PCOC palliative care outcomes collaboration

Quality Improvement Activity	
Project Title:	Improving the Management of Fatigue – Step 1 Audit
Service Name:	Central Adelaide Palliative Care Service – Community
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Section 1: Linking the project to benchmarks, standards and service level factors (relating to the project)	
PCOC Benchmark:	3.5 and 3.6 Fatigue (SAS)
Service Level Factors Associated with PCOC Key Strategies & 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 needs Standard 2: Developing the care plan Standard 4: Providing care Standard 7: Service culture Standard 8: Quality improvement	
Problem	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 service provides palliative care in both the inpatient and community settings. The service has been participating in PCfaOC since 2014 and uses PCOC both as a clinical

	programme, and for data collection for the purposes of benchmarking and quality improvement. The purpose of this exercise was to review the clinical response of the service to community patients who recorded high SAS scores at phase end for the problem of fatigue (a score of 7 or above). For the PCOC reporting period January to June 2019, eight patients were reported to have ended a phase with fatigue SAS scores of 7 or greater, with two patients ending more than 1 phase with fatigue SAS scores of 7 or greater.
PCOC evidence	PCOC Supplementary Report for Central Adelaide Palliative Care Service for reporting period January to June 2019 (see Appendix A). Adaptation of PCOC Quality Improvement Audit tool to audit 'Management of Fatigue'
Timeframe	The timeframe this activity was conducted was across a period of two weeks in December 2019.
Staff involved	This activity was conducted by Karen Jacquier, Nurse Consultant, Service Development for CAPCS.
Method	The PCOC Supplementary Report for the service for the reporting period January – June 2019 was reviewed, with 10 patient episodes ending a phase with a high SAS score for fatigue. Two patients ended more than 1 phase with a high SAS score for fatigue. All 8 patients were selected for audit. The Audit tool used was an adaptation of a PCOC Quality Improvement Audit, amended for the purpose of this exercise. The Audit is attached as Appendix B, and the Audit Tally Sheet is attached as Appendix C. For each patient, the electronic medical record was reviewed for the following: • Was there a high SAS Fatigue score recorded on the PCOC Assessment flowchart? • Who is documented as having assessed the SAS Fatigue score (patient/carer/clinician)? • Was the high SAS Fatigue score clearly identified in the corresponding clinical note? • Was there an action plan detailed to address the high SAS Fatigue score? • Was there a referral made to an OT, and if yes what was the length of time between referral and OT assessment? • If applicable, was the OT assessment documented in the clinical notes? • Were referrals made for other support services, and if yes, which services? • Was there any evidence in the clinical notes of written resources providing information about fatigue being provided to the patient and/or carer? • Was there any documentation to indicate a reduction in the SAS Fatigue score to 6 or less, following OT assessment and/or subsequent clinical assessment? • If yes, was the score documented in the PCOC data sheet?

Results	• All Fatigue SAS scores were reported by clinicians, despite the SAS being a patient rated symptom scale. • Only one patient had clinical documentation of fatigue as a symptom *listed* in the clinical notes correlating to the date a severe (9) PCOC Fatigue SAS score documented. The clinical entry did not articulate a severity or distress score for fatigue. • No corresponding clinical entry identified or articulated the *distress* from fatigue as being high. • One audited patient has a documented fatigue SAS score and full suite of PCOC assessments without any evidence of having any type of clinical contact. • There were no corresponding action plans for patients with a recorded high fatigue SAS score. • Although 2 patients had documentation of a referral plan to OT for assessment, these referrals were not as a result of the high SAS Fatigue scores, and were unrelated to this recorded symptom. • Additionally, there were referrals for other support services for some of the audited patients, but again these were unrelated to the high SAS fatigue scores. • There was no evidence of written resources about fatigue being provided to the patients and/or carers. • Corresponding PCOC phase allocation: 4 patients entered deteriorating phase with SAS Fatigue scores of 7 or above, 2 patients entered terminal phase with SAS Fatigue scores of 7 or above, 2 patients had cases closed for inpatient admission with Fatigue SAS scores of 7 or above.
Outcome	Areas Identified for improvement: • Ongoing education identified for correct assessment using the SAS tool. Definition of SAS scores to be reinforced as patient rated "distress" scores, not severity of symptom. Clinicians to ask patients to rate their own levels of distress for all SAS symptoms including fatigue. This will result in correct assessment and provide opportunity for clinicians to open dialogue with patients about their distress and what can be done/interventions put it place to improve it. • High SAS Fatigue scores should correspond with an appropriate phase allocation. Severe or high scores in any symptom warrant urgent attention and review of care plan. Correct phase should reflect this need. Ongoing education re phase allocation required. PCOC Data and audit results discussed with Nurse Unit Managers, PCOC champions and other disciplines who use PCOC.

	Consideration is being given to developing an agreed management plan for management of fatigue and distress from fatigue Future PCOC reports will be monitored for improvement, with repeat audits in 6 & 12 months if required.
Outputs	Quality Improvement Audit tool for Management of Fatigue (Appendix B) Audit Tally Sheet (Appendix C) In progress – Plan for Management of Fatigue, and Distress from Fatigue In progress – Automatic referral pathways to OTs and other disciplines for management of moderate and severe fatigue and distress from fatigue.

***PCOC 17.04.2020**

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