醫院管理局進修學院
Hospital Authority
Institute of Health Care

INSTITUTE OF ADVANCED ALLIED HEALTH STUDIES
專職醫療深造學院

Overseas Corporate Scholarship Program 2017-18

Sharing on

Allied Health Professionals of Palliative Care (PC) Service with Multidisciplinary Approach

Program Objectives

- To explore Allied Health contribution in the structure-process-outcome of PC in Australia
- To probe the best use of the system infrastructure (including allied health) for provision of quality PC in both PC specialist & non-specialist settings
- To scrutinize care model & pathway assisting interdisciplinary collaboration in end-of-life care
- To comprehend community partnership in supporting patients and carers
- To learn the measurement outcome for PC

Multidisciplinary Team

PT	Emily TSANG	CMC
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ST	David CHOW	FYKH/GH
Dietitian	Vaneses AU	BBH/SCH/SH
CP	Kitty WU	HAHO
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Programme

Week 1	4th Sept	5th Sept	6th Sept	7th Sept	8th Sept
am	Mary Potter Hospice	CareSearch at Flinders University	Australian Palliative Care Conference 2017	Australian Palliative Care Conference 2017	Australian Palliative Care Conference 2017
pm	Repatriation General Hospital				

Week 2	11th Sept	12th Sept	13th Sept	14th Sept	15th Sept
	Greenwich Hospital	Concord Hospital	Workshop on Palliative Care Outcomes Collaboration	St Vincent's Hospital	Calvary Health Care Kogarah

APCC 2017

- Biannual conference
- Theme of 2017: Connecting with Community
- 3 days conference
- APCC 2019: Perth

Palliative Care Outcomes Collaboration (PCOC)

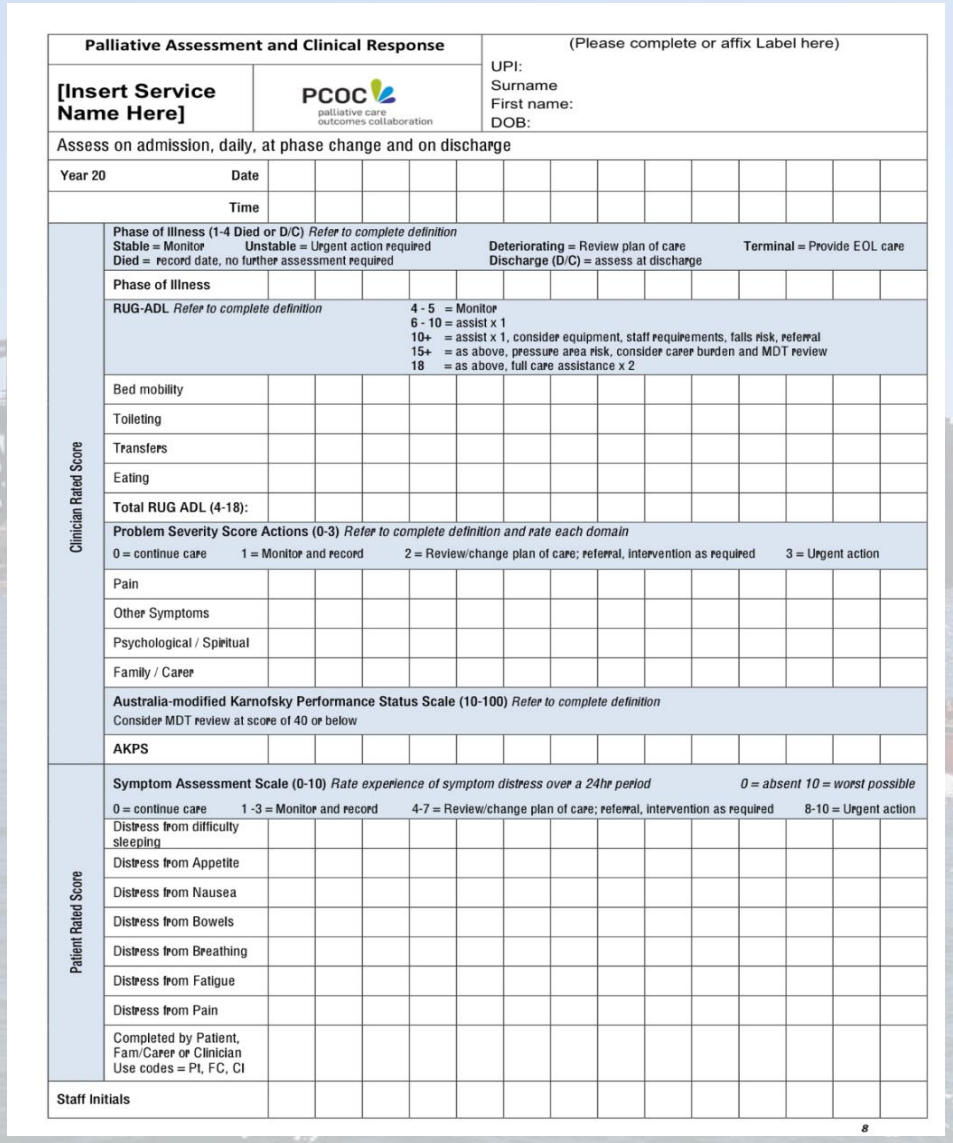
- Target Audience:
  - Clinicians who are new users of the PCOC assessment tools
  - Clinicians implementing PCOC into routine clinical practice

- Content:
  - Assessing the Phase of Illness
  - Assessment tools for symptom and functional assessment
  - Assessment data, what it tells us and how to use it
  - Barriers & strategies for integrating PCOC assessments into practice
  - Content of Patient Outcome Reports
  - Outcome Measures and Benchmarks

PCOC

- Started from 2005. Widespread used in all PC settings in Australia
- National program designed to embed standardized and validated clinical assessment tools as part of routine clinical practice
  - Standardized point of care assessment in palliative care services
  - Entry of clinical assessment data into an electronic database
  - Six monthly patient outcome report (including nationally agreed benchmarks) derived from data submitted
  - Targeted feedback by PCOC Quality Improvement Facilitators (QIFs) and development of a service specific quality improvement action plan
- The **FIVE** clinical assessment framework consists of:
  - **Palliative Care Phase (Phase)**
  - **Resource Utilization Group – Activities of Daily Living (RUG-ADL)**
  - **Australia-modified Karnofsky Performance Status (AKPS) Scale**
  - **Palliative Care Problem Severity Score (PCPSS)**
  - **Symptom Assessment Scale (SAS)**

PCOC



Palliative Assessment and Clinical Response

[Insert Service Name Here]

PCOC palliative care outcomes collaboration

(Please complete or affix Label here)

UPI:
Surname
First name:
DOB:

Assess on admission, daily, at phase change and on discharge

Year 20	Date															
	Time															
Clinician Rated Score	**Phase of Illness (1-4 Died or D/C)** *Refer to complete definition* **Stable** = Monitor **Unstable** = Urgent action required **Deteriorating** = Review plan of care **Terminal** = Provide EOL care **Died** = record date, no further assessment required **Discharge (D/C)** = assess at discharge															
	Phase of Illness															
	RUG-ADL *Refer to complete definition* 4 - 5 = Monitor 6 - 10 = assist x 1 10+ = assist x 1, consider equipment, staff requirements, falls risk, referral 15+ = as above, pressure area risk, consider carer burden and MDT review 18 = as above, full care assistance x 2															
	Bed mobility															
	Toileting															
	Transfers															
	Eating															
	Total RUG ADL (4-18):															
	Problem Severity Score Actions (0-3) *Refer to complete definition and rate each domain* 0 = continue care 1 = Monitor and record 2 = Review/change plan of care; referral, intervention as required 3 = Urgent action															
	Pain															
	Other Symptoms															
	Psychological / Spiritual															
	Family / Carer															
	Australia-modified Karnofsky Performance Status Scale (10-100) *Refer to complete definition* Consider MDT review at score of 40 or below															
	AKPS															
Patient Rated Score	**Symptom Assessment Scale (0-10)** *Rate experience of symptom distress over a 24hr period* *0 = absent 10 = worst possible* 0 = continue care 1 -3 = Monitor and record 4-7 = Review/change plan of care; referral, intervention as required 8-10 = Urgent action															
	Distress from difficulty sleeping															
	Distress from Appetite															
	Distress from Nausea															
	Distress from Bowels															
	Distress from Breathing															
	Distress from Fatigue															
	Distress from Pain															
	Completed by Patient, Fam/Carer or Clinician Use codes = Pt, FC, Cl															
Staff Initials																

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PCOC

- Palliative Care Phase

Palliative Care Phase	Actions if this is a new Phase	Actions if Phase is the same as previous assessment
Stable	▪ Continue as per plan of care.	▪ Continue as per plan of care. ▪ Commence discharge planning if appropriate.
Unstable	▪ Urgent intervention and escalation required. ▪ Change plan of care. ▪ Urgent medical review and or allied health services. ▪ Review within 24 hours.	▪ Continue urgent action, adjust plan of care, refer, and intervene. ▪ When no further changes to the care plan are required, change Phase.
Deteriorating	▪ Change in plan of care required to address increasing needs. ▪ Referral to medical or allied health may be required. Family / carer support may increase.	▪ Review and change plan of care. ▪ When deterioration plateaus, change Phase to Stable.
Terminal	▪ Commence end of life care (adjust plan of care if required). ▪ Discuss change in condition with family and those important to the patient.	▪ Continue end of life care as per plan of care. ▪ Communicate changes to family and others important to the patient. ▪ If patient not likely to die within days re-assess Phase. ▪ End the Episode of Care when patient dies.
Bereavement or Post Death Support*	▪ Provide bereavement support to family and those important to the patient.	▪ If family require ongoing support, refer to appropriate service (family member becomes a client in their own right).

*Bereavement phase excluded from outcome measures

PCOC

- Potential actions following RUG-ADL assessment:

Item	Description	Score	Recommended Actions
Bed mobility, Toileting, Transfer	Independent / supervision only	1	▪ Provide equipment if required (monkey bar, walking stick etc.). ▪ Monitor for changes.
	Limited physical assistance	3	▪ Ensure care plan clearly describes the assistance required by staff. ▪ Consider a Falls Prevention Plan. ▪ Provide equipment if required.
	Other than two person physical assist	4	▪ Provide equipment / device as required. ▪ Ensure care plan clearly describes the assistance required by staff and instructions regarding use of device. ▪ Provide clear instructions to the patient regarding use of the device.
	Two or more person physical assist	5	▪ Ensure care plan clearly describes the assistance required by staff. ▪ Provide equipment.
Eating	Independent / supervision only	1	▪ Monitor for changes.
	Limited assistance	2	▪ Provide assistance required according to service guidelines / protocols. ▪ Ensure care plan clearly describes the assistance required by staff.
	Extensive assistance / total dependence / tube fed	3	▪ Ensure care plan clearly describes the assistance required by staff. ▪ Provide mouth care according to service guidelines / protocols.

Total Score Range	Recommended Actions for Total Score
Total Score of 4-5	Independent. Monitor
Total Score of 6-13	Requires assistance May be at risk of falls and pressure areas.
Total Score of 14-17	Requires assistance of 1 plus equipment. Greater risk of falls and pressure areas.
Total Score of 18	Requires 2 assist for all care. Greater risk of pressure areas.

PCOC

- Australia-modified Karnofsky Performance Status (AKPS) Scale

Point on AKPS Scale	Recommended Action
Patient has AKPS of 90, 80 or 70 at episode start	▪ Consider completing an advance care planning discussion with the patient and their substitute decision-makers.
Patient has AKPS of 60	▪ Consider referral to allied health if patient has been in active work and is no longer able to work.
Patient has AKPS of 50	▪ Consider discussion at multidisciplinary team meeting and review care plan. ▪ Provide appropriate equipment as required. ▪ Consider referrals for community packages. ▪ Complete a caregiver assessment.
Patient has AKPS of 40 or 30	▪ Consider discussion at multidisciplinary team meeting and review care plan – patient may be commencing deterioration and further supports may be required. ▪ Consider pressure area care. ▪ Provide appropriate equipment as required (for example, alternating pressure mattress). ▪ For community patients – consider impact of care on family caregiver. Complete a caregiver assessment.
Patient has AKPS of 20 or 10	▪ Commence end of life care planning. ▪ If death is likely in days, change to Terminal Phase.

PCOC

- Palliative Care Problem Severity Score (PCPSS)
- Symptom Assessment Scale (SAS)

PCPSS & SAS Score	Potential actions
Absent **PCPSS = 0** **SAS = 0**	▪ Problem / symptom distress absent. Continue with current care. ▪ Routine assessment. ▪ Phase may be Stable or Terminal.
Mild **PCPSS = 1** **SAS = 1-3**	▪ Problem / symptom distress managed by existing plan of care and routine care. ▪ Treat problem / symptom according to service protocols. ▪ Monitor and record any relevant information. ▪ Phase may be Stable, Deteriorating or Terminal.
Moderate **PCPSS = 2** **SAS = 4-7**	▪ Problem / symptom distress requires change in plan of care, referral and escalation. ▪ Document review and implement any new interventions as per care plan. ▪ Phase may be Deteriorating or Terminal.
Severe **PCPSS = 3** **SAS = 8-10**	▪ Problem / symptom distress requires immediate action. ▪ Plan of care is ineffective. ▪ Urgent intervention, referral and escalation required. ▪ Change of care plan indicated. ▪ Review within 24 hours. ▪ Phase Unstable or Terminal.

PCOC

Links:

- PCOC Clinical Manual
  - http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf
- Introduction to PCOC Assessment Tools
  - http://ahsri.uow.edu.au/pcoc/assessment-tools/index.html
- These resources include SAS brochures and form translated into 14 languages
  - http://ahsri.uow.edu.au/pcoc/sastranslations/index.html
- Symptom Assessment Scale(SAS) - Translated Brochure and Form
  - http://ahsri.uow.edu.au/pcoc/sastranslations/index.html
- PCOC National Reports - Archive
  - http://ahsri.uow.edu.au/pcoc/reports/national-archive/index.html
- National Outcome Measures and Benchmarks
  - http://ahsri.uow.edu.au/pcoc/benchmarkmeasures/index.html

Learning Points

- **Allied health professionals** should be involved in streamlined care model and pathway enhancement in end-of-life care
- **Multidisciplinary team** (MDT) model and MDT symptoms management programmes
- Skill-equipped voluntary groups to provide complementary therapies to patients and carers
- Empowerment of volunteers to provide general caring to PC patients
- Community allied health team
- Enhancement of PC Day Centers
- Palliative Care Outcomes Collaboration (PCOC)
- Training to PC and non-PC staff

Recommendations for the Services:

1. Manpower planning
2. Streamlined Care model and pathway
3. System infrastructure
4. Training
5. Community partnership
6. Outcome measures and performance monitoring

1. Manpower Planning

- Designated PC-trained allied health
- Designated PC team
- Diversity of AH
- Source of Funding

2. Streamlined Care Model & Pathway

- Daily conference
- Referral system
- AH consultation service
- One-stop allied health service
- MDT symptom management programs

MDT Symptom Management Program

- **Breathlessness Program**
- empower patients
- Assessment by a doctor and a physiotherapist, weekly 2-hour group exercise session for 4 weeks
- Education from occupational therapist, clinical psychologist, social worker and dietitian.

MDT Symptom Management Program

- **Lymphoedema Program**
- PT + OT
- Optimal QOL
- Symptom-oriented care
- Management of swelling
- Management of skin integrity
- Prevention of secondary infection

MDT Symptom Management Program

- **OT & dietitian collaborative program** for PC patients

3. System Infrastructure

- Provide **family and visitor kitchen** for easy gathering and food preparing for patients
- Provide appropriate **furniture** and **amenities** for family to facilitate them staying and spending time with patients e.g. garden for patients, common room for patients & family, chapel
- Provide **facilities** and **activities** (e.g. jolly trolley, smoking area for PC patients) to support carers and fulfil patient's last wish
- PC Day Centre

3. System Infrastructure (Cont'd)

- Equip with **patient journey board** in nursing station for easy reference of patient status and caring plan
- **Integrate e-documentation** for better communication on patients' treatment/caring plan

4. Training

- Communication skills training
- PC training for non-PC allied health professionals and supporting staff
- On-line PC training for all allied health professionals (e.g. EOLE, palliAGED, PCC4U)
- Advanced training for PC staff
- Invite PCOC trainers
- Visit PC settings in different hospitals
- Job rotation
- Overseas training

5. Community Partnership

- Skill-equipped voluntary groups for some complementary therapies, massage therapy etc.
- Volunteer support to PC
- Developed community allied health team
- Support die at home/OAH

6. Outcome Measures and Performance Monitoring

- Using **Palliative Care Outcomes Collaboration (PCOC)**
- Collecting patients' and relatives' **satisfaction rating**, and allow making reference to Australian practice


THANK YOU!