The Palliative Care Quality Improvement Project in regional WA

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Background

Palliative care across regional, rural and remote (RRR) Western Australia (WA) is varied and faces many challenges such as a transitory health workforce, an ageing population and the state's unique geography.

WA has a population of 2.4 million, 78% of which lives in the greater Perth area.¹ However, death rates are higher in rural regional WA than in major cities.² Many towns are very remote and have small populations that do not have access to comprehensive health or medical services and can be vast distances from the regional WA Country Health Service (WACHS) centres. For example, a town such as Mt Magnet (population 664 people)³ is situated 340 km from Geraldton (population 37,000)⁴ (Figure 1), the regional centre where the palliative care team is based.

Figure 1 Health Regions of Western Australia Country Health Service⁵
A rural audit of palliative care conducted in WA in 2007 found that many rural services care for small numbers of palliative care patients, have staff with little palliative care specific education, and most education received is of an informal nature. Although a lack of knowledge about implementing palliative care standards was reported, there was agreement of a need for systems to improve care, for example clinical pathways. The audit also identified that little attention had been given to a palliative care governance structure or developing service models to meet the Australian Palliative Care Standards.2

Research indicates that individuals residing in regional areas, and who are agreeable to palliative care, are less likely to receive care from a specialised palliative care service than their urban counterparts.5 6 Furthermore, it is recognised that primary health and community care providers are the main providers of this non-specialised palliative care.

Recommendations in the Palliative Care in Western Australia: Final Report December 2005, seek to address the unique needs of WA regional and remote palliative patients through the implementation of an integrated state wide palliative care model, the Rural Palliative Care Model in Western Australia.8 Key recommendations from the Rural Palliative Care Model were that:

1. A state-wide palliative care education plan and implementation strategy be developed to provide access to a health professional workforce with palliative care knowledge and skills.

2. There is a coordinated approach, with the Palliative Care Network linking stakeholders to the development and implementation of pathways and protocols to guide rural primary care providers in appropriate timely management of palliative care patients.

The Rural Palliative Care Model in Western Australia is now being implemented across the seven WACHS regions. The WA Cancer and Palliative Care Network (WACPCN) and WACHS have collaborated to establish the state-wide rural model framework which includes a core palliative care team comprised of a Regional Palliative Care Nurse Manager, additional clinical nursing support, a social worker and administrative support personnel in each region. These palliative care teams provide regional coordination and have the clinical expertise to build capacity in health professionals throughout the regions. The Nurse Managers and Social Workers from the seven regions meet regularly, face to face and via videoconference, as the Rural Palliative Care Specialist Group.

The Palliative Care Quality Improvement Project has been developed and implemented by the WACPCN in partnership with the WACHS and the Palliative Care Outcomes Collaboration (PCOC) through the Cancer and Palliative Care Research and Evaluation Unit (CaPCREU). The project aims to work with the Rural Palliative Care Specialist Group to develop a network of health professionals in each WACHS region with a special interest in palliative care and to build their clinical palliative care skills to provide care for people in local communities with advanced illnesses at the end of life.

**The Palliative Care Quality Improvement Project**

The Palliative Care Quality Improvement Project uses a train the trainer method within each WACHS region. An invitation is sent to each rural health service within a region to ask them to identify a minimum of two nursing staff to attend workshops and become the local palliative care link nurses. These nurses are provided with resources and supported to act as local mentors—training and supporting people within their organisation in the use of the WA Liverpool Care Pathway (WA lcp) (an end of life care pathway based on the Liverpool Care Pathway,7 modified with support from Marie Curie Palliative Care Institute Liverpool, the originators of the Pathway) and the five PCOC clinical assessment tools.

The workshop is then facilitated by the Project team and includes training in the following components:

- implementation of the WA lcp and PCOC assessment tools within a quality improvement framework
• the use of the WA lcp
• the use and embedding of the five clinical assessment tools used by the Palliative Care Outcomes Collaboration program (PCOC) into routine clinical practice
• influencing change; driving clinical use of the tools
• the structure of palliative care services within the region and intended ways of working together to build capacity in local communities.

Following the workshops, the Regional Palliative Care Teams meet with the local link nurses as a Special Interest Group via videoconferences every 1-2 months. The Project Team has been invited to participate to support the use of the tools.

This report focuses on the roll-out of the five clinical assessment tools supported by PCOC.

The Palliative Care Outcomes Collaboration (PCOC) Program

PCOC is a quality initiative developed specifically to support continuous improvement in the quality and effectiveness of palliative care service delivery across Australia. PCOC was established initially in 2005 to acquire some national outcomes data about palliative care. In 2008, Benchmarks were developed as standards against which services could measure their performance and to which they could aspire.

Clinical assessment

The PCOC program involves the use of five standardised and validated assessment tools to measure various aspects of the patient’s and family’s condition on a day to day basis (Table 1). The goal is to incorporate these tools into routine clinical practice and to use the assessments to “trigger” interventions such as pain management or referral to other disciplines.

Table 1 The five assessment tools used in the Palliative Care Outcomes Collaborative Program and the domains measured by each tool

<table>
<thead>
<tr>
<th>Tool</th>
<th>Developer</th>
<th>Function</th>
<th>What the tool tells us</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHASE</td>
<td>Eagar et al, 2004</td>
<td>Palliative Care Phase of illness</td>
<td>Condition of the patient relative to the disease trajectory</td>
</tr>
<tr>
<td>RUG-ADL</td>
<td>Fries et al, 1994</td>
<td>Resource Utilisation Groups—Activities Daily Living</td>
<td>Describes the functional status, level of dependency and resources required to care for the patient</td>
</tr>
<tr>
<td>Australian Karnofsky Performance Scale (AKPS)</td>
<td>Abernethy et al, 2005</td>
<td>Performance Status</td>
<td>Patients performance, what they are actually doing and supports prognostication</td>
</tr>
<tr>
<td>Palliative Care Problem Severity Score (PSS)</td>
<td>Eagar et al, 2004</td>
<td>Clinician rated measure of the severity of physical and psychological problems</td>
<td>Clinician rated measure of the overall severity of pain, other symptoms and psychological/spiritual distress of the patient and distress of family/carer</td>
</tr>
<tr>
<td>Symptom Assessment Scale (SAS)</td>
<td>Kristjanson et al, 1999</td>
<td>Specific symptoms and their severity</td>
<td>Patients level of distress relating to individual symptoms in the preceding 24 hours</td>
</tr>
</tbody>
</table>

Reporting and quality improvement

Patient assessment data is submitted to the PCOC National office by each participating service every six months. PCOC then analyses the data and prepares a service specific report of service outcomes against
four national performance benchmarks. The Report can be used to track a service’s progress in meeting the benchmarks, and to identify areas where the service is not performing well; Reports can trigger quality improvement initiatives. Services are assisted in their understanding and use of the tools, collection of data and interpretation of and use of reports by Quality Improvement Facilitators who are trained and managed centrally by the PCOC National Office but are available locally. In the past, PCOC has specifically targeted specialist palliative care services but the Palliative Care Quality Improvement Project aims to embed the use of the tools into routine practice for all services caring for people who have an advanced life-limiting illness. PCOC is funded under the National Palliative Care Program and is supported by the Australian Government Department of Health and Ageing.

Benefits of PCOC

Use of the five clinical assessment tools has been shown to facilitate the comprehensive assessment of patients and families with palliative needs and assist with holistic care planning in conjunction with the WA ICP. As the PCOC program has matured and palliative care services have become more proficient in their use of the assessment tools, a number of additional benefits have been observed. Increasingly, the tools are becoming the foundation and the drive of the patient’s plan of care. But importantly, it provides a common language around the patient’s care supporting effective transfer of clinical information. By using the tools, a clear clinical picture of the individual patient can be conveyed both verbally and when reporting in medical records. Clear communication has been identified as supporting seamless delivery of care—across different organisations as well as within organisations. Families and patients learn the language of “the Tools” which enhances communication and promotes inclusion of the carer/family as part of the unit of care.

It is anticipated that by embedding these tools into routine practice, health professionals will improve their ability to identify and address their palliative patient’s needs and concerns, plan their patient’s care in a more confident, timely and appropriate manner, and therefore improving the total care of both the patient and their family.

One of the most important features of the PCOC program is that it has a strong quality control mechanism, ensuring that the use of the assessment tools is consistent across Australia. Training is centrally developed and managed (out of the University of Wollongong) but locally delivered by a trained Quality Improvement Facilitator from CaPCREU, located at the University of Western Australia.

Results

Where is the palliative care quality improvement project up to?

Roll-out of the Project has been slower than planned with commencement in each Region dependent on the preparedness of the Regional Palliative Care Team and competing commitments of local health services. To date, initial workshops have been conducted in three Regions which have resulted in more than 82 staff being trained. Participants of all Regional workshops were invited to complete a pre and post workshop evaluation to provide immediate feedback to the Project Team of participant understanding and their unmet needs to guide further Regional-specific education and support. Evaluation also provides the Project Team with an opportunity for continuous quality improvement in the delivery of the workshops. To date, 57 workshop participants have completed an evaluation. Most participants reported that the content (98%) delivery (95%) and relevance (97%) of the workshops was ‘very good’ or ‘excellent’. The majority of participants reported an improvement in their knowledge of the WA ICP and PCOC clinical assessment tools pre to post workshop attendance (Figure 2).
Areas for workshop improvement were also explored, with *Provide better information prior to the workshop* the leading suggestion (21%), followed by *A lot more time for the workshop needed* (12%) and *Provide more stimulating activities* (9%).

Many nurses who attended the workshops have taken on the role of mentors to introduce the tools to their colleagues and to act as local palliative care “link nurses” as a more structured approach is developed in the region. While formal assessment of the Project is yet to be undertaken, feedback from the Rural Palliative Care Specialist Group has highlighted a number of positive improvements within regions, such as:

- The standardised training of clinicians in the use of the assessment tools means that we have a consistent objective measure of patient problems and intervention outcomes.
- All local staff know how to assess palliative care patients in a standardised way. If in doubt, they can refer back to the training tools available through PCOC or through their palliative care link nurse.
- Local services, in consultation with the Regional Palliative Care Teams, have started developing protocols to identify when a patient should be reviewed or a change in care is needed based on the severity of symptoms and patient needs identified using the assessment tools.
- Patients are engaged in assessing their own concerns and expressing their own symptom priorities.
- Use of the assessment tools provides a language that has a consistent, clear meaning for communication with other local health professionals and which enhances communication with the Regional Palliative Care Team.
- Supports regional action planning, including strategies for improving clinical communication and partnering to build capacity in local communities. Engaging with the Palliative Care Quality Improvement Project has meant that GPs, community nurses and rural hospital staff have a much better understanding of where they can go for help and when they should seek help.
Regional Palliative Care Nurse Managers and local service link nurses are keen to commence PCOC data collection to inform quality improvement activities.

Where to next?
The roll out of the Palliative Care Quality Improvement Project is a work in progress. The remaining four Regions of the WACHS will receive the initial clinical education prior to training in data collection and use of clinical outcomes feedback reports which are available for health services who join the PCOC program. As this is a collaborative project and the goal is to ensure that the use of the five “PCOC assessment tools” are embedded into routine practice in a sustainable way, it is important that the Project team works with Regional Palliative Care Teams and local health services to negotiate how and when they will be best served through the implementation of the Project.

Evaluation of the overall Project is planned on completion to assess changes in regional palliative care delivery. Preliminary data collection is under way as part of the auditing process for the WA lep implementation. Importantly, when roll-out is completed, it is anticipated that WACHS Regions will be routinely collecting patient assessment data and submitting it the PCOC National program. Hence, a mechanism will be in place to evaluate changes in patient outcomes.

Conclusion
This quality improvement project supports regional, rural and remote health care providers to identify and assess their palliative patients’ needs and plan care in a more confident, timely and appropriate manner. Furthermore, early feedback indicates that the project has resulted in improved health professional collaboration, networking and capacity building and, at a state level, supports quality care provision and the seamless transition of patients between services.

Acknowledgments
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2. WA Cancer and Palliative Care Network. Rural Palliative Care Model in Western Australia. Perth: Government of Western Australia Department of Health, 2008.


