PCOC palliative care outcomes collaboration

Quality Improvement Activity

Project Title: Embedding outcome measurement into routine processes - Scheduling and discharge

Service Name: Sacred Heart Community Palliative Care Team

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Project Completion or Finalized Date: 2016

Benchmarks or focus areas: Embedding outcome measurement

Problem

Sacred Heart Community Palliative Care Team (Sacred Heart CPCT) is a specialist, consultative, multidisciplinary team located in the heart of Sydney, Darlinghurst, New South Wales. Sacred Heart CPCT assesses and manages patients at varying stages of their illness, including a high proportion of patients from culturally and linguistically diverse communities.

In 2015, Sacred Heart CPCT undertook the MDT project, which strengthened functionality and increased efficiency of the MDT meetings. Whilst implementing the MDT project, Sacred Heart CPCT Nurse Manager (NM) and Clinical Nurse Consultant (CNC) identified that:

- Staff were unclear on how frequently they should be scheduling reviews and when to discharge palliative care patients
- There was inconsistencies and inefficiencies with current scheduling and discharge practices
- Staff required structured processes to help guide decision making and achieve consistency in practice.

As an extension of the MDT project, the Sacred Heart CPCT commenced a project to incorporate PCOC assessment tools into visit scheduling and discharge planning processes. The project aimed to standardise these routine processes to enable timely, patient-centred care in response to identified needs.

PCOC evidence

Implementing, embedding and sustaining the PCOC program into routine practice requires action in the following key strategy areas: leadership and governance, assessment, training and education, data entry and quality improvement. (PCOC clinical Manual, April 2018). The strategy area encompassing 'Leadership' has a number of enabling factors that support services to embed PCOC into routine policy, practice and use for quality improvement. One such enabling factor is PCOC Assessment Protocol is included in governance for triage, assessment and care planning (i.e. in relevant organisational policies/ procedures).

Timeframe

The project commenced in 2016, and took six months from initial discussions to the finalised templates.

Staff involved

The NM and CNC led the project. The resources were developed in consultation with the MDT.

Interventions and processes

The NM and CNC discussed feedback received from MDT meetings and identified the need to document and introduce structured processes for visit scheduling and discharge planning.

The NM and CNC met with members of the MDT to discuss their insights from the recent MDT meetings and gained agreement to develop resources to be used by all members of the CPCT. The NM and CNC used PCOC Assessments to assist in defining criteria for scheduling visits and discharging patient and developed the resources in collaboration with the MDT.

The following resources were developed:

- CPCT visit schedule: Using Palliative Care Phase to direct frequency of contact, visits and guide expectations of care planning.
- CPCT Workload planner: Using Palliative care phase to outline the expected length of visit. This was introduced to promote safe workloads for nursing staff and acted as a guideline to assist with workload planning.
- CPCT Discharge process: Using length of time in the Stable phase to identify patients appropriate for discharge and guidance on other factors for consideration.

Prior to introduction, the resources were provided to all MDT members for comment and input. These comments were discussed with the MDT and consensus obtained to finalise the resources.

The resources were provided to all staff and incorporated into the orientation pack for new staff.

Results

The visit schedule and discharge planner were well received by staff and anecdotally, improved service delivery and organisation of the Sacred Heart CPCT.

Anecdotally, the benefits of the discharge process include:

- Increase in confidence presenting cases to the MDT
- Increase in number of nurses presenting cases to the MDT
- Delivery of 'discharge MDT' where only patients for discharge are discussed, thereby improving efficiency
- Increased capacity of the team to respond to patients requiring multidisciplinary care
- Improved communication between disciplines

Anecdotally, the visit schedule helped with prioritisation of patients and assisted with workload planning for nursing staff.

The workload planner resource was not well received by staff. This is believed to be due to the prescriptive nature of the document and the original mode of introduction perceived as directive rather than guiding. This resource has recently been revised and work is underway to reintroduce and reposition the resource as a guidance tool.

During introduction of the tools, there has been sustained recruitment and retention issues within Sacred Heart CPCT which has led to a decrease in the experience and expertise across the team. This may have impacts on the effectiveness of the interventions.

Outcome
Embedding outcome measurements into routine processes supports staff with decision-making, empowers clinicians to discuss their patients during MDT's and improves efficiency. Collaboration between MDT members is important when changing routine processes to ensure staff have opportunities to contribute their ideas, experiences and expertise to processes relevant to their daily work, promote commitment and buy-in to implement new processes and improve understanding and consistency between clinicians in processes that help govern patient care. Processes that support clinical decision-making need to be developed with the flexibility to accommodate patient complexities and other factors relevant to the local context (e.g. cultural factors).
Outputs
The project involved the development of three outputs that are included as appendices: • Appendix A: CPCT visit schedule using PCOC phases • Appendix B: CPCT Workload planner • Appendix C: CPCT discharge processes

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