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BELFAST**



QUALITY IN PALLIATIVE CARE DAY SERVICES: WHAT IS IT AND HOW DO WE CAPTURE IT?



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OBJECTIVES

What is quality (in healthcare)?

Why, how, and should it be measured?

Quality measurement in Palliative Care Day Services?

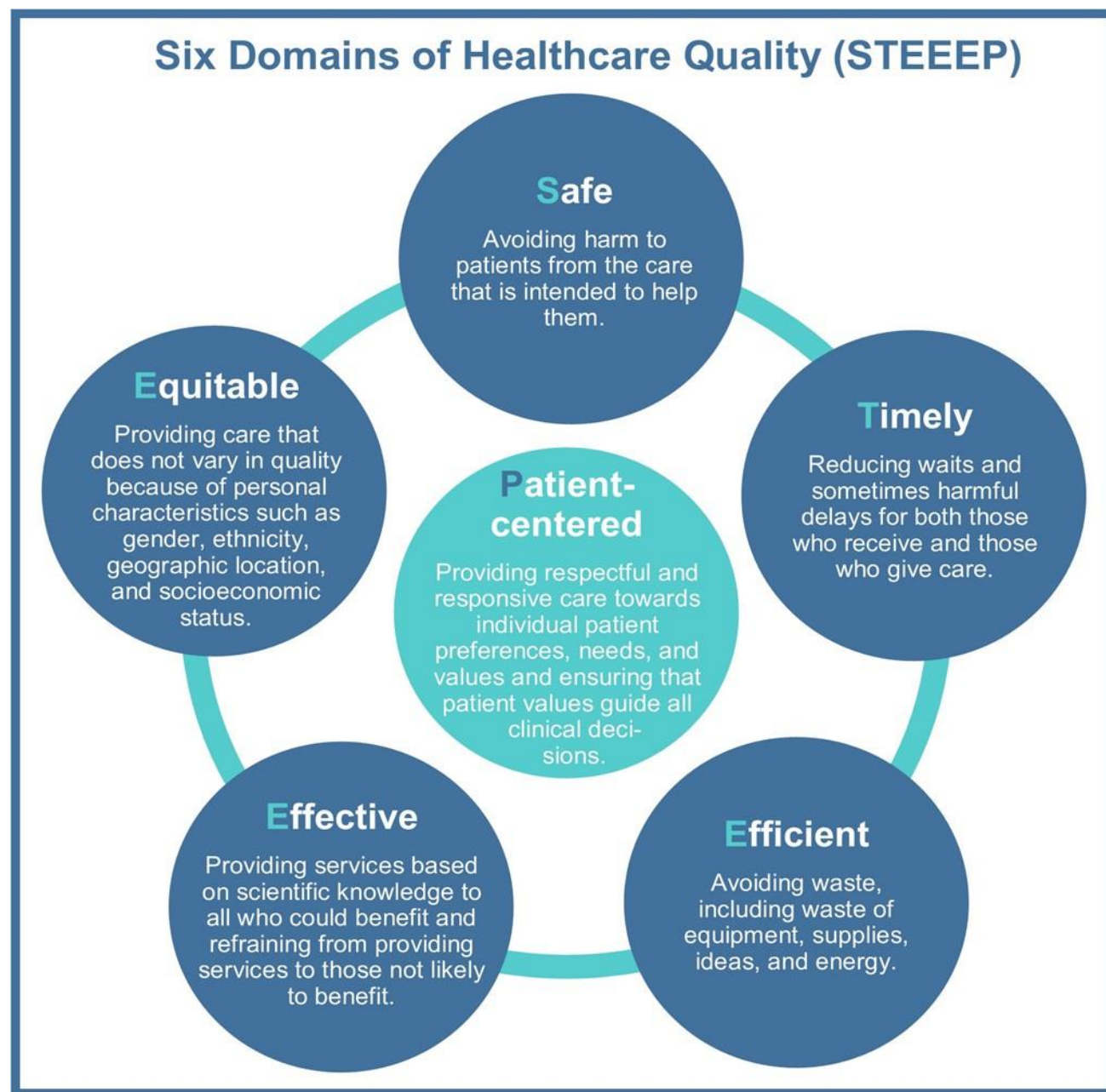
Introduction to the QUALPAL study

Review of the QUALPAL Quality indicator set

Next steps...

WHAT IS HEALTHCARE QUALITY?

- Most influential contemporary definition of healthcare quality is based on the Institute of Medicine's STEEEP framework



<https://www.snih.org/healthcare-quality-dimensions-through-public-health-history-part-1/>

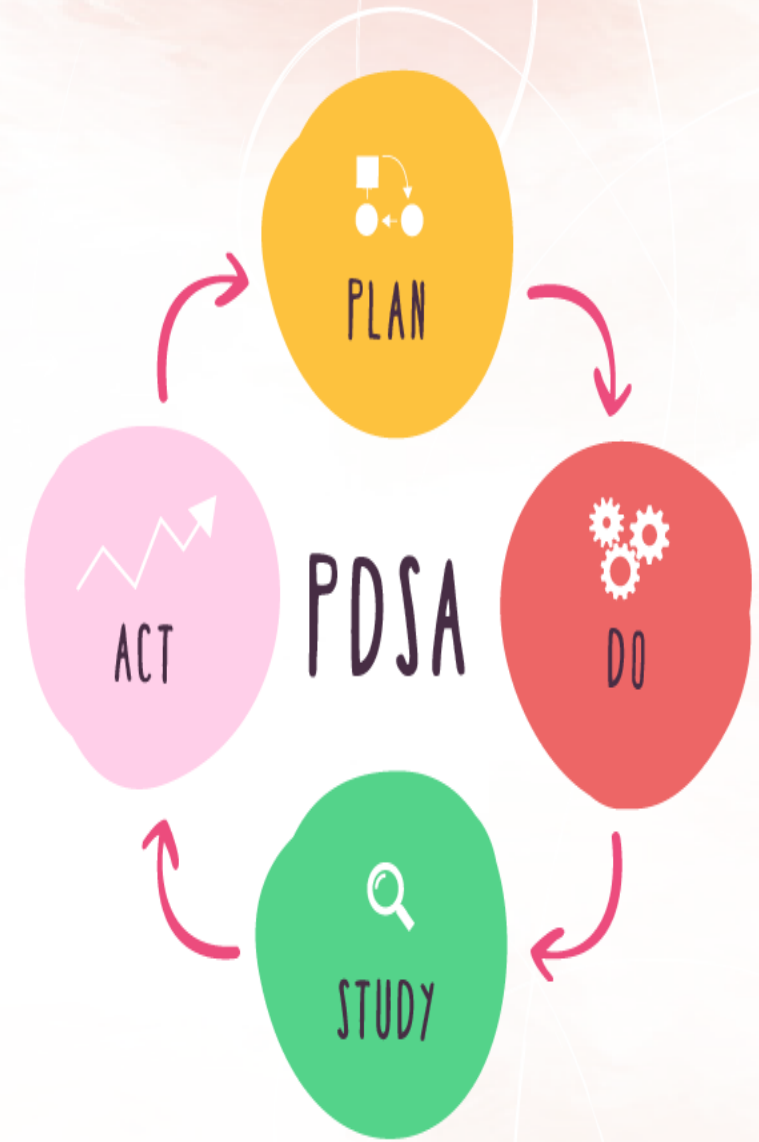
WHY SHOULD IT BE MEASURED?

- **As a basis for quality improvement**
- Demonstrate good service delivery
- Public reporting
- Patient choice
- “Pay for Performance”
- Improving efficiency

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

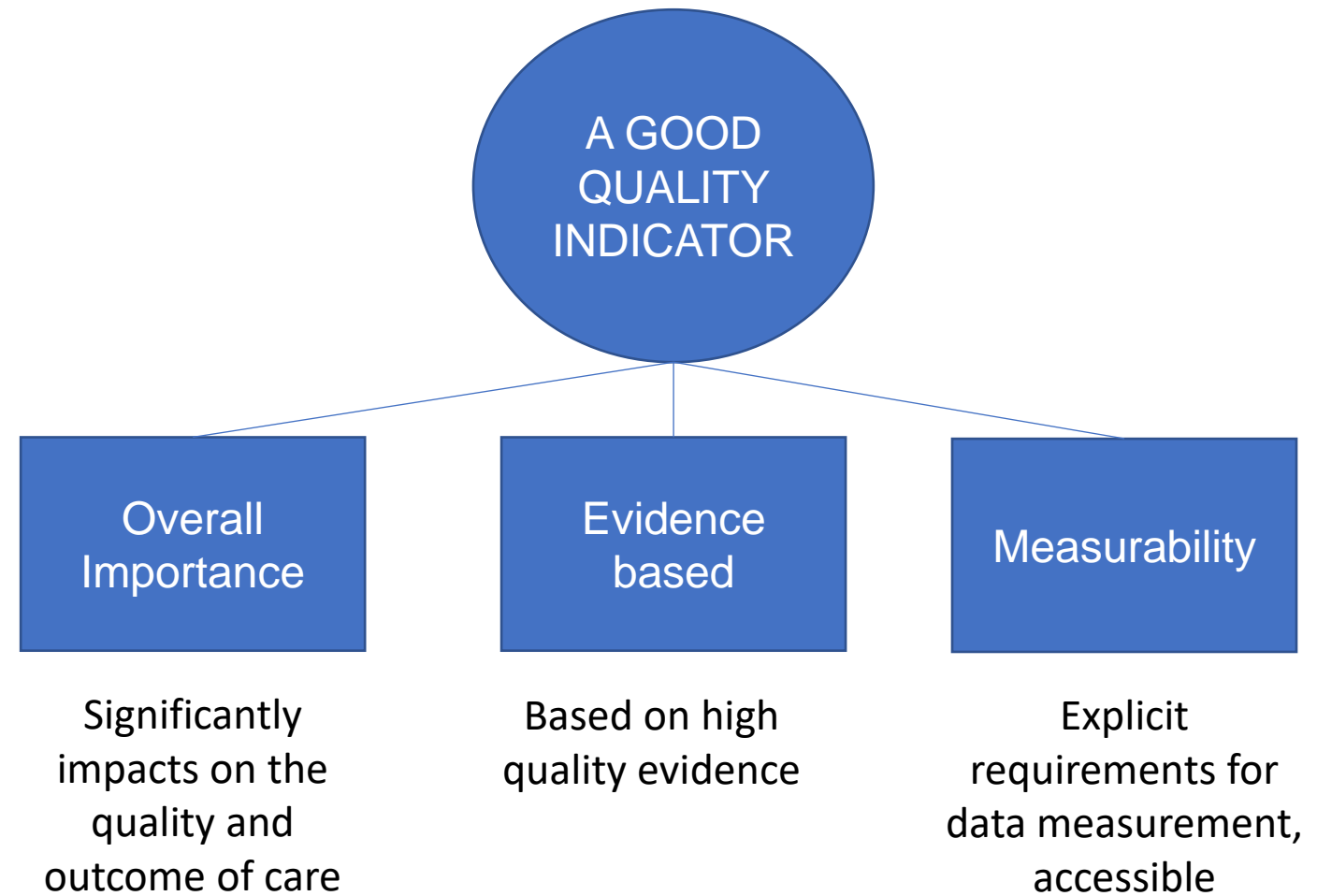


BUT...

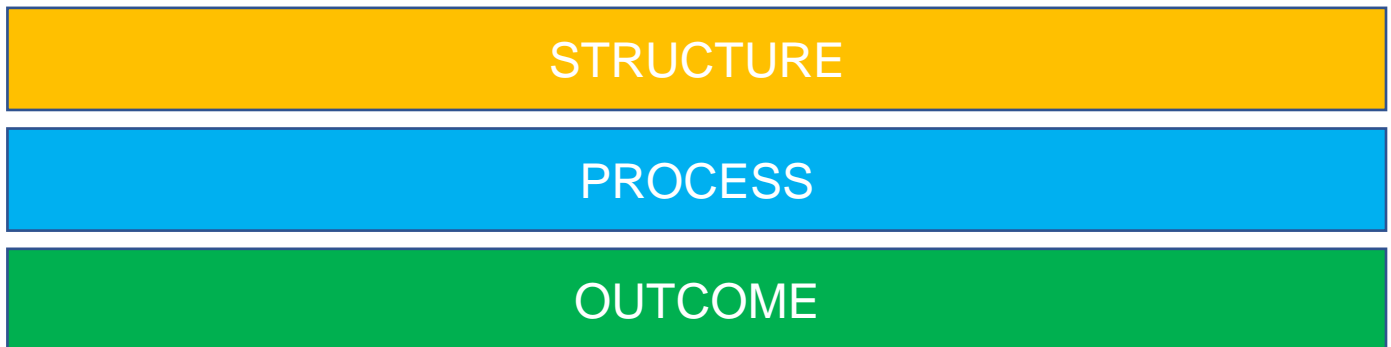
- Not everything that can be counted counts, and not everything that counts can be counted.
- Evidence of 'gaming'
- Over-reliance on targets can have negative impacts on services
- Concerns about data quality

HOW SHOULD IT BE MEASURED? – QUALITY INDICATORS

- Quality indicators have been described as specific and measurable elements of practice that can be used to assess the quality of care.



Donabedian's framework



QUALITY INDICATORS IN PALLIATIVE DAY SERVICES

1. In a climate of increasing demand and financial restrictions, service providers need to demonstrate quality of services
2. Quality indicators provide a means of defining, measuring and comparing the quality of key aspects of care
3. Measurement of quality indicators can help to stimulate, motivate and evaluate initiatives to improve patient care
4. Target resources in an appropriate and effective way
5. Need to reflect the goals of PCDS – with its focus on early intervention, social care, rehabilitation, and its diverse population.

THE QUALPAL STUDY

GOAL – To develop a set of quality indicators (QIs) for the assessment of all aspects (structure, process and outcome) of quality of care of Palliative Care Day Services

- using rigorous methods
- addressing the 3 criteria for ‘good indicators’
- engaging with the PCDS community



PROJECT TEAM: Dr Noleen McCorry [co-project lead], Prof Martin Dempster [co-project lead], Dr Kathy Armour, Professor Joanna Coast, Professor Joachim Cohen, Professor Michael Donnelly, Dr Anne Finucane, Dr Joan Fyvie, Dr Louise Jones, Professor George Kernohan, Dr Kathleen Leemans, Dr Sean O'Connor, Professor David Oxenham, Dr Paul Perkins

HOW WE DEVELOPED THE QUALPAL INDICATOR SET

Adapted RAND/UCLA Method for specification of Quality Indicators

Systematic Review of Existing Evidence

182 indicators identified and sent to expert panel



Expert Panel meeting

Confirmed removal of 71 indicators
Discussion of remaining indicators



Consolidation of Quality Indicators

Overlapping indicators removed. Resulting in 30 indicators



Independent Ratings by Expert Panel

16 panel members rated 182 indicators for 'appropriateness'



Independent Ratings by Expert Panel

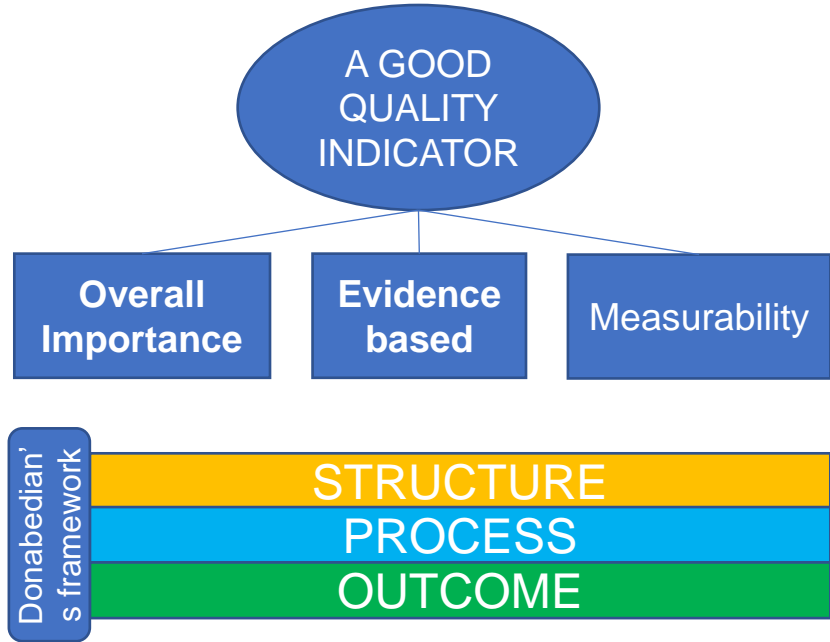
Panel members independently re-rated remaining 111 indicators for 'appropriateness' and 'necessity'. 51 indicators retained



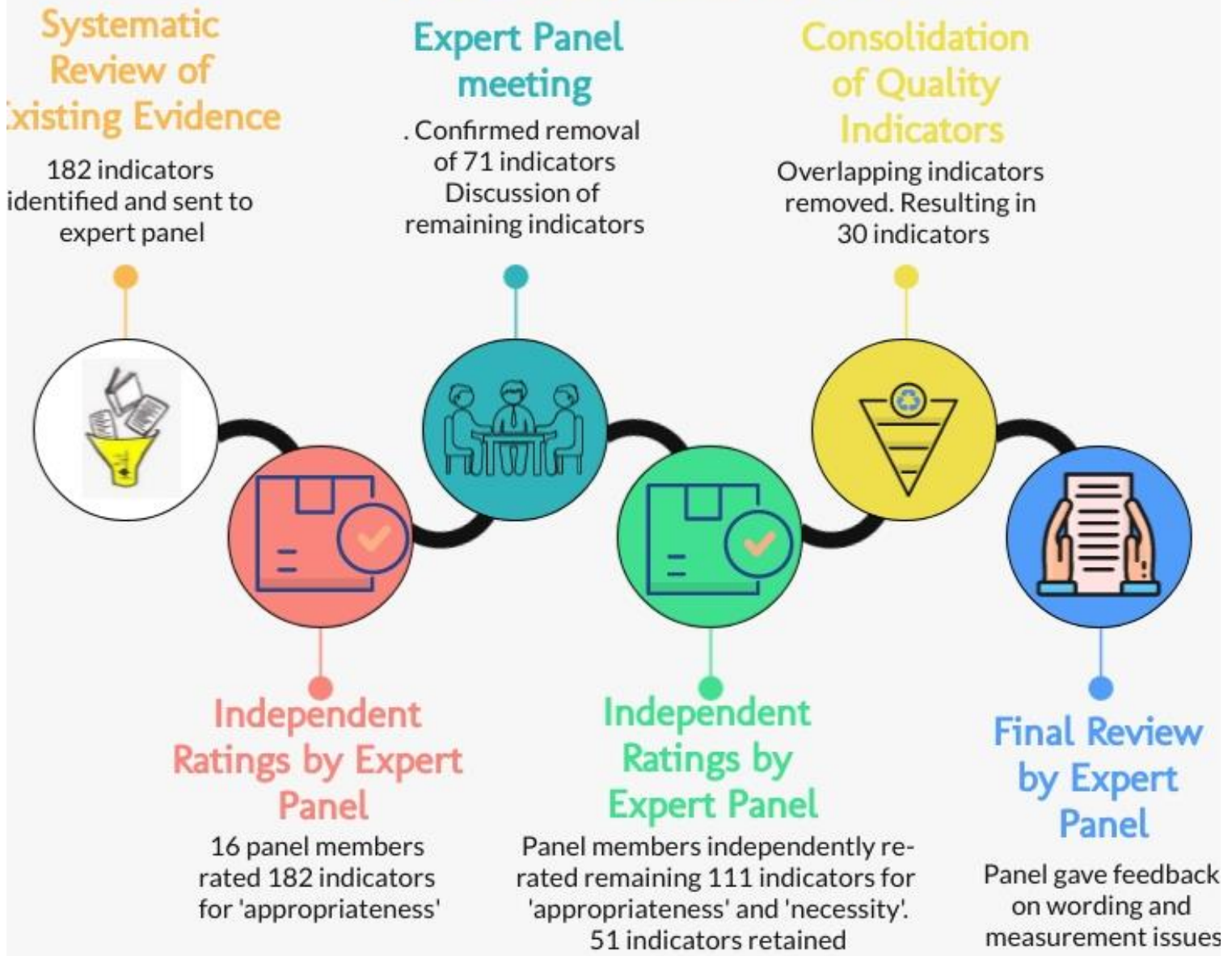
Final Review by Expert Panel

Panel gave feedback on wording and measurement issues





Adapted RAND/UCLA Method for specification of Quality Indicators



FINAL QUALPAL INDICATOR SET

Physical (5 QIs)

- Assessments of pain, fatigue, breathlessness, functional ability

Psychological (3 QIs)

- Assessments of anxiety, depression, cognitive ability

Spiritual (1 QI)

- Documentation of spiritual aspects of care discussion or assessment

Information (1 QI)

- Service users provided appropriate information on their condition, options

Care coordination & continuity (9 QIs)

- Needs assessment, care pathways, communication with GP, SOPs

Care planning (2 QIs)

- SOP for use of multidisciplinary care plan

Outcome measurement (4 QIs)

- Assessment of satisfaction, quality of life

Staff training (1 QI)

- Staff have access to training

Service environment (3 QIs)

- Suitable equipment and settings to deliver care

Legal and ethical aspects (1 QI)

- Service users with documentation of informed consent

FINAL QUALPAL INDICATOR SET

A. Physical care and support, assessment and treatment

A1. Proportion of service users with assessment of pain severity at screening using a valid measure

A2. Proportion of service users with moderate or severe pain assessed to explore possible causes of pain

A3. Proportion of service users with assessment of breathlessness at screening using a valid measure

A4. Proportion of service users with assessment of fatigue at screening using a valid measure

A5. Proportion of service users with assessment of functional status to identify daily activity limitations completed before a multidisciplinary care plan

Outcome measurement (4 QIs)

- Assessment of satisfaction, quality of life

Staff training (1 QI)

- Staff have access to training

Service environment (3 QIs)

- Suitable equipment and settings to deliver care

Legal and ethical aspects (1 QI)

- Service users with documentation of informed consent

FINAL QUALPAL INDICATOR SET

Physical (5 QIs)

- Assessments of pain, fatigue, breathlessness, functional ability

B. Psychological care and support, assessment and treatment

B6. Proportion of service users screened for depression at screening using a valid measure

B7. Proportion of service users screened for anxiety at screening using a valid measure

B8. Proportion of service users with assessment of cognitive functioning

Outcome measurement (4 QIs)

- Assessment of satisfaction, quality of life

Staff training (1 QI)

- Staff have access to training

Service environment (3 QIs)

- Suitable equipment and settings to deliver care

Legal and ethical aspects (1 QI)

- Service users with documentation of informed consent

FINAL QUALPAL INDICATOR SET

Physical (5 QIs)

- Assessments of pain, fatigue, breathlessness, functional ability

Psychological (3 QIs)

- Assessments of anxiety, depression, cognitive ability

C. Spiritual and emotional care and support

C9. Proportion of service users with documentation of a spiritual aspects of care discussion or assessment completed before a multidisciplinary care plan

Care planning (2 QIs)

- SOP for use of multidisciplinary care plan

Outcome measurement (4 QIs)

- Assessment of satisfaction, quality of life

Staff training (1 QI)

- Staff have access to training

Service environment (3 QIs)

- Suitable equipment and settings to deliver care

Legal and ethical aspects (1 QI)

- Service users with documentation of informed consent

FINAL QUALPAL INDICATOR SET

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- Assessments of anxiety, depression, cognitive ability

Spiritual (1QI)

- Documentation of spiritual aspects of care discussion or assessment

D. Information and Communication with Service Users

D10. Proportion of service users who report that they are provided with sufficient, appropriately tailored information or advice on their condition and on intervention options to support decisions on agreed care planning

Staff training (1 QI)

- Staff have access to training

Service environment (3 QIs)

- Suitable equipment and settings to deliver care

Legal and ethical aspects (1 QI)

- Service users with documentation of informed consent

E. Co-ordination and continuity of care

E11. Proportion of service users with a comprehensive needs assessment completed before a multidisciplinary care plan to identify main symptoms and concerns and their effect

E12. Service has a written care pathway for assessment and management of moderate or severe pain including appropriate onward referral routes

E13. Proportion of service users with documentation of re-assessment at regular review in line with time points agreed in the multidisciplinary care plan

E14. Service has a written standard operating procedure defining timeframes for time to initial contact, completion of needs assessment and multidisciplinary care plan

E15. Proportion of service users with documentation of appropriate intervention in line with the agreed, multidisciplinary care plan

E16. Proportion of service users with documented communication between the service and the General Practitioner providing information on care needs and the agreed care plans

E17. Proportion of service users with a care plan available as specified by the service's written standard operating procedure for development and usage of multidisciplinary care plans

E18. Proportion of service users with documented evidence of being offered the opportunity for completion of advance care planning

E19. Proportion of service users with quality of life assessed using a valid measure at screening and at regular review in line with time points agreed in the multidisciplinary care plan

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Information (1 QI)

- Service users provided appropriate information on their condition, options

Care coordination & continuity (9 QIs)

- Needs assessment, care pathways, communication with GP, SOPs

F. Care planning, goal setting and shared decision making with service users

F20. Service has a written standard operating procedure for development and usage of multidisciplinary care plans

F21. Proportion of service users with documentation of main care goals in the multidisciplinary care plan

Service environment (5 QIs)

Suitable equipment and settings to deliver care

Legal and ethical aspects (1 QI)

- Service users with documentation of informed consent

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- Service users provided appropriate information on their condition, options

G. Evidence of effectiveness, outcome assessment and measurement

G22. Service has a written policy for reviewing and updating standard operating procedures and care pathways

G23. Proportion of service users re-assessed at regular review who report that main care goals are met in line with the multidisciplinary care plan

G24. Proportion of service users with assessment of satisfaction with overall care and support performed using a valid measure

G25. Proportion of service users with assessment of satisfaction with involvement in shared decision making

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Outcome measurement (4 QIs)

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H. Staff training and education, service and professional development

H26. Extent to which staff have access to training around core components of care as part of continuing education and personal development

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- Assessment of satisfaction, quality of life

I. Access to services and service environment

I27. portion of service users with a record of time in days from referral date to first attendance date offered by service

I28. The service provides suitable equipment and settings to deliver care

I29. Service has a written policy for defining standards for equipment and settings which are available for delivery of care

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Outcome measurement (4 QIs)

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Staff training (1 QI)

- Staff have access to training

J. Societal, ethical and legal aspects of care

J30. Number of service users with correctly completed documentation of informed consent to treatment or medical intervention

MEASURABILITY?

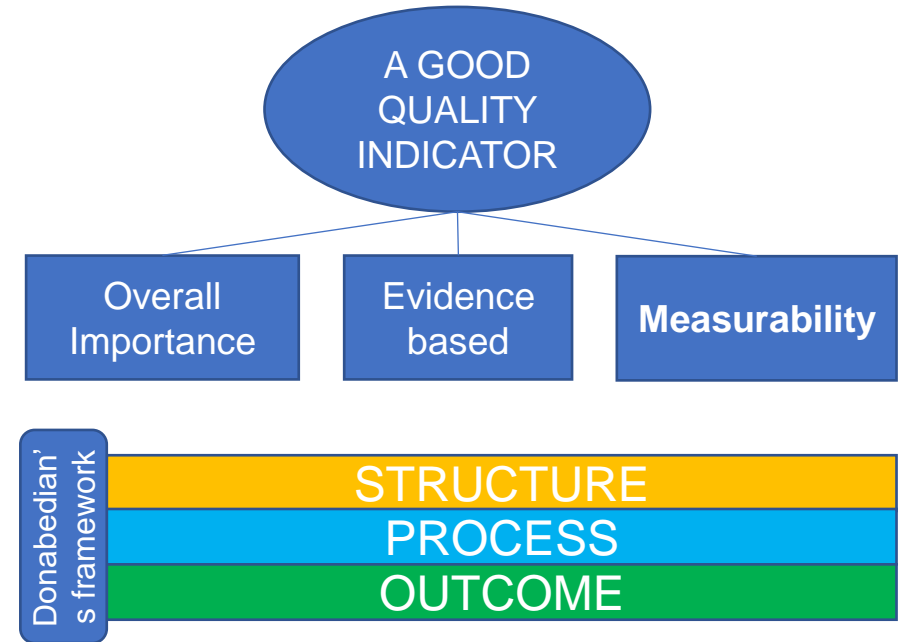
Description: Proportion of patients who have an assessment of pain severity at screening using a valid measure

Numerator: Number of service users with assessment of pain severity at screening using a valid measure

Denominator: All day service users

Exclusions: Service users with significant cognitive impairment

Specifications: 'pain severity', 'screening', 'valid measure'



LOGO	PALLIATIVE DAY SERVICE QUALITY INDICATOR SET: DATA ABSTRACTION FORM A [PATIENT LEVEL INDICATORS]	ABTRACTOR: <input type="text"/>	DATE: <input type="text"/>	SITE: <input type="text"/>
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DATA SAMPLE & REFERENCE PERIOD:		e.g. 15 consecutive service users discharged in period (INSERT DATES)																																																																																																	
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	<u>Key terms/definitions:</u> <ul style="list-style-type: none"> • Service users: Patients attending day hospice • Pain severity: Unidimensional assessment of current pain level using a valid measure and accepted descriptors of pain severity or intensity (e.g., Pain Visual Analogue Scale (VAS), Pain Numerical Rating scale (NRS) or Pain Verbal Rating Scale (VRS)** • Screening: Processes of assessment undertaken during the early stages (within 1-3 visits) of attendance at day service, at triage, or at the beginning of a new episode or phase of care • Valid measure: The measure is appropriate and has acceptable validity and reliability when used according to specific instructions 																																																																																																		
	** Observational or other non, self-reported measures are not included in assessment of this indicator																																																																																																		
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<https://www.qub.ac.uk/psycholonline>



QUALPAL STUDY - CHALLENGES

- Ease of data extraction, including:
 - accessibility of information
 - time taken
 - resources
- Can the QIs be assessed using existing information?
- Do the QIs make sense, eg. are they clear and specific?
- Can the documentation be improved?

FEASIBILITY TESTING

N = 5 UK PALLIATIVE DAY CARE SERVICES

N = 82 PATIENT RECORDS

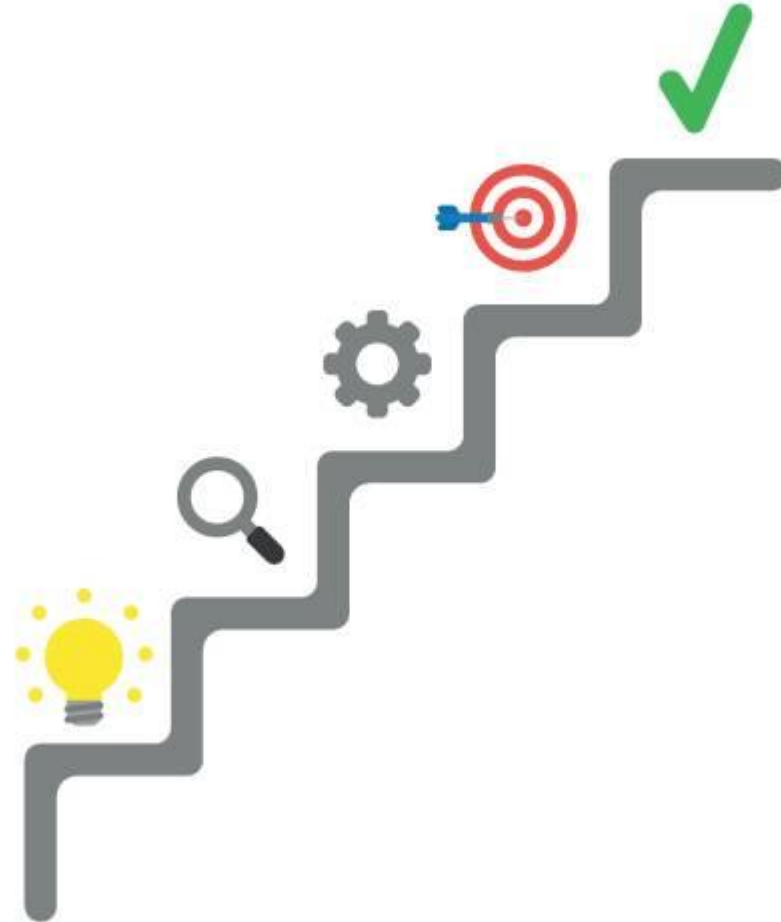
- Data abstractors reported:
 - Data abstraction perceived as time-consuming
 - Abstractors had to refer to several different sources of information
 - Data abstractors were not confident about the process for *calculation* of each indicator
- Most variability for:
 - Assessment of patient satisfaction
 - Recording of care goals
 - Completion of care plans
- **Least likely to be met:**
 - **QoL assessment**
 - **Availability of MD care plan**
 - **Assessment of satisfaction with decision making**
- **Most likely to be met:**
 - **Documentation of time to referral to first attendance date offered**
 - **Informed consent to treatment**
 - **Communication between service and GP**

QI	Patient and staff level indicators*	Mean (%)	SD	Range
A1	Pain severity assessed at screening using a valid measure	76.8	10.2	67-93
A2	If moderate or severe pain present, patient assessed to explore possible causes of pain	63.8	15.1	50-87
A3	Breathlessness assessed at screening using a valid measure	73.2	13.8	55-86
A4	Fatigue assessed at screening using a valid measure	68.8	16.6	47-93
A5	Functional status assessed to identify daily activity limitations prior to formulating care plan	64.8	17.3	46-93
B6	Depression assessed at screening using a valid measure	49.4	21.3	27-75
B7	Anxiety assessed at screening using a valid measure	45.6	9.2	34-56
B8	Cognitive function assessed	56.0	17.1	32-78
C9	Spiritual aspects of care discussion or assessment completed before care plan	59.8	21.6	26-85
D10	Patient provided with sufficient information or advice to support decisions on care planning	16.4	4.5	10-21
E11	Comprehensive needs assessment completed before care plan	42.2	29.2	0-78
E13	Re-assessment made at regular review in line with time-points agreed in care plan	71.8	28.8	23-93
E15	Appropriate intervention documented in line with the agreed care plan	54.6	25.5	28-93
E16	Communication between the service and general practitioner documented	89.2	17.6	58-100
E17	Care plan available as specified by standard operating procedure	15.0	22.4	0-54
E18	Opportunity offered for completion of advance care planning	56.0	20.3	37-90
E19	Quality of life assessed using a valid measure	11.0	15.6	0-38
F21	Care goals documented in care plan	65.2	20.9	32-86
G23	Care goals met at regular review in line with care plan	35.0	33.4	12-93
G24	Assessment of satisfaction with overall care and support using a valid measure	43.4	27.9	0-78
G25	Assessment of satisfaction with involvement in decision making	17.6	36.1	0-82
I27	Time in days from referral date to first attendance date offered	95.8	6.2	86-100
J30	Documentation of informed consent to treatment or medical intervention completed	93.4	11.2	74-100
H26	Staff with access to training around core components of care	100.0	0.0	100-100

QI	Service level indicators*	% of services meeting the QI
E12	Care pathway for assessment and management of pain including onward referral routes	40% (2/5)
E14	Written standard operating procedure defining timeframes	20% (1/5)
F20	Written standard operating procedure for development and usage of care plans	40% (2/5)
G22	Written policy for reviewing and updating standard operating procedures and care pathways	40% (2/5)
I28	The service provides suitable equipment and settings to deliver care	60% (3/5)
I29	Written policy for defining standards for equipment and settings available for delivery of care	60% (3/5)

NEXT STEPS

- Focus on:
 - Usability
 - Implementation
 - Collaboration
 - Resourcing



THANK YOU

- OUR RESEARCH TEAM
- OUR FUNDERS (MARIE CURIE)
- YOU, FOR LISTENING
- NIHR DAY CENTRE RESEARCH FORUM
- THE EXPERT PANEL

Gill Horne	Rowcroft Hospice, Torquay
Christina Faull	LOROS, Leicester
Adrian Tookman	Marie Curie Hospice, Hampstead
Neale Connor	Sobell House, Churchill Hospital, Oxford
Rebecca Day	Sue Ryder, Leckhampton Court Hospice, Cheltenham
Amy Outingdyke	St Joseph's Hospice, London
Caroline Belchamber	Bournemouth University
Lesley James	Marie Curie Hospice, West Midlands
Lindsay Day	St Catherine's Hospice, West Sussex
Loretta Gribben	Northern Ireland Hospice
Gail Eva	Brunel University
Susan Campbell	University of East Anglia
David Vonberg	St Michael's Hospice, Hereford
Steve Barnes	Willen Hospice, Milton Keynes
Sarah Holmes	St Barnabas Lincolnshire Hospice
Julie Lamb	St Benedict's Hospice, Sunderland
Emily Stowe	St Clare Hospice, Essex
Michelle Aslett	Marie Curie Hospice, West Midlands
Ruth Keeble	Marie Curie Hospice, West Midlands
Elaine Stevens	University of the West of Scotland



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For further information contact: Dr Noleen McCorry
n.mccorry@qub.ac.uk

You can access the list of Quality Indicators for PCDS:
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6350181/>