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Using Palliative Care Assessment Tools to Influence and Enhance Clinical Practice

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The Palliative Care Outcomes Collaboration focuses on supporting palliative care services in Australia to measure service- and patient-level outcomes, and to use these data to drive continuous quality improvement. The introduction of a suite of clinical assessment tools nationally has resulted in important enhancements to care provision at individual service level. Improved communication, enhanced assessment of patient needs, and improved identification of triggers for the need to change care plans or for referral have resulted from this change.

With specialist palliative care services now recognized as an integral component of contemporary healthcare, systems for monitoring and ensuring the quality of such services are essential. The Palliative Care Outcomes Collaboration (PCOC) commenced in 2005 in Australia as an ongoing national quality improvement initiative for palliative care. The initiative is based on a model that emphasizes outcomes measurement as a routine part of clinical practice, a comprehensive description of which has been reported elsewhere (Eagar et al., 2010). This model promotes the use of common definitions, standardized assessments of agreed indicators of quality palliative care, and benchmarking based on these agreed indicators. Quality improvement initiatives based on these benchmarking activities are then supported. Integral to the success of PCOC has been the national introduction of five standardized assessment tools into routine clinical care, providing data that enable benchmarking and identification of areas for improvement. Importantly, the introduction of systems that support routine and standardized clinical assessments has in itself resulted in some important outcomes for participating palliative care services in Australia. The purpose of this article is to describe the process of introducing routine clinical assessments into the day-to-day practice of palliative care services in Australia and, through case studies, to identify some of the measurable outcomes that have resulted at the service level from this system-wide adoption of standardized assessment tools.

Using standardized clinical assessments in healthcare

The introduction of structured approaches to clinical assessment is well established as enabling a more comprehensive and consistent way of identifying and meeting client needs (Bourbonnais et al., 2004). Structured approaches to assessment can take many forms, but typically involve regular ongoing assessment using assessment tools that are both reliable and valid. Regular ongoing assessments in palliative care clinical practice have the
potential to enable consistent monitoring of disease status and prognosis, the effectiveness of interventions, accurate symptom assessment to ensure appropriate clinical management, and better-quality discussions around the concerns and priorities as defined by the patient. (Soni et al., 2002; Ewing et al., 2006; Spertus, 2008). The use of standardized approaches to clinical assessments, and a common language associated with these agreed assessment approaches, enhances communication between health professionals and is also a mechanism for reliable communication with patients.

Previous palliative care studies have reported that use of standardized clinical assessment tools in routine practice has resulted in enhancements to care. For example, the use of the Edmonton Symptom Assessment Scale in routine practice has been reported to result in clinicians interpreting symptoms earlier and more efficiently, and providing greater continuity of care within the interdisciplinary team (Dudgeon et al., 1999). Similarly, use of validated pain assessment methods in a pediatric setting was reported to result in nurses thinking and acting differently in relation to pain management (Simons & MacDonald, 2006). These authors identified that in instigating pain assessments routinely on admission there was a greater likelihood of children’s pain being detected and treated earlier, with nurses taking more ownership of pain assessments and increasingly involving parents in these.

Systematic assessment of symptoms, such as fatigue, has also been reported as being associated with reduced symptom distress and improved communication about symptoms, as clinicians are able to more fully appreciate the burden of symptoms if they are assessed regularly (Davis et al., 2008).

**PCOC Standardized clinical assessments**

A central premise of PCOC is that the collection, aggregation, and reporting of clinically useful data in a timely manner will provide valuable information to drive quality improvement initiatives at an individual service level. A key part of this process has been the implementation of routine outcomes measurement, using a suite of validated and reliable assessment tools to standardize patient assessment.

PCOC tools were selected following a thorough literature review and approval by the PCOC Scientific Clinical Advisory Committee (SCAC). The SCAC comprises representatives of the key stakeholders at state and national levels. Many of the tools had also been used in previous national palliative care programs, including the National Palliative Care Program’s Rural Palliative Care Program (2004 to 2007) (Rawlings et al., 2006).

The five clinical tools that constitute the assessments within the current PCOC data-set reflect the core domains of physical, social, emotional, and well-being that palliative care encompasses. These tools include the Palliative
Care Phase (Eagar et al., 2004), Symptom Assessment Score (SAS) (Kristjanson et al., 1999), Resource Utilization Group/Activities of Daily Living (RUG/ADL) (Fries, et al., 1994), Australian Modified Karnofsky Performance Score (AKPS) (Abernethy et al., 2005), and Palliative Care Problem Severity Score (PSS) (Eagar, Green, Gordon, & Smith, et al., 2004).

The Palliative Care Phase
Phase: The palliative care phase classifies the stage of the patient’s illness into stable, unstable, deteriorating, and terminal, within the episode of care. Phase also includes the family and/or carer. It can be an indicator of acuity and can be used to reflect complexity in conjunction with other tools. Palliative Care Phases provide a clinical picture of a patient trajectory including a distinction between expected and un-expected changes in the type of care required. A fifth phase, bereavement, may be assigned when immediate post death bereavement support is provided for the family/carer.

Symptom Assessment Score
SAS: A seven-item patient-rated tool to measure symptom distress, a valid and reliable tool. The seven symptoms are rated by the patient on a scale of 0 to 10, with zero being no symptom distress and 10 the worst possible distress. The symptoms are pain, fatigue, breathing, bowels, nausea, appetite problems, and insomnia.

Resource Utilization Group / Activities of Daily Living (RUG /ADL)
RUG/ADL: A scale measuring four late loss activities of daily living—bed mobility, toileting, transfer, and eating, with a total score from these activities determining level of dependency. The scores range from a minimum of 4 (independent or supervision only) to 18 (extensive assistance/total dependence).

Australian Modified Karnofsky Score
AKPS: A validated scale that assesses three dimensions of health status—activity, work, and self-care. The RUG-ADL is more sensitive with the lower AKPS scores. The scores range from 100 (normal, no complaints/evidence of disease) to 0 (dead).

Palliative care Problem Severity Score
PSS: A clinician-rated tool, it includes four global domains—pain, other symptoms, psychological/spiritual, and family/carer. The PSS is used as a screening tool and may be used as a trigger for referral to a specific discipline requiring a more comprehensive, specialized assessment.

A key part of the work within PCOC is providing education and assistance with implementing the PCOC clinical assessment tools. PCOC education thus includes a structured pro- gram that is individualized for services. The education pro- gram includes background information on PCOC, the rationale for participation, instruction on the use of the five clinical tools (including case
studies), examples of how assessments have been integrated into practice, and a plan for ongoing education, such as inclusion in in-service and orientation programs. As recommended by others who have similarly attempted system-wide implementation of pain and symptoms assessment tools (Bourbonnais et al, 2004), this formalized education helps to ensure consistent use of the tools. On completion of the education program, clinical staff enter assessment data using either paper-based or electronic records adapted to enable data collection as part of routine clinical practice (Cur- row et al., 2008).

Quality Improvement Facilitators (QIFs) are employed within PCOC to provide leadership in the areas of quality improvement and to provide education and foster an environment of evaluation of interventions, process practice changes, and improvement of clinical outcomes. The QIF positions are similar to Service Improvement Facilitator roles described in the NHS in the UK, whose role is to facilitate and generate change and quality improvement (NHS Radiology Service Improvement team, 2004). Specifically, the QIFs work with services to integrate changes in process and a culture of practice that promotes positive outcomes, a strategy successfully employed elsewhere (Nemeth, 2003; Goman, 2000).

QIFs also focus on facilitating a team approach and identifying clinical leaders to support implementation of routine assessments. Such an approach is consistent with literature that highlights that inadequate or inappropriate leadership is a key barrier to successful change (Masso & McCarthy, 2009; Scott et al., 2003). Moreover, strategies used to engage team members in use of the tools recognize potential barriers to implementation and ways to overcome these barriers. For example, adopting structured frameworks has been promoted to clinicians and managers as not adding extra work, but rather formalizing the work often undertaken instinctively in health professionals’ interactions with patients (Dunckley et al., 2005). As the tools describe acuity, measure functional and ADL ability, and assess symptoms, QIFs work with services to integrate such measures as part of the day-to-day work of the palliative care interdisciplinary team to improve the quality of patient care. The tools take as little as 10 minutes to complete, covering the domains of care that are routinely assessed when working clinically with patients.

**Australian palliative care services experience of using routine clinical assessments**

Adoption of PCOC has seen widespread changes to individual behaviors and practices that have been instrumental in creating and sustaining new ‘norms’ and practices that are embedded into the organization (Kassean & Jagoo, 2005). Specific examples of changes in practice reported by services as an outcome of implementing routine clinical assessments are described in the following section. These changes include improved communication, enhanced assessment of patient needs, and improved identification of triggers for the need to change care plans or for referral.
Improved Communication
PCOC assessment tools have in some services facilitated improved communication within the multidisciplinary team. This enables health professionals to systematically identify changes in acuity and in function, and to have a common language for sharing such changes. Multi-disciplinary meetings are thus more likely to employ shared understandings of a patient’s condition and needs (Box 1).

Enhanced assessment of patient needs
Phase can be an indicator of acuity and complexity in conjunction with other tools, and provides a clinical indication of the type of care required. RUG and AKPS are an indicator of functional status, performance status, and prognosis, and the PSS and SAS together describe symptoms and their severity. Together, all tools can be used to identify more individualized management strategies to improve care (Box 2).

Improved identification of the need for changes in care
The clinical assessment tools have been used by some services to apply a systematic framework to guide decision-making about the need for changes in care. Clinicians often instinctively know when things are starting to change for a patient, but to have a more formalized, documented process has been reported by some services as having improved their care (Box 3).

For example, one service has reported that patient scores from the routine collection of symptom data using the symptom assessment scale are used to plan and monitor care (Lewin et al., 2008). This service has also described the potential for routine clinical data to be used in auditing care and identifying areas for improvement, comparing cost-effectiveness, and examining service performance (Charlton et al., 2002).

Case Studies of routine clinical assessment
Services participating in PCOC describe how they have effectively used the five assessment tools in routine clinical practice. A case study is presented to illustrate such changes (Case Study).

Conclusion
Implementation of PCOC has seen registered services begin to trial various practice improvements using the assessment tools as the framework for measuring outcome improvement. Much of this is now being embedded in clinical practice, with services encouraged to make changes in their daily practice, through use of the tools in addition to data collection that has more to do with improving practice and therefore outcomes. The examples provided in this article suggest that the utilization of standard assessment and documentation to support a multidisciplinary approach to assessment and care is contributing to improvements in patient care.
The PCOC experience with implementing routine clinical assessments has identified that successful implementation and management of change is contingent on many factors, including ownership of the process by those involved, positive communication, leadership, realistic time frames, recognition of the value of the planned change, other examples of success, and particularly ongoing commitment in many forms and at many levels (Hamilton et al., 2007, Stetler et al., 2008). Clinicians’ experience with using the routine clinical assessment tools as part of PCOC has been positive, resulting in improvements to clinical care. It is expected that there will be further developments in this area as PCOC moves into the second phase.

**BOX 1: Improving Communication**
- The use of a white board for recording Phase, RUG/ADL, and PSS provides a snapshot picture of the patients’ condition and needs in real time. This clinical picture tells staff at a glance the acuity of each patient and their functional dependency in order to prioritize assessment by the multidisciplinary team members. For example, the medical staff review the patients in the unstable phase, the pastoral care worker supports the families of patients in the terminal phase, and the physiotherapist reviews patients in the stable phase with functional needs and nursing staff allocated based on acuity and dependency.
- Standardized assessment tools provide the vehicle for a common language that describes across settings the condition and needs of palliative care patients. For example, a patient in the terminal phase with a high RUG score, being admitted to an inpatient unit, informs the staff of the type of care required for the patient and their family or, if being discharged to the community, tells the staff the resources to be considered to provide quality care. The common language is understood by staff across settings.
- Caseload reviews using the five assessment tools. For example, patients in the community who have been receiving regular visits from the palliative care service and their assessments have not changed, indicating no immediate palliative care needs are discharged to the primary health care team with the documentation of current assessments.

**Box 2: Enhanced assessment of patient need**
- The Phase, RUG/ADL, and AKPS assessment tools are beneficial to predict appropriate timing for input of physical resources by physiotherapist or occupational therapist.
- The RUG-ADL assessment in the community enables staff to consider family/carer needs and burden.
The Phase and the AKPS are used as part of determining prognosis, and an AKPS score of 30 or 40 for patients in the deteriorating or terminal phase triggers the need for a case conference with the GP and review of care requirements and availability of medications if a home death is planned.

- The five assessment tools give a clinical picture and assist in prioritizing access to service based on need. A patient with high SAS scores signifies a medical review of symptoms urgently.

- The Phase, PSS, and SAS assessments are used to review the length of time in a phase and hence the effectiveness of interventions. A patient in the unstable phase after 7 days is reviewed for effectiveness of interventions.

**Box 3: Identification of the need for changes in care**

- The AKPS is used in community services as a trigger for reassessment. An AKPS score of 50 requires the reassessment of patient and family/carer needs in the home. This includes assessment for manual handling, falls risk, and pressure area risk. An AKPS score of 60 calls for proactive case conferencing and care planning.

- The Phase is used in inpatient settings to dictate a change in care. When a patient is assessed in the terminal phase, a change in care occurs with the implementation of an end-of-life care pathway. High scores for the PSS and the SAS alerts urgent change in care is required.

**CASE STUDY**

Mrs P was admitted to a Palliative Care Inpatient Unit participating in PCOC in which the five assessment tools were completed daily and at other times when a phase changed. Mrs P had been experiencing severe pain from bony metastases. On admission, Mrs P was assessed phase 2, PSS for pain 3, other symptoms 2, psychological/spiritual 2 and family/carer 2. RUG score was 14 and AKPS 50. From the SAS, Mrs P reported her pain on the SAS at 8 and breathing 4. Fatigue, nausea, insomnia, and bowels were asymptomatic. Mrs P was given medications for her pain and dyspnoea, referred to the physiotherapist for mobility (RUG 14) and breathing (SAS 4), and the social worker (PSS psychological/spiritual 2 and family/carer 2).

The staff completed the PCOC assessments routinely and reported an improvement in Mrs P at each nursing handover and clinical meeting. Using the information from the assessments the management plan was reviewed and changed. Mrs P was discharged on the 5th day with a handover to the community team using the information from the PCOC assessments during her admission. The assessments on the 5th day were phase 1, PSS for pain 0, other symptoms 0, psychological/spiritual 1 and family/carer 0. RUG score was 10 and AKPS 60. Mrs P reported her pain on the SAS at 0 and breathing 1.
References


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