How do Pallative Care Specialists add value?

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Introduction

With current financial constraints and pressures it is more important than ever that specialist hospital palliative care teams (HPCT) can demonstrate their worth. Key questions when considering how professionals and services add value to patient care are:

- **Can you demonstrate how you spend your time?**
- **Can you describe the complexity of your work?**
- **Can you quantify your contribution?** (Leary 2011)

The collaborative working practice of HPCT means that it is difficult to ascertain the key influences on patient outcomes (Corner 2002). There is a need for a method of assessment that demonstrates how and where the HPCT add value to the care of palliative patients.

Aims

To test a tool that demonstrates the scope of practice and complexity of care delivered by HPCT
To demonstrate the areas where HPCT add value

Methods

Following a literature review a specialist intervention tool was developed. This tool scores activity within eight domains of care commonly assessed and managed by HPCT. The Lothian Specialist Palliative Care Intervention Tool (LSPCIT) is shown in figure 1.

LOTHIAN SPECIALIST PALLIATIVE CARE INTERVENTION TOOL

Date: Total Time: Type of contact: 1stVisit/Follow up visit/Telephone/Family meeting/ Bereavement Visit/Specialist r/v Total Score:

Area of intervention	Level of intervention	Score	Area of intervention	Level of intervention	Score
Symptom Assessment Score 4 worst symptoms Please note each symptom and score separately 1.................. 2.................. 3.................. 4..................	Check of symptom severity with no change to plan of care	1	**Family Issues**	Assessment of family members understanding of current situation	3
	Full assessment of symptom severity with implementation or revision of plan of care	2		Support of family members in difficult situations including bereavement	3
	Full assessment of symptom severity and discussion of plan of care with palliative care colleague for second opinion	3		Family meeting to discuss ongoing care, anticipatory care planning, DNACPR and appropriate place of care Will include some or all of these things	4
	As above with discussion/telephone contact to palliative medicine consultant for second opinion	4			
	Joint visit to assess symptoms severity and plan care	5		Multidisciplinary meeting with patient and family involving different team professionals which explores and includes some or all of the above	5
Emotional Spiritual Psychological Issues	Engagement and establishment of relationship	1	**Level of Specialist Review**	Telephone advice/discussion with referring team	2
	Assessment and exploration of spiritual/emotional issues	2		Visit/review of patient by band 6 CNS	3
	Assessment of knowledge and understanding of disease and current issues /support network/adjustment and coping WHAT MATTERS/PATIENT PRIORITIES	3		Review of patient by band 7 CNS /speciality Doctor	4
	Assessment of anxiety/depression and associated risk assessment	3		Consultant review of patient and specialist advice/opinion given	5
	Assessment of more than 1 of the above issues	4	**Staff Support and Education**	Liaison/education of staff relating to ongoing plan for patient	2
	Ongoing management of identified psychological, emotional or spiritual issues and/or distress	4		Staff education/support arising from specific incident or patient eg case review or informal teaching	3
	Joint visit with PSYCHOLOGY/SPIRITUAL CARE to assess identified issues and plan care	5		Liaison regarding complex interventions requiring teaching and support eg: ketamine/phenobarb/methadone	4
Anticipatory/ Advanced Assessment and Planning	Assessment/advice re ESCALATION, ANTICPATORY MEDS, DNACPR, KIS FOR I/P OR O/P	3	**Specific Liaison/Handover to another service**	Liaison with other services requiring 1-2 phone calls or contacts	2
	Discussion/review about DNACPR, KIS, ANTICIPATORY MEDS and advanced planning of medical care with patient or referring team	4		Challenging liaison with other services requiring multiple phone calls or contacts	3
	Joint visit with SOCIAL WORK/ DISCHARGE FACILITATOR with patient or referring team	5		Arranging complex admission or discharge requiring specialist services to arrange and requiring complex liaison with teams involved	4
Patient/Carer Education	Education of patient or carer re ongoing management plan. Eg management of symptoms	2		Liaison with multiple services regarding complex patient requiring many contacts and ongoing support	5

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The tool also records the length and type of intervention; specialist review, telephone review, first visit, follow-up visit and family meeting
The HPCT used the tool for a 4 week period to document and score each intervention. Each intervention was coded to patients to allow analysis of all interventions and complexity per patient.

Results

Demonstrating how we spend our time:

- 277 interventions scored in 4 week study period
- These related to 74 patients

Figure 2 shows the proportions of intervention categories: 2 specialist review, 21 telephone review, 44 first visits, 208 follow up visits and 2 case conferences.

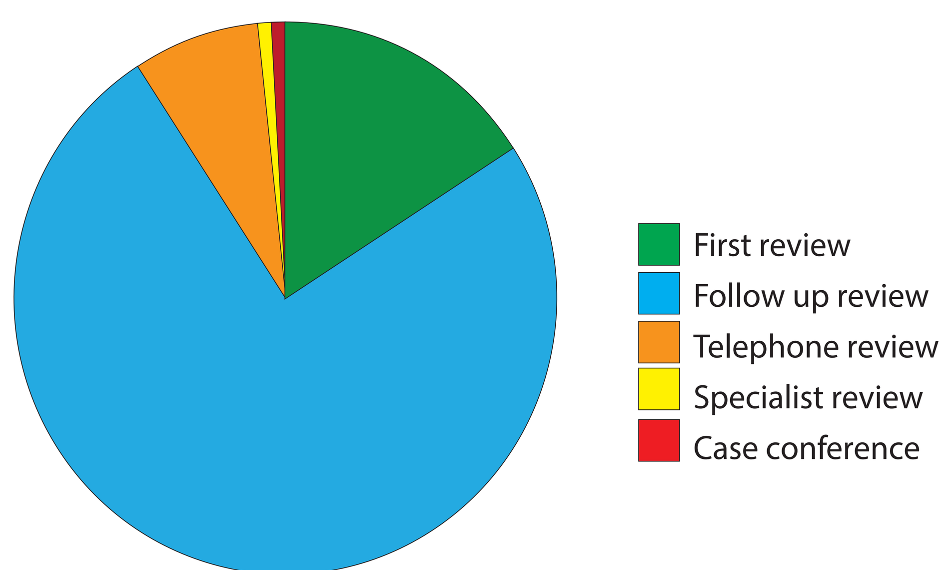

Figure 2 Intervention Categories

Of the 74 patients; 21 were telephone reviews and analysed separately, illustrated in figure 3, 2 were specialist opinion of patient care without patient review and 52 were followed up by HPCT of which 8 were already on caseload at start of pilot.

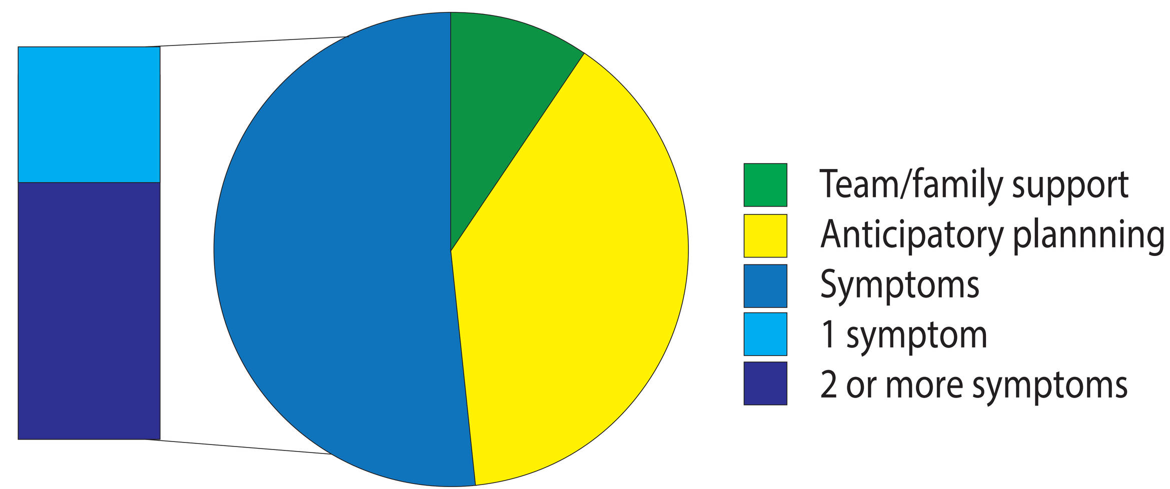

Figure 3: Content of telephone reviews

Figure 4 illustrates the number and type of intervention per patient.

- The length of time for a first visit ranged from 15 to 120 minutes (mean 54 minutes).
- The length of time for a follow up visit ranged from 5 to 120 minutes (mean 33 minutes).

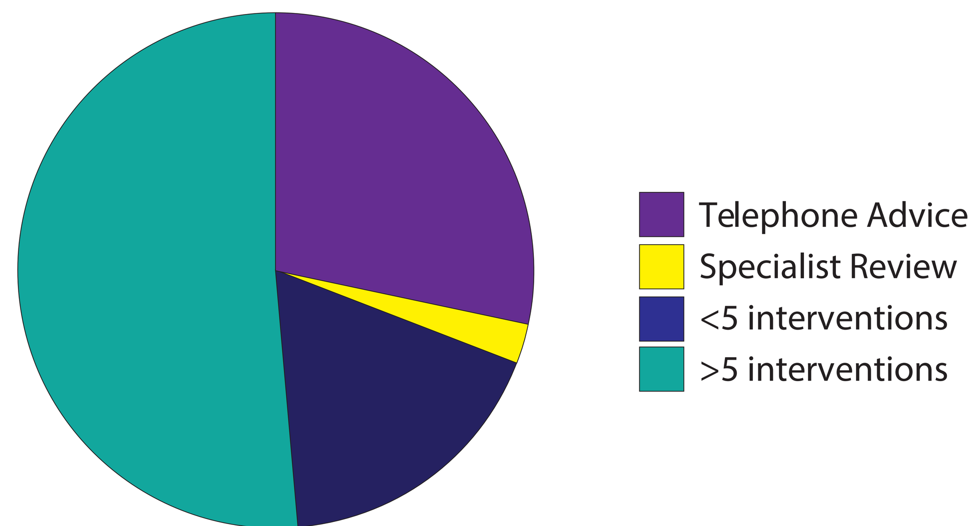

Figure 4 No and type of intervention/patient

Describing the complexity of our work:

The main reason for referral to HPCT was as follows;

- pain control
- symptom control
- end of life care
- appropriate place or direction of care.

The LSPCIT allows up to 4 symptoms to be recorded and scored as appropriate with each intervention. Figure 5 shows the number of symptoms assessed per intervention over all 277 interventions.

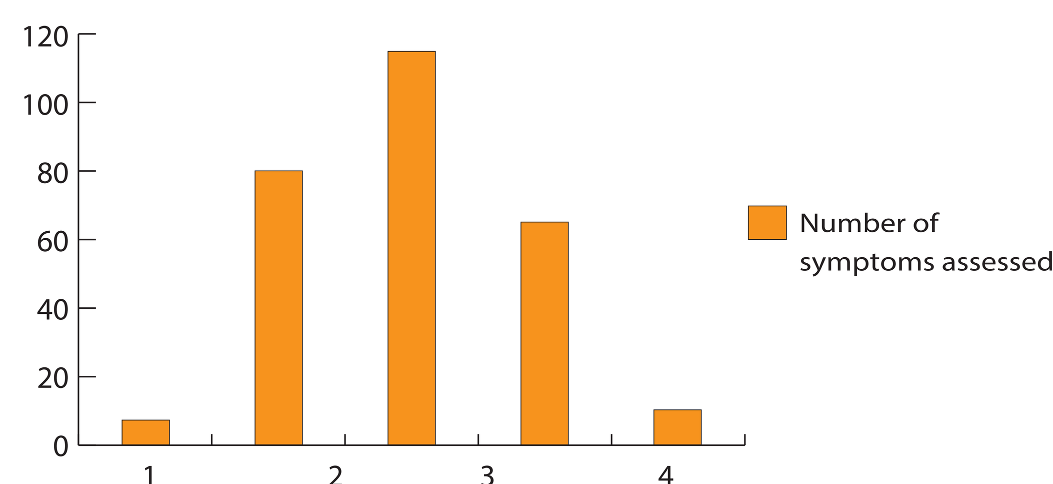

Figure 5: Number of symptoms assessed/intervention

Figure 6 illustrates the number of symptoms assessed when compared to reason for referral showing that the team were also consistently assessing and advising on symptom management even when this was not the primary reason for referral 25% of patients had a short but intense involvement of HPCT, 4 or fewer interventions, but with all eight domains of care addressed. HPCT were involved with this group of patients for a range of 1 – 5 days (mean 2.4 days).

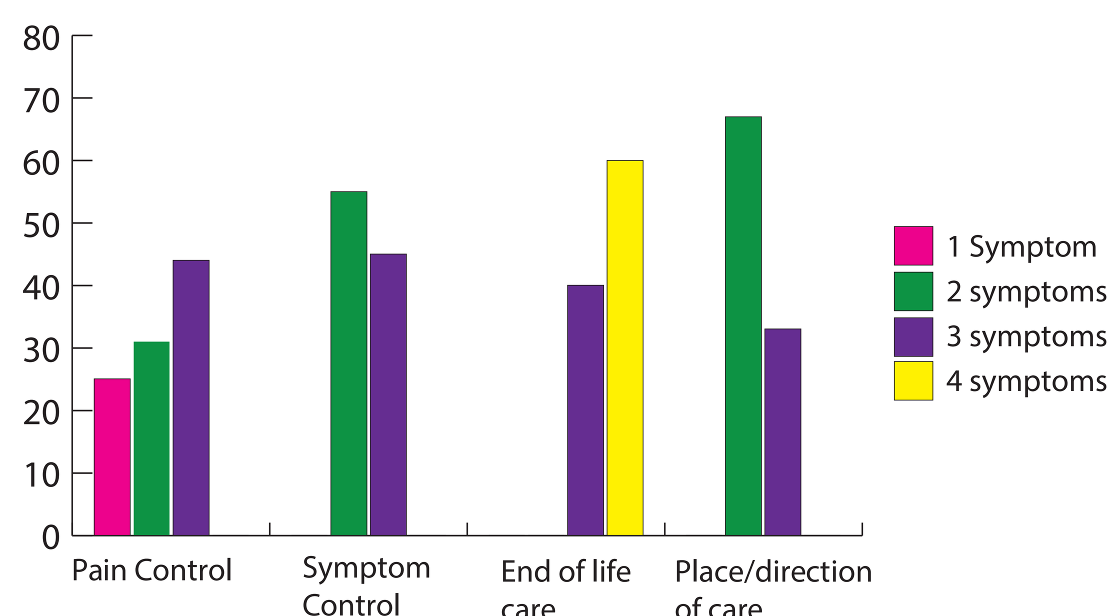

Figure 6: Main reasons for referral vs no of symptoms assessed

Figure 7 shows the outcomes in of this group of patients. 11/14 (79%) had a very small window of opportunity to transfer to optimal place of care facilitated by HPCT.

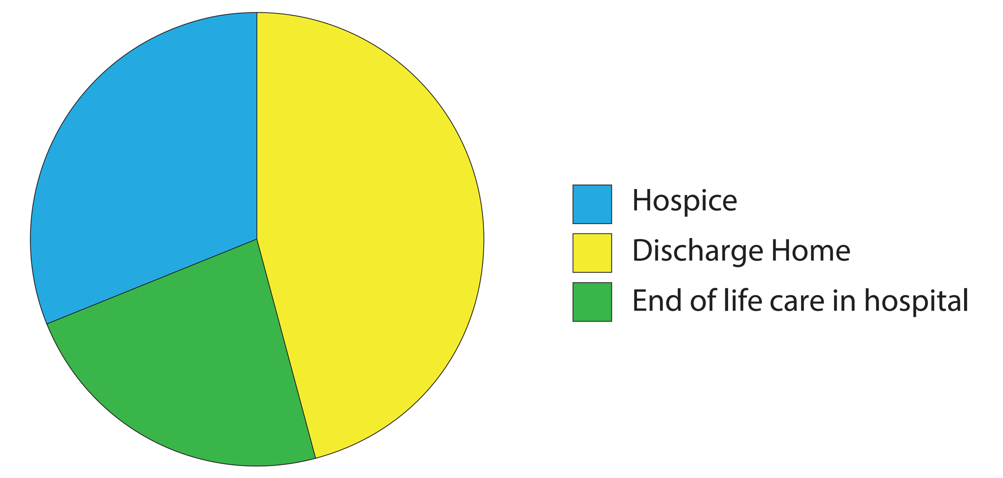

Figure 7: Outcome for patients with 4 or less interventions

Quantifying our contributions:

- 60% of the 277 interventions were multi-dimensional with 5 or more of the 8 domains of care assessed
- 71% of the 277 interventions included assessment of patient priorities and discussions related to advanced care planning
- 100% of the 52 patients followed up by HPCT had all the domains of care addressed over the period the team were involved

The majority of patients were referred to HPCT for pain control or for symptom control; however the areas where the team adds value can be seen more clearly using the LSPCIT. Analysing the domains of care related to emotional support/patient priorities, advanced planning/ escalation, family support and handover discussions with primary care or hospice, reveals that the HPCT contribute consistently in these areas. Figure 8 shows the percentage of times these areas were addressed by HPCT in relation to the main reason for referral and illustrates the team were regularly addressing these areas irrespective of the main reason for referral.

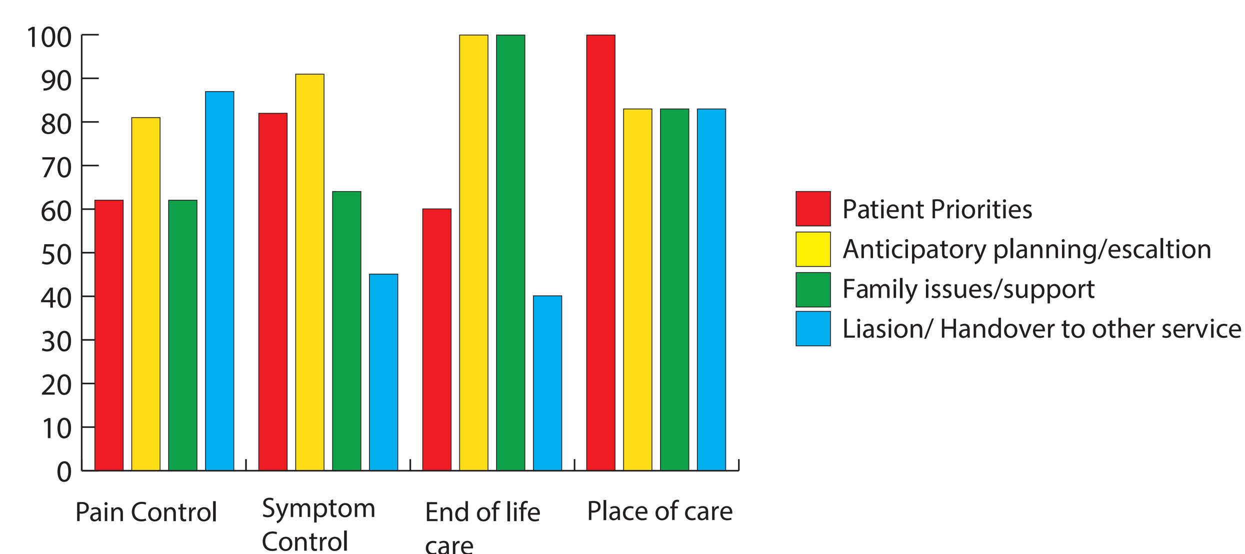

Figure 8: Percentage of times activity in named domains vs main reason for referral

Conclusions

The aim of palliative care is to provide impeccable assessment and holistic care. The collaborative nature of hospital palliative care alongside the "softer" elements of palliative care, make it more challenging to quantify the contribution made by a specialist palliative care service.

- The LSPCIT is a helpful tool in making the scope of HPCT clearer.
- It can help quantify where specialist palliative care are influencing patient outcomes.
- Traditionally HPCT collects data on number of visits, and/or number of days of involvement with a patient.
- This tool helps to illustrate the scope, intensity and complexity that is involved in each of these visits, and with this group of patients how much can be achieved in a very short period of involvement with HPCT
- The domains of care could be applicable to both hospital and community palliative care

Recommendations

The scoring system of the tool needs more research and evaluation.
More work is needed on the LSPCIT to ensure reliability and to test further in different settings.

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NHS Lothian