PCOC palliative care outcomes collaboration

Quality Improvement Activity

Project Title: Clinical traffic light symptom response system

Service Name: Bethesda Health Care: Palliative Care Unit

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Benchmark or focus are:

Benchmarks 3.1 to 3.10 Change in symptoms (Anticipatory and Responsive Care)

Service Level Factors Associated with PCOC Key Strategies and Enabling Factors:
Key Strategy 1: Leadership: organisation and service level
Key Strategy 2: Local processes in place to support routine assessment
Key Strategy 3: Processes to support PCOC data entry, extraction and quality
Key Strategy 4: PCOC is included in orientation and education for all disciplines
Key Strategy 5: PCOC data is used for quality improvement and research

Elements of NSQHS Standards:
Standard 1: Clinical Governance
Standard 2: Partnering with Consumers
Standard 5: Comprehensive Care
Standard 6: Communicating for Safety
Standard 8: Recognising and Responding to Acute Deterioration

Elements of PCA Standards:
Standard 1: Assessment of need
Standard 2: Developing the care plan
Standard 3: Caring for carers
Standard 4: Providing care
Standard 5: Transitions within and between services
Standard 8: Quality improvement

Problem	Bethesda Palliative Care unit is a 24 designated-bed palliative care unit located at Bethesda Hospital in metropolitan Perth, in the suburb of Claremont, Western Australia. Patients are admitted to the PCU for a variety of reasons including acute symptom control, medical review, patient respite, carer stress and terminal care. The care is provided by a team of multi-disciplinary specialists in palliative care (nursing, medical and allied health). Bethesda PCU observed inconsistency with how the assessment tools were being using in the unit. This pertained to the Symptom Assessment Scale (when completed by proxy) and the Palliative Care Problem Severity Score tool. This inconsistency in scoring was identified by the unit's Staff Development Nurse, responsible for data entry of the scores into the IT system. On recognition of the problem, the issue was raised immediately by the SDN as a matter for urgent address and for further staff education.

	An evaluation of the literature was completed to explore best practice and evidence based responses to clinical symptom assessment scores for patients with life-limiting conditions. This project ran concomitantly and complimentary with their Unstable Phase Project.
PCOC evidence	• Bethesda PCU internal audits of PCOC assessments, scoring and clinical response by the SDN. • Performance in Bethesda's PCOC Outcome Measure and Benchmarks have demonstrated improvement over time since the introduction of the traffic light system in 2016.
Timeframe	February 2016 to May 2016
Staff involved	• Nurse Unit Manager • Staff Development Nurse • Palliative Care Consultants • Clinical Staff

Interventions and processes	A review of the literature by the SDN presented a traffic light system concept. This idea was presented to the PC team and with unanimous agreement, a protocol of response was designed informed by the literature by the SDN.
	
	The system included:
	• Protocols to explain/outline the response system (see attachments).
	• Colour coded magnetic dots for the patient whiteboard identifying and reflecting the following responses:
	  • Red – SAS scores of 8-10 and/or PCPSS 3; urgent review
	  • Yellow – SAS scores of 4-7 and/or PCPSS 2; monitor and review as needed
	  • Green – SAS scores of 0 -3 and/or PCPSS 0 or 1; patient comfortable, continue to monitor
	• Lanyards were designed for staff, reflecting the traffic light response system
	
	Nursing staff were trained to update the whiteboard with a magnetic dot reflecting the highest score of ANY of the patients' SAS or PCPSS scores.
	
	At the launch of the project, training on the system was delivered, including the provision of the accompanying traffic light lanyards.

Results	The system worked effectively, and as such remains in place. The SDN completed audits from ensuing patient assessments and data entry sessions. These reviews demonstrated improved consistency in staff scoring for both the SAS and PCPSS tools. Anecdotal feedback from the medical team included the ability to get a quick visual check - to see if any patients require an urgent review. From an education perspective, the SDN concluded that the system was a valuable educational tool too. It highlighted incorrect interpretation of the assessment tools, particularly the SAS as an assessment of distress. For example, when patients are being flagged as 'red' yet the symptoms are not causing the patient severe distress.

Outcome	This project identified the educational needs of staff regarding the PCOC assessment tools. Through a collaborative approach, the SDN was supported to design a system of response that was clinically effective, efficient, and met all of the team's needs. The clear design and language used in the traffic light system successfully informs and supports staff to recognise and communicate patient and or family/carer needs appropriately within the greater PCU. Change was observed in clinical practice – in consistency and reliability of assessment scores, and in the timeliness and appropriateness of response to patient and or family/carer needs.
Outputs	TRAFFIC LIGHT SYSTEM2.docx TRAFFIC LIGHT SYSTEM2a.docx

***PCOC 17.04.2020**

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