Version 1.3

Responding to Urgency of Need in Palliative Care (RUN-PC) Triage Tool

USER MANUAL

Palliative Nexus

University of Melbourne and St Vincent's Hospital Melbourne

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DEVELOPMENT

The Responding to Urgency of Need in Palliative Care (RUN-PC) Triage Tool has been informed by a mixed methodology, multi-stage body of research. An initial review of palliative care triage literature was followed by qualitative work[1,2] involving Victorian health care professionals (n=20) across discipline (medical, nursing, allied health), specialty (palliative care, general practice, internal medicine, district nursing) and site of care provision (community, inpatient, hospital consultation). The results of these were used to generate and refine a list of triage factors which were incorporated into a draft triage tool which was piloted with a group of Victorian palliative care clinicians (n=11).

The triage factors were then tested in a large online international discrete choice experiment[3,4] wherein palliative care clinicians (n=772) around the world were asked to select which patients had the most urgent needs from a series of hypothetical pairs of scenarios, an example of which is displayed in Table 1 below. Analysis of the response patterns demonstrated the relative importance of each triage factor and allowed numerical weightings to be allocated for the scoring system of the final RUN-PC Triage Tool.[4]

Table 1: Example of hypothetical scenario pair

These two patients have both been newly referred to you today. In the context of your primary role (inpatient palliative care unit, hospital consultation or community palliative care consultation) which patient will you admit to your service or see first?	
Patient A	**Patient B**
Mrs Smith is having moderate pain and severe anxiety. Her caregiver is not distressed. Mrs Smith understands her prognosis and has clear goals of care. Her care needs are increasing and are expected to soon exceed current arrangements. She is expected to die within days. She is currently in her desired site of care.	Mrs Jones is having mild pain and no anxiety. Her caregiver is moderately distressed. Mrs Jones urgently wants to discuss her prognosis and make important decisions. Her care needs are being adequately met by current arrangements. She is expected to die within days. She is not currently in her desired site of care.

The final triage tool was then validated using a series vignettes based on real-world referrals to specialist palliative care community, inpatient and hospital consultation services. The tool has good intra- and inter-rater reliability, and moderate to good correlation to the current reference standard of expert opinion. Recommended response times were generated for each clinical setting.[5]

FUNDING

The development of the RUN-PC Triage Tool was supported by the Victorian State Government Department of Health and Human Services, the St Vincent's Hospital Research Endowment Fund, the Bethlehem Griffiths Research Foundation and the Australian Government Research Training Program Scholarships.

The RUN-PC Triage Tool pilot implementation project was supported by the Victorian State Government Department of Health and Human Services, Safer Care Victoria and Melbourne City Mission Palliative Care.

INTENDED USE

1. Who should use the tool?

The RUN-PC Triage Tool is intended for the prioritisation of patients for inpatient palliative care admission, inpatient palliative care consultation and community palliative care consultation. It is intended to be completed by a clinician or triage officer who has an appropriate level of training and clinical experience in palliative care to ascertain accurate assessments of the triage factors from the referrer, thus it is not to be included for others to complete in referral forms. More in-depth interviewing may be required for some referrers than others in order to glean the necessary information.

2. Waiting list management

Patients with higher RUN-PC Triage Tool scores should be tended to first, aiming for within the recommended response times for that setting, unless there are complicating factors (eg patient requires a single room and only shared rooms are available, patient requires an interpreter for home visit). Patients who receive the same triage score should be prioritised in order of time of referral on a first-come first-served basis. Wait-listed patients should be re-assessed regularly to monitor if their situation becomes more or less urgent. The frequency of re-assessment is dependent on their acuity level. A suggested minimum is weekly but for a patient considered likely to deteriorate quickly, daily or alternate daily may be warranted.

3. Clinical judgement and safety

Given that most triage assessments are made on the basis of secondary information without opportunity to directly assess the patient themselves, the safest approach is to err on the side of over-calling rather than under-calling potential problems. If there is any concern or uncertainty on behalf of the triage offer, it is safer to rate a problem as 'moderate' or even 'severe' on the RUN-PC Triage Tool and then discover upon first clinical contact that it was actually only 'mild' or 'moderate', rather than to cautiously rate it as 'mild' or 'moderate' and then discover upon first clinical contact that it was actually a 'moderate' or 'severe' problem.

Exceptional circumstances may require an emergent response, even if the triage score is not high. The tool therefore begins with a caveat about medical and psychiatric emergencies. Clinicians should also employ their clinical judgement and escalate particular cases when appropriate.

The RUN-PC Triage Tool determines the urgency of referrals, not the appropriateness or eligibility of referrals. A score of zero on the RUN-PC Triage Tool indicates low urgency rather than the referral being inappropriate for specialist palliative care. Likewise, a high score does not necessarily mean the referral is appropriate for specialist palliative care – acute medical services may be more appropriate for that particular situation, disease stage and goals. The decision as to whether a patient is appropriate and eligible to receive specialist palliative care should therefore be made independently, as per local practices and protocols.

TOOL ITEM INTERPRETATION

1. Emergencies

Patients who have or are likely to be developing a medical emergency and want investigation and/or intervention need urgent medical attention. A palliative care admission or consultation may not always be the most appropriate course of action and presentation to an Emergency Department may be required. Likewise, a psychiatric emergency for the patient or caregiver may require urgent intervention. Discuss these patients with a senior clinician immediately, regardless of the RUN-PC Triage Tool score.

2. Triage Items

1. Physical suffering or distress of patient

- Any physical symptom experienced by the patient **and** causing suffering or distress
- May include pain, dyspnoea, nausea, vomiting, constipation, diarrhoea, itch, agitation, confusion
- Do not include symptoms such as fatigue if not causing distress
- Use the language of 'suffering' or 'distress' to assist referrers to identify how the symptoms are impacting the patient's experience

2. Psychological or spiritual suffering or distress of patient

- Any psychological symptom experienced by the patient **and** causing suffering or distress
- May include anxiety, depression, existential distress
- Use the language of 'suffering' or 'distress' to assist referrers to identify how the symptoms are impacting the patient's experience

3. Distress or burnout of caregiver

- Distress or burnout experienced by the caregiver
- May include anxiety, depression, exhaustion, existential distress
- May apply to the **lay caregiver** even when the patient is in a hospital or a residential care facility, or may apply, albeit less commonly, to the **health professional**(s) involved

4. Urgent and complex communication or information needs of patient **and/or** caregiver

- Mismatched goals of care or understanding of disease stage may influence management decisions that lead to suffering (eg pursuing investigations or aggressive therapies when unlikely to impact poor prognosis)
- Advance care planning discussions may be pressing when a patient is deteriorating rapidly or may soon be unable to comprehend or communicate (e.g. in the setting of a progressive neurological disease)

5. Significant discrepancy between care needs and current care arrangements

- Care needs may include hygiene, medication administration (eg subcutaneous infusions), psychological care, medical management
- Care arrangements may include lay caregivers' abilities, willingness and capacity, professional caregivers' expertise and accessibility (including outside business hours), equipment, location (including implications for lay caregiver's transportation needs)
- This item is a dynamic and contextual concept, as a patient with a good performance status but poor supports may have more urgent needs than a patient with a poor performance status but good supports
- Use discretion when selecting 'impending' or 'current', for example, inadequate home arrangements when an inpatient is being discharged from inpatient care tomorrow could be assessed as 'current' by a community palliative care service whilst a request for respite next week could be assessed as 'impending' by an inpatient service

6. Mismatch between current site of care and patient or caregiver's desired site of care

- **Distress** of patient or caregiver due to current site of care
- This is relevant even if care is adequate in the current location, as facilitating care that enables patients to be cared for their desired site of care is an important patient-centred outcome

7. Patient is imminently dying

- The patient is expected to die within days and no acute intervention is planned or required
- Typical features may include reduced conscious state, loss of swallow and profound fatigue and weakness

3. Score and recommended response times

Once the calculated score is obtained, aim to respond within the recommended response times for each setting as per the table below.

Category	Definition	Scores
Inpatient Unit setting		
1. crisis	requiring admission to inpatient palliative care unit within 24 hrs	51-100
2. urgent	requiring admission to inpatient palliative care unit within 48 hrs	41-50
3. non-urgent	requiring admission to inpatient palliative care unit within 72 hrs	21-40
4. routine	requiring admission to inpatient palliative care unit within 7 days	0-20
Hospital Consultation setting		
1. crisis	requiring palliative care hospital consultation within 24 hrs	31-100
2. urgent	requiring palliative care hospital consultation within 48 hrs	11-30
3. non-urgent	requiring palliative care hospital consultation within 72 hrs	0-10
Community setting		
1. crisis	requiring community palliative care consultation within 24 hours	31-100
2. urgent	requiring community palliative care consultation within 72 hours	21-30
3. non-urgent	requiring community palliative care consultation within 7 days	11-20
4. routine	requiring community palliative care consultation within 14 days	0-10

3. Further Information

In some instances, it will be necessary to proceed with a triage decision despite incomplete information, and thus one or more 'unknown' responses on the tool. This is at the discretion of the triage officer, in accordance with their clinical acumen and competing demands.

This item allows the triage officer to highlight such referrals with incomplete information and also those referrals with potentially unreliable information provided from the referrer. Further collateral history should be sought urgently from alternative sources (eg family member, general practitioner, community palliative care team) and the tool completed again with updated information.

4. Additional Comments

A free-form section for additional qualitative information has been provided so that complexities possibly not captured by the triage tool or details of further information to be gathered can be noted.

FREQUENTLY ASKED QUESTIONS

CAN THE TOOL BE USED TO TRIAGE PAEDIATRIC CASES?

The RUN-PC triage tool was not designed for use in the paediatric setting and this cohort of patients may have differing needs and issues. A paediatric version of the RUN-PC triage tool may be developed in future.

WHY DOES 'MILD' SCORE ZERO?

Adding this extra level to each triage factor would have made the statistical analysis of the discrete choice experiment much more complex. The investigator group felt that the clinical difference between 'nil' and 'mild' would not have a large enough impact on clinicians' assessment of urgency to justify this added complexity. However, to maintain the face validity of the tool, clinicians can document 'nil' or 'mild' so that two otherwise equal patients can be differentiated informally.

WHY DOES 'UNKNOWN' SCORE ZERO?

Referrals with missing data are problematic, but the validation study showed that allocating median or even maximal scores to any 'unknown' factors actually decreased the reliability of the tool. To maintain the face validity of the tool, clinicians can document 'unknown' as a prompt for further information gathering with a plan to re-triage the patient as soon as further information is available.

HOW SHOULD RESPITE REFERRALS BE TRIAGED?

Complete the tool according to the patient's current situation at the time of the triage assessment. 'Significant discrepancy between care needs and current care arrangements' (Item 5) regarding discrepancy in care should be 'impending' leading up to the required period of respite (e.g. if a caregiver is planning a holiday) or 'current' (e.g. if a caregiver has been incapacitated). Other items may also be relevant such as psychological distress of the patient or caregiver distress. It may be necessary to repeat the triage assessment as the date of required respite draws near, as the score may increase.

HOW SHOULD THE NEED FOR A SYRINGE DRIVER BE ADDRESSED?

Patients being discharged from an inpatient setting whilst on a continuous subcutaneous infusion may require the involvement of a community palliative care service to enable the infusion to be continued. This issue was specifically raised during the qualitative stage of the RUN-PC Triage Tool's development. Participants in the focus groups reported that syringe driver management was an operational issue and in some geographical areas could be tended to by district nursing or hospital out-reach teams, thus a dedicated item on the tool was not necessary. Our guidance is to complete the tool as usual and incorporate this need into 'Significant discrepancy between care needs and current care arrangements' (Item 5) but override the final score if in your local policy is to automatically give priority to such referrals.

HOW SHOULD CASES INVOLVING SUSPECTED ABUSE BE TRIAGED?

Situations of physical and/or psychological abuse are very serious and warrant urgent attention. Depending on the severity and immediate risks, it may be appropriate to respond as per an emergency and escalate the case for urgent attention, regardless of the triage score. In other situations, these problems may flag on one or more triage domains. Whilst this issue wasn't specifically addressed in the qualitative work, triage items that would be relevant are 'Significant discrepancy between care needs and current care arrangements' (Item 5) and 'Psychological or spiritual suffering or distress of patient' (Item 2), and in some cases, 'Mismatch between current site of care and patient or caregiver's desired site of care' (Item 6) , 'Distress or burnout of caregiver' (Item 3) and/or 'Physical suffering or distress of patient' (Item 2) also.

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CONTACT

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APPENDIX: RUN-PC TRIAGE TOOL

Responding to Urgency of Need in Palliative Care (RUN-PC) Triage Tool					
Medical emergency suspected or impending (eg spinal cord compression, SVC obstruction, airway obstruction, seizures, acute bleeding) or psychiatric emergency (eg agitated delirium, suicidality) ➡	**Complete tool and discuss with senior clinician immediately, regardless of score**				
1. Physical suffering or distress of patient	unknown 0	nil 0	mild 0	moderate 14	severe 32
2. Psychological or spiritual suffering or distress of patient	unknown 0	nil 0	mild 0	moderate 6	severe 14
3. Distress or burnout of caregiver	unknown 0	nil 0	mild 0	moderate 5	severe 13
4. Urgent and complex communication or information needs of patient or caregiver			unknown 0	no 0	yes 8
5. Significant discrepancy between care needs and current care arrangements		unknown 0	no 0	impending 6	yes 10
6. Mismatch between current site of care and patient or caregiver's desired site of care			unknown 0	no 0	yes 9
7. Patient is imminently dying			unknown 0	no 0	yes 14
				TOTAL	**/100**
Further information required? (for example, if items marked 'unknown' above')				yes	no
Planned review date:					
Additional comments:					

Score	Recommended Response Time
Referrals to inpatient setting	
51-100	1. crisis: requiring admission to inpatient palliative care unit within 24 hrs
41-50	2. urgent: requiring admission to inpatient palliative care unit within 48 hrs
21-40	3. non-urgent: requiring admission to inpatient palliative care unit within 72 hrs
0-20	4. routine: requiring admission to inpatient palliative care unit within 7 days
Referrals to hospital consultation setting	
31-100	1. crisis: palliative care hospital consultation within 24 hrs
11-30	2. urgent: palliative care hospital consultation within 48 hrs
0-10	3. non-urgent: palliative care hospital consultation within 72 hrs
Referrals to community setting	
31-100	1. crisis: requiring community palliative care consultation within 24 hours
21-30	2. urgent: requiring community palliative care consultation within 72 hours
11-20	3. non-urgent: requiring community palliative care consultation within 7 days
0-10	4. routine: requiring community palliative care consultation within 14 days

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