The development of a triage tool for in-patient palliative care services

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Background

• In Australia: → greater demand for palliative care services
  – series of demographic factors
  – promotion in non-malignant diagnoses
• Number of services have established waiting lists for SPC based loosely on notion of ‘urgency’
  – but variation in conceptualisation
  – lack of transparency and standardised decision making
Aims

• To develop an inpatient palliative care admission triage (IPAT) tool which
  – assigned priority according to clinically relevant variables
  – allowed change according to clinical change and time spent on the waiting list.

• To evaluate the utility and acceptability of this tool in two inpatient PCUs
Method – 2 phases

1. Developmental phase

- Core group of PC HCPs, series of semi-structured discussions
  - Relevant clinical & administrative variables wrt urgency of a patient awaiting admission
  - Informed by tool developed St Francis Hospice Raheny, Dublin*
  - comparative weightings (scores) assigned.

- Total score = sum each variable score
- Recalculated with clinical change &/or time on waiting list
- Final tool piloted with 5 patients – acceptable face validity

- * Personal communication C Murtagh.
Method – 2 phases

2. Implementation and evaluation phase

- All patients referred 2 inpatient PCUs over 3/12
- Completed IPAT score, waiting list prioritised according score calculated.
- Updated with change / time
- Evaluation of IPAT sought according to HCP users.
- Semi-structured focus groups, recorded, transcribed and thematic analysis.
- Ethics approval: QI activity.
# Inpatient Palliative Care Admissions Triage Tool

## Patient Details
- **Name:** [Name]
- **Date:** [Date]
- **Patient URI/No.:** [Number]

## Site:
- Acute Public Hospital
- GEM
- Rehab
- Private
- Home
- Hostel/SAH
- NH

## Reason for Admission
- Terminal care
- Symptoms control
- Respite
- Discharge planning

## Prognosis:

<table>
<thead>
<tr>
<th>Prognosis</th>
<th>1st week</th>
<th>2nd week</th>
<th>3rd week</th>
<th>4th week</th>
<th>5th week</th>
<th>Weekly Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1 week</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>1-4 weeks</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>1-3/12 weeks</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>&gt;3/12 weeks</td>
<td>[ ]</td>
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<td>[ ]</td>
</tr>
</tbody>
</table>

*Add 5 points for each week on waiting list.*

## Physical Symptoms:
- Uncontrolled
- Partially controlled
- Controlled but requiring nursing care
- None

## Psychosocial Distress:
- Severe
- Moderate
- None

## Phase:
- Stable
- Unstable
- Deteriorating
- Terminal

## Adequate Care Environment (Consider home setting, environment, carer(s), LMO support)
- Yes
- Partial
- No

## Total Points

## Outcome:
- **Date of Admission:** [Date]
• 234 patients in 3 month period.
• Place of care:
  – acute public hospital (53% and 42%),
  – home (30% and 36%)
  – private hospital (16% and 17%)
• Reason for referral:
  – terminal care (mean 56.3%, range 25-100%),
  – symptom control (mean 27.2%, range 0-54%)
  – respite care (mean 9.7%, range 0-50%)
  – restorative care (mean 4.8%, 0-22%)
  – discharge planning (mean 2%, range 0-11%).
• Time to admission:
• 34% admitted on the same day
• 69% admitted within 3 days
• 86% admitted within 6 days of referral.
• Those on WL > 12 days: patients refused offered bed, family wishes, new emergent problems requiring investigations.
<table>
<thead>
<tr>
<th>Table 2: Patients’ characteristics at time of referral</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prognosis</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 1 week</td>
<td>22 (10)</td>
</tr>
<tr>
<td>More than 1 week &amp; less than 4 weeks</td>
<td>125 (57)</td>
</tr>
<tr>
<td>Between 4 &amp; 12 weeks</td>
<td>49 (22)</td>
</tr>
<tr>
<td>More than 12 weeks</td>
<td>24 (11)</td>
</tr>
<tr>
<td><strong>Physical symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>Uncontrolled</td>
<td>45 (20)</td>
</tr>
<tr>
<td>Partially controlled</td>
<td>126 (57)</td>
</tr>
<tr>
<td>Controlled but requiring attention</td>
<td>48 (22)</td>
</tr>
<tr>
<td>None</td>
<td>1 (0.5)</td>
</tr>
<tr>
<td><strong>Psychosocial distress</strong></td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>54 (25)</td>
</tr>
<tr>
<td>Moderate</td>
<td>141 (64)</td>
</tr>
<tr>
<td>None</td>
<td>24 (11)</td>
</tr>
<tr>
<td><strong>Phase</strong></td>
<td></td>
</tr>
<tr>
<td>Stable</td>
<td>21 (10)</td>
</tr>
<tr>
<td>Unstable</td>
<td>66 (30)</td>
</tr>
<tr>
<td>Deteriorating</td>
<td>118 (54)</td>
</tr>
<tr>
<td>Terminal</td>
<td>14 (6)</td>
</tr>
<tr>
<td><strong>Adequate care environment</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12 (5)</td>
</tr>
<tr>
<td>Partially</td>
<td>128 (58)</td>
</tr>
<tr>
<td>No</td>
<td>80 (36)</td>
</tr>
<tr>
<td>Length Of Time On Waiting List</td>
<td>Mean IPAT Score (n)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td>Site 1 F</td>
</tr>
<tr>
<td>Admitted same day</td>
<td>15 (20)</td>
</tr>
<tr>
<td>1-3 days</td>
<td>13 (14)</td>
</tr>
<tr>
<td>4-6 days</td>
<td>11 (10)</td>
</tr>
<tr>
<td>7-9 days</td>
<td>15 (2)</td>
</tr>
<tr>
<td>10-12 days</td>
<td>0 (0)</td>
</tr>
<tr>
<td>13-15 days</td>
<td>13 (1)</td>
</tr>
<tr>
<td>&gt;15 days</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>
Clinical utility: Focus groups

• 2 Focus groups (13 participants) : acute hospitals, community services and inpatient PCUs.

• Broadly described (1) the utility and (2) educational function of the tool.
1) Utility of the tool

- Easily completed, some noted was a burden
- For some patients, tool alone inadequate to convey the complexity
- Mirrored usual decision making
- Providing objective support to justify decision reached.

‘It was extra paperwork when I would normally have been doing this kind of thing in my head’.

Overall I found this tool useful in busy times.
2) Educational function of the tool
- means to enhance practice & educate staff esp those less experienced.

*It assists (us to) reflect upon what we do.*

*It gave structure to my decision making. I was able to justify my decisions.*

*It is ... useful with poor (inadequate information) referrals I can ask direct questions which then directs my thinking.*
Summary

• Tool reflects clinical need, mirrors clinical decision-making
• Useful decision-making device in times of high demand
• Unexpected role in education and training
• Enables equity of access, transparency
• Further work required to refine, validate the tool.