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.

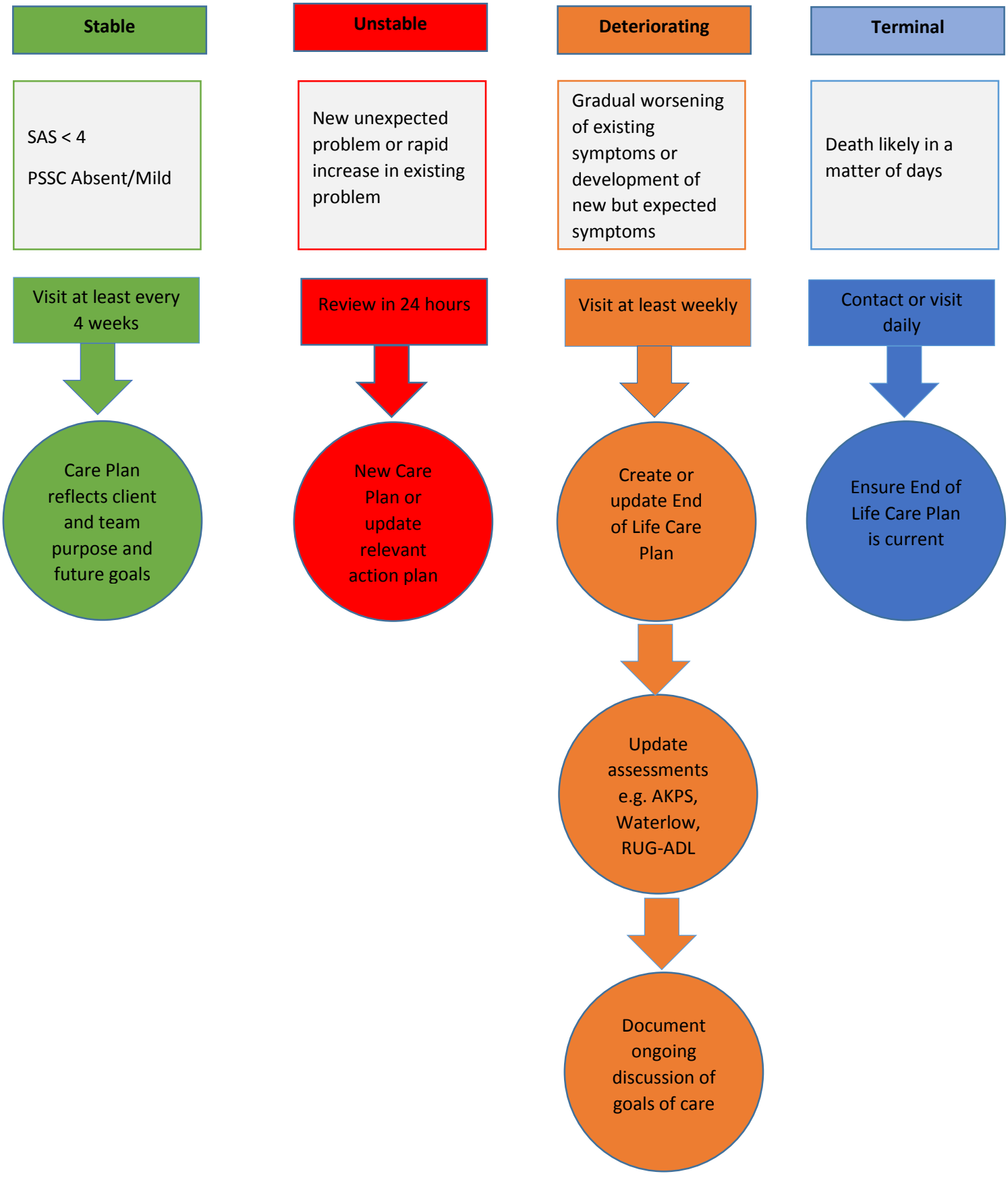
The workload planner resource was not well received by staff. This is believed to be due to the prescriptive nature of the document and the original mode of introduction perceived as directive rather than guiding. This resource has recently been revised and work is underway to reintroduce and reposition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

Appendix A

CPCT Visit schedule using PCOC Phases



Appendix B

CPCT Workload Planning - Guidelines

CPCT work hours are 0830-1700, including 30 mins unpaid meal break.

Expectation of 5 hours face to face clinical work daily.

This increases to 6- 6.5 hours with Triage as there is no requirement for driving time and note writing is done at point of call.

Workload planning:

CPCT Visit schedule using PCOC Phases

Stable	Unstable	Deteriorating	Terminal
SAS < 4 PSSC Absent/Mild	New unexpected problem or rapid increase in existing problem	Gradual worsening of existing symptoms or development of new but expected symptoms	Death likely in a matter of days
Visit at least every 4 weeks	Review within 24 hours	Visit at least weekly	Contact or visit Daily

To maintain contact with patients we need to be able to plan workloads ahead of schedule. This involves a process of daily and weekly and monthly planning, using the team diary as a planning tool.

Visits for stable patients should be booked in advance.

Space can be left daily for unplanned unstable and new referrals.

Expected/Predicted length of time for visits

Stable	Unstable	Deteriorating	Terminal	New referral	Phone calls
30 minutes	60 minutes	45-60 minutes	New set up for Syringe driver 120 minutes Ongoing Syringe Driver 60mins	120 minutes	15 minutes
10 mins Documentation	30 mins documentation + referrals	10 minutes documentation	30 mins documentation	30 minutes documentation	10 mins documentation

Planning New Referral Visits

Category C

Referred from POW or SVH Consult Service: Nurse only visit hand over at MDT and registrars can see when required

Referred from external consult Service or GP: Consider registrar for first visit, but may be a nurse only visit depending on symptoms

Category B

Referred from POW or SVH Consult Service: Nurse only visit hand over at MDT and registrars can see when required

Referred from external consult Service or GP: Consider registrar for first visit if Problem severity scores > 2 on triage and no plan is place

Category A

Referred from POW or SVH Consult Service: May be a nurse only visit if plans are in place.

Referred from external consult Service or GP: Prioritise for joint visit with Registrar

Daily Morning Meeting

Coordinated by CNC /ACNC

Time frame 15-20 minutes at 0845

Case Manager Responsibility:

Identify patients that require visits and document in the diary. Note patients Full Name, phase, call or visit and expected length of visit. The diary is a legal document so should be completed in pen and legible writing.

You should be looking at the triage board to allocate new referrals (this can be done in advance so patients and families are notified in a timely manner)

You must call in to CNC/A.CNC if your planned visits have exceeded expected time (e.g. stable patient is now deteriorating and you need more time). This means your work can be redistributed if needed.

You must call in to CNC/A.CNC if you have to attend any extra visit that are not in the diary.

Diary entry could look like this:

	Patient Name	Phase	Contact type	Expected length
Nurse 1	John Smith	Stable	H/V	30 +10
	Jan Jam	deteriorating	H/V	45 +10
	Sun Rise	Stable	h/v	30 + 10
	New Referral	TBC	H/v	120 +30
				Total = 285 mins (= 4 ¾ hours)

Suggestions: Plan your stable patients ahead of time- you can put these in the diary 1-2 weeks in advance or make the next appointment when you see them ensuring they are aware to contact if symptoms change.

Focus the visit around SAS scores. This helps to direct the purpose of the visit.

If you have a day with only 1- 2 hours face to face plan, allocate a new referral into your time.

CNC responsibility:

Facilitate meeting and keep to 20 min time frame

Facilitate reallocation of work (to another day or another team member) if Face to face exceeds 5 hours.

Facilitate allocation of work if Face to Face is below 5 hours.

Facilitate allocation of new referrals and Cat A referrals in conjunction with case managers.

Appendix C

CPCT Discharge Processes

Discharge Criteria

Reasons for referral have been addressed	Patient is Stable*, or Dertorating** in expected way	Patient and family have no ongoing specialist palliative care needs

RACF

- One off consultation
- Attend Consultation
- Advise on management
- Discharge

RACF

- Ongoing supportive Care
- Interventions initiated
  Regular patient follow provided
  Stable* for 3 consecutive months, OR deteriorating** in an expected way, with no complex palliative issues
- Referrer, GP, Patient, Family & Staff agree that care needs are being met by RACF
- Discharge

Community Patients

- Care needs are met informally (eg family, frineds) or by private crae arrangements (paid carer)
- Interventions initiated
  regular follow up provided
  Stable* for 3 consecutive months
- Patient has a GP providing Regular medical reviews +/- community case manager (e.g Geriatric Flying Squad, Heart Failure Team
- Referrer, GP, Patient and Family are agreeable to discharge from CPCT
- Discharge

Note: if there is disagreement about appropriateness for discharge, a team or family conference should be organised

Discuss Discharge at MDT → Communicate in writing with GP & referrer to advise of discharge → Document discharge in PCS and end EOC

*PCOC definition of stable, ** PCOC definition of deteriorating