2013

Using PCOC tools for transition of care

Claire Johnson  
*University of Western Australia*

Tanya Pidgeon  
*University of Western Australia*

---

**Publication Details**

Using PCOC tools for transition of care

Abstract
PCOC is a quality initiative developed specifically to "support continuous improvement in the quality and effectiveness of palliative care service delivery across Australia".

Keywords
pcoc, transition, care, tools

Publication Details

This conference paper is available at Research Online: http://ro.uow.edu.au/ahsri/237
Using PCOC Tools for transition of care

Claire Johnson, Tanya Pidgeon
What is PCOC?

PCOC is a quality initiative developed specifically to "support continuous improvement in the quality and effectiveness of palliative care service delivery across Australia".

- Established in 2005 → quality improvement initiative
- Measures patient outcomes in palliative care
- Specifically targeted at specialist PC services
- National approach
- Benchmarks added in 2008
PCOC Assessment Tools

- Phase\(^1\): Stage of illness – patient and family
- RUG-ADL\(^2\): Functioning, dependency and resources
- AKPS\(^3\): Performance and prognostication
- PCPSS\(^4\): Distress – patient and family, includes psych/spiritual
- SAS\(^5\): Distress – 7 symptoms, patient perspective

Reports also gather other patient and episode of care information such as Diagnosis, age, gender, and LOS.

\(^1\)Eagar et al 2004; \(^2\)Fries et al 1994; \(^3\)Abernethy et al 2005; \(^4\)Eagar et al 2004; \(^5\)Kristjanson et al 1999
PCOC- Additional benefits

- Assessment tools drive the focus of care/care planning
- Improved symptom management
- Acknowledgment of the carer/family as part of the unit of care
- Provision of a common language
- Consistent, clinical picture of the individual patient
- A seamless service between home, hospital and inpatient palliative care
- Enhanced communication between patients, families and clinicians
- Consistent, formal documentation of assessment
- Assessment across domains provides referral triggers
Standardised, centrally managed, and locally delivered training by PCOC quality improvement facilitators means a consistent approach to:

- The use of the tools
- Assessment of patients
- Language
- Documentation
- Reporting
- Benchmarking/monitoring service performance
- Interpretation of reports
Case study

Introducing Bob Callis

Age: 55 years
Diagnosis: Adv. lung Ca with bony metastasis
Diagnosed: April 19, 2012
Medical Hx: Smoker for 15 years, ceased 20yrs ago, nil other sig. hx
Social Hx: Lives with wife Maisie (Bob’s carer) and their 2 teenage children

Maisie believes Bob is “getting worse” so she contacts the community PC service and requests a visit. Maisie reports that she is feeling fatigued & unwell.
Inter-jurisdictional Communication

- **PC Phase**: 2 (Unstable)
- **AKPS**: 50
- **RUG ADL**: 13/18 (needs help with bed mobility, toileting, transfers & eating).
- **PCPSS**: Pain = 3, Other symptoms = 3, Psych/spiritual = 3, Family/carer = 3. (3 = severe)
- **SAS**: Difficulty Sleeping = 8, Appetite problems = 2, Nausea = 8, Bowels = 9, Breathing = 7, Fatigue = 7 and Pain = 9. (patient rated scores, out of 10)
## Within-service communication

<table>
<thead>
<tr>
<th>Rm</th>
<th>Name, DOA</th>
<th>Phase</th>
<th>RUG</th>
<th>Dr</th>
<th>Equip</th>
<th>Appts</th>
<th>C+C</th>
<th>ACAT</th>
<th>F/M</th>
<th>D/C</th>
<th>Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Omar Little</td>
<td>8/2</td>
<td>1</td>
<td>KT</td>
<td></td>
<td>Hep C</td>
<td>X</td>
<td>X</td>
<td></td>
<td>3/7</td>
<td>Sally</td>
</tr>
<tr>
<td>2</td>
<td>Deidre Bunion</td>
<td>20/1</td>
<td>3</td>
<td>KT</td>
<td>Hoist, IDC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sally &amp; Jo</td>
</tr>
<tr>
<td>3</td>
<td>Mathilda da Silva</td>
<td>24/1</td>
<td>1</td>
<td>DO</td>
<td>SC Pump, IDC</td>
<td>MRSA +</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Sally &amp; Jo</td>
</tr>
<tr>
<td>4</td>
<td>Yuji Matsumoto</td>
<td>4/2</td>
<td>2</td>
<td>DO</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>PASN/NH</td>
</tr>
<tr>
<td>5</td>
<td>Bob Callis</td>
<td>18/2</td>
<td>3</td>
<td>KT</td>
<td>W/frame, SC Pump</td>
<td>RTX 2/6</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>Rob</td>
</tr>
<tr>
<td>6</td>
<td>Walter White</td>
<td>11/2</td>
<td>3</td>
<td>KT</td>
<td>Hoist, IDC</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>PASN/NH</td>
</tr>
<tr>
<td>7</td>
<td>Lien Nguyen</td>
<td>15/2</td>
<td>1</td>
<td>DO</td>
<td>Hoist</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Rob &amp; Jo</td>
</tr>
<tr>
<td>Name/Age/Diagnosis</td>
<td>Presenting Problems</td>
<td>Family</td>
<td>Care Needs</td>
<td>Pump/Pain Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------</td>
<td>--------</td>
<td>------------</td>
<td>------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Bob Callis</strong></td>
<td>Pain-9 (3)</td>
<td>W= Maisie</td>
<td>Phase: 2</td>
<td><strong>DR THOMAS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Nausea-8</td>
<td>RUG-ADL: 13</td>
<td>DOA: 18/2 home</td>
<td>Crisis order</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced lung Ca with bony metastasis</td>
<td>SOB-7</td>
<td>Mobility: Ambulating with frame – occasionally requires assistance</td>
<td></td>
<td>6 fractions of radiotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anorexia-2</td>
<td></td>
<td>Diet: Independent in care</td>
<td>SC pump</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insomnia-8</td>
<td></td>
<td>Bladder/bowels: Constipation, last BO 5/7</td>
<td>O2 therapy via nasal cannula</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Constipation-9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fatigue-7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deteriorating mobility/functioning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family/carer (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psych/sp (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reassessment and care planning

Several days later…

- **Phase:** 3 (Deteriorating)
- **AKPS:** 40
- **RUG ADL:** 10/18 (little more mobile)
- **PCPSS:** Pain = 2, Other symptoms = 3,
  Family/carer = 3
  Psych/spiritual = 2 (2 = moderate)
- **SAS:** Difficulty Sleeping = 2, Appetite = 2,
  Nausea = 2, Bowels = 1, Breathing = 6,
  Fatigue = 1, and Pain = 1
Summary - key message

Why does this work?

Standardisation and consistency!

- Assessment
- Language
- Reporting
- Used by everyone in the same way
- Not just data collection
Kathy Eager - Chief Investigator, University of Wollongong
David Currow - Chief Investigator, Flinders University
Patsy Yates - Chief Investigator, University of Technology Queensland
Tanya Pidgeon - WA Quality Improvement Facilitator

www.pcoc.org.au

Funded under the National Palliative Care Program and is supported by the Australian Government Department of Health and Ageing