PCOC palliative care outcomes collaboration

Quality Improvement Activity	
Project Title: Patients in unstable phase for more than 3 days	
Service Name: Albany Community Hospice (ACH)	
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Project Completion or Finalized Date: 25/01/2021	
Benchmark: Patients in unstable phase for 3 days or less	
Problem	The PCOC benchmark of 'Pts in unstable phase for 3 days or less' was not met in Jan-June 2019 (PCOC report). The PCOC benchmark is 90%, ACH results were 81.5%. The aim of the QI activity was to improve responsiveness to patients in the unstable phase by reviewing assessment processes and auditing all patients who did not meet the unstable phase benchmark of 3 days or less. Albany Community Hospice is an 8-bed specialist palliative care facility where patients can receive support and symptom management in a home-like environment. It is licensed as a private hospital and has a contract with the state government for the provision of inpatient palliative care for public patients. It employs nursing and support staff who in conjunction with the patient's own GP provide 24hr care with specialist palliative care oversight.
PCOC evidence	The PCOC benchmark of 'Pts in unstable phase for 3 days or less' was not met in Jan-June 2019 (PCOC report). The PCOC benchmark is 90%, ACH results were 81.5%. Two QI activities were performed in December 2019 to gather information as to why benchmark was not being met: Case review (n=10) of patients who were in unstable phase for more than 3 days. This showed: • Most patients had a response to their symptom/problem need and their care plan reviewed but some were not re-assessed in a timely manner • 50% of these patients had complex psychosocial needs and/or complex symptom management • 50% of patient had missing SAS scores which made it difficult to assess the end of the unstable phase • This showed that although the plan of care was usually reviewed and changed to address the needs of the patient in a timely manner; the phase may not have been re-assessed in a timely manner to correspond with the plan of care. It also highlighted that 50% of these patients had complex psychosocial needs and/or complex symptom needs management. 50% of cases audited had 1-4 days of SAS not reported thereby leaving the patient in unstable phase as the SAS was not being updated. Phase definition audit (n=11) showed that 23% of phases overall were incorrectly identified
Timeframe	December 2019-Jan 2021

Staff involved	Clinical nursing (lead author); Quality Improvement Coordinator (2nd author); Clinical Hospice Manager; all of nursing team
Interventions and processes	1. Implement Daily 11am Team meeting "The Huddle" to discuss PCOC scores including phase. This is to improve the accuracy of phase definition and to ensure that this is being re-assessed daily at a minimum and that care planning is updated in response to these assessments. 2. Altered clinical handover format to include PCOC language – Phase, KPS and SAS. Including highlighting in red any SAS 4 or above on the clinical handover sheet as requiring urgent action/intervention as per the ACH PCOC Assessment Plan. 3. Clinical handover sheets now updated before each shift change. These were previously only updated by night shift then changes were handed over verbally to the two following shifts (afternoon and night). Risk identified that clinical information may not be communicated to subsequent shifts as relying on verbal handover process. 4. Ensure all staff do the PCOC essentials online training – on commencement of employment (orientation) and as a yearly mandatory competency. 5. PCOC discussion and training to be included as a recurring agenda item at Clinical Team meetings held 6/52.
Results	1. To measure compliance with Daily 11am Team meeting via use of a daily attendance sheet - compliance 68% for the period of Jan-July 2020. 2. To measure compliance with the updating of handover sheets via audit of saved clinical handover sheets - compliance 86% for the period of Jan-July 2020. 3. Benchmark of 'Pts in unstable phase for 3 days or less' was met in Jan – June 2020 our results 95%.
Outcome	This activity improved assessment processes, increased accurate use of phase, improved communication and led to achievement of a PCOC benchmark. Use of case review and a phase definition audit identified that phases were not being reviewed daily, that PCOC language was not embedded in clinical handover format and that the clinical handover sheets were not updated each shift. By implementing the Daily 11am Team meeting to discuss PCOC scores including phase and updating these on the clinical handover form at every shift the culture of inclusion of PCOC scoring including phase definition was improved in the organisation. This contributed to the benchmark being met in the 6 monthly period following this. This has been sustained with further improvement of 98.3% in the June-December 2020 report.
Outputs	"Clinical Handover Policy" was edited to include these changes including the use of "The Huddle" The clinical handover sheet was edited to include Phase, RUG-ADL and Karnovsky fields.

***PCOC 17.04.2020**

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ALBANY COMMUNITY Hospice

ALERT KEY: **A** = Allergy **CI** = Cognitive Impairment **DM** = Dementia **DL** = Delirium **F** = Falls **H** = Hearing **I** – Infection **PI** = Pressure Injury **V** = Vision

HANDOVER SHEET

DATE: Click to select a date. **TIME:** _____

ROOM 1	ALERT:			ROOM 2	ALERT:			ROOM 3	ALERT:			ROOM 4	ALERT:		
NAME		AGE		NAME		AGE		NAME		AGE		NAME		AGE	
URN		DOB		URN		DOB		URN		DOB		URN		DOB	
ADMISSION DATE				ADMISSION DATE				ADMISSION DATE				ADMISSION DATE			
DIAGNOSIS				DIAGNOSIS				DIAGNOSIS				DIAGNOSIS			
DOCTOR				DOCTOR				DOCTOR				DOCTOR			
GOALS OF CARE				GOALS OF CARE				GOALS OF CARE				GOALS OF CARE			
PHASE		RUG-ADL		PHASE		RUG-ADL		PHASE		RUG-ADL		PHASE		RUG-ADL	
KARNOVSKY				KARNOVSKY				KARNOVSKY				KARNOVSKY			
SOCIAL				SOCIAL				SOCIAL				SOCIAL			
SYMPTOMS AND TREATMENT				SYMPTOMS AND TREATMENT				SYMPTOMS AND TREATMENT				SYMPTOMS AND TREATMENT			
MOBILITY				MOBILITY				MOBILITY				MOBILITY			
BOWELS				BOWELS				BOWELS				BOWELS			
BLADDER				BLADDER				BLADDER				BLADDER			
MEDICATIONS				MEDICATIONS				MEDICATIONS				MEDICATIONS			

HANDOVER SHEET

ALERT KEY: **A** = Allergy **CI** = Cognitive Impairment **DM** = Dementia **DL** = Delirium **F** = Falls **H** = Hearing **I** – Infection **PI** = Pressure Injury **V** = Vision

ROOM 5	ALERT:			ROOM 6	ALERT:			ROOM 7	ALERT:			ROOM 8	ALERT:		
NAME		AGE		NAME		AGE		NAME		AGE		NAME		AGE	
URN		DOB		URN		DOB		URN		DOB		URN		DOB	
ADMISSION DATE				ADMISSION DATE				ADMISSION DATE				ADMISSION DATE			
DIAGNOSIS				DIAGNOSIS				DIAGNOSIS				DIAGNOSIS			
DOCTOR				DOCTOR				DOCTOR				DOCTOR			
GOALS OF CARE				GOALS OF CARE				GOALS OF CARE				GOALS OF CARE			
PHASE		RUG-ADL		PHASE		RUG-ADL		PHASE		RUG-ADL		PHASE		RUG-ADL	
KARNOVSKY				KARNOVSKY				KARNOVSKY				KARNOVSKY			
SOCIAL				SOCIAL				SOCIAL				SOCIAL			
SYMPTOMS AND TREATMENT				SYMPTOMS AND TREATMENT				SYMPTOMS AND TREATMENT				SYMPTOMS AND TREATMENT			
MOBILITY				MOBILITY				MOBILITY				MOBILITY			
BOWELS				BOWELS				BOWELS				BOWELS			
BLADDER				BLADDER				BLADDER				BLADDER			
MEDICATIONS				MEDICATIONS				MEDICATIONS				MEDICATIONS			

CLINICAL HANDOVER POLICY

Table of Contents

Introduction ***1***

Purpose and Scope ***1***

Definition of Terms Used ***1***

Roles and Responsibilities ***2***

Policy Statement ***2***

Procedure *3*

Continuous improvement and monitoring ***4***

References ***4***

Related Documents ***4***

INTRODUCTION

The aim of clinical handover is to accurately communicate clinical information when the responsibility and accountability for all aspects of the patient care is being transferred from one health professional to another. Poor clinical handover can have extremely serious consequences for patients, resulting in delayed treatment, tests being missed or duplicated and wrong medication being administered to the patient.

PURPOSE AND SCOPE

The purpose is to achieve effective and high-quality communication that ensures the ongoing safety and continuity of care for the patient. Clinical handover occurs between shifts, inter-hospital transfers, admissions and discharges.

This policy, as amended from time to time, applies to all directors, staff, contractors, contractors' employees and volunteers of Albany Community Hospice (ACH), hereafter referred to as employees.

DEFINITION OF TERMS USED

Accountability	The act of accepting, acknowledging and assuming the responsibility for action/decision, encompassing the obligation to report, explain and be answerable for resulting consequences
Clinical handover	Any situation in which professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, is transferred to another person or professional group on a temporary or permanent basis.
iSoBAR	The mnemonic used to guide the structure and content of clinical handovers.
Patient Identification	The process by which a patient is identified utilising three approved patient identifiers such as patient name (family and given names); Date of Birth and healthcare record number (URN).

ROLES AND RESPONSIBILITIES

Board of Management

- To approve policies that promote patient safety by ensuring effective identification, monitoring and management of clinical risks.
- To ensure that responsibilities in relation to the management of clinical risks is clearly allocated to roles and are appropriately resourced.

Medical Advisory Committee

- Will provide organisational governance and leadership in relation to safe and effective clinical handover.

Clinical Hospice Manager

- Will ensure ACH has the systems in place to make sure that effective and consistent agreed processes for handover are applied whenever accountability and responsibility for patient care is transferred.
- Will ensure sufficient resources are in place to enable effective handover, staff training in handover, and on-going evaluation of the effectiveness of handover to occur.

Nursing Staff

- Adhere to the principles and aims of this policy and ensure they operate in accordance with it.
- Will ensure their timely participation in the handover process.
- Will ensure that any incidents relating to handover are reported via the clinical incident management process.

Credentialed Doctors

- Adhere to the principles and aims of this policy and ensure they operate in accordance with it.
- Accept the responsibility to handover clinical information, goals of care and current management plans if another doctor is taking over care or providing temporary cover
- Ensure that handover to a covering doctor occurs in a timely fashion, and that the hospice is notified, and the receiving doctor is accredited to admit to hospice.
- Ensure they receive a full medical handover for transfer of patients from another facility.

POLICY STATEMENT

Albany Community Hospice (ACH) strives to protect patient safety. Evidence indicates that ineffective handover can lead to;

- Incorrect treatment
- delays in diagnosis and treatment
- adverse events
- increased length of stay
- increase in expenditure
- unnecessary tests, treatments and communications
- patient complaints
- malpractice claims

ACH promotes that standardisation of handover, as part of a comprehensive, system wide strategy will aid effective, concise and inclusive communication in all clinical situations and contribute to improved patient safety. All handovers, other than discharges, must use the iSoBAR tool to guide the content and

structure of the handover. Where practicable, handover should be conducted with the involvement and participation of the patient and/or family.

iSoBAR Tool

i	**IDENTIFY**	Introduce yourself, your patients and reason for handover
S	**SITUATION**	Describe the current clinical situation of the patient
o	**OBSERVATIONS**	Include vital signs and assessments
B	**BACKGROUND**	Pertinent patient background information
A	**AGREE A PLAN**	Given the situation, what needs to happen
R	**READBACK**	Confirm shared understanding and accountability has been transferred

Procedure

Patient Identification: All clinical handovers must begin with patient identification utilising three patient identifiers – these are the patient's name (family and given names); Date of Birth and healthcare record number (URN) as per the Patient Identification Policy.

All clinical handovers must utilise the agreed ISOBAR tool to guide the content and structure of the handover. This will ensure the most pertinent information is shared for every patient.

Environmental controls such as shutting doors to the Nurses station and using the do not disturb sign on the door will be in place to limit non-critical interruptions to communication during handover. Please ensure privacy is assured to maintain confidentiality and ensure these disruptions are minimised. Nursing staff shall have adequate crossover time for shift handovers with minimal interruptions and ensure confidentiality is maintained in handover process.

Credentialed doctors have a responsibility to handover clinical information, goals of care and current management plans if another doctor is taking over care or providing temporary cover as per their signed Expression of Interest to provide Medical Services. Hospice must be informed of this change and this is to be documented in PalCare and on the front of the patients' bedside medical chart.

There are three nursing handovers per day, (i.e.at the commencement of each shift) using the Clinical Handover Form which is updated prior to handover by the Registered Nurse handing over care. This will include a confidential handover in the office, identifying the patient using the 3 key patient identifiers and a bedside handover inclusive of the patient and family/carer at least once daily in the afternoon. The bedside handover will include identifying the patient and introduction of the nurse taking over and key goals of care at that point of time, introducing the family/carer present and reviewing the medication chart and any pumps or devices.

All clinical handovers will be supported by use of observations from the PCOC suite of palliative care assessments using Phase of Care, Karnofsky Performance Scale (KPS) Self Assessed Symptoms (SAS) and Palliative Care Problem Severity Score. (PCPSS) They should include current, appropriate clinical notes, test results, appointment schedules, and appropriate, succinct information regarding 'care for the individual's needs.

A daily team review of these assessments "The Huddle" occurs at 11am in the nurses' station before PCOC data is entered on PalCare to ensure consistency and support/guidance in response to care planning from data collected.

Handover sheets between shifts are generated each shift for the following shift to ensure accuracy and records of these are kept in secure files on data base with restricted access to clinical staff only and audited for review of process for safety and quality.

A handover of care occurs at the weekly MDT meeting to external service providers.

Patients whose care and responsibility is to be transferred from ACH to another facility will require clinical staff to prove identity using the 3 key patient identifiers and to provide a formal verbal and written handover to the receiving clinician either prior to, or on transfer of the patient. A medical discharge summary shall accompany each patient. *(See Admission & Discharge Checklist)*

Clinical Handover to partnering service providers must follow this policy and security of information must be assured (as per the *Confidentiality Policy*) and with the informed consent of the patient and their family/carer.

All clinical staff will be educated on this policy at commencement of employment through the orientation process. Updates to this policy shall be discussed at Clinical Team Meetings.

If any clinical incidents arise from a clinical handover, they are reported as a clinical incident/near miss. This is an important source of information about gaps in our system and can identify areas for improvement.

CONTINUOUS IMPROVEMENT AND MONITORING

Audits are scheduled periodically to monitor clinical communication and these are reviewed by the Clinical Hospice Manager and relevant committees. All resulting quality improvement activities will be detailed in the Quality Improvement Register and overseen by the Quality Improvement Group. Results from audits will be reported to the Medical Advisory Committee if necessary.

REFERENCES

- Australian Commission on Safety & Quality in Health Care
    - Clinical Governance Standard 1

      https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard (accessed 18/02/2020)
    - Partnering with Consumers Standard 2

      https://www.safetyandquality.gov.au/standards/nsqhs-standards/partnering-consumers-standard (accessed 18/02/2020)
    - Comprehensive Care Standard 5

      https://www.safetyandquality.gov.au/standards/nsqhs-standards/comprehensive-care-standard (accessed 18/02/2020)
    - Communicating for Safety Standard 6

      https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard (accessed 18/02/2020)
    - Recognising and Responding to Acute Deterioration Standard 8

      https://www.safetyandquality.gov.au/standards/nsqhs-standards/recognising-and-responding-acute-deterioration-standard (accessed 18/02/2020)
- Government of Western Australia Department of Health, (2013). “WA Health Clinical Handover Policy”.
- Government of Western Australia Department of Health, (2013). Operational Directive 0403/12: Clinical Handover Policy.

RELATED DOCUMENTS

- EOI to Provide Medical Services
- MDT Operational Guidelines
- Clinical Handover Form
- Patient Identification Policy