PCOC palliative care outcomes collaboration

Quality Improvement Activity	
Project Title: Creation of a Palliative Care Observation and Response Chart	
Service Name: Mater Private Hospital Brisbane, Palliative and Supportive Care Consultation Liaison Service	
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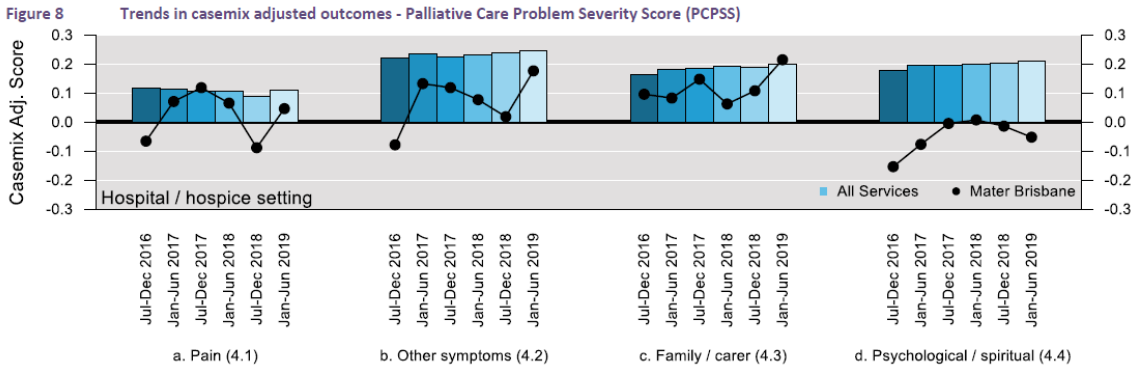
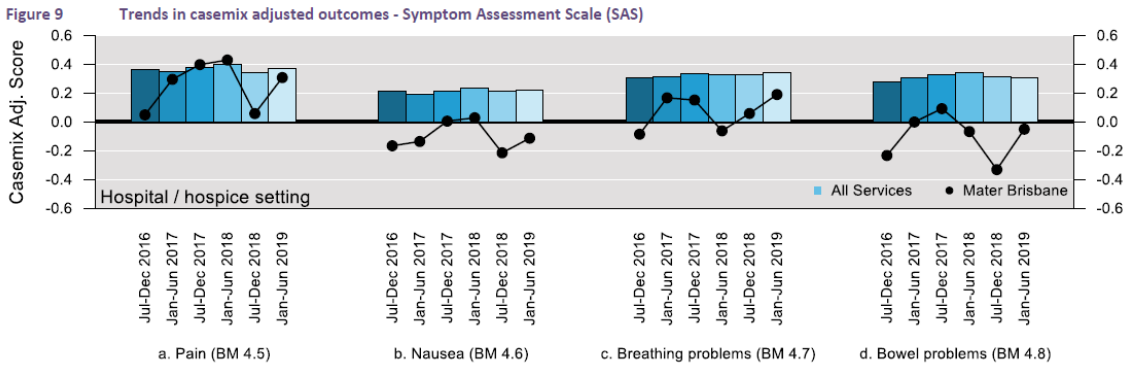
Project Completion or Finalized Date: 2018	
Benchmark or focus are: Improvement in assessment and response to palliative needs with a focus on the unstable phase benchmark	
Problem	Mater Private Hospital Brisbane is the largest of Mater Health Service's private facilities with 323 beds. The consultation liaison team, consisting of two clinical nurse consultants (1.2 FTE) and 1 FTE palliative medical specialist provide in-reach specialist palliative care via a five-day-a-week service with limited after hours support. They see around 350 patients a year, most of whom (over 60%) commence an episode in the unstable phase with severe symptoms or problems requiring an urgent response. In Queensland, most hospitals, including the Mater Private use the Queensland Adult Deterioration Detection System (Q-ADDS) to record and document the frequency of patient observations/vital signs. While the Q-ADDS is appropriate for documenting elements of the care provided to palliative patients who are receiving active treatment, it does not effectively capture the needs of palliative patients and the type and frequency of care provided by the specialist team. The palliative care team thus identified that there was inconsistent and at times, insufficient documentation around symptom assessment for palliative patients. There was also no standardised procedure for response to assessments, escalation of care, and referral to allied health. They hypothesised that this might be negatively affecting their capacity to show improvement on the unstable phase benchmark and other benchmarks requiring multidisciplinary interventions, i.e. psycho-spiritual distress, family/carer distress, and responsive management of fatigue.
PCOC evidence	Prior to the project, for the reporting period January to June 2017 (Report#23), the service only achieved the unstable outcome measure for 54.9% of patients, well below the 90% benchmark. They were failing to meet the 60% benchmark for responsive family/carer distress, at 47.6%, and responsive fatigue management at 58.9%. While they were just meeting the responsive PCPSS pain benchmark at 60.3%, there was room for improvement. Their outcomes for the case-mix adjusted PCPSS and SAS scores were significantly below the national average for inpatient services as shown in the figures below.





Timeframe	The project was conceptualised in early 2017. The chart was developed and piloted over several months in late 2017 and embedded into routine use from the start of 2018.
Staff involved	Danielle Roach (Palliative Care Clinical Nurse Consultant) initiated and led the project in conjunction with the Palliative Care team and Cancer Care Services. The hospital-wide End of life Working Party were also involved in all steps.
Interventions and processes	The CNC attended a palliative care health roundtable in early 2017 at which there was discussion with other services around appropriate palliative observation/assessment and how to best capture this information in a clinically useful way. The CNC decided to undertake a project to create and implement a customised palliative care observation chart with the aim of standardising palliative care symptom assessment and response and ensuring accurate documentation. They also intended to share this document with colleagues in other medical settings to assist them to recognise and respond to palliative needs and to facilitate referral to the consult team as appropriate. The CNC first undertook a period of consultation with her team and a review of the tools they were routinely using. After a further period of research, a draft observation chart was created by combining several assessment tools including domains of the Palliative Care Problem Severity Score (PCPSS) and the Symptom Assessment Scale (SAS) as well as guidelines around mouth care, skin integrity and pain assessment for non-communicative patients. A key inclusion of the observation chart is the 'track and trigger' function. This includes 'ACTIONS REQUIRED' prompts for pain and other symptoms based on four levels of severity (absent, mild, moderate and severe). To systematize the clinical care provided in terms of the escalation of care and frequency of review, a recommended clinical response is prescribed for each level in accordance with locally available resources such as allied health. For example if a patient has a severe pain score of eight or higher, the clinical response is to contact the treating team for review and to increase observations from 4 hourly to hourly until the pain becomes mild or absent. The form also records the interventions and helps to monitor their effectiveness over time.

	The form was initially piloted within Cancer Services. The CNC devised a feedback form and asked the nursing staff to complete it throughout the trial. The feedback received was very positive and minimal changes were required. With the support of the End of Life Working Party the CNC then focused on staff training, ensuring that all Doctors were aware of the form. The introduction of the form was combined with a campus wide Advanced Care Plan (ACP) rollout and through this mechanism the form was presented at several nursing forums and education events. The Mater Education Team has now taken responsibility for ongoing nurse training on the form.
Results	Overall improvements in patient outcomes (PCOC reports) and observed improvement in communication of patient needs.
Outcome	The creation and implementation of the chart has led to an improvement in the consistency of palliative care assessment and response and documentation of the care provided by the consult team. This has resulted in modest improvement in management of the unstable phase. Better and more timely referral to allied health has also led to improvements against symptoms/problems which require non-pharmacological interventions such as family/carer distress and psycho-spiritual problems. The palliative care team have received positive feedback from colleagues in other wards, particularly those who do not have an oncology background. They report that the tool provides them with much needed guidance in assessing patients with palliative needs, providing appropriate care and knowing when to refer patients to allied health and/or specialist palliative care. As a result, the palliative care team thus feel that there is better hospital-wide awareness of the discipline of palliative care and the depth and holistic nature of the person-centred care, which is the cornerstone of palliative care. They report that they have had an increase in referrals to their team by other clinicians who are not able to achieve optimal symptom control and management, particularly for non-malignant diagnoses. It has also standardised the palliative care approach by doctors who do not refer patients to palliative care. While the CL team has not yet been able to access hospital data, they would like to investigate whether there has been a reduction in calls to the medical emergency team at end of life. They do have an auditing process led by the Quality Improvement Unit which has shown a significant increase in the number of ACPs being completed in a timely and complete manner. This data is presented to the End of Life working party and Clinical Governance Committees on a regular basis.
Outputs	The Observation Chart- Palliative Care has been implemented in the consult service and hospital wide at the Brisbane Mater Private and Public Hospitals. It has also been utilised within other Mater Health services including Redlands and Springfield and there have been enquires from other Queensland-based Mater Health services about implementing the form in the future. The CL team have granted permission for their document to be shared and it will be attached to this report as an appendix.

***PCOC 17.04.2020**

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