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The impact of a novel tool for comprehensive assessment of Palliative Care (MPCAT) on assessment outcome at 6 and 12 months follow up.

Authors: Martina O'Reilly BSc OT (Hons), PhD Candidate, Milford Hospice, Castletroy Limerick, Ireland.

Professor Philip Larkin, BSc (Hons) MSc PhD, RN, RCN, RHV, RNT, Professor of Clinical Nursing (Palliative Care), School of Nursing, Midwifery & Health Systems, University College Dublin and Our Lady's Hospice and Care Services Harold's Cross, Dublin, Ireland

Dr Marian Conroy, MB, FRCP, Consultant in Palliative Medicine, Milford Care Centre, Limerick and University Hospital Limerick, Ireland.

Dr Feargal Twomey MB MRCPI, Consultant in Palliative Medicine, Milford Care Centre, Limerick and University Hospital Limerick, Ireland.

Dr Micheal Lucey, MB B Med Sci. FRCPI MBA Consultant in Palliative Medicine, Milford Hospice, Castletroy Limerick, Ireland.

Professor Colum Dunne, BSc (Hons), PhD, MBA Director of Research, Graduate Entry Medical School, University of Limerick, Ireland.

Professor David Meagher, Professor of Psychiatry, Graduate Entry Medical School, University of Limerick, Ireland

Correspondence to: Martina O'Reilly, Head of Education, Research and Quality,
Address: Milford Care Centre,
Castletroy,
Limerick
Telephone Direct: 353-61-485881
Email: m.oreilly@milfordcarecentre.ie

Abstract

Context: Assessment in palliative care settings should be focused, sensitive, specific and effective in order to minimise discomfort to vulnerable and often highly morbid patients. This report describes the development of an admission assessment protocol for a Specialist Palliative Care Inpatient Unit (SPCU) and its implementation into clinical practice.

Objectives: To develop and investigate the impact of the implementation of a Specialist Palliative Care admission assessment tool on documentation of key patient needs.

Methods: The outcome of a systematic literature review was used to develop an admission assessment protocol (the intervention) in a SPCU. Mixed methods were utilised to facilitate a comprehensive evaluation pre and post intervention to test the effectiveness, feasibility and acceptability of the intervention.

Results: The documented evidence of pain assessment improved from a baseline rate of 71% to 100% post intervention. This improvement was maintained 12 months post introduction of the tool ($p < 0.001$). The documented evidence of screening for spiritual distress increased from a baseline rate of 23% to 70% at 6 months and to 82% at 12 months ($p < 0.001$). The number of referrals made in the first 24 hours after assessment increased post intervention (physiotherapy, $p = 0.001$, occupational therapy, $p = 0.001$, social worker, $p = 0.005$, pastoral care, $p = 0.005$), this was maintained at 12 months. Significantly more clinicians (88%) agreed that palliative care domains were comprehensively assessed post intervention in comparison to 59% pre intervention ($p = 0.01$).

Conclusion: Introducing the MPCAT was associated with significant improvement in assessment of multiple important aspects of patient need.

Key Words: Palliative care; assessment; pain; physical; psychological; spirituality.

Running Title: Systematic assessment in Specialist Palliative Care

Introduction

Fundamental to the practice of palliative care is the “*impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual*”.¹ Responsiveness to patient need is thus predicated upon comprehensive and accurate assessment conducted in collaboration with the patient and which considers their familial and social circumstances.^{2,3} Assessment should focus on the dimensions of need which can be relieved through palliative care intervention. Palliative care domains of need include physical symptoms, cognition, function, the needs of carers, psychological, spiritual and social issues.^{4,5} The choice of tools to aid assessment should be guided by the need to be as brief as possible to avoid burdening the patient as well as including tools that are sensitive, have comprehensive coverage of domains of need and are validated for use in palliative care. The outcome of the assessment is ideally a prioritised list of symptoms and needs requiring intervention, from which a care plan can be developed in consultation with the patient.

However, optimal assessment of palliative care need does not always occur in real-world practice.⁶⁻⁸ Lack of assessment has been attributed to a variety of factors including inadequate preparation and training,⁹ clinician anxiety and desire to avoid situations where patients will exhibit strong emotions,¹⁰ difficulties in distinguishing symptoms,¹¹ lack of confidence¹² and lack of time.¹³ In busy modern clinical environments the clinician is presented with many competing tasks and requirements. The burden of documentation and its detraction from time available for patient care is a source of particular tension and stress for clinicians who have been shown to spend as much as 25% of their time on documentation of care.¹⁵

However, evidence indicates that the use of standardised validated systematic assessment tools improves the effectiveness and accuracy of assessments^{15,16} and can improve patient outcomes.¹⁷⁻¹⁹ There are a number of symptom assessment tools which have been validated in a palliative care population including the Edmonton Symptom Assessment Scale (ESAS),²⁰ Memorial Symptom Assessment Scale (MSAS),²¹ Rotterdam Symptom Checklist (RSCL),²² Cambridge palliative care assessment schedule (CAMPAS-R),²³ Sheffield Profile for Assessment and Referral to Care, UK (SPARC)²⁴ and the Needs near the end-of-life care screening tool (NEST)²⁵. However domain coverage varies considerably. None of the tools include a validated means of detecting cognitive impairment. Criteria to determine the patient’s spiritual needs are not included in the

ESAS, MSAS, CAMPAS-R or RSCL. Only the CAMPAS-R and the SPARC consider carers needs.

This article reports the implementation of a comprehensive evidenced based palliative care assessment tool in a Specialist Palliative Care Unit (SPCU). The purpose of this article is to report changes in documented evidence of assessment as a result of the implementation of the proforma and the results of clinicians' evaluation of the admission assessment process.

Methods

A comprehensive review of literature relating to multidisciplinary admission assessment in palliative care was conducted using a systematic approach (unpublished data). A Steering group comprising consultants in palliative medicine, clinical nurse managers, social workers and pastoral care professionals was established to oversee the redevelopment of the admission assessment process. The outcome of the literature review and feedback from clinicians informed the development of an evidence-based admission assessment protocol 'The Milford Palliative Care Assessment Tool' (MPCAT) with accompanying guidelines (the intervention).

The MPCAT includes a number of evidence based tools (see Table 1), including questioning guidelines adapted from the Pain Assessment Questionnaire for a Patient with Advanced Disease.²⁶ For example the clinician is requested to enquire about pain intensity at the time of assessment and at its worst over the last twenty fours using a 0 -10 numerical rating scale.^{27, 28} An adapted version of the symptom assessment checklist described by Homsy et al, 2006 was utilised in that the symptoms were grouped according to the respiratory system, cardiovascular, central nervous systems and the upper, middle and lower gastrointestinal system to aid recall.¹⁶ The Palliative Performance Scale (PPS)²⁹ and the Palliative Performance Index (PPI)³⁰ were chosen to assess function and prognosis. The Blessed Short Orientation Memory Test (SOMCT)³¹ and Confusion Assessment Method³² were used to detect cognitive impairment and delirium. With regard to Spiritual Distress, the tools chosen for inclusion in the admission assessment proforma included the FICA³³ and the questioning guidelines from the Mount Vernon Cancer Network (MVCN).³⁴ Graduated interviews to screen for the priority issues relevant to the patients

psychosocial needs^{3, 5, 35-38} and carers needs^{3,5,33,38,39} identified in the literature were developed. A training programme that included didactic presentations and workshops to educate all medical, nursing, social work and pastoral care staff (n=50) on administration of the MPCAT was implemented.

Views of clinicians regarding the initial assessment process and suggestions for development were sought at two time points, pre intervention and post intervention through a bespoke survey of all clinicians working in the SPCU. The survey was developed in conjunction with the steering group members and piloted with those members of the steering group not working in the SPCU. No changes were made post piloting.

All consecutive inpatients who were admitted to the Specialist Palliative Care Unit (SPCU) during the data collection period were considered for inclusion. Inclusion criteria agreed with the medical team included:

- Patients were aged over 18 and could understand English
- Patients had to be physically and psychologically well enough to participate (based on clinical judgment).

Patients meeting the inclusion criteria were approached by the researcher to seek their informed consent to participate. Patients were interviewed at two time points and charts audited at three time points. Pre intervention baseline relates to interviews and audits conducted prior to any change to the admission assessment proforma at Milford Care Centre.

The case records of 35 patients were reviewed in the pre intervention stage. The integration of the admission assessment protocol into practice was monitored post introduction of the MPCAT. Audit of 46 case records occurred at 6 months (post intervention stage - time 1) and audit of 42 case records occurred at 12 months (post intervention stage - time 2). Only the admission assessment documentation of the case records was audited at the pre intervention stage and the post intervention stages. Referral rates and referral patterns amongst interdisciplinary team members were monitored at these three time points. Eight workshops were held with staff to

disseminate audit results. Ethical approval was received from the Mid-West Regional Hospital Scientific Research Ethics Committee.

Statistical Analysis

Data from the patient chart audit and the clinician survey were tested for normality and were non-normal in distribution. The data collected through patient chart audits were described using frequencies and percentages. A Mann Whitney U test was used to test for difference in patient ages. Chi squared tests were used to examine for differences between intervention phases with regard to diagnosis and gender of patients, and to determine if there was a difference between documented evidence of assessment and the phase of the intervention. Chi squared tests were used to determine if there were differences in role, years of palliative care experience and ratings on the staff survey and the phase of intervention.

Results

Patient characteristics

Table 2 depicts the demographic and general clinical characteristics of the patients included at the three time points. There was no statistical difference in respect of gender, age, and diagnosis or admission stage in patients who were interviewed at these time points (See Table 2).

Rate of Assessment evidenced through case record audit

The initial assessment highlighted areas of suboptimal assessment relating to a number of physical symptoms, cognitive impairment and psychosocial needs. For example, determination of delirium, resuscitation status, financial concerns, or preferred place of care at end of life was not evidenced in the admission assessment pre intervention but was incorporated into the MPCAT. The evidence of assessment of spiritual distress, depression, the patient's resilience, and carer's needs were less than 25% prior to intervention. (See Table 3 for a summary of assessment of individual domains of need).

Pain and Physical Symptoms

Pre intervention, there was documented evidence of assessment of pain in 71% (n=25) of charts. Outcome of the assessment of pain was unclear in 14% (n=5). There was no evidence of assessment of pain in 14% (n=5). Post intervention pain was assessed in 100% (n=46) of cases. This improvement was maintained at the second post intervention assessment with clear documented evidence of assessment of pain in 100% (n=42) charts, time 2 (p<0.001).

The most prevalent physical symptoms reported in palliative patients are pain fatigue, lack of energy, weakness, appetite loss, weight loss, dry mouth, constipation, insomnia, dyspnoea and nausea.⁴⁰ Additional important physical symptoms include vomiting, coughing, sweating, drowsiness and diarrhoea.^{5, 38} The rate of assessment of all physical symptoms significantly increased post intervention with the exception of lack of appetite (see Table 4).

Cognitive Impairment

Although the evidence of assessment of cognitive impairment improved at the first post intervention audit, the rate of assessment dropped by 25% to slightly lower than the pre intervention rate at the second post intervention assessment. The CAM was implemented in 87% of cases post introduction of the MPCAT. However, the rate of assessment of delirium reduced by 19% at the second post intervention assessment in comparison to the first post intervention assessment (see Table 4).

Spiritual Needs

Pre intervention, the patients religion was specified in 91% (n=32) of case notes but there was no evidence of documentation of spiritual needs in 46% (n=16). The outcome of assessment was unclear in 31% (n=11) and there was clear assessment of spiritual needs in 23% (n=8) charts. Post intervention, the evidence of screening for spiritual need increased to 70% and 82% at the first and second post intervention assessments, respectively (p<0.001).

Psychosocial Needs

There was clear evidence of screening for depression in 67% (n=31) of cases at the first post intervention audit in comparison to 21% (n=7) of cases pre intervention. The improvement in evidence of assessment increased to 79% (n=30) at 12 months post intervention ($p<0.001$).

The most common issue not assessed at the first and second post intervention assessments related to determining if there were legal or financial issues that the patient wanted assistance with during the admission. However evidence of assessment of financial issues increased from 37% (n=17) at the first post intervention assessment to 62% (n=26) at the second post intervention assessment ($p<0.001$). At the first post intervention assessment, 33% (n=15) of patients specified their preferred place of care on admission in comparison to 24% (n=9) at the second post intervention assessment.

Assessment of Carer's Needs

The only question relating to assessment of carer's needs in the pre intervention stage was labelled as "Family Issues" in the nursing documentation. There was clear evidence of assessment of this issue, typically relating to impact of the illness on a family member in 27% of charts (n=9). There was no family present during admission in 6% of charts (n=2) and there was some documentation relating to this issue in 21% (n=7) of charts, but the outcome of the assessment was unclear.

Assessment of carers' needs was the domain that was least assessed in the first post intervention assessment results. If determination of carers' understanding of diagnosis and prognosis is excluded, there was no documented evidence of assessment of carer's needs in 59% (n=26) of charts. By the second post intervention assessment, there was an average completion rate of 62% across the items relating to assessment of carers needs (See Table 5).

Referral to other members of the multidisciplinary team

The percentage of referrals to physiotherapy, social work, occupational therapy, pastoral care and complementary therapy within the first 24 hours was significantly greater at Time 1 than the pre intervention baseline for all disciplines. This increase in speed of referrals was maintained at Time 2 for all disciplines except complementary therapy (Table 6). The median number of referrals to other disciplines (including dietitian, art therapy, music therapy and horticulture) was significantly higher post intervention ($p=0.002$).

Patient priority issues

Each patient was asked to identify the symptoms or issues they most wanted help with from the team. The symptoms or issues documented in the care plan summary for each patient were compared against that which the patient identified. There was an increase in the number of care plans which clearly identified the symptoms and issues identified by the patient post intervention from 80% ($n=37$) in the first post intervention care plans in comparison to 63%, ($n=22$) pre intervention. However, this increase was not statistically significant.

Views of clinicians

Health care professionals ($n=40$) responded to a survey to elicit their views of the admission assessment pre intervention. The clinical backgrounds of respondents were medical ($n=4$), nursing ($n=27$) and therapy and social care staff ($n=9$). Post intervention, 37 responded, including medical ($n=5$), nurses ($n=23$) and therapy and social care staff ($n=9$). There was no significant difference between respondents pre and post intervention in role, years of palliative care experience, or years at Milford Care Centre. The majority of respondents had between 3 and 10 years' experience ($n=24$ pre intervention, $n=21$ post intervention).

The majority expressed a view that the admission assessment process could be improved pre intervention (82%, n=28). A similar percentage reported that the assessment could be further improved post intervention, (77%, n=24). However, more respondents reported that MPCAT comprehensively assessed all domains of need (88%, n=30) post intervention in comparison to (59%, n=19) pre intervention, $p = 0.011$. Less respondents reported that there was a need to incorporate additional evidence-based tools to the admission assessment post intervention (19%, n=5) in comparison to pre intervention (73%, n=24) ($p < 0.001$). More respondents agreed that there was no need for further training post intervention (52%, n=19) in comparison to pre intervention (18%, n=7) ($p = 0.006$). Furthermore, significantly more respondents reported that the MPCAT facilitated assessment of carer's needs post intervention (88%, n=28) in comparison to 30% pre intervention (n=10) (see Table 7).

Post intervention, although some respondents reported the admission assessment was improved, many areas for further review and improvement were highlighted. Feedback from staff highlighted the need to provide training for new staff to properly induct them, and the need to differentiate between types of admission including repeat admissions and admission of patients who were imminently dying, post intervention. Of concern to the staff was the length of the admission assessment proforma and the consequent burden to patients and their own time.

Discussion

We studied the impact of the development and implementation of a specialist palliative care admission assessment tool on documentation of key patient needs both 6 and 12 months after its introduction. We also found positive perspectives among clinical staff in terms of the appropriateness and acceptability of the tool.

The baseline audit identified gaps in the assessment process prior to intervention including low rates of assessment of a number of symptoms and lack of assessment relating to delirium,³⁵ prognosis,⁴¹ resuscitation status and preferred place of care at end of life.^{3,38}

The post intervention findings indicated significant improvement in the documented assessment of symptoms and issues relevant to a variety of domains of palliative care. This increase was maintained at the second audit phase for the majority of symptoms. Moreover, it improves

assessment practice in a way that endures over time and is associated with increased immediate use of available resources to meet identified patient needs (i.e. referral to multidisciplinary colleagues within 24 hours). This latter finding is especially useful given that the median length of stay in the SPCU in which this study is located has decreased over the past number of years such that it is important that intervention by relevant disciplines is initiated as early as possible in the patient's admission.

The only area where improvement in rate of assessment from baseline was not maintained was in respect to cognitive impairment. The importance of assessment of cognitive impairment is supported by its high frequency within palliative care populations⁴² and because it is a strong predictor of prognosis.^{41,43} Routine observation is often insufficient to detect its presence.⁴⁴ In addition, cognitive difficulties are frequently reversible.^{45,46} Delirium or cognitive failure is particularly prevalent in the terminal stages of palliative care patient's illness trajectory and should be screened for at the time of admission in order to be able to detect changes in patient status.⁴⁷

Evidence suggests that standardised systematic assessment is a critical component of a comprehensive admission assessment and can increase accuracy and efficiency of the assessment process.^{16,48} Increasing the comprehensiveness of assessments has increased the accuracy of assessments.⁴⁹ The tools included in the admission assessment were evidence based and facilitated a more comprehensive assessment of the most common symptoms experienced and key domains relevant to palliative care. Utilisation of empirically derived assessment tools, coupled with extensive consultation with clinicians, utilisation of the techniques of continuous quality improvement and critical reflection were central factors in the improvements demonstrated in this study.

Consultation and engagement with steering group members was critical to the development of the admission assessment proforma and fundamental to the success of the intervention.⁵⁰ The assessment process in its totality was developed in collaboration with the aforementioned that were subsequently responsible for implementing the assessment. This meant that feasibility within the clinical setting, including minimisation of burden to the patient and impact on clinician time, was prioritised when choosing tools for inclusion in the admission assessment process.

Additionally, interconnecting evidence based tools were employed allowing for increased efficiency in assessment procedures. For example, the outcome of questions from the SOMCT can be used when screening for delirium. Similar questions were asked in the assessment of carers need as had been asked in the assessment of the patient's psychosocial needs. This facilitated efforts to compare the agreement between perception of the patient and carer in respect of psychosocial issues such as communication, sources of resilience, and financial distress. The feasibility of completion of a comprehensive assessment and effectiveness is increased as a result of this overlap.

Achieving change in complex clinical systems is difficult, and requires careful planning and resources.⁵¹ Educational interventions that are purely didactic are rarely effective when used alone in terms of altering clinical practice or outcomes.^{52, 53}

In this study engagement included interactive informal and formal workshops and feedback sessions in respect of individual evidence based tools and the assessment process as a whole. This interactive process focussed on alteration of practice, critical reflection and discussion of outcome - which was repeated and continued over an extended period of time in line with the principles of adult education.^{54,55} This process of continuous and prolonged engagement was an instrumental component in optimising the integration of the MPCAT into practice.

Clinicians reported that there was increased assessment of palliative care domains, less need for training and increased likelihood of assessment of carers needs. However, there were still areas for improvement. Although results indicated significant improvement in respect of assessment of psychosocial, spiritual issues and assessment of carer's need post assessment, this is partly attributable to the low baseline rate of assessment of these domains and the rate of assessment of these issues remained less than physical symptoms at one year follow up after introduction of the MPCAT.

The lower rate of assessment may be attributable to staffs' willingness, confidence and competence to engage in investigation of psychosocial and spiritual needs of patients. It must be recognised that communication at end of life is difficult, requires considerable skill and competence⁵⁶ and is often inadequate in clinical practice.³ Inadequate preparation and training in

communication is a significant factor in emotional burn out and stress in clinicians.⁹ Time allocated to undergraduate training in palliative care is considerably less than that which is recommended.^{57, 58} For many disciplines undergraduate and post graduate training is ad hoc, lacking in consistency, coordination and standardization, and is focused on acquisition of knowledge rather than skills.⁵⁹ Importantly, when provided training typically emphasizes the management of physical symptoms.⁵⁸

Equally, studies indicate that the factors associated with the illness experience; such as impact of the illness on the family, psychological distress, changes in role, fears related to increasing dependency, financial pressure, and spiritual issues are frequently the dominant concerns for the patient.^{60, 61} The results reported in this study suggest that even in the hospice setting, assessment and treatment of spiritual and psychosocial needs requires further attention. The development of a comprehensive assessment process and proforma are an important element in assuring the effectiveness and rigour of an assessment process. However, other factors including training, competence, confidence, resources, culture and work practices are also key issues to be considered in order to achieve enduring change.

Limitations:

This is a single site study with small sample sizes leading to difficulties in the generalisability of results. Factors that may have influenced the admission assessment process over the period of the intervention cannot be controlled for in a pre and post study design. Ideally a randomised controlled study in multiple centres should be conducted to determine if these results can be replicated. The researchers should be blinded to assignment of staff and patients to the intervention or control arm of the studies. Further studies which include examining the effect of the intervention over a longer time period and with larger sample sizes should be conducted.

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Table 1 Evidence based tools incorporated in the MPCAT

Tool	Reference
Pain: Adapted Pain Assessment Questionnaire for a Patients with Advanced Disease (PAQ)(adapted)	Jacox et al., 1995 ²⁶
Cognition: The Blessed Short Orientation Memory Test (SOMCT)	Katzman et al.,1983 ³¹
Symptoms: Symptom assessment checklist (adapted)	Homsy et al, 2006 ¹⁶
Function: The Palliative Performance Scale (PPS)	Olajide et al., 2007 ²⁹
Prognosis: Palliative Performance Index (PPI)	Stone et al., 2008 ³⁰
Delirium: Confusion Assessment Method (CAM)	Ryan et al., 2009 ³²
Spiritual Distress: FICA	Okon, 2005 ³³

Table 2 Demographics of patients, whose charts were audited and who agreed to be interviewed.

	Pre Intervention, n=35	Pre Intervention, Time 1, n=46	Pre Intervention, Time 2, n=42
Mean Age, Standard Deviation (SD)	67.1 (12.5)	68.7 (13.1)	68.3 (14.7)
Male Gender	54%	48%	57%
Female Gender	46%	52%	43%
Malignant Diagnosis	86%	96%	95%
Non Malignant Diagnosis	14%	5%	5%
Patients with an ECOG Score of 2 or less	50%	68%	Not collected
First Time Admission	74%	87%	74%
Repeat Admission	26%	13%	26%

Table 3 Documented evidence of Assessment of Palliative Care Domains of Need

	Pre Intervention, n = 35	Post Intervention Time 1, n=46	Post Intervention Time 2, n=42
Physical Symptoms	65%	96%	99%
Cognitive Impairment	34%	86%	65%
Function	66%	91%	79%
Spiritual Distress	23%	70%	82%
Patient Psychological Needs	11%	63%	81%
Family/Carer Needs	4%	24%	62%
Average	34%	72%	78%

Table 4 Documented percentage evidence of assessment of Physical Symptoms, cognition and delirium and psychosocial issues

	Pre Intervention Percentage Assessment, n=35	Post Intervention Time 1, Percentage Assessment, n=46	Post Intervention Time 2, Percentage Assessment, n=42	Pⁱ
Pain	71%	100%	100%	0.0001
Fatigue	68%	91%	100%	0.0001
Nausea	57%	96%	98%	0.0001
Vomiting	51%	96%	98%	0.0001
Disturbed Sleep	66%	98%	100%	0.0001
Shortness of Breath	71%	96%	100%	0.0001
Cough	66%	91%	100%	0.0001
Constipation	66%	96%	97%	0.0001
Diarrhoea	43%	93%	97%	0.0001
Lack of appetite	91%	100%	100%	0.054
Weight Loss	74%	98%	100%	0.012
Ulcers	69%	100%	100%	0.0001
Dry Mouth	86%	98%	98%	0.005
Sweating	40%	83%	100%	0.0001
Cognition	69%	87%	62%	0.538
Delirium	0%	87%	68%	0.0005
Determination of resuscitation status	0%	91%	93%	0.0005
Spiritual Distress	23%	70%	82%	0.001
Depression	20%	67%	79%	0.0005
Anxiety	31%	59%	82%	0.0005
Impact of the Illness	14%	91%	95%	0.0005
Support Needs Determined	11%	85%	93%	0.0005
Patients view of family coping	3%	52%	79%	0.0005
Family member that the patient is worried about	6%	52%	75%	0.0005
Financial worries	0%	37%	62.2%	0.0005

ⁱRefers to pre intervention versus post intervention Time 1 and Time 2

Table 5 Documented percentage evidence of assessment of carer needs.

	Pre Intervention, n=35	Post Intervention, Time 1, n=46	Post Intervention, Time 2, n=42	Pⁱ
Impact of illness on the carer determined?	14%	30%	68%	0.0005
Carer's view of family coping determined?	3%	27%	76%	0.0005
Carer's view of family communication about the illness determined?	0%	26%	70%	0.0005
Determination of a family member that the carer is concerned about?	3%	24%	70%	0.0005
Carer's aims for the admission determined	6%	30%	69%	0.0005
Preferred place of care at end of life as specified by the carer	0%	4%	18%	0.005

ⁱRefers to pre intervention versus post intervention Time 1 and Time 2

Table 6 Percentage of patients referred to members of the multidisciplinary team within the first 24 hours.

	Pre Intervention, n = 35	Post Intervention Time 1, n = 46	Post Intervention Time 2, n = 42	Pⁱ
Physiotherapy	41%	80%	81%	0.001
Occupational Therapy	37%	76%	79%	0.001
Social Worker	20%	67%	79%	0.005
Pastoral Care	11%	70%	73%	0.005
Complementary Therapy	11%	41%	19%	0.016

ⁱRefers to pre intervention versus post intervention Time 1 and Time 2

Table 7 Staff perspectives (percentages) on the admission assessment and the need for change

	Pre Intervention n=40	Post Intervention n=37	p
Admission Assessment could be improved	82	77	NS
Documentation could be improved	78	81	NS
No need for further training	18	52	0.006
Additional evidence based assessment tools are required	73	19	0.0005
The current admission assessment documentation comprehensively assesses all domains of need	59	88	0.011
The current assessment document supports the documentation of carers needs	30	88	0.0005