Gippsland Region
Palliative Care
Consortium

Palliative Care Project Plans

In 2015-16, the GRPCC offered quality improvement grants to local Health Services to undertake projects that would directly improve the delivery of palliative care to clients living with life limiting illnesses in Gippsland.

To create some sustainability to the investment in these grants, the GRPCC is offering these project plans and accompanying documents and proforma to assist other services to develop their own implementation plans for palliative care activities. These plans are free for you to download, but in the instance that they are used, we would appreciate you notifying us, and acknowledging the GRPCC (use the feedback tab on GRPCC front page www.grpcc.com.au).

We have endeavoured to ensure that health services have been de identified in these documents, without removing information that may be pertinent to the plan.

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Gippsland Region Palliative Care Consortium

Implementation of PCOC (Into a community palliative care service).

Original project plan

NAME OF PROJECT	**PCOC implementation and support for community based palliative care**
BACKGROUND	**The PCOC program began in 2006.** **PCOC tools are validated tools that can provide a standardised framework to assist Clinicians to consistently document and communicate:** **a) the assessors clinical findings** **b) the subjective information from the patient** **PCOC data is submitted by registered participants.** **PCOC Reports would be used to identify gaps, drive education and improve palliative care outcomes.** **Identified problems/issues include:** **a) variations in individual clinician's approach to assessment and documentation** **b) inconsistent language used for clinical handover** **c) anecdotal evidence of unplanned admissions to hospital to treat reversible symptoms due to less than optimal timing for interventions in the community**
AIM	**Embed the use of PCOC tools for each (*organsiation name*) community palliative care clinical visit.** **To explore the advantages of registering the organisation as a PCOC tool user.** **To improve early recognition of trends or deterioration.** **To facilitate early interventions thus minimising unplanned admissions to hospital for symptom management.** **To develop consistent language for clinical handover.** **To standardise documentation for ease of monitoring and evaluation.**

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PROJECT SCOPE	**20 week project to incorporate the following:** • Audit community palliative care service PCOC usage • Provide education based on audit results • Develop ISBAR clinical handover sheet • Investigate benefits for organisation of registering as a PCOC participant and present findings/recommendations to _________ committee • Attend paired visits with nurses to observe and direct PCOC tool usage • Provide education for GPs and Practice Nurses in *(local)* area • Report/present audit results (on completion of the project) to ___________ committee • Regular reports to ______ **Clients under the age of 18 years will be excluded from this project.** **PCOC tool usage during an acute admission to hospital will be excluded from this project due to limited time frames and funding availability**
FUNDING REQUESTED	**$ ______ for a dedicated PCOC facilitator, working 16 hours per week for a period of 20 weeks, who would develop a 20 week plan to incorporate the items listed under project scope.** **Classification for the position - Grade 4A**

OBJECTIVES	STRENGTHENING PALLIATIVE CARE STRATEGIC DIRECTION*	MEASURES	OUTCOMES
Service access and provision will be a seamless transition between funding sources	Strategic direction 4.	LOS data in quarterly VINAH report	**Chronic disease management provided under appropriate funding stream (malignant and non-malignant)**
Decreased unplanned admissions to hospital by improved early intervention in the community setting	Strategic direction 4.	Audit (IPM data) unplanned admissions to hospital retrospective vs post PCOC implementation	**Patient's symptoms will be identified for early intervention through the use of a standardise approach to assessment and reporting**
Common language used between Palliative Care service providers	Strategic direction 3.	Standardised ISBAR clinical handover sheet audit	**Clinical handover sheet will be used when transferring care between providers or when reporting escalation of issues**

***** The "Strengthening Palliative Care Strategic Direction" has now been replaced by the "Victorian end of life care framework" 2016, that can be accessed at https://www2.health.vic.gov.au/palliative-care

Phase 1

Key Performance Indicator	Previous Quarter Outcomes	Quarterly Activity Status	Next Quarter Objectives
Appoint Project Officer	N/A	Position Advertised, awaiting interviews	Project Officer appointed
Educate staff re: PCOC Tool	N/A	N/A	All staff educated in utilising PCOC tool.
Implement PCOC	N/A	N/A	Each palliative care client has PCOC Tool in use. - Random audit of 10 registered palliative care clients to determine use
Correctly identifying phases of care	N/A	N/A	Audit - Random audit of 10 registered palliative care clients to ensure phase indicated correlates with supporting documentation
Change of phase triggering an intervention	N/a	N/A	- Random audit of 10 registered palliative care clients to ensure when change of phase identified, interventions carried out
Standardised Assessment	N/A	N/A	- Random audit to ensure each client has the PCOC and that it is being completed at each contact (phone and in person)
Registered Palliative Care unplanned Inpatient admissions	N/A	N/A	Assess Data to monitor influence of PCOC tool in early intervention leading to decreased hospital admissions

Final Report

Key Performance Indicator	Final Outcome	Evidence	Sustainability	Continuous Improvement
Staff education: PCOC tool	16 out of 30 staff attended PCOC fundamentals workshops.	Staff that have attended the PCOC fundamentals workshops have provided positive feedback for the workshop. Understanding and compliance have improved overall with use of the PCOC assessment form.	Given that PCOC funds the fundamentals workshops, the benefits and opportunity that will arise from all staff attending the workshops will benefit all of our palliative care clients now and into the future.	Continue to encourage all staff to attend the PCOC fundamentals workshops.
Implementation of the PCOC assessment tool	Overall, implementation of the PCOC assessment tool has been well received amongst staff who have embraced the implementation process. Compliance has improved over the last 6 months as staff knowledge and understanding of the tool has improved.	Since commencing the project, staff compliance has improved approx. 10% and is now over 90% for each visit or scheduled telephone call. Completion of all components of the tool has improved, with only 1 component from one visit being missed overall from the last 2 monthly audits. Documentation for interventions ≥ 4 for the SAS still requires ongoing education and support.	Implementation of the PCOC tool will still be required for new staff as they join the team. If service registers for PCOC data submission, further implementation will be required to develop staff knowledge in relation to entering of data into UNITI.	Ongoing audits to monitor staff compliance and understanding of the PCOC assessment tool as well as identifying areas required for further education.

Key Performance Indicator	Final Outcome	Evidence	Sustainability	Continuous Improvement
Unplanned inpatient admissions.	Only retrospective audit completed. Audit identified that prior to the implementation of the PCOC assessment tool, patients would likely have benefited from the PCOC tool. The repeat audit for the same time period with the PCOC tool in place will be conducted.	In the retrospective audit, review of clinical notes of unplanned admissions to (*health service palliative clients*) for constipation revealed that 3/5 patients would have likely benefited from the PCOC assessment tool being in place.	Being able to conduct the repeat audit for the same time period with the PCOC tool in place will identify the impact that the PCOC tool has had in relation to unplanned admissions to *(health service)*.	Results posed may also be useful in identifying other tools that may require implementation to reduce unplanned admissions to *(health service)*
Identifying phases of care.	Staff understanding regarding 'phases of care' has improved over the course of the year as a result of 1:1 time, continued use and attendance to PCOC fundamentals workshops.	Audits conducted to identify staff understanding of 'phases of care' revealed that there was some lack of knowledge about the phases – in particular phase 2 and 3. This improved over the year and as a result, PCOC benchmark 2 - % of pts in the unstable phase for 3 days or less has improved to 83% - close to the 90% national benchmark.	With the organisations plan to register for PCOC data submission, future audits that look at identifying phases of care will likely be based on PCOC benchmarks and audit tools that PCOC have created.	Further education is still required around 'phases of care' - in particular for new staff so as they can better grasp a greater understanding of the PCOC tool and its components.