Palliative Care and Pain Satisfaction: The Miriam Hospital's Relationship with Home and Hospice Care of Rhode Island for a Palliative Care Consult Service

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BACKGROUND

- As initiatives around pain management have evolved at our acute care institution, we have recognized the positive impact of a Palliative Care Consult Service (PCCS) on our multidisciplinary efforts to improve pain satisfaction and patient and family experiences.
- While consult growth has been steady since starting in 2008, referrals were often made very late in the hospitalization and RN/MD staff were observed to have a poor understanding of the differences between palliative care and hospice services, causing confusion that often delayed or deferred referrals .
- It was also identified that patients with progressive and debilitating cardiac disease or advanced dementia could benefit from earlier Palliative Care consults, but clinicians were less likely to make these referrals. A comprehensive plan was developed by nursing leadership, the geriatric clinical nurse specialist and leadership from HHCRI to increase consults by targeting two units that had previously generated the fewest consults.

GOALS OF THE PILOT PROJECT

GOALS:

To increase staff understanding of:

- ✓ Palliative Care
- ✓ Differentiation Between Palliative Care and Hospice
- ✓ Triggers for referral to Palliative Care Consult Service

To promote interdisciplinary team communication to identify potential referrals by education to target audience of:

- ✓ Unit staff (RN's, C.N.A's, Unit Secretaries, Unit Managers)
- ✓ Rehabilitation Staff (PT, OT, SLP)
- ✓ Case Managers
- ✓ Social Workers
- ✓ Physicians - Hospitalists; Residents and Interns
- ✓ Nurse Practitioners

TARGET: INCREASE CONSULTS ON THESE TWO UNITS FROM July 1, 2012 to Dec 31, 2012 by 20% over a six month period.

Education to staff occurred in May - June 2012
Data from January –June would be the comparison

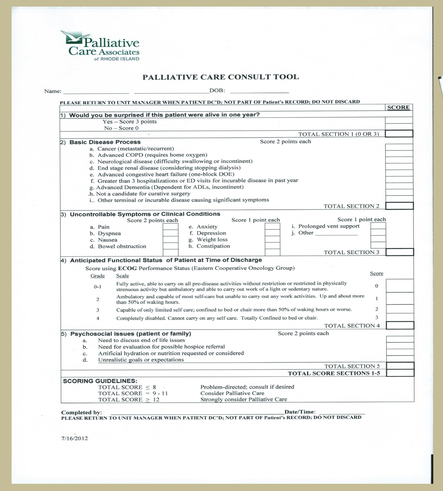
ACTION PLAN

- Educational tools from HHCRI were customized for these two units (one medical and one med-surg) and their specific patient population.
  - Education focused on the difference between palliative care & hospice;
  - The benefits of palliative care for patients with advancing dementia and progressive congestive heart failure (the primary population of these two units), as well as patients with repeated admissions for these
  - Use of the tool as a trigger at daily multidisciplinary rounds for beginning conversations with MD's, NP's etc..
- Education was delivered through online learning and by on unit in-services and staff meetings.
  - Education was done by the Geri CNS and the Palliative Care NP and MD
- The NICHE GPCA modules for Pain, Sleep and Palliative Care were also implemented for all C.N.A's on these units through an online learning platform.
- The Consult Tool was widely distributed to all units, and laminated copies were used at daily unit rounds to identify patients who could potentially benefit

HHCRI TOOLS USED AT TMH

Tool used by staff at daily multidisciplinary rounds; and to trigger RN and MD staff to implement consults

HHCRI brochure for patients and families – placed on all units and available to families



Palliative Care Associates of RHODE ISLAND

PALLIATIVE CARE CONSULT TOOL

Name: _____ DOB: _____

PLEASE RETURN TO UNIT MANAGER WHEN PATIENT DC'D; NOT PART OF Patient's RECORD; DO NOT DISCARD

	SCORE
1) **Would you be surprised if this patient were alive in one year?** Yes – Score 3 points; No – Score 0. TOTAL SECTION 1 (0 OR 3)	
2) **Basic Disease Process** Score 2 points each: a. Cancer (metastatic/recurrent); b. Advanced COPD (requires home oxygen); c. Neurological disease (difficulty swallowing or incontinent); d. End stage renal disease (considering stopping dialysis); e. Advanced congestive heart failure (one-block DOE); f. Greater than 3 hospitalizations or ED visits for incurable disease in past year; g. Advanced Dementia (Dependent for ADLs, incontinent); h. Not a candidate for curative surgery; i. Other terminal or incurable disease causing significant symptoms. TOTAL SECTION 2	
3) **Uncontrollable Symptoms or Clinical Conditions** Score 2 points each: a. Pain; b. Dyspnea; c. Nausea; d. Bowel obstruction. Score 1 point each: e. Anxiety; f. Depression; g. Weight loss; h. Constipation; i. Prolonged vent support; j. Other _____. TOTAL SECTION 3	
4) **Anticipated Functional Status of Patient at Time of Discharge** Score using ECOG Performance Status (Eastern Cooperative Oncology Group). Grade 0-1: Fully active, able to carry on all pre-disease activities without restriction or restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature. Grade 2: Ambulatory and capable of most self-care but unable to carry out any work activities. Up and about more than 50% of waking hours. Grade 3: Capable of only limited self care; confined to bed or chair more than 50% of waking hours or worse. Grade 4: Completely disabled. Cannot carry on any self care. Totally Confined to bed or chair. TOTAL SECTION 4	
5) **Psychosocial issues (patient or family)** Score 2 points each: a. Need to discuss end of life issues; b. Need for evaluation for possible hospice referral; c. Artificial hydration or nutrition requested or considered; d. Unrealistic goals or expectations. TOTAL SECTION 5. **TOTAL SCORE SECTIONS 1-5**	

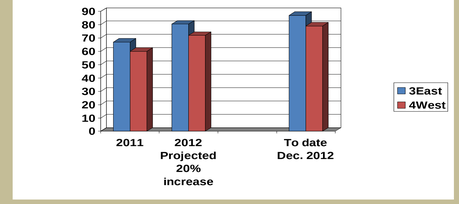
SCORING GUIDELINES:
TOTAL SCORE ≤ 8 — Problem-directed; consult if desired
TOTAL SCORE = 9 - 11 — Consider Palliative Care
TOTAL SCORE ≥ 12 — Strongly consider Palliative Care

Completed by: _____ Date/Time: _____
PLEASE RETURN TO UNIT MANAGER WHEN PATIENT DC'D; NOT PART OF Patient's RECORD; DO NOT DISCARD

7/16/2012

RESULTS

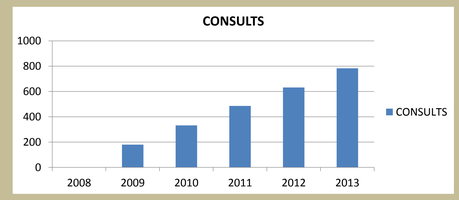
Consult Growth on the Pilot Units



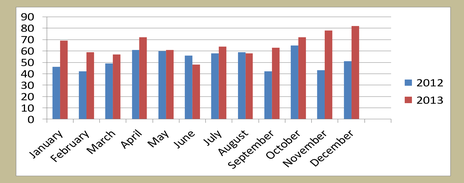
IMPLICATIONS FOR PRACTICE HOSPITAL WIDE

- Achieving the desired improvement of 20% on both units and overall positive feedback, the project was expanded to all inpatient units in January 2013.
- Palliative Care Consults have sustained growth and consults are being initiated earlier, sometimes on day of admission. In addition to staff, we are seeing consults requested by families at time of admission.

Consult Growth Overall By Year



Consult Growth By Unit 2012-2013



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