NSAP Webinar
Planning the changes
– tips from the floor

25th September 2013
Prioritising referrals to a community palliative care service

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Sacred Heart Service

- Located in Metropolitan Sydney with a population of approximately 400,000
- Community, in-patient, hospital consult and Day Centre
- Referrals received from multiple sources
- Multidisciplinary Team
- First visit usually conducted by nurse and doctor
Reason for action

- Inadequate Staffing
- Large volume of referrals
- Perceived pressure to see everyone quickly
- Staff feeling like they were “neglecting” patients already registered
- A review of how referrals were actioned
Planning

• AIM
  – Prioritise referrals appropriately
  – Have a system to use to prioritise
• MEASURE
  – Response time from referral to initial contact (to meet PCOC Benchmark)
• IMPROVEMENT
  – What changes can be made?
Literature Review

- No Validated tool for triaging referrals to palliative care services
- Most literature focussed on referrals to in-patient units
- Fergus et al (2008)-unable to validate inpatient triage tool based on Support Team Assessment Tool (STAS)
- Philip et al (2010)- success in developing & implementing tool for inpatient unit
- Caldicott et al (2010) tool for community based specialist palliative care team. Tool not validated and not available for other services
Literature Review – Common Themes

• Need for a validated tool
• Need for transparency in meeting & prioritising competing needs
• Need for assessment based on multiple symptom domains & clinical judgement
• Limitations: poor inter-rater correlation
Recent Literature

• Tan et al 2012: Evaluated triage tool in a community palliative care service
  ➢ Introduced in response to increase service demands and service restraints
  ➢ Enables systematic method of dealing with referrals, and contributed to equitable provision of service & appropriate management of resources
Engaging with Stakeholders

- Nursing team meeting:
  - clear guidelines would enable new referrals to be prioritised objectively
  - Need a formal and transparent system
  - Need to manage referrals from multiple centres
- Sought comment from referrers and kept main referrers informed of project
- Multidisciplinary team invited to have input
Some comments

• “I like the tool…add a field for medical decision making eg stopping chemo, turning off defibrillator…”

• “Tool looks interesting…look at the RUG-ADL with priority given to higher dependency levels…patients with low RUG-ADL may be able to attend OPD…”

• “…modified Karnofsky is a better measure to use, RUG-ADL is more about resource use”
Compiling the tool

- Aiming to meet benchmark for contact time within 48 hours
- Based PCOC data set for domains of symptoms
- Rating Scale for each symptom domain
- Clinical Judgement recognised as important in triage process- designed to be used by clinicians.
- Ethics approval for single site low risk research- final step before rolling out
The tool

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<tr>
<th>Problem</th>
<th>Score</th>
<th>Comment</th>
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<tr>
<td>Fats</td>
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<td>Other Symptoms</td>
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<td>Family/Care</td>
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<td>Physical Care Needs</td>
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<td>Acuity Score</td>
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<td>ECOG/WHO</td>
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<td>Medical Decision</td>
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<td>Total Score</td>
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Category A: Score ≥16 Visit within 1 working day of referral
Category B: Score 8–15 Visit within 3 working days of referral
Category C: Score ≥8 Visit within 5–7 working days of referral
Category D: Other (e.g. not yet ready to be acted on, early referral, service declined)

References:
- POUC assessment tool
- Royal College of Physicians
- Draft Community Palliative Care Team Triage Tool

Version 11.0
08/10/2012
Time Frame

• Initial discussions about the pressure of managing referrals- August 2011
• Literature review August 2011
• 1st Draft of tool for comment- September 2011
• 1st tool used with patients draft 8 – 13/12/2011
In hindsight...

- Don’t be tempted to ‘just get started’ & rush the preparation

- Set a time line and outcome measures (and stick to it)
Reference List

• Coldicott R, Campbell M, Rowland SBMJ (2011) Is a triage system of referrals to a community palliative care nurse specialist team workable? Support Palliative Care; 1: 213 [poster]

• Coldicott R, (2011) Personal email communication

• Fergus CJY; Nicol JS; Russell (2008) Is a STAS-based tool valid to triage patients at a specialist palliative care inpatient unit?(includes abstract); PB; International Journal of Palliative Nursing, Jan; 14 (1): 24-9 (journal article - questionnaire/scale, research, tables/charts) ISSN: 1357-6321 PMID: 18414329 CINAHL AN: 2009825528

• NSW Health: Palliative Care Strategic Framework 2010-2013 PD 2010_003. publication date 13/01/2010


Questions
NSAP CQI Webinar

Implementing change: Preparing for change – tips from the coalface

Wednesday 25th September 2013
Pain Assessment tools are catalysts for communication

Caroline Short CNC
Cessnock Kurri Kurri Singleton Palliative Care Service, NSW
Cessnock Kurri Kurri Singleton

- Specialist Palliative Care – Community based.
- 6.2 FTE RN and 0.5 SW
- Cessnock & Singleton LGA’s
- 72,000 people; 10,000 Squ. Kms.
- **Partnerships**: GP’s; community, hospital & ACF nurses; AH, Volunteers, Calvary Mater Specialists; NGO’s;
- Singleton high income
- Cessnock SEIFA Index
- Itinerant Populations
- Wine, Mines, Dairy, Health
- Health Promoting Philosophy
Reason for action

• NSAP Project: Assessment and Care Planning with aim of consumer involvement.

• Local Focus: PCA NSAP Pain Assessment Project

• Required leadership and strategic support.

• Required self-evaluation of gaps in assessment and care planning.

• Identified Pain assessment methods as area of need.
• Brainstorming and Multi-voting
RATIONALE FOR PAIN TOOLS

• Team used VAS in an ad hoc informal manner.

• Pain is a highly prevalent and feared symptom among palliative care patients (Caraceni & Cherny et al 2002).

• Research indicates VAS’s are valuable for every patient experiencing pain

• VAS provide a framework for developing a common language to promote communication (Williamson & Hoggart 2005).
Planning and Implementing

- Required two team members, a project leader and project assistant.
- **The project assistant - invited from generalist community nursing - perceived to reduce bias in the outcomes.**
- Support provided by the NSAP team project facilitators and local executive sponsorship.
- **A literature search for validated pain assessment tools and journal articles to guide tool selection and implementation into practice was conducted.**
- Brain storming session outcomes identified the pain assessment tool produced by the Peter McCallum Institute Model as per (McCaffery & Pasero 1999; Portenoy & Tanner 1996) as the preferred tool.
• The project involved incorporation of the tool into the initial assessment, with an additional copy of the tool kept in the home-file for ongoing clinical assessment, and for utilisation by the patient and/or carer if needed to communicate pain severity during the after-hours to the nurse on-call.

• **Education was provided to the team regarding methods of use of the tool.**

• The tool consisted of a VAS allowing patients to pictorially describe the severity of their pain by selecting the smiley face on a scale of 1 to 10 with 10 being the worst pain possible.

• **Additionally, the tool allowed the patient and/or carer to graphically depict the location of pain, and contains prompts for descriptive language regarding the quality and effects of pain described by the patient.**
Engaging with Stakeholder

• A common theme in the comments provided by staff during survey was the staff perception of the immediate benefits for managing pain.

• Comments include the tool provides the platform for the patient to use their own language; it’s easy and has the potential to remove barriers regarding pain discussions between patients and their carers; it is easier for carers when they ring the service, they can indicate the difference in pain severity and location without struggling for words.
EVALUATION PLAN

• Evaluation built into project, process and outcomes. Designed against aims.

• The project evaluation included staff surveys, verbal feedback from patients and carers, and report of overall medical record outcomes.

• Ten medical record audits were attended monthly for six months by the community nurse to assess for utilisation and consistent use of the VAS.
Outcomes

• Chart 1- VAS UTILISATION May – December 2011
• The medical record outcomes demonstrated 48 files (80%) consistently utilised the VAS over the six month period June to November 2011 increasing to 54 files (90%) in December. The medical record audits demonstrated staff’s adoption and embracing of the VAS tool. Chart 1 demonstrates sustainability after the six month period.
OUTCOMES/FEEDBACK

• The results were reported monthly at the business meeting enabling staff to sustain focus, improve utilisation and share stories of patient feedback and perceived benefit.

• Feedback from patients/carers includes the tool has supported them to communicate more effectively with each other, the palliative care team and the GP’s.

• An unexpected outcome is the development of a common universal language regarding pain between patients, carers, health care staff and GP’s; and the application of the VAS severity scale to describe other symptoms such as nausea, constipation, dyspnoea, and other forms of distress.
Reference List

- Caraceni, A; Cherny, N; Fainsinger, R; Kaasa, S; Poulain, P; Radbruch, L; De Conno, F; Pain Measurement Tools and Methods in Clinical Research in Palliative Care: Recommendations of an Expert Working Group of the European Association of Palliative Care. *Journal of Pain and Symptom Management*. Vol 23 No 3 2002 p 239-255
- Hunter New England Local Health District Strategic Plan: Towards 2015
• Pain Assessment Tool produced from the Peter McCallum Institute Model.

• Palliative Care Australia Standards for Providing Quality Palliative Care for all Australians. 2005. Palliative Care Australia Canberra. P183-200, 223.


• Palliative Care New South Wales: NSW State Budget Submission 2011-12, June 2011.


• Rawlings,D; Hendry, K; Mylne,S; Banfield, M; Yates, P. Using Palliative Care Assessment Tools to influence and Enhance Clinical Practice. *The Journal for the Home Care and Hospice Professional* Vol 29 No 3 2011 p139-145