PCOC palliative care outcomes collaboration

Quality Improvement Activity

Project Title: Patients in the unstable phase for longer than three days

Service Name: Gold Coast Health Community Palliative Care Service

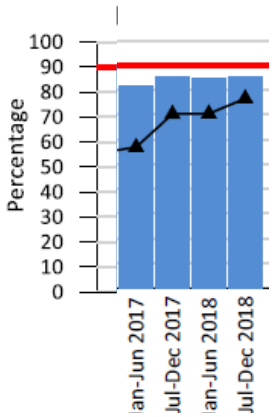
Authors (*lead): Brian Everson, Clinical Nurse – E: brian.everson@health.qld.gov.au

PCOC Contact: Anna McPherson, Improvement Facilitator QLD – E: anna.mcpherson@qut.edu.au

Clare Christiansen, Improvement Facilitator QLD – E: clare.christiansen@qut.edu.au

Project Completion or Finalized Date: January 2019

Benchmark or focus are: Unstable phase benchmark

Problem	Clients in the unstable phase for greater than 3 days (72 hours). There has been some improvement after the introduction of a PCOC communication board and a handover scrum each morning. However, we wanted to investigate if our model of care was having an effect on our results. The model of care of the Community Palliative Care service is predominately a five day per week consultative service, utilizing non-government organizations (NGOs) to deliver primary nursing care. The Gold Coast Hospital and Health Service (GCHHS) covers an area with a population greater than 600,000. The demand for the Community Palliative Care Service has grown significantly over the past few years.
PCOC evidence	As shown by the triangles in the graph to the right, the service's performance is significantly below the 90% benchmark for the unstable phase, and also below the national average for all community services (blue bars). Prior to the project commencement (January 2018) in the January to June 2017 reporting period the service had an average unstable phase length of 7.2 days, more than double the national community average of 3.1 days. In the same time period, 43% of unstable phases were not meeting the benchmark, representing 25 patients who were in an unstable phase for four days or more. 
Timeframe	After reviewing the results of the 2017 reports, the quality improvement activity was initiated in January 2018 and continued until January 2019.
Staff involved	Brian Everson - Clinical Nurse Andrew Broadbent – Medical Director Julie – Ann Brydon – Team Leader Joyce Glen – Allied Health Assistant All other staff members were involved in daily PCOC meetings
Interventions and processes	At an in-service the team reviewed the PCOC reports for 2017 and agreed to undertake a quality improvement project focussed on improving their results on the unstable phase outcome measure. The team hypothesised that the limitations of their five-day service might be impacting the ability to respond to urgent needs in a timely manner and requested additional PCOC supplementary data showing the day the unstable phase commenced. The CN then used this data to determine

which unstable phases encompassed a weekend, and the proportion of patients that were potentially in an unstable phase for longer than three days *because* of the lack of service over a weekend. The results of this investigation on 2017 data showed that the proportion of patients affected by a weekend was minimal.

It was thus confirmed that the team needed to focus on processes and procedures to ensure that the unstable phase was being correctly assessed and documented. The CN used the 'Response to assessments' and 'Phase assessments' PCOC audit tools to help structure a comprehensive review of their practices around unstable phases.

The team reviewed the PCOC Board which they use to track unstable patients and noted that it lacked key information pertaining to length in the unstable phase: the date a client entered the unstable phase. The Board was thus redesigned to include this date and enable the team to monitor a patient's time in the unstable phase and prioritise care accordingly. At the morning PCOC scrums the team also decided to trial "PCOC Live" meaning that any phase changes were agreed upon as a team and made on the board during the scrum. It was anticipated that the outcome from these changes would minimise the number of patients in the unstable phase for longer than three days, with the exception of those with an unstable phase including a weekend for which the service is unable to meet the benchmark within the current resource model. While it was initially thought the PCOC scrum time of 15 minutes would be ample to make changes to PCOC data, it needed to be lengthened to complete the PCOC Live process.

Audits also revealed several other issues regarding the way PCOC data was being recorded and shared amongst team members who are situated across different offices. The Community team uses an electronic form which is saved on a specific hard drive to record patient information and assessment scores. It was assumed that all team members could access this drive however it became apparent that some clinicians, particularly Registrars were not routinely being granted access at the start of their rotation. Processes were thus put in place to ensure that these issues were resolved. PCOC Online Education for all clinicians was also added to the orientation and has been made mandatory for all staff, with a 12-monthly review.

Issues with missing PCOC documentation were also highlighted. For example, some patients were reviewed by a team member and while PCOC assessment scores and phase change data was recorded in their medical notes, this information was not recorded on the PCOC form. A small percentage of unstable clients also had missing discharge scores or phase change information as their community episode had ended with admission to a private hospital and the Community team was not notified of this at the time.

Following this process, the team created a documented titled, '*Work Instruction for the Collection and Completion of patient data for PCOC*' to help standardise assessment processes and documentation.

Results

As shown in the table below, since the project commenced in 2018, there has been an overall improvement on the unstable phase benchmark. The average length of unstable phases is now much closer to the national average for community services.

The results indicate that this project has enabled the service to achieve the unstable benchmark for a greater proportion of clients between Monday to Friday than previously. It also highlights that more resources would be required to adequately address unstable patients after hours and over the weekends, confirming the limitations of the current model of care.

Indicator	Jan-Jun 2017	Jul-Dec 2017	Jan-Jun 2018	Jul-Dec 2018
Average unstable phase length (days)	**7.2**	**3.4**	**4.2**	**3.2**
% unstable phases >3 days as a proportion of all unstable phases	**43%** (25/58)	**39%** (39/101)	**28%** (20/71)	**22%** (22/98)
% patients potentially unstable for >3 days due to weekend as a proportion of all unstable phases >3 days	..	..	**33%** (7/21)	**60%** (14/23)

Outcome	Improvement in the management of unstable clients and the identification of service-level changes that are required to meet client needs. We continue to refine our assessment processes and support staff to assess unstable clients. There is ongoing education and mentoring of team members.
Outputs	A document titled, '*Work Instruction for the collection and completion of patient data for PCOC*' under the GCHHS Community Supportive and Specialist Palliative Care team has been formalised. Permission has been given to share the document and it will be attached as an annex.

***PCOC 17.04.2020**

The quality improvement report and associated documents are placed in the public domain for others to use. Please acknowledge the source as the service and lead author. If you wish to modify the content please contact the lead author or service directly.