Whole of team approach to improving family and carer outcomes

Service: **Central Adelaide Palliative Care Service – Community**

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Section 1: *Linking the project to benchmarks, standards and service level factors*

(select which relate to this project)

Project Title: Family/Carer Project: Community Service

Project Completion or Finalized Date: June 2019

Benchmark: 3.10 PCPSS Family/Carer Responsive Care (Moderate/Severe)

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

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 8: Quality improvement

BPSO (Best Practice Spotlight Organisation) Implementation of Best Practice Guideline: Person and Family Centred Care

Section 2: *Background and evidence*

The background to this activity:

Central Adelaide Palliative Care Service (CAPCS) is a large metropolitan specialist palliative care service located in the Central Adelaide Local Health Network in Adelaide, South Australia.

The community palliative care team did not meet the Family/Carer benchmark (3.10) for the July-December 2018 reporting period. This measure is to improve family / carer problems by reducing moderate to severe scores to the absent to mild range. Services aspire to achieve this 60% benchmark. Overtime, a review of results showed that the community arm of CAPCS had consistent difficulty in meeting this benchmark. Another possible contributing factor was that for this same period, there was also an increasing number of community admissions.

Our team wanted to understand the reasons for this result.

Evidence

Baseline audit

We used the PCOC supplementary reports for all patients that did not meet this benchmark. These reports provided the details for us to undertake an audit of the severe family/carer problems.

We audited 21 assessment forms and progress notes. Clinical records were reviewed to compare the severe PCPSS Family/Carer scores with clinical entries in the case records to establish:

a) If the corresponding clinical entry indicated a severe PCPSS score (correct/incorrect PCOC score).
b) If the patient identified as having a severe PCOC PCPSS Family/Carer score had a management plan to address this issue.
c) If the patient's management plan included a referral to psychosocial support services (CAPCS Social Worker assigned to relevant community area).

From these audits there were two main findings:

1. Incorrect scoring and recording for the PCPSS Family/Carer domain,
2. A lack of reporting of clear management plans in patients' clinical records to address severe scores.

CAPS Community Benchmark Results for Moderate to severe family / carer problems				
PCPSS Family/Carer	Report Jul-Dec 2017	% Below Benchmark	Report Jan-Jun 2018	% Below Benchmark
Moderate / Severe	37.1%	22.9%	38.2%	21.8%

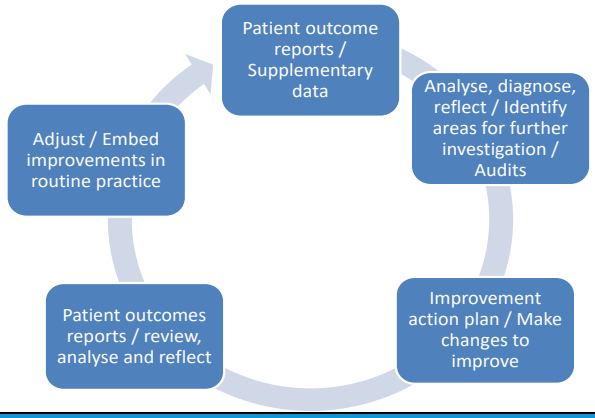
Review of resources
Central Adelaide Palliative Care Service has 3.7FTE x of social work to support approximately 450 patients in the community setting. CAPCS performance in PCOC Outcome Measure and Benchmark for PCPSS 3.10 Family/Carer problems may not reflect favourable psychosocial outcomes in the family/care domain for patients identified as having moderate or severe problems at episode start due to the FTE of SW staff.

Review of referrals to Social Work
We identified that the family / carer scores were not consistently used to prompt a referral. The PSS score field was often left as moderate or severe without appropriate adjustment to the PCPSS Family/Carer score once a management plan had been established and the family/carer distress/problem reduced.

Review of assessment processes
Social work team were not routinely involved in using the PCOC assessment tools (PCPSS). We found that despite referral to social work, and consequently the enhancement of the patient/family's care plan, the effectiveness of interventions were not captured in our PCOC data.

Education
Education was provided to the whole team on use of the PCPSS as a screening tool. This included: directions to medical and nursing staff to use the PCPSS Family/Carer domain as intended - a screening tool - to prompt SW referral and more intensive assessment by the SW team; education for nursing staff around the definition and use of PCPSS Family/Carer to eliminate incorrect scoring; education around the need to document a management plan addressing extreme scores - to allow timely assessment and the enhancement of the existing management plan to address complex issues.

Problem	CAPCS community team not meeting the benchmark for family/carer problems. There has been no improvement in this result overtime. The results for this outcome measure was a significant concern to the service.
Measures	We will measure impact of our intervention using the PCOC Patient Outcome reports and Supplementary reports. We will also report on the findings of the audits overtime using case studies to highlight identified improvement opportunities.
The aim and objectives of the intervention	**Aims:** 1. To improve Family/Carer PCPSS outcomes through accurate assessment of family/carer needs with a validated carer assessment tool; informing appropriate referral to CAPCS psychosocial services and allow in-depth psychosocial assessment for targeted and individualised interventions. 2. To improve patient and family/carer outcomes across symptom and problem domains using the PCOC tools through the enhanced support of carers/family. **Objectives:** Family/carer burden and distress will be reduced through: • Improving early identification of problems using PCPSS scores to trigger deeper assessment or referrals to allied health/social work services. • Improving collaboration with carers to identify issues, solutions and psychosocial and support needs based on the assessment • Improve documentation of assessed need and response to clinical interventions with accurate documentation of the PCPSS Family Carer scores.
Intervention	We implemented the follow strategies: 1. Identified specific education needs of clinicians in the assessment of the PCPSS Family/Carer domain. 2. Discussed the findings of the PCPSS Family/Carer domain audits at Nursing Team meetings and with the Psychosocial Team Lead to focus attention on the problem and aims of the QI project. 3. Developed clinical pathways/protocols for all CAPCS clinicians to ensure appropriate referral to allied health to manage family/carer problems with moderate or severe PCPSS Family/Carer scores. 4. Social work developed, initiated and implemented a protocol Fact Sheet) which includes routine monitoring of moderate and severe PCPSS Family/Carer scores at Multidisciplinary Community Team meetings. 5. Directed that the PCPSS Family/Carer domain be used as a screening tool to prompt referral to social work to assess carer needs at point of care (in real time). 6. PSS scores of 2 or 3 for family/carer triggered referral for an in-depth psychosocial assessment, and re-assessment or review following intervention and consequent modification of the plan of care. 7. Ensured individual care plans for family/carers were developed and documented in medical/ clinical records. 8. Ensured PCPSS scores for family/carer were reviewed post interventions and revised where appropriate; there was a focus on social work being responsible for recording PCOC scores for this domain at psychosocial assessment, and during and post interventions.
Timeframe	12 months and ongoing

The lead/s of this activity	Nurse Consultant: Service Improvement NUM: Community Social Work Lead
This activity involved the following staff	Nursing team Social Work Medical Team
Method	Plan-Do-Study-Act cycle to implement and review. CACPS Community team will be provided with ongoing feedback from reports, data and QI strategies throughout this cycle at handovers and MDT meetings for reflection and comment and input. 

Section 3: ***Post Implementation***

Complete this section following the intervention e.g. post one, two or three PCOC reports

Did the changes result in an improvement?

There were changes in the way our team works but we have not yet seen any improvement on benchmark performance over time, from July – December 2017 to July – December 2018; there was a worsening in benchmark performance by 5.1% over the 12 month period measured. This may coincide with the change to entering retrospective data rather than real time data for this reporting period.

PCPSS Family/Carer	Report Jul-Dec 2017 BM result	% Variation to BM BM result	Report Jan-Jun 2018	% Variation to BM BM result	Report Jul-Dec 2018	% Variation to BM BM result
Moderate / Severe	37.1%	22.9% below BM	38.2%	21.8% below BM	32.0%	28.0% below BM

Outputs

As part of this quality improvement activity we created the following:

1. Response protocols and pathways to improve referral to the allied health team.
2. An audit tool for social work, and utilised by SW, to become more aware and proactive in using PCOC clinical assessment tools in routine patient and family care and to drive improvement in the PCPSS Family/Carer domain in real time.
3. Formal carer/family protocol (developed in conjunction with community clinicians).
4. Documentation of the audit process to present to the service and as a record of completion.

These resources are attached for reference.

Results

Result of the intervention on patient and family/carers

We observed an improvement on assessment of the PCPSS domain of Family/Carer problem severity and the recording of scores – supporting improved response, timely and appropriate reviews. There is enhanced communication and monitoring within the MDT community team of patients' family/carers needs and gaps. We also found an enhanced and thorough assessment for family/carers with moderate and severe scores.

Results	**Result of the intervention on service delivery / organisation** Organisational changes included: • A closer working relationship between community medical, nursing and social work staff to identify, assess and manage family/carer problems in the community. • Recognition of the role and active participation of social work in supporting family/carers in the community. • Formalised protocol for response to moderate/severe PCPSS Family/Carer scores. • Protocols and Pathways have been developed and endorsed within the organisation. • Improved communication within the MDT community team for this domain. • Improved understanding of the PCPSS – how to assess, how/when to respond. • A Family/carer response protocol developed in conjunction with community clinicians.
Sustainability	We now have protocols and pathways to guide the routine referral to social work services for moderate to severe PCPSS scores in the Family/Carer domain. This is supported by a Social Worker carer support and consent Protocol, called a Fact Sheet. We now conduct bi-annual audits using a PCPSS Family/Carer Audit Tool for community social workers. This will help us to monitor the results of the interventions.
Summary and future action plan	Although CAPCS Community team observed a worsening performance in their PCPSS Family/Carer benchmark results since focusing on this problem (July – December 2017 to July – December 2018), this outcome is not uncommon in the initial stages of implementing a QI project. By focusing on a problem, all aspects of a problem are evident, and then can be thoughtfully analysed and evaluated with QI actions developed. As such, this QI project highlighted gaps and the need for improving the embedding of and routine use of PCPSS Family/Carer domain within the community team. For the CAPCS community team, initial improvements have been observed and expressed by their team via: • Heightened awareness of PCPSS assessment, particularly for the Family/carer domain; • Improved engagement and communication with their allied health/social work team; • Improved communication and reporting in clinical notes and at MDTs; • Enhanced accountability by allied health in response and recording of the PCPSS Family/Carer scores, including improved referrals to SW, and reciprocated response and communication from SW to the clinical team; • Improved patient/family/carer communication and assessment; • The development of resources to support sustained improved assessment, understanding and trigger timely MDT referral and response to the PCPSS Family/Carer domain. Plan: • To review next PCOC reports and data for PCPSS Family/Carer Domain (3.10) (PCOC reporting period: Jan – June 2019) • If future CAPCS' PCOC reports and data do not demonstrate an improvement for the Family/Carer domain (3.10), and as per the strategies outlined in this document, the team will have sound evidence to communicate their inability to respond to the needs of the population they serve; their patients' family/carers have needs beyond the capacity of the CAPCS' team.

***PCOC 17.04.2020**
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