PCOC

palliative care
outcomes collaboration

Assessment & Response Protocol

ahsri
australian
health services
research institute

UNIVERSITY
OF WOLLONGONG
AUSTRALIA

PCOC is an outcome and benchmarking program. PCOC creates a clinical language by embedding five validated clinical assessments to systematically measure and improve patient and family/carer outcomes. For more information visit the PCOC website.

Prepared by Clapham S, Connolly J and Hope C for the Palliative Care Outcomes Collaboration (2020) Australian Health Services Research Institute (AHSRI), University of Wollongong, NSW 2522 Australia.

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About this resource

The purpose of this protocol is to support clinicians to use PCOC's assessment and response framework to identify, respond to and communicate patient, and family/carer's needs. The resource contains strategies for embedding the assessment tools into routine practice.

Who is this resource for?

This protocol is for managers, clinical leaders and all clinicians involved in routine assessment and response to patients, and their family / carer's, needs.

This protocol is used in collaboration with PCOC's clinical forms and is supported by PCOCs Education Guide and the Quality and Change Guide.

Frequency of assessment

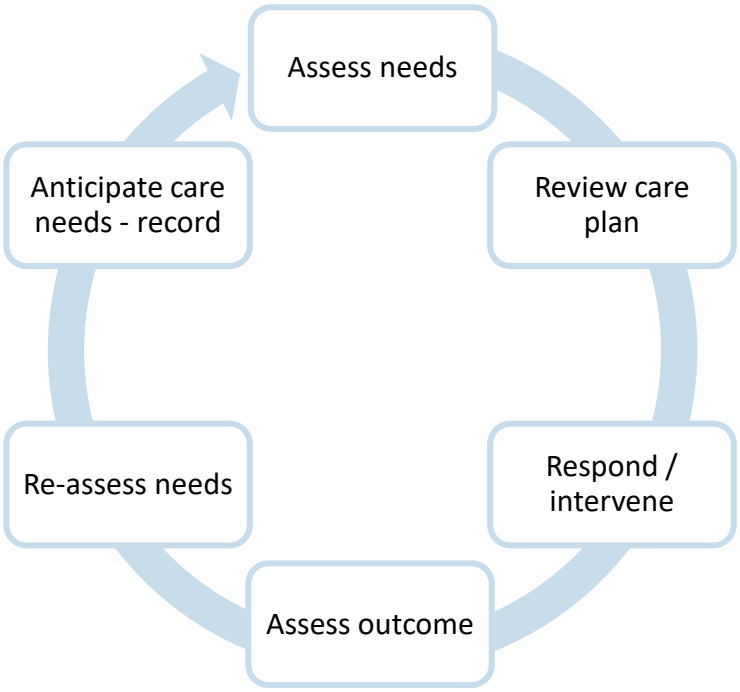
All five assessment tools are to be used as a suite. Assessment frequency points are:

1. On admission or commencement of care
2. A minimum of daily in inpatient settings and residential aged care
3. At each contact in community and consultation settings (outpatient, community, general practice)
4. At change in care plan or patient and family / carer needs (palliative care phase change)
5. At discharge

Assessment Scores and Recommended Response

For each assessment tool there are recommended responses and follow up actions. Figure 1 represents the cycle of assessment and response. Each assessment requires a clinical response which is followed by a reassessment of the intervention and outcome.

Figure 1 Assessment and response cycle



Key Message

Use assessment scores & actions to anticipate and respond to identified needs.

Anticipatory Care and Responsive Care

The assessment and response framework aligns with the PCOC outcome measures and benchmarks relating to anticipatory and responsive care. A positive patient outcome is achieved when the patient has absent to mild symptom / problem scores at the end of a phase.

- The absent to mild range of symptom and problem scores trigger monitoring and review of care plans. This is referred to as anticipatory care.
- The moderate to severe range of symptom and problems scores trigger interventions and actions to respond to needs. This is referred to as responsive care.

Forms	Lanyard cards
Assessment and Response Form	Assessment and Response, actions
	Assessment definitions, abbreviated
The Symptom Assessment Scale Form	The SAS ruler, representing faces and numerical scale

Palliative Care Phase: clinical response

The Palliative Care Phase is determined by a holistic assessment of the needs of the patient and their family/carers, and this is often informed by other assessment tools in the suite. Table 1 lists the potential actions following phase assessment.

Table 1 Potential actions following Phase assessment

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. ▪ Monitor and review to ensure care plan is effective and anticipates future care needs of patient and family/carer. ▪ Commence discharge planning if appropriate. Ensure the following care setting is able to support patient/family/carer needs as per existing care plan.
Unstable	▪ Urgent intervention and escalation required. ▪ Change plan of care. ▪ Urgent medical and/or allied health services review. ▪ Review within 24 hours.	▪ Continue urgent action, adjust plan of care, refer, and intervene. ▪ Monitor assessment scores for patient/family/carer change in condition; improvement in scores suggests plan is working. ▪ When no further changes to the care plan are required, change Phase.
Deteriorating	▪ Change in plan of care required to address increasing needs (not-urgent). ▪ Referral to medical or allied health likely. ▪ Family / carer support may increase.	▪ Review and change plan of care. ▪ When no further changes to the care plan are required, change Phase.

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. ▪ Continue to assess patient and family / carer using assessment suite, responding as appropriate. ▪ 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/post death support phase excluded from PCOC outcome measures

Resource Utilisation Group-Activities of Daily Living (RUG-ADL): clinical response

The RUG-ADL assesses the level of functional dependence, based on what a patient actually does, rather than what they are capable of doing. Table 2 lists potential actions following RUG-ADL assessment.

Table 2 Potential actions following RUG-ADL assessment:

Item	Description	Score	Recommended Actions
Bed mobility, toileting, transfer	Independent / supervision only	1	▪ Provide equipment if required (bed mobility aid or walking aid, etc.). ▪ Monitor for changes
	Limited physical assistance	3	▪ Ensure 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 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 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 plan clearly describes the assistance and aids required by staff.
	Extensive assistance / total dependence / tube fed	3	▪ Ensure plan clearly describes the assistance and aids required by staff. ▪ Provide mouth care according to service guidelines / protocols. ▪ Allocate for patient who is totally dependent for all care, including those in the terminal phase.
		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.

Australia-modified Karnofsky Performance Status (AKPS) Scale: clinical response

The AKPS is a measure of the patient's performance across the dimensions of activity, work and self-care. Table 3 lists potential actions following AKPS assessment.

Table 3 Potential actions following AKPS assessment

Point on AKPS Scale	Recommended Action
Patient has AKPS of 90, 80 or 70 at episode start	▪ Consider advance care planning with the patient and their substitute decision-makers.
Patient has AKPS of 70 or 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.

Palliative Care Problem Severity Score (PCPSS) and Symptom Assessment Scale (SAS): clinical response

The PCPSS and SAS assessments are used to measure symptoms and problems experienced by the patient and their family / carer.

The PCPSS is clinician rated and supports the global screening for the overall degree of problems within four key palliative care domains (pain problems, other symptom problems, psychological / spiritual problems and family / carer problems). PCPSS is a four point numerical rating scale (0-3).

The SAS is patient rated (where possible) and assesses the patient's level of distress relating to seven common symptoms (difficulty sleeping, appetite problems, nausea, bowel problems, breathing problems, fatigue and pain). SAS is an 11-point numerical rating scale (0-10).Table 4 lists potential actions following PCPSS and SAS assessment. Table 5 lists potential actions specifically for the family / carer problem domain (PCPSS).

Key Message

- The absent to mild range of symptom and problem scores trigger monitoring and review of care plans.
- The moderate to severe range of symptom and problem scores trigger interventions and actions to respond to needs.

Table 4 Potential actions following PCPSS and SAS assessments

PCPSS & SAS	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.

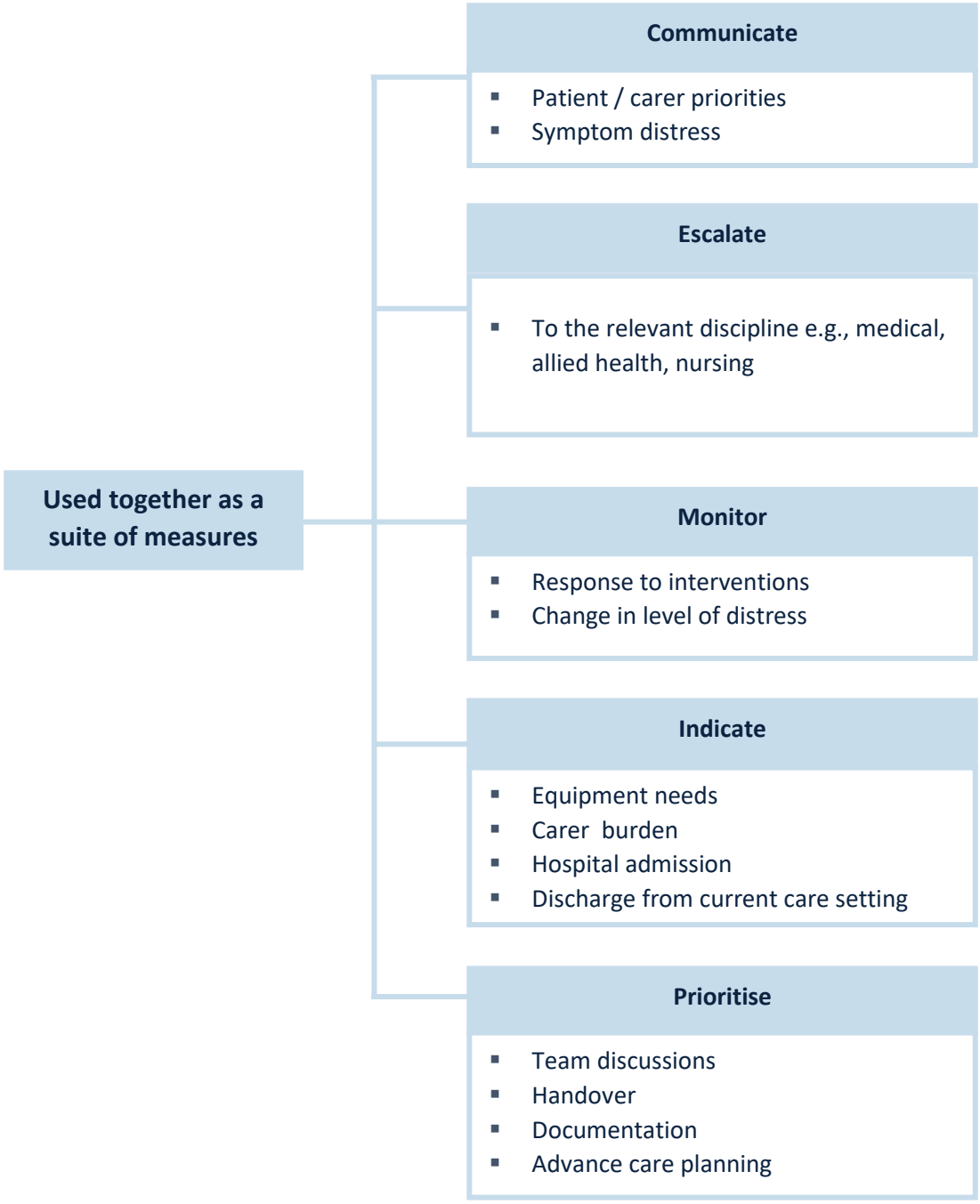
Table 5 Potential actions for PCPSS family and carer domain

PCPSS	Description / clinical indicators	Potential Actions
0 **Absent**	Patient has no family / carer. If family / carer present, there are no problems (or emerging problems) identified.	Consider an advance care planning discussion with the patient and the family / carer.
1 **Mild**	The family / carer are experiencing a problem(s) but these are not impacting significantly on the care of the patient and are being addressed by the current plan of care.	Document current problems and follow care plan. Discuss family / carer situation and problems at multidisciplinary team meeting. Monitor changes to family / carer problems through daily assessment for inpatients and at every contact for patients of community and consultation / liaison services.
2 **Moderate**	The family / carer are experiencing one or more problems that are influencing the care of the patient. The problem(s) may be new or existing.	Document current problems. Complete multidisciplinary review of care plan and develop strategies for addressing problem(s). These may include (but are not limited to): ▪ Referral to social worker / counsellor / family therapy services ▪ Referral for pastoral care ▪ Provision of equipment ▪ Referral for community care assistance (personal care, cleaning service etc.) ▪ Volunteer support ▪ Referral for respite care (in-home, day respite etc.) ▪ Education for family / carer
3 **Severe**	The family / carer are experiencing a serious problem(s) that is/are significantly impacting upon the care of the patient. This may be a new (acute) problem or it may be an exacerbation of an existing problem. *Note: If family / carer domain of PCPSS is assessed as severe, the patient is likely to be in the unstable phase.*	An immediate response and review of care plan is required. Complete multidisciplinary review of care plan and develop strategies for addressing problem(s). These may include (but are not limited to): ▪ Referral to other support services (social worker, counsellor, psychologist etc.) ▪ Referral of family / carer to their GP or other medical practitioner ▪ Admission to hospital for community patient

Building the assessment & response protocol into routine practice

Successful incorporation of the assessment and response protocol requires integration into all aspects of routine provision and delivery of care. Figure 2 below provides guidance for building the protocol into routine practice.

Figure 2 Guidance for building the protocol into routine practice



All of the PCOC Tools & Resources listed in this document are available on the PCOC website www.uow.edu.au/ahsri/pcoc