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Community Palliative Care Triage Guideline

A local initiative of South Western Sydney Local Health District

May 2023

END OF LIFE AND PALLIATIVE CARE NETWORK

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The SWSLHD Community Palliative Care Service

SWSLHD overview

The Community Palliative Care Service is part of the Primary and Community Health Network within the South Western Sydney Local Health District (SWSLHD). SWSLHD serves a large and diverse area that:

- covers a land area of 6,248km^2 and covers seven local government areas (LGAs), including Bankstown, Fairfield, Liverpool, Campbelltown, Camden, Wollondilly and Wingecarribee
- is expected to increase in population by 17% over the next 10 years, representing a rise of 18,000 people per annum
- records 12,000 births per year (more than 13% of births in NSW)
- is the most ethnically diverse health area in Australia (32% of the population speak a language other than English at home)
- includes a population where 10.3% of people (n=84,500) are over 65 years of age
- includes a population where 22% of people (n=196,000) are children under 15 years of age.

Figure 1: South Western Sydney Local Health District Community Health Service Map

Available at: https://www.swslhd.health.nsw.gov.au/CommunityHealth/locations.html

SWSLHD Primary and Community Health Network staffing

Across the SWSLHD Primary and Community Health Network, the following positions are based across five community health centres (CHCs) in Bankstown, Fairfield, Hoxton Park, Rosemeadow and Bowral:

- 5 FTE nurse unit managers (NUMs)
- 4.8 FTE clinical nurse consultants (CNCs) in palliative care
- 141.27 approved FTE (actual 135.09 FTE) community health nurses (CHNs) – this includes registered nurses (RNs), enrolled nurses (ENs) and specialist palliative care RN and clinical nurse specialist (CNS) positions.

Referrals to the SWSLHD Community Palliative Care Service

The SWSLHD Community Palliative Care Service receives referrals from:

- hospitals (public and private, internal and external to SWSLHD)
- general practitioners (GPs)
- other services such as non-government organisations (NGOs), private agencies, residential aged care facilities (RACFs)
- clients and/or families or carers.

The Triple I (Intake, Information and Intervention) Hub is the central point for primary and community health services within the SWSLHD. The hub offers a contact point for clients, carers and agencies who need referrals to community palliative care services. Referrals are processed by the hub and are then directed to the appropriate CHC. A care coordinator is assigned by the NUM (or delegate) and a triage phone call is scheduled within 24 hours of referral, seven days per week.

Generally, the Triple I Hub does not notify referrers if or when their referral has been received or acted upon, unless the client is unable to be contacted. Where possible, GPs are involved in the care of clients, particularly if the service requires them to be directly involved in the care of the client; however, this is managed on a case-by-case basis.

The triage guideline identifies how quickly the client needs to be seen by the nursing team. It will not generally identify if a client requires medical home assessment, functional allied health assessment or psychosocial allied health assessment. Rather, these would be identified at the initial nursing visit.

Table 1 shows the total number of referrals to the SWSLHD Community Palliative Care Service for 2019 and 2020. Table 2 shows the number of home deaths in that period across the respective SWSLHD Community Palliative Care teams.

Table 1: SWSLHD Community Palliative Care Service total referrals (not individual clients) by centre, 2019-2020

Community	2019	2020	Yearly average
Bankstown	717	734	725.5
Fairfield	653	701	677
Liverpool	633	686	659.5
Macarthur	1055	1151	1103
Wingecarribee	229	222	225.5
Total	**3,287**	**3,494**	**3,390.5**

Table 2: SWSLHD Community Palliative Care Service home deaths by centre, 2019-2020

Community	2019	2020	Yearly average
Bankstown	49	68	58.5
Fairfield	47	48	47.5
Liverpool	63	60	61.5
Macarthur	92	101	96.5
Wingecarribee	42	42	42
Total	**293**	**319**	**306**

Community palliative care services

- The SWSLHD Community Palliative Care Service is a nurse-led model. The care coordination of palliative care clients is managed by the CHNs. They are supported by a team of specialist palliative care nurses, including CNCs, CNSs and RNs, who work within a consultative model. These specialist palliative care nurses provide expertise to support the CHNs in their management of palliative care clients.
- A consultative specialist palliative care nursing service is also provided to:
  - clients residing in RACFs
  - private nursing agencies providing care to iCare Dust Diseases care
  - the Department of Veterans Affairs (DVA)
  - clients receiving Level 4 Home Care Packages (HCP).
- The nurse manager for Primary and Community Health provides line management to CNCs, and Community NUMs lead the specialist palliative care nurses.

- Medical governance is retained by GPs, and support is provided to GPs in managing clients with complex symptoms by both the specialist palliative care nursing team and specialist palliative care medical officers.
- Allied health services are also available to all palliative care community clients, as required.
- At the time of the initial triage call, all clients are provided with the local SWSLHD 24-hour contact number to access Palliative Care Telephone Support after hours.
- Families and carers are provided with a bereavement package of resources, either at an appropriate time before death or post death. Bereavement support includes a support visit following the client's death, and information related to bereavement counselling services.

Community palliative care telephone triage project

The triage project was initiated in April 2020 as part of planning for the community palliative care COVID-19 response. It was introduced as it was identified that the service did not have a formal and consistent method across the district for prioritising referrals to the Community Palliative Care nursing service. A triage guideline was developed by the Community Palliative Care CNC Group. It includes the following:

- A guide to documents that should be reviewed in the Electronic Medical Record (eMR) system before the call
- A script for nursing staff to follow to introduce the triage process
- Use of the PROMSNAMES assessment guide acronym (although this was already used in practice):

  Pain
  Respiratory
  Orientation/Oral
  Mobility
  Social/Sleep
  Nausea
  Appetite
  Medication
  Elimination
  Skin assessment

The process of triage has been integrated into the service and is supported by the SWSLHD Primary and Community Health Palliative Care Model of Care.

Before the guideline was implemented, the CHNs were asked to complete a survey about their experience of triage. A focus group was held with nurses at one centre to identify concerns about the triage process. The focus groups and surveys showed that the CHNs valued having a formal structure to guide the triage process. It was identified that a structured triage phone call that involved a clinical assessment would require more than the allocated 10 minutes for triage, so the baseline triage time schedule was increased to 20 minutes before the introduction of the guideline.

Benefits of the triage model

The structure of the new Community Palliative Care triage guideline enables clinicians of different skill levels to complete a palliative care triage call. The prompt questions ensure that the nurse attending the palliative care triage phone call has a structure to follow. The script gives guidance for the clinician to introduce the service and helps facilitate consistency in how the service is introduced to new clients. The structure of the call fosters rapport with clients and carers from initial contact.

Clinical assessment at the point of triage enables early referral to allied health services if required, and appropriate timing of the initial visit according to severity of symptoms on telephone assessment. The triage guideline gives clear directions on the expected time frames for allocation of clients to a care coordinator and from referral to triage. It also sets out a pathway outlining how to proceed if a client cannot be contacted or declines service. Assessing the client's symptom burden enables CHNs to prioritise their workload and prioritise joint visits with the specialist palliative care nursing team referrals to be managed.

Education on the implementation of the triage guideline was initiated to ensure staff were aware of how the guideline should be used, where to document their findings and how to escalate any concerns identified at triage.

Client and carer experience

The service collects feedback from clients through surveys such as My Experience Matters (district patient/client experience survey tool) and patient rounding (phone call from NUM to client/family/carer). The service also receives feedback directly from clients or carers through phone contact and communication. No direct consumer feedback has been sought or provided on the implementation of the triage tool, but consumer representatives were involved in the development of the model of care that outlines the role of triage in the service.

The triage guideline makes a difference to clients, carers and families by commencing the therapeutic relationship and assessment from the point of triage. Nursing staff attending triage have reported anecdotally that by explaining the service and providing advice on symptom management from the initial triage call, they are able to build rapport and put clients and carers at ease with accepting the service. Clients are also left at ease if they decline the service at the point of triage, with a clear explanation of how they can make contact again if required. Providing clients and carers with the 24-hour contact number from the point of triage also provides an enhanced level of support from initial service contact.

Staff experience

Staff were given the opportunity to participate in focus groups as well as respond to electronic surveys pre and post the implementation of the triage guideline. The focus groups identified that CHNs value triage for:

- assisting them to prioritise workloads
- building rapport with clients and carers and reassuring them about their referral to palliative care

- beginning the therapeutic relationship
- being able to explain their role.

Nurses with less experience identified that having a guide would help them with triage. The biggest obstacle to effective triage was identified as time.

Two surveys were conducted via Survey Monkey. The survey was sent separately to the CHN group and the specialist palliative care nursing team with the assumption that this group would have more experience and comfort attending a triage call.

Table 3: SWSLHD staff experience survey results

Question example	Community health nurses	Palliative care nurses
Have you made a palliative care triage phone call	78% Yes	90% Yes
Reading the client's previous eMR	78% Rated Very Important	93% Rated Very Important
Booking a time for first home visit/clinic visit	47% Rated Very Important	66% Rated Very Important
Providing education, information to carer	57% Rated Very Important	73% Rated Very Important
Providing the Palliative Care 1300 number	73% Rated Very Important	80% Rated Very Important
Gaining a clinical assessment	63% Rated Very Important	78% Rated Very Important

CHNs reported that having a structure to follow assists in the flow of the triage call. As the specialist palliative care nurses are co-located with the CHNs, the latter are able to seek advice and feedback at the time of triage. The triage guideline is an example of collaboration to ensure a consistent approach across the district to the prioritisation of palliative care referrals to the service.

What tips do you have for others?

Engagement with the CHN teams was crucial to the success of the triage process. This helped most of the team see the value of a comprehensive phone assessment as the starting point of care, rather than an extra task they had to do in an already busy work schedule.

The triage guideline was developed and rolled out in response to an uncertain COVID-19 environment. Linking the guideline to a documentation format that was already in place enabled the new triage guideline to be adopted by the CHNs.

An implementation challenge was delivering consistent education across the geographically dispersed teams. The CNCs at each of the CHCs are responsible for delivering the education. An education plan was developed with standardised flowchart and PowerPoint slides to ensure consistency of information was delivered to staff working across the LHD. Education on the new triage guideline continues to be included in orientation programs for new CHNs when they commence work with the palliative care team.

The new triage guide enabled the service to utilise the format to maintain comprehensive phone assessments for clients during the 2021 COVID-19 lockdown period. This was a challenging time with an increase in acuity and volume of referrals coupled with some clients being reluctant to have services delivered in their home. Having a guide that was flexible and able to be used not only to triage new referrals but also prioritise current clients was beneficial.

Next steps

The SWSLHD Community Palliative Care Service hopes to:

- embed the triage guideline into the service's model of care
- ensure education for new staff is standardised and routinely provided at all CHCs
- conduct regular audits on the use of the triage guideline, to monitor compliance
- consider a specific client/carer review of the triage process for consumer evaluation.

Supporting documents

The following resources are available to support the tool. To access these, please email ACI-PallCare@health.nsw.gov.au.

- Triage guideline
- Flowchart
- Triage documentation examples
- Audit tool
- Staff education presentation

Appendix

Alignment of the Community Palliative Care triage guideline with the Clinical Principles for End of Life and Palliative Care Guideline

Key action area		Evidence
1. Screening and identification	✓	As per the triage guideline, the RN must review the eMR before making the initial triage phone call. Recommended documents include: a recent discharge summary; diagnosis and relevant medical history; documentation of goals of care; post discharge plans; and a medication summary. Clients are then screened for suitability as part of the initial triage phone call.
2. Triage	✓	The triage guideline includes a telephone script for clinicians with different skills mix to conduct a palliative care triage call, which ensures consistency in triage calls to improve outcomes for clients. SWSLHD's triage model helps the Community Palliative Care Service ensure the appropriate timing of an initial home visit to clients, based on the severity of their needs.
3. Comprehensive Assessment	✓	As part of the initial triage call, the RN conducts a comprehensive triage assessment, which also ensures early referrals to the Community Palliative Care Service's allied health professionals. As per the triage guideline, the initial phone call includes a comprehensive assessment prompted by the PROMSNAMES process and PCOC tools.
4. Care Planning	✓	The initial triage assessment prompts comprehensive care planning and allocation of a care coordinator, which is then clearly documented in the client's eMR.
5. Open and Respectful Communication	✓	The initial triage phone call introduces the Community Palliative Care Service and builds rapport with clients and carers from the first contact.
6. Symptom Management	✓	The PROMNAMES assessment completed at triage asks about distressing symptoms, with a number of prompting questions that the triage RN can use to guide symptom assessment. The triage guideline includes PCOC tools, such as the Symptom Assessment Scale (SAS) and Palliative Care Problem Severity Scale (PCPSS), which prompt escalation to the Community Palliative Care Team, based on the severity of symptoms (as per the SAS).
7. 24/7 Access to Support	✓	At the time of the initial triage phone call, all clients are provided with the After Hours Palliative Care Telephone Support number, which is available 24/7.

8. Place of Death	✓	The SWSLHD Palliative Care Triage model supports clients to be cared for and die at home (if that is their wish) by facilitating early referral to allied health and identification of unmanaged symptoms and carer stress (through the PCPSS).The SWSLHD Specialist Palliative Care nursing consult service is provided to clients in RACFs, private and government care services (such as iCare Dust Diseases Board, DVA and HCP recipients) to ensure that palliative care clients can remain in the location of their choosing, where possible.
9. Grief and Bereavement Support	✓	Families and carers are provided with a bereavement package of useful resources around the time of death. Bereavement support is provided to families, which includes a support visit following the client's death, and they are given information on bereavement counselling services in the community.

Acknowledgements

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