PCOC palliative care outcomes collaboration

Quality Improvement Activity

Project Title: Improving community palliative care patient outcomes: The design of a service-specific PCOC workshop

Service Name: Mercy Palliative Care

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Benchmark or focus are: 2 Patients unstable for three days or less

3.2 Clinician rate pate (Moderate/Severe)

Problem

Mercy Palliative Care is a community-based palliative care service catering for the western suburbs of Melbourne. Historically only nursing staff conducted Palliative Care Outcomes Collaboration (PCOC) assessments and PCOC data collected using a paper based form. Our PCOC data identified that there was problem with the way we provided symptom management. Initially our belief was that the problem was in the paper-based method of data collection. We found it difficult to reconcile our excellent patient feedback with our PCOC reports.

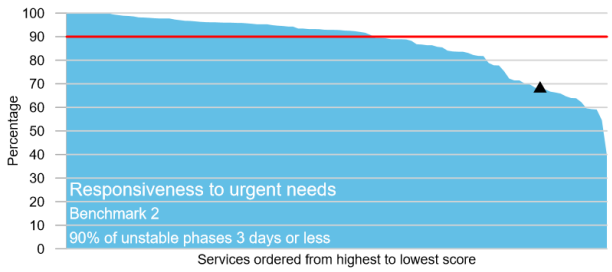
The aim of the project was to understand the cause of our PCOC data and if required to develop a process to improve patient outcomes. Our main objective were:

- To reduce the number of patients who remained in the unstable phase for more than three days.
- To reduce the number of patients who had moderate or severe clinician reported pain

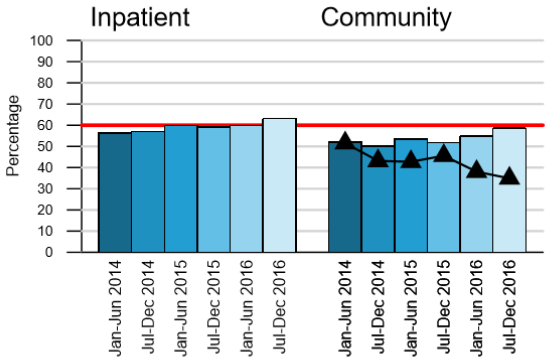
PCOC evidence

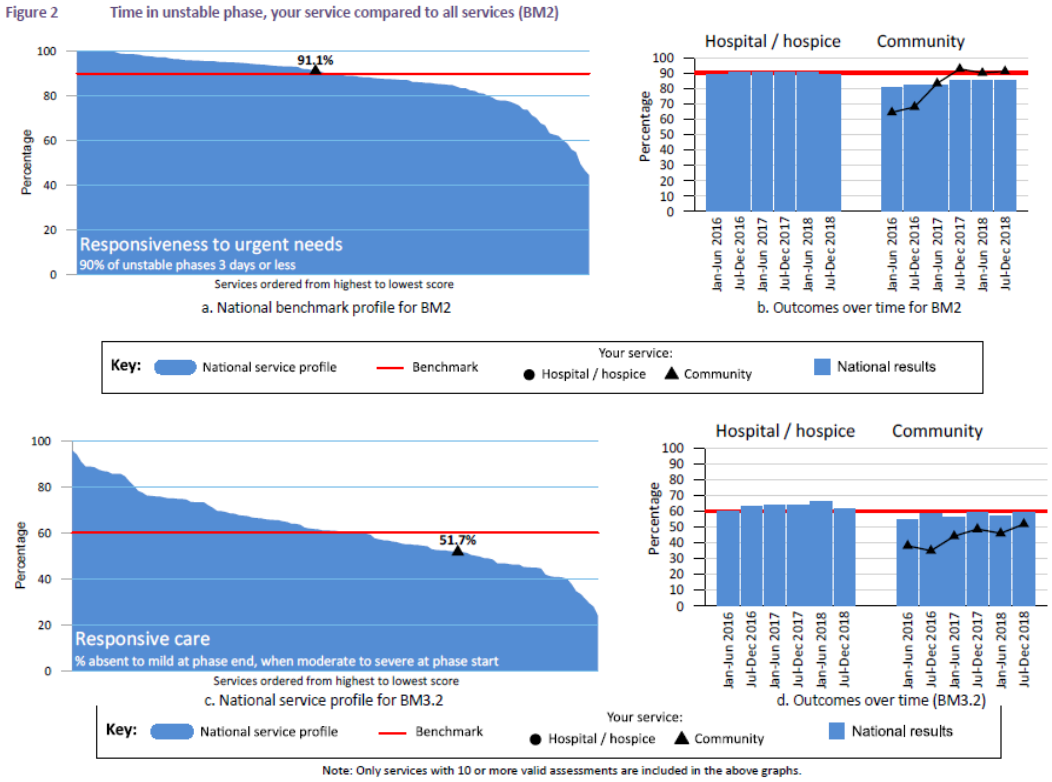
The PCOC outcomes reports highlighted an area from improvement:

Figure 3 Time in unstable phase, your service compared to all services (BM2)



a. National benchmark profile for BM2

	 *d. over time profile for BM3.2* Our PCOC data indicated that we had significant room for improvement trying to reduce the number of patients in the unstable phase for more than three days. It also appeared that our patients with clinician rated moderate or severe pain at phase end was increasing over time.
Timeframe	The timeframe for implementation was six months.
Staff involved	This activity involved the following staff: Fran Gore; Manger, Mercy Palliative Care Jenny Grace; Clinical Support Nurse Martin Kaltner; Quality and Education Clinical Nurse Consultant
Interventions and processes	• PCOC was able to provide reports on patients not reaching benchmark in the unstable phase and patients who reported distress from moderate to severe pain. From this information, a file review uncovered three significant areas for improvement. Our staff needed a better understanding of the PCOC assessments and how to use the PCOC report in a way to improve patient outcomes. We also needed to improve the method of our data collection. • The method of upskilling our nursing staff was with an initial half-day workshop, which we designed. The session began with time spent exploring our data and reviewing case studies. The session culminated in the implementation of a new escalation protocol/ flow chart to using PCOC scores to determine clinical interventions. • Over a six-month period, we presented the half-day workshops in which all nursing staff participated. The workshop had three goals: 1) To improve the understanding of PCOC assessment; 2) To explore what our PCOC data mean to the service; and 3) To implement a new escalation protocol using PCOC scores to influence clinical interventions. • PCOC outcomes reports are regularly provided to staff.
Results	Between July and December 2016, 67.9% of patients met the unstable benchmark (BM 2). Between July and December 2018, 91.1% met the benchmark (BM 2). This constituted an improvement of 23.2%. Between July and December 2016, 34.9% of patients with moderate or severe clinician rated pain at phase start had absent or mild clinician rated pain at phase end. Between July and December

	2018, 51.7 of patients with moderate or severe clinician rated pain at phase start had absent or mild clinician rated pain at phase end. This constituted an improvement of 16.8% 
Outcome	Our data shows that embedding PCOC assessment in clinical decision-making has improved patient outcomes. This has been aided by incorporating PCOC assessment in our MDTs and discussing PCOC outcome reports during staff meetings. Our new data collection method allows us build a more complete picture of what patient and carer needs are. This was further enhanced by the allied health staff being trained to conduct PCOC assessment.
Outputs	• A PCOC training package was developed and all staff were required to attend. The package was delivered in 3.5hr training session. Include was PCOC education, PCOC outcomes discussion and case study review. A revised version is now delivered to all new nursing and allied health. • A PCOC escalation protocol was developed and a laminated A5 copy given to each staff member • Paper based form for data collection has been replaced with an electronic form to capture. This electronic method allows us to capture 'missing' data such as assessments from phone calls. • Local procedures have been rewritten to include using PCOC assessments to determine action

***PCOC 17.04.2020**
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