PCOC palliative care outcomes collaboration

Quality Improvement Activity	
Project Title: Identifying and responding to the Terminal Phase	
Service Name: St John of God Bunbury Hospital – Specialist Palliative Care Unit (SJGBH-PCU)	
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Project Completion or Finalized Date: December 2016	
Benchmark or focus area: Patients Dying Outside Terminal Phase	
Problem	St John of God Bunbury Specialist Palliative Care Unit is a 10 bed inpatient palliative care unit operating as a ward in a regional private hospital in Western Australia. The service has a comprehensive interdisciplinary team with dedicated clinical staff and is the only palliative care unit (PCU) in the South-West with both a fulltime palliative medicine specialist and a clinical nurse specialist. The interdisciplinary team also comprises of an advanced palliative trainee, a clinical nurse, nurse unit manager, registered and enrolled nurses and patient care assistants. The extensive allied health care team includes pastoral practitioners, physiotherapy, an occupational therapist, dietician, social worker and a music therapist commencing in 2020. Due to demand for specialist palliative care services a second Palliative Medicine Specialist commenced in 2019 with a primary consultancy role. All inpatients are reviewed on a daily basis by a palliative medicine specialist. The service has been participating in PCOC since 2011 when patients were predominantly, admitted to the PCU under local GPs for end of life care and/or respite care. In 2012 SJGBH-PCU employed their first palliative medicine specialist followed by the clinical nurse specialist role. Since 2013, the PCU has been consistently improving in all benchmarks and outcome measures over time. Through their PCOC data and reports, the service identified 20 patients that died outside the terminal phase in the period June – December 2015. This represented a significant proportion of all deaths recorded in this period for the service – 27%. Correct identification of the terminal phase enables patients to be commenced on The Care Plan for the Dying Person (EOLC pathway) and ensures high quality end of life care is delivered in a timely fashion. This includes appropriate discussions with family and carers preparing them for the death of their loved one. The aim of this Quality Improvement Project was to improve the identification and response to the terminal phase though audit, feedback and education.
PCOC evidence	1. PCOC report for service, reporting *period June – December 2015*. 2. PCOC supplementary reports, *Deaths outside the Terminal Phase.* 3. PCOC Retrospective Audit tool, *Phase definition.*
Timeframe	The project was undertaken during a three-month period following the PDSA (plan, do, study, act) quality cycle: including audit, feedback to the team regarding results and focussed education.
Staff involved	The project was conducted by Eileen Harris – Clinical Nurse Specialist, Palliative Care, SJGBH-PCU.

Interventions & processes

The PCOC report identified a high number of patients dying outside the terminal phase. This was significant for a specialist palliative care unit where there is an expectation that dedicated staff are skilled in identifying the advent of the terminal phase.

Interventions included:

Audit

- A retrospective audit was undertaken utilising the PCOC *Phase Definition* audit tool. The PCOC assessment form and medical records of the 20 patients who died outside the terminal phase were examined to verify phase assignment for accuracy. Audit results were summarised and a short report written.

Education

- In-service sessions to feedback audit results were undertaken with the clinical team and new or changed processes identified including real and/or perceived barriers to the identification of the terminal phase.
- CNS devised an education plan to address knowledge gaps and overcome identified barriers.
- Data Entry person identified an earlier knowledge deficit related to data entry and this was subsequently rectified.
- Processes for improved communication of the patients' palliative care phase were reviewed.

Results

Patients Dying outside of Terminal Phase

Total number of audits conducted	20
Patients who were reported as dying outside of the Terminal Phase	20
Patients who actually died outside of Terminal Phase	11/20 = 55%
Total number of Terminal Phases recorded on PCOC Assessment Tool	9/20 = 45%
Number of Terminal Phases correctly recorded on PCOC assessment tool, according to Phase definition	9/20 = 45%
Number of Phases **incorrectly recorded** as outside of Terminal Phase **by data entry person** (e.g. deteriorating/unstable)	9/20 = 45%
Total number of patients commenced on EOLC pathway	15/20 = 75%
Total number of patients commenced **on EOLC pathway** but **not recorded as in the Terminal Phase**	6/20 = 30%

Phase Definition Audit

Total number of audits conducted	**20**	
Total number of Phases recorded	**51**	
	Numbers	**Total %**
Number of Phases **correctly recorded** according to Phase definition	32	62.74%
Number of **Phases incorrectly recorded** according to Phase definition	19	37.25%
Stable Phase (1)	**5** (*deteriorating/terminal)	
Unstable Phase (2)	**3** (*deteriorating/terminal)	
Deteriorating Phase (3)	**11** (*terminal/unstable) **denotes the correct phase*	

	Analysis: ▪ Whilst 75% of all patients who died were placed on the end of life care pathway, 30% of these patients did not have a Phase 4 (terminal phase) recorded on their PCOC Assessment tool. ▪ Only 1 of the 20 patients who died experienced a rapid deterioration of their condition, which was a barrier to timely commencement of the EOLC pathway and appropriately updating their PCOC Phase 1/20 (5%). ▪ Incorrect data entry resulted in the PCOC report reflecting that 20 patients died outside of the Terminal Phase during June to December 2015. Auditing processes revealed the true figure was 11 patients. This error occurred in relation to the data entry person being new to the role. ▪ Incorrect use of the PCOC assessment tool attributed to 10 patients being incorrectly assigned outside of Phase 4 (terminal phase). 4 patients did not commence the EOLC pathway on admission resulting in incorrect phase assignment despite the patient actively dying. The EOLC pathway was actioned for the remaining 6 patients although their PCOC Phase did not reflect this. ▪ Total number of incorrectly assigned PCOC Phases was high at 37% with **19/51** incorrectly assigned. Clinical staff omitted to change the PCOC Phase to Terminal on 11 occasions despite clear documentation in the patient record. ▪ Incorrectly, assigned Phases included 5 Stable phases, 3 unstable phases and 11 Deteriorating phases. ▪ Notably staff unfamiliar to the PCU attributed to a number of incorrectly assigned phases however, not all. Clinicians working regularly within the PCU made a significant number of errors in Phase identification. ▪ Audit was undertaken during a period of time when PCOC Phases were updated daily i.e. once per 24 hours and have since increased to each shift.
Outcome	The entire clinical team engaged with PCOC. PCOC became the common language used by the interdisciplinary team during clinical handover and in team meetings accurately communicating patients' current care needs. The following changes were implemented as a result of this activity: ▪ Clinical co-ordinators to promote discussion between team regarding PCOC Phases and plan of care during clinical handover. ▪ Discussion of PCOC phases during morning medical round and at twice-weekly team meetings. ▪ PCOC assessments are completed every shift (as a minimum) AND whenever a change in patient condition occurs. ▪ Staff skilled in palliative care to undertake PCOC assessments. ▪ Student nurses not to undertake PCOC Phase assignment. ▪ Provision of focussed education to improve both understanding of PCOC Phases and accuracy when assigning Phases. ▪ New staff orientation booklet for PCU with PCOC assessment noted as a core competency with 'live' links to the PCOC website enabling clinical staff to participate in self-education. ▪ Clinical staff new to the PCU to continue to attend a PCOC workshop within their first 6-12 months of employment to introduce PCOC assessment tools. ▪ Data entry person provided with link to PCOC website to access further information. Ongoing support provided by clinical nurse specialist. Repeat audits conducted following next PCOC report for reporting period January – June 2016, both for patients dying outside terminal phase, and assigning PCOC phases.

	These audits showed substantial improvement in reducing the number of deaths outside terminal phase – 14% compared to previous report of 27%. The figures continued to improve with data from the following reporting period July – December 2016 showing a further reduction of deaths outside terminal phase to 12.5%.
Outputs	Phase audit reports and ongoing PCOC education sessions. SJGBH policies refer to PCOC Phases relating to observations for palliative care patients, including those on an EOLC pathway and admission/discharge of palliative patients to and from the PCU. Staff orientation booklet – PCOC included as core competency, with links to PCOC website to access online training packages. Completion of PCOC online modules within 6 – 12 weeks of employment is expected.

***PCOC 17.04.2020**

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