Email contact: susan.grant@nt.gov.au

1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?

- In our NSAP self assessment in 2011, patient electronic records, referral forms and home files, as well as feedback from staff, were used to identify Support for Carers as an area for improvement.
- We were aware there was room for improvement of our practice based on the *Clinical Practice Guidelines for the Psychosocial and Bereavement Support of Family Caregivers of Palliative Care Patients, 2010*.
- There is a lack of evidence re indigenous notions of carer and their support and information needs.
- We were keen to join the collaborative for the opportunity to learn from other palliative care services, access the support and expertise of the NSAP team, and prioritise support for carers.

2. What were the key issues that you were trying to address in the project?

- Although support for carers was included as part of a holistic assessment, it wasn't prioritised or documented consistently.
- We were interested to see if the project could support us in responding to indigenous approaches to caring for the palliative patient.
- We were hoping to build the capacity of our team for QI activities in the context of busy workloads.

3. What was the aim of your project?

- Improving support for carers by (80% or over documented evidence of); patient identification of carer and their role, acceptance of the role and responsibility by the carer, and awareness by the carer of palliative care and other support services and resources.
- Assisting staff to develop skills in continuous quality improvement by participation in project.

4. What change(s) were implemented in your project using the PDSA cycles?

- Audit tool developed and implemented.
- PDSA cycles around improved support for carers were conducted in 3 main areas:
 - Documenting conversations about the carer, their role and supports available on intake forms and electronic records- 3 cycles refining who is responsible for documentation and what information is documented.
 - Placement of information for carers in home files – 2 cycles involving initiating and improving content.
 - Improving collaboration with carer agencies – 3 cycles involving improving networks with carer organisations, increasing number of referrals and improving timing of referrals to carer organisations. An unexpected outcome was the discovery that the carer organisation conducted its own carer needs assessment.

5. What are the key results of your project?

- Overall a positive change in practice re support for carers - prompter attention to carers needs via discussion, information, collaboration and early referrals.
- Project targets were mostly met – see below:
 - 80% documented evidence of patient identification of carer; 50% or more discussion about carer role with patient (issues of culture and timing here).
 - 80% documented evidence of acceptance of the role and responsibility by the carer.
 - 80% awareness by the carer of palliative care and other support services and resources.
 - Improved knowledge of and collaboration with other agencies supporting carers (via monthly meetings and 80% increase in no and timing of referrals).
- Increased capacity in team for QI projects demonstrated by the participation in project and monthly NSAP meetings.

6. What measures demonstrated your project results?

- Audit results from project evaluation questions.
- Information for carers placed in home folders.
- Number and timing of referrals to carer organisations.
- No of contacts with carer organisations.
- Qualitative feedback from team members.

7. What worked well to make the changes in practice?

- Involving the multidisciplinary team – they were busy, but agreeable philosophically.
- Keeping the project on the agenda by ‘bugging’ other team members to be involved, sharing auditing and results, and as a standing item on team meeting and quality meeting agendas.
- PDSA methodology encouraged experiment and small incremental changes.
- NSAP expectations were not too overwhelming given busyness and pressures of the service.
- Skill building and sharing of ideas at Learning Session Workshops.

8. What were the challenges to changing practice and how did you overcome them?

- Lack of executive leadership engagement due to staff movements- engaged support of clinical leader instead.
- A small, busy and overstretched team – improvements lost as workloads increased and key staff were away – tried to normalise support for carer as standard practice, involved other team members in audit to identify gaps in practice and opportunities for improvement, and experimented with who in team did documentation.
- 65% of our clients are indigenous. We found the audit questions limiting in trying to capture much of our work with indigenous carers. An ongoing challenge is the lack of evidence for improving our practice in relation to indigenous carers. We need more research in this area.

9. What sustainability strategies do you have in place?

Outcome

- Support for carers is a standing item on Territory Palliative Care quality meetings and team meeting agendas.
- Carer details were already embedded in paper and electronic templates. The change required was to use these consistently and make documentation of carer a standard part of referral into the service.
- Ongoing monthly file audits of evaluation questions for 3 months, then quarterly, and feedback results via team meetings.

Culture

- Engagement of clinical leader and support of multidisciplinary team.
- Hopefully project outcomes will contribute to a more positive organisational culture re QI activities.
- Relationships.
- Enhanced collaboration with other services is seen as beneficial by staff.
- Networks in place to ensure that carers receive referrals, assessment and support as appropriate.

10. What is your take home message?

- A busy team needs convincing and cajoling for QI activities, but it is worth the effort.
- In rural and remote practice with small teams and vast geographic distances, it makes sense to collaborate with other services. You don't have to do it all yourself!
- Reinforced that the basic unit of care is the patient and their carers in their community.
- The collaborative project is a great opportunity to learn from other specialist services and be supported by the NSAP team.

11. In moving forward what are you next steps?

- We need to hear more from carers themselves!
- Ongoing file auditing of evaluation questions for sustainability.
- Continue monthly meetings with carer organisations.
- More research about indigenous carers is needed.

Territory Palliative Care, Top End

Author/s: Cheryl Nash, Social Worker/Volunteer Coordinator

Email contact: Cheryl.nash@nt.gov.au

1. What evidence was used in your NSAP self assessment that identified Support for Carers as an area for improvement?

- The evidence was sourced from the client's referral documentation; electronic file as well as the hospital and community hard files and through conversations with carer's themselves.

2. What were the key issues that you were trying to address in the project?

- The key issues were to identify the carer on the initial assessment form; document the carer's needs on the electronic progress notes. A formal Carer assessment tool was not used; however the action plan was included in the progress notes.
- The team in Darwin felt that, given the internal and external issues affecting the team: major construction, relocation of half of the team, and inconsistency of workforce as well as the timing of the project, it was unrealistic to undertake all three of the project aims and would concentrate solely on the first two, to identify a carer and discuss the role with a health professional.

3. What was the aim of your project?

The team in Darwin decided that we could successfully address the first two aims of the project, these being:

- All patients would be asked if they had someone who they identified as their carer (not all clients of this service have someone who is caring for them and it was agreed that it was important to also note this on the system).
- All carer's will have discussed the caring role with a health professional and agreed to be the patient's carer.
- All carers will be provided with information on the services and supports provided by Territory Palliative Care and other related agencies.

4. What change(s) were implemented in your project using the PDSA cycles?

There were two changes implemented in the project using the PDSA cycles:

- If a carer is identified by the client, and the carer agrees to the role, it will be noted on the client's electronic file under relationships as "being cared for by"..... (Often the carer is not a relative but a neighbour or close friend).
- A booklet was to be put together, reflecting information and services available to carer's in the Darwin region of the Northern Territory. It is the hope of the team that funding can be sourced to have the booklet professionally printed and distributed to each identified carer.

5. What are the key results of your project?

- Key result 1: Members of the Multidiscipline team are more aware that the goals and needs of the carer are not always the same as the goals and needs of the client. While goals and needs may differ it is important to give them equally weight for the long term benefit of the patient. An informed and supported carer can often mean a less anxious client.
- Key result 2: While carer's needs and wishes were acknowledged by the team, they were not documented or acted upon. This project has highlighted the necessity of not only formally acknowledging the carers needs but also taking the next step in documenting them and then addressing them with a Carer Support Plan.
- Key Result 3: During case meetings discussion now occurs as to the needs of the carer in relation to bereavement risk, these are documented for future follow up by the Bereavement Coordinator.

6. What measures demonstrated your project results?

- Measure 1: Increased documentation of carers needs in client's medical notes (Electronic and hard file).
- Measure 2: Increased discussions documented between Carer's and Health Care Professional.

7. What worked well to make the changes in practice?

- The small size of the team.
- The willingness of the team to make changes – there were already lots of changes occurring in and around the team and its environment, this was seen as just one more change, and the diversity of the multidisciplinary team.
- The willingness of the team to enter into discussions of carers needs at case and family meetings.

8. What were the challenges to changing practice and how did you overcome them?

- Challenge 1: The volume of work given the small size of the team
- Challenge 2: Staff turnover
- Challenge 3: Changing environment

The team is aware that sustainable change will not happen overnight. All team members acknowledge that it is in the client's long-term best interest to have the client's carers needs assessed and supported (including bereavement risks). The team is also aware that it is better to move slowly in a forward direction and achieve success than to rush forward, take on too much before being ready, and fail. Already the issue of the changing environment has been resolved.

9. What sustainability strategies do you have in place?

There are currently 3 sustainability strategies in place within the team:

- Strategy 1: Workplace champions.
- Strategy 2: The format of documentation for referral is now inclusive of carers.
- Strategy 3: Documentation of Carer's needs is now included in case and family meetings.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- Without carers needs being acknowledged, documented and addressed many palliative care patients' needs would not be met. By supporting the carers we are ultimately providing a better outcome for our patients. When carer's needs are acknowledged and met, the bereavement risks documented and addressed then hopefully the bereavement risk is reduced.

11. In moving forward what are your next steps?

- It is hoped that in the near future we can move forward with formally assessing and documenting carer's needs and formulating a plan of action (again documented) from this.

Western District Health Services

Author/s: Erika Fisher, Clinical Nurse Consultant

Email contact: Erika.fisher@wdhs.net

Why we did the project

- The need to improve carer support was identified during our second NSAP self assessment snapshot. The self assessment indicated to us that there was a lack of information and resources available for carers, and there was no documented evidence of any carer assessment undertaken. The Victorian Palliative Care Satisfaction Survey (VPCSS) outcomes for the past three consecutive years have also identified support for carers as one of the top five priorities for our service.
- In the project we did not have good documented evidence that the role of the carer has been discussed, assessment of the carer and formulating a care plan accordingly.

Focus of the project

- The focus of this project was to acknowledge the holistic needs of the carer through assessment and care planning processes by means of documented evidence of discussions with regards to the role of the carer, education and assessment of needs. This was for the community patients in our service and did not include the inpatient component.

Changes made

- A major change for our service was the implementation of the Carer Support Needs Assessment Tool (CSNAT). The CSNAT was implemented for every patient in the service, not only new patients.
- There was an increase in the number of patient records that had recorded discussions of the carer role. By improving our documented evidence, staff are now more aware of the community's concept of a carer, which helps them in their discussions with families. Anecdotally, it has also led to an increase in applications for the Carer Allowance through Centre Link.
- There were also monthly audits on new patients as well as general documentation audits to monitor compliance.
- The project had good executive support, with staff very open to change. Carers have also commented positively, saying for example, 'I feel more supported' and 'It was easy to understand.'

Challenges

- We had a change of management during the project and needed to brief and update the new manager to ensure ongoing support for this strategic, national approach to support carers. Because staff were also rotating through the service the discussions around carer support had to be included in handover and multidisciplinary team (MDT) discussions.
- The service uses a patient electronic record system (PERM), which dictates what assessment tools are to be used. This meant that for the project the documentation had to be paper based and did not provide the overall assessment score or complexity of the patient as this information was in different places. There are limitations in what documented evidence could be entered in a specific area; for example we had to create means to make comments in the progress note and carer page on PERM. This made the audit process challenging.

Sustainability

- To ensure sustainability of the measures we have introduced, this activity will be included in the service's business plan and quality program. It will become part of our accreditation process, linked to National Quality and Safety Standard 2. We have also included support for carers as part of our ongoing NSAP Action Plan and continue documentation audits and discussions to maintain momentum.

What have we learned?

- The whole process is about improving the patient and carer experience of palliative care; it is a continual process. Sometimes we have to take a step back and review what we have done to make improvements and learn from our mistakes. Initially we decided to use the tools that were already in PERM such as the Distress Thermometer. But later found that it was not carer specific and focussed more on the patient. Also PERM would not allow double entry on the same assessment tool.
- Through the carer assessment we have identified the need to have a carer information package that will include information on local as well as national resources. In moving forward we have also decided to join forces with Barwon Health to work on the next project, which is good for sharing resources and getting the spread of the outcomes.

West Gippsland Healthcare Group

Author/s: Barb Milner, District Nursing Nurse Manager & Diane More, Associate Director of Nursing
Email contact: barb.milner@wghg.com.au

Specific:

- To Identify who the carer was.
- To establish the carer's role was a mutual agreement by both the patient and the carer.
- To ensure the role of the carer need to be explained so the carer understood the commitment.
- To ensure the needs assessment of the carer would be completed by the staff, with an associated action plan developed based on the identified needs.
- To establish a trend analysis of the most utilised services the carer required.

Measurable:

- Through auditing, a base line of how often carers were identified and supported was measured. To fulfil the aim of the project ongoing auditing will be undertaken. This will identify the number of carers who were identified and had their role explained and their needs assessed will be measured and compared to the total number of admissions for the duration of the project.

Achievable:

- All patients admitted to Palliative Care unit will be approach to identify who their carers are and for ongoing sustainability we will use validated tools to continue this process.

Result:

- By the end of this project we would clearly identify the carer and have an understanding of any needs they would require and how as team we could assist to make this the best experience for them.

Time frame:

- 6 months

When identifying who the career was there were many assumptions as to who the carer was and the expectations of that role. It was found that often there was not one designated person but a shared responsibility. If the patient lived with a partner they would automatically be given the role of the carer, but occasionally it would be a neighbour or daughter not living with the patient who had the role. The information we would give to a carer was going to be dependent to some degree on what relationship they had with the patient. With this information it was felt important that "carer" was defined.

A search for the definition of a carer was undertaken by our Palliative Care Nurse Practitioner candidate.

The findings were as follows:

Carers are defined as "lay people in a close supportive role who share in the illness experience of the patient and who undertake vital care work and who undertake vital care work and emotional support and management" 1

From this we developed our own three tier level of a carer.

What is a Carer?

- A spouse /partner/live in carer/mother /father etc who lives with the person and provides carer 24/7 and acknowledges they are a full time carer.
- Family or friend who does not live with the person but provides integral day to day care ie food preparation, driving, help attend appointments, housework and personal care.
- Extended network of carers who provide occasional care with food, housework and appointment times

This clearly described the level of caring that the person was able or willing to give and was helpful in how to tailor our approach to assessing their needs.

We started the PDSA cycle and worked our way through identifying the carer, their needs and developing plans / actions and monitoring to see how the project was progressing.

The first change was a revised admission process; this took a few attempts to finally come up with an appropriate draft form that captured the documentation required.

The next step was to have a validated tool that could be used to assist with identifying any needs a carer may have. Using the Carer Support Needs Assessment Tool (CSNAT) the palliative care team could identify the areas where they were having trouble or felt they needed more support.

This process was slow to be completed on each admission and then produced another problem of what were the staff doing with the information they had gathered?

The staff had identified issues but still nothing was being done, with this in mind a plan of care for the carer was developed. This new documentation now allowed staff to not only identify a problem but to also develop a plan of care to help the carer.

It also meant that at different times during the patient's journey we could now reassess the carer and how they were managing with the patient changes in their condition.

With changes to the documentation staff were prompted to ask and complete the necessary paper work to support the project.

The strategies we used to achieve sustainability:

- Monthly audits of all new admissions to palliative care, which in the beginning was disappointing but now that the palliative care team leaders can see the benefit of this project it has become part of the admission process and they have extended this to all current clients and their carer.

The outcome:

- All palliative care patients' carers are identified by the new admission form and the carers needs assessed by the CSSNAT tool, then a plan of care is developed to meet the documented needs.
- These now form part of the medical record and assessment requirements of this group of patients.
- Further development of our existing admission and assessment folders has taken place. Therefore, we have developed a folder which has information for the carer and patient which also addresses the bereavement phase.
- There is an established bereavement program that triggers an alert on our patient information system so that visits are scheduled during the bereavement period.

We are developing a visibility study of the most used services by the carer and will look at what the trend suggests that most frequent needs for carers are and how our service can help the carers in these areas.

The take home message:

- If staff see the benefits of a change that you make to a practice staff are more likely to continue with it.
- That the carer is now being acknowledge and supported for the role they play in the palliative care patients' journey.

REFERENCE:

1. National Institute for Clinical Excellence (NICE).Guidance on cancer services improving supportive and palliative care for adults with cancer. Oxford: 2004

Yorke and Lower North Health Service

Author/s: Shelley Tregilgas, Palliative Care Coordinator

Email contact: shelleytreg@bigpond.com

- 1. What evidence was used in your NSAP self-assessment that identified Support for Carers as an area for improvement?**
 - Inconsistent bereavement support for carers.
 - Inconsistent documentation of carer needs and support.
 - Palliative Care Standards; 4 & 8, rated at medium priority.
- 2. What were the key issues that you were trying to address in the project?**
 - Inconsistent support depending on location/services/staff.
 - Targeted and timely referrals for the carer.
 - Evidence of conversations with carers specific to the carer role and a documented action plan.
- 3. What was the aim of your project?**
 - Consistent holistic support for all carers of palliative patients.
- 4. What change(s) were implemented in your project using the PDSA cycles?**
 - Introduction, training, uptake of the Carer Support Needs Assessment Tool (CSNAT) across cluster by community nurses and palliative care coordinators.
 - A CSNAT work instruction developed.
 - Training and development with 80% of workgroup.
 - Introduction of CareSearch carer resources.
- 5. What are the key results of your project?**
 - The CSNAT prompted more conversations with carers about their role and also subsequent documentation of these conversations.
 - Positive feedback from carers.
 - Referral pathway for carers to utilise social work and carer networks in a timely manner.
- 6. What measures demonstrated your project results?**
 - Training and development register recording all staff who have received training about how to use the CSNAT.
 - Audit results beginning to show conversations with carers are being documented and include CSNAT for new admissions to the service since inception on October 1st 2013.
 - Carers and staff using the CSNAT have mentioned that they find the tool provides a focus and acknowledgment for the carers.
- 7. What worked well to make the changes in practice?**
 - Involvement and learning through the project.
 - Development of a project plan and timeline.
 - Case stories shared with team after good result following use of CSNAT.
 - Support from Pall Care Coordinators and Community Health Nurses across cluster.
 - Support from Team Leader, Tim Garfield.
- 8. What were the challenges to changing practice and how did you overcome them?**
 - Providing on site education across multiple sites, required two separate visits to capture key staff.
 - Whilst all staff have been very receptive, having staff who are 'leaders' on board has been vital in uptake of change. [as I do not work routinely at all sites I was unaware who these 'leaders' are and did not meet with them until second round of site visits in Jan/Feb 2014].
 - Referral numbers have been lower than usual and therefore less repetition to solidify practice.
- 9. What sustainability strategies do you have in place?**
 - Feedback from the team in April will guide ongoing practice...
 - Inclusion of CSNAT and carer resources in pall care new admission packs.
 - Audit in April re completion and use of CSNAT.

- Inclusion of use of CSNAT and carer needs in care plan in yearly audits of deceased clients.
- Will conduct NSAP qualitative carer survey before June 30th 2014.

10. What is your take home message (something that you have learnt as being part of this collaborative improvement project)?

- Get to know the team you are working with as individuals and value what they bring to the table and share the small successes.

11. In moving forward what are your next steps?

- Looking forward to feedback from team in April after more widespread use of CSNAT tool and talking about sustainability.