PCOC palliative care outcomes collaboration

Quality Improvement Activity

Project Title: Creation of a Palliative Care Observation and Response Chart

Service Name: Mater Private Hospital Brisbane, Palliative and Supportive Care Consultation Liaison Service

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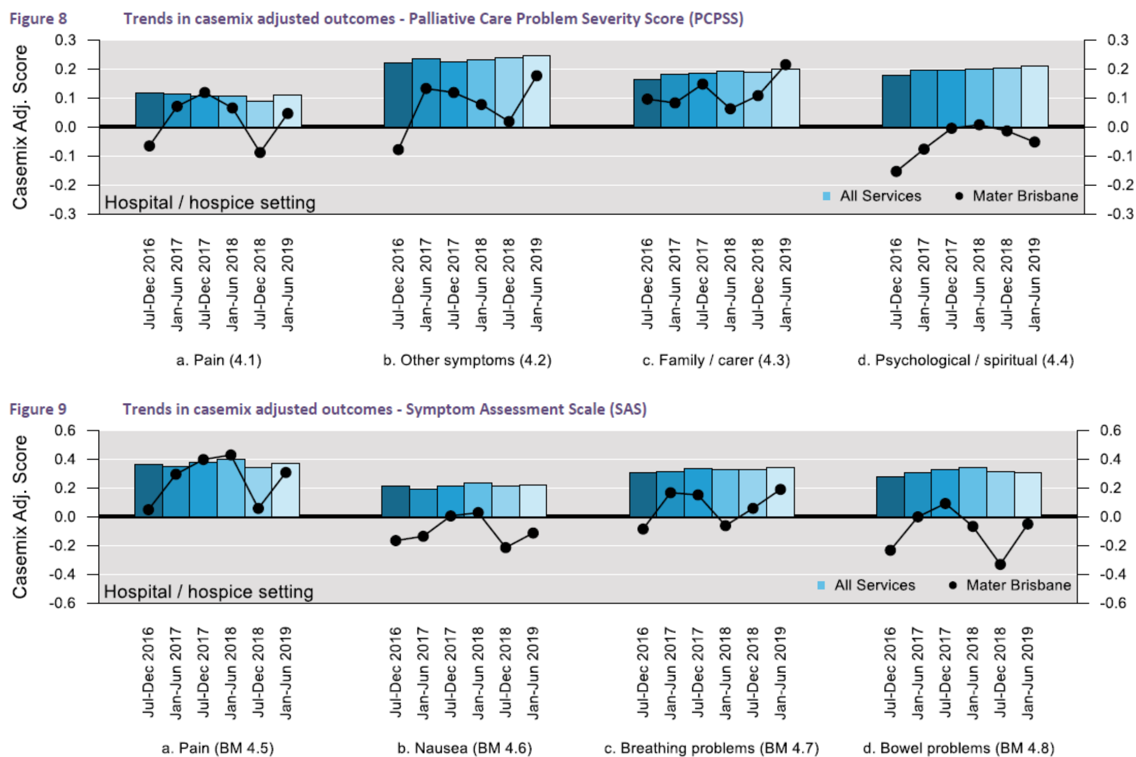
Project Completion or Finalized Date: 2018

Benchmark or focus are: Improvement in assessment and response to palliative needs with a focus on the unstable phase benchmark

Problem	Mater Private Hospital Brisbane is the largest of Mater Health Service's private facilities with 323 beds. The consultation liaison team, consisting of two clinical nurse consultants (1.2 FTE) and 1 FTE palliative medical specialist provide in-reach specialist palliative care via a five-day-a-week service with limited after hours support. They see around 350 patients a year, most of whom (over 60%) commence an episode in the unstable phase with severe symptoms or problems requiring an urgent response. In Queensland, most hospitals, including the Mater Private use the Queensland Adult Deterioration Detection System (Q-ADDS) to record and document the frequency of patient observations/vital signs. While the Q-ADDS is appropriate for documenting elements of the care provided to palliative patients who are receiving active treatment, it does not effectively capture the needs of palliative patients and the type and frequency of care provided by the specialist team. The palliative care team thus identified that there was inconsistent and at times, insufficient documentation around symptom assessment for palliative patients. There was also no standardised procedure for response to assessments, escalation of care, and referral to allied health. They hypothesised that this might be negatively affecting their capacity to show improvement on the unstable phase benchmark and other benchmarks requiring multidisciplinary interventions, i.e. psycho-spiritual distress, family/carer distress, and responsive management of fatigue.
PCOC evidence	Prior to the project, for the reporting period January to June 2017 (Report#23), the service only achieved the unstable outcome measure for 54.9% of patients, well below the 90% benchmark. They were failing to meet the 60% benchmark for responsive family/carer distress, at 47.6%, and responsive fatigue management at 58.9%. While they were just meeting the responsive PCPSS pain benchmark at 60.3%, there was room for improvement. Their outcomes for the case-mix adjusted PCPSS and SAS scores were significantly below the national average for inpatient services as shown in the figures below.



Timeframe

The project was conceptualised in early 2017. The chart was developed and piloted over several months in late 2017 and embedded into routine use from the start of 2018.

Staff involved

Danielle Roach (Palliative Care Clinical Nurse Consultant) initiated and led the project in conjunction with the Palliative Care team and Cancer Care Services. The hospital-wide End of life Working Party were also involved in all steps.

Interventions and processes

The CNC attended a palliative care health roundtable in early 2017 at which there was discussion with other services around appropriate palliative observation/assessment and how to best capture this information in a clinically useful way. The CNC decided to undertake a project to create and implement a customised palliative care observation chart with the aim of standardising palliative care symptom assessment and response and ensuring accurate documentation. They also intended to share this document with colleagues in other medical settings to assist them to recognise and respond to palliative needs and to facilitate referral to the consult team as appropriate.

The CNC first undertook a period of consultation with her team and a review of the tools they were routinely using. After a further period of research, a draft observation chart was created by combining several assessment tools including domains of the Palliative Care Problem Severity Score (PCPSS) and the Symptom Assessment Scale (SAS) as well as guidelines around mouth care, skin integrity and pain assessment for non-communicative patients.

A key inclusion of the observation chart is the ‘track and trigger’ function. This includes ‘ACTIONS REQUIRED’ prompts for pain and other symptoms based on four levels of severity (absent, mild, moderate and severe). To systematize the clinical care provided in terms of the escalation of care and frequency of review, a recommended clinical response is prescribed for each level in accordance with locally available resources such as allied health. For example if a patient has a severe pain score of eight or higher, the clinical response is to contact the treating team for review and to increase observations from 4 hourly to hourly until the pain becomes mild or absent. The form also records the interventions and helps to monitor their effectiveness over time.

	The form was initially piloted within Cancer Services. The CNC devised a feedback form and asked the nursing staff to complete it throughout the trial. The feedback received was very positive and minimal changes were required. With the support of the End of Life Working Party the CNC then focused on staff training, ensuring that all Doctors were aware of the form. The introduction of the form was combined with a campus wide Advanced Care Plan (ACP) rollout and through this mechanism the form was presented at several nursing forums and education events. The Mater Education Team has now taken responsibility for ongoing nurse training on the form.
Results	Overall improvements in patient outcomes (PCOC reports) and observed improvement in communication of patient needs.
Outcome	The creation and implementation of the chart has led to an improvement in the consistency of palliative care assessment and response and documentation of the care provided by the consult team. This has resulted in modest improvement in management of the unstable phase. Better and more timely referral to allied health has also led to improvements against symptoms/problems which require non-pharmacological interventions such as family/carer distress and psycho-spiritual problems. The palliative care team have received positive feedback from colleagues in other wards, particularly those who do not have an oncology background. They report that the tool provides them with much needed guidance in assessing patients with palliative needs, providing appropriate care and knowing when to refer patients to allied health and/or specialist palliative care. As a result, the palliative care team thus feel that there is better hospital-wide awareness of the discipline of palliative care and the depth and holistic nature of the person-centred care, which is the cornerstone of palliative care. They report that they have had an increase in referrals to their team by other clinicians who are not able to achieve optimal symptom control and management, particularly for non-malignant diagnoses. It has also standardised the palliative care approach by doctors who do not refer patients to palliative care. While the CL team has not yet been able to access hospital data, they would like to investigate whether there has been a reduction in calls to the medical emergency team at end of life. They do have an auditing process led by the Quality Improvement Unit which has shown a significant increase in the number of ACPs being completed in a timely and complete manner. This data is presented to the End of Life working party and Clinical Governance Committees on a regular basis.
Outputs	The Observation Chart- Palliative Care has been implemented in the consult service and hospital wide at the Brisbane Mater Private and Public Hospitals. It has also been utilised within other Mater Health services including Redlands and Springfield and there have been enquires from other Queensland-based Mater Health services about implementing the form in the future. The CL team have granted permission for their document to be shared and it will be attached to this report as an appendix.

***PCOC 17.04.2020**
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OBSERVATION CHART - PALLIATIVE CARE

Unit Record No. ______
Surname ______
Given Names ______
DOB ______ Sex ______

AFFIX PATIENT IDENTIFICATION LABEL HERE

Order from print supplier

Assessment	Scale
Date	
Time	
Assessment completed by proxy (Y/N)	
Pain: • Refer to guidelines on page 3 for non-communicative patient • Score 0 - 10 (10 being the worst pain imaginable) • Observe for non-verbal cues • Ensure patient's position not contributing to pain • Consider pre-emptive PRN analgesia before activities likely to cause pain.	10
	8 - 9
	6 - 7
	4 - 5
	1 - 3
	0
Agitation/ Restlessness: • Exclude reversible causes of agitation e.g. urine retention, constipation, opioid toxicity, hypoxia, pain, position.	Severe
	Moderate
	Mild
	Absent
Breathing problems: • Consider position change or use of fan • Consider appropriateness of oxygen therapy • Consider referral to physiotherapy.	Severe
	Moderate
	Mild
	Absent
Nausea and vomiting: • Consider regular antiemetics • Consider antiemetics pre-meals • Consider referral to dietician	Severe
	Moderate
	Mild
	Absent
Fatigue: • Consider referral to physiotherapy or OT	Severe
	Moderate
	Mild
	Absent
Respiratory secretions: • Consider change to semi-prone position • Consider antisecretory agent • Discuss and educate family/ other.	Severe
	Moderate
	Mild
	Absent
Emotional distress: • If expressed consider referral to Pastoral Care/ Psychosocial OT/ Social Work.	Severe
	Moderate
	Mild
	Absent
Family/ Carer distress: • Notify treating team with concerns • Offer pastoral care • Inform Team Leader/ NUM • Consider referral to Social Work.	Severe
	Moderate
	Mild
	Absent
Is the patient having difficulty sleeping? • Consider environmental factors • Discuss with treating team.	Yes
	No
Is the patient incontinent or retaining urine? • Manage incontinence with appropriate aids • If patient has not voided > 8 hours → perform bladder scan.	Yes
	No
Is the patient constipated or has diarrhoea? • Document on Bowel Chart • Discuss management of constipation or diarrhoea with treating team.	Yes
	No
Are the patient's eyes unclean or dry? • Cleanse eyes with normal saline as required.	Yes
	No
Is the patient's mouth unclean or dry? • Refer to guidelines on page 4 • Refer to treating team if oral candida present.	Yes
	No
Is the patient's skin integrity compromised? • Refer to guidelines on page 4 • Continence managed with aids if necessary • Consider referral to OT if lymphoedema present.	Yes
	No
Intervention	(e.g. 'A')
Initials	

OBSERVATION CHART- PALLIATIVE CARE 300

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OBSERVATION CHART - PALLIATIVE CARE

Unit Record No.	
Surname	
Given Names	
DOB	Sex

AFFIX PATIENT IDENTIFICATION LABEL HERE

OBSERVATIONS

- This form is to be used in conjunction with Q-ADDS chart? ☐ Yes ☐ No
  If a Q-ADDS chart is not required this must be directed by the medical officer and documented in the *Progress Notes*.
- Acute Resuscitation Plan (ARP) completed? ☐ Yes ☐ No Date completed:
- Observations to be completed 4 hourly unless otherwise indicated. Refer to **ACTIONS REQUIRED** table for symptom and pain interventions.
- Symptoms must be assessed according to the patient's level of distress relating to each symptom.
- If patients are asleep or unresponsive, patient assessments should be recorded proxy by nursing staff according to signs of distress.
- If symptoms are absent or not applicable then they are scored as 0 or absent.
- Referrals to allied health professionals should be made in consultation with the treating team.
- When graphing observations, place a dot (•) in the appropriate box and join to the preceding dot (e.g. /).

ACTIONS REQUIRED →for pain assessment

Score 8 – 10 Severe	→ If score remains 8 or above for 2 consecutive assessments, despite use of PRN medication and/ or other strategies, contact treating team for review. Conduct hourly monitoring until pain score < 4.
Score 4 – 7 Moderate	→ Consider interventions/ PRN medications. Increase frequency of monitoring of pain to hourly until pain score < 4.
Score 0 – 3 Mild/ Absent	→ Continue current management.

ACTIONS REQUIRED →for other symptoms (excluding pain)

Severe	Symptom is present in the worst form imaginable for patient	→ If symptom remains severe for two consecutive assessments despite use of PRN medication and/ or other strategies, contact treating team for review.
Moderate	Symptom present and moderately inhibiting ADLs. Intervention required	→ Consider use of PRN medication to treat symptom or employ other management strategy.
Mild	Symptom present and mildly inhibiting ADLs. Intervention required	→ Consider use of PRN medication to treat symptom or employ other management strategy.
Absent	Symptom not present or not applicable to patient	→ Continue monitoring symptoms.
Yes	Symptom present	→ Consider actions on page 2 and 3 and refer to guidelines on page 4; Escalate concerns to treating team.

INTERVENTIONS	Relating to observations from page 3
If an intervention is administered, record here and note letter in Intervention row on page 3 in appropriate time column	A
	B
	C
	D
	E
	F
	G
	H
	I

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Pain assessment in a non-communicative patient

- **Total scores** range from 0 –10 (based on a scale of 0 – 2 for five items), with a higher score indicating more severe pain (0 = "no pain" to 10 = "severe pain").
- A possible interpretation of the scores is: 1 – 3 = mild pain; 4 – 7 = moderate pain; 8 – 10 = severe pain.

Behaviour	Score 0	Score 1	Score 2	Score
Breathing independent of vocalization	Normal	• Occasional laboured breathing • Short period of hyperventilation	• Noisy laboured breathing • Long period of hyperventilation • Cheyne-Stokes respirations	For illustration purposes only do not write score here
Negative vocalization	None	• Occasional moan or groan • Low-level speech with a negative or disapproving quality	• Repeated troubled calling out • Loud moaning or groaning • Crying	
Facial expression	Smiling or inexpressive	• Sad • Frightened • Frowning	• Facial grimacing	
Body language	Relaxed	• Tense • Distressed • Fidgeting	• Rigid • Fists clenched • Knees pulled up; pulling or pushing away • Striking out	
Consolability	No need to console	• Distracted or reassured by voice or touch	• Unable to console, distract, or reassure	
			Total score	

Mouth care guidelines

Mouth condition	Frequency	Instructions
Mouth clean and moist and patient tolerating normal oral intake	Twice a day	• Brush teeth using soft brush • Mouth cares as indicated if receiving chemo/ radiation therapy • Moisture therapy for lips
Mouth coated or mucositis present	Minimum of four times each day	• Brush teeth using soft brush twice a day • Use mouthwashes alternating 20 to 30mL of 0.9% sodium chloride with sodium bicarbonate solution • Moisture therapy for lips
Presence of oral candida (thrush)	Minimum of four times each day	• Brush teeth using soft brush twice a day • Use mouthwash 20 to 30mL of sodium bicarbonate solution • Moisture therapy for lips • Request treating team prescribe antifungal agent(s)
Patient in terminal phase or unable to receive oral intake	Every 2 hours	• Use large cotton swabs or sponge sticks moistened in water or liquid of patients choosing • Goal is to maintain moisture • Request treating team prescribe artificial saliva or oral moisture gel • Moisture therapy for lips

Skin integrity guidelines

Patient independent and skin intact	1. Cleanse skin daily and when necessary with pH neutral cleanser and dry thoroughly 2. Protect skin with water based emollients
Patient mobility restricted	1. Cleanse skin daily and when necessary with pH neutral cleanser and dry thoroughly 2. Protect skin with water based emollients 3. Consider Physiotherapy or Occupational Therapy referral
Patient immobile or skin integrity compromised	1. Cleanse skin daily, and promptly after episodes of incontinence, with pH neutral cleanser and dry thoroughly 2. Protect skin by applying water based emollients twice daily 3. Use barrier cream to compromised skin or treat pressure area as per hospital guidelines 4. Use pressure relieving device such as Aircell mattress 5. Strive to reposition patient 4 hourly on a pressure relieving mattress or 2 hourly on a regular mattress 6. Wound care referral if indicated 7. If patient is in pain during turns/ hypiene cares →pre medicate 30 minites prior to activity
Patient in terminal phase	1. Cleanse skin daily, and promptly after episodes of incontinence, with pH neutral cleanser and dry thoroughly 2. Protect skin by applying water based emollients twice daily 3. Use barrier cream to compromised skin or treat pressure area as per hospital guidelines 4. Use pressure relieving devices such as Aircell mattress 5. Strive to reposition patient 4 hourly on a pressure relieving mattress or 2 hourly on a regular mattress 6. Careful positioning avoiding vigorous skin rubbing, friction and shearing forces 7. If patient is in pain during turns/ hygiene cares →pre medicate 30 minutes prior to activity 8. The goal in terminal phase is to maintain comfort, prolonged time spent in the same position will contribute to discomfort

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