Quality assurance and the palliative care team

Part of the nurse manager’s role is to understand the complexities of running a specialist unit and to be aware of the increased focus on quality assurance programmes. This article describes how one model can be applied to involve all members of a palliative care team in the process of assessing and improving the quality of service provided.

In the rapidly developing area of palliative care, it is essential that nurses ensure the service they offer to their patients is underpinned by robust quality mechanisms. In striving to improve the standards of care offered to patients and their families, nurses should utilise models of quality in their practice, for example, Maxwell’s model of quality (Maxwell 1984) (Box 1).

A certain degree of mystery seems to surround the subject of quality assurance (Bassett 1994). In order to understand quality in health care, therefore, it is important to review the history of quality assurance in health.

DEVELOPMENT OF QUALITY ASSURANCE

Definitions of quality include having ‘a high degree of goodness or worth’, and being ‘of first rate’. Aspects of assurance include ‘belief and trust in one’s own worth’ and ‘a promise’. Ideally, quality assurance programmes should integrate these elements.

Formalised quality assurance strategies can be traced back as far as Florence Nightingale (Hinkley 1991, Maxwell 1984). She kept records and statistics relating directly to the care of her patients. This methodical and painstaking measurement of facts and statistics led to improved knowledge, which she, in turn, used to increase her influence with the War Office in London. Her research was used to improve the quality and quantity of resources for the servicemen wounded in the Crimean War.

Clearly, when nurses petition for increased resources, those requests supported with reasoned, well-researched statistical information will be more successful than those based on intuition and emotion alone. Since Florence Nightingale’s pioneering practice, nurses have kept and maintained copious records, but have not used them to evaluate quality of nursing care or as arguments in favour of resources. They seem merely to have created mountains of paper (Bassett 1993).

The relatively recent interest in the study of quality in health care can be traced back to Maxwell (1984). He documented his concern about the lack of quality in health care. Maxwell pointed out that no formalised mechanisms existed in the UK for the independent assessment of the quality of medical care. He proposed six dimensions of quality that needed to be assessed. Maxwell’s model has since become a standard measure for quality and has been adapted for many uses in health care. It can be applied to almost any area of organisation, for example, devising and implementing quality programmes in palliative care.

QUALITY SYSTEMS

Akinsanya (1992) stated that: ‘There is increasing evidence to suggest that the quality of education and practice does not depend on commitment alone, but rather on the recognition of those factors which influence its possible attainment.’ In the UK, the UKCC has indicated its commitment to increased quality in both pre-registration (UKCC 1986) and post-registration (UKCC 1989) education.

Akinsanya (1992) believed that, traditionally, any threats and problems faced by the profession have been solved largely by groups and factors that are outside nurses’ control. Nurses must set their own agenda for change. An essential component of that change must be the adoption of quality assurance strategies in nursing care. Jolly (1989), for example, indicated that the concept of ‘customer’ should be developed by nurses. This concept should also include funding


Access to services
Relevance to need
Effectiveness
Equity
Social acceptability
Efficiency and economy.
MANAGEMENT

Access to services

Maxwell’s model can be used to help achieve radical change in the way nurses think about their roles, how they examine the way they work, and the influence they have in the care of the patient.

**APPLYING MAXWELL’S MODEL IN PALLIATIVE CARE**

Maxwell used six dimensions of quality to specify, measure and assure quality.

**Access to services** Palliative care must be available to all members of society who will benefit from the service. Maxwell believed that this should not be limited by time or place. The service should be organised in a flexible way. The DoH (1995) stated that successful treatment and care depends on the provision of effective cancer care services. Access to palliative care services for those from an ethnic minority is arguably less easy than for white, middle class people. Gaffin (1995) pointed out that nurses must work to overcome these discriminatory barriers.

Specialist staff must be available at all times to provide advice and care for patients with severe symptoms. This is clearly essential to the quality of care offered to patients. The quality of an organisation affects both users and providers of the service. Therefore, realistic and flexible working arrangements need to be made for staff working within the team. Staff may require considerable flexibility in order to work around childcare facilities or professional updating and study. This is not always easy to provide. However, if achieved, such care of staff can pay dividends in improved morale. Existing shift patterns may need reassessment and working hours may need to be adjusted to support increased adaptability.

**Relevance to need** Close collaboration between service managers, practitioners and purchasing health authorities is important. This can help to ensure the mutual requirement for quality in practice. Managers, staff and purchasers of health care must create a partnership based on equality, to try to prevent imbalance and bias. McCarthy (1995), for instance, highlighted that adolescents with cancer did not always receive relevant care. In her unit, a united approach to adolescent care was adopted that resulted in a better quality service.

The National Council for Hospice and Specialist Palliative Care Services (NCHSPCS) (1993) stated clearly that needs assessment is essential to provide high quality care to patients and clients. Geographical factors must be taken into consideration regarding the type and specialism of palliative care services. For example, local needs or regional guidelines may specify that an area needs a hospice that provides only day care or perhaps, a community-based service would be more appropriate.

Medical and nursing staff must be appropriately trained and experienced. Skill mix must be flexible; specialists in all areas of symptom control should be integrated into the palliative care team.

Generally, it is important to increase knowledge and expertise in palliative care. Nurses must beware of concentrating expertise in small localised pockets. It is vital to act as educators generally, improving standards for palliative care across the country.

**Effectiveness** Outcome measures are extremely important to all branches of nursing. Palliative care must be ready to prove its effectiveness along with other specialties in health care. Higginson (1993) also stated that outcome measures in palliative care have been slow to emerge, due in part to the difficulty of measuring quality of life when a patient is dying. However, Higginson (1993) showed that measurement is possible: the Support Team Assessment Schedule (STAS) has been used with considerable success in the palliative care setting.

Patients must, of course, be cared for in an effective way. Nursing care must be fully research based. Support staff, such as university lecturers, should be included in the care team to assist with education for both qualified practitioners and nursing students. Practice development advisers may help staff to set and measure standards of care for patients and relatives. Effective styles of management should be employed which incorporate specialist quality training that highlights the need for every team member to be responsible for all the work which involves them.

Time should also be provided for in-service updates. Nurses and doctors on a unit must be encouraged to attend courses that will enable them to improve the care they give. Members of the unit team should take every opportunity to promote the aims and philosophy of the team.

**Equity** All patients and clients must receive the highest standard of medical and nursing care, even during times of staff shortage or high patient dependency. If necessary and practicable, staff from other patient care areas should be drafted in. This, in turn, will maintain and improve the relationship between wards and the palliative care unit.

Healthcare funding must be shared more equally by health commissioners and by provider units (NCHSPCS 1994). Resources and general responsibilities need to be balanced effectively between all members of staff. This promotes a feeling of ownership and improves quality by giving everyone a vested interest in excellence. Managers should attempt to meet the professional and occupational needs of all staff wherever possible.

**Acceptability** Patient satisfaction must be at the top of nurses’ list of priorities. Mor et al (1988) believed patient satisfaction to be the single most
important measure of the service nurses offer to clients. Patients who are dying are often happy to suggest ways of improving services for the benefit of others in the future.

The philosophy, mission statement or stated objective of the team must be dynamic, clear and underlie the aim for quality. All those working within the team should maintain and develop effective interpersonal skills and foster close co-operation between colleagues. This is important when working in what can be an extremely stressful environment. When problems arise, a mature and creative approach should be followed to support all members of the team.

Similarly, the public image of the service is also important. Local support of the service encourages not just donations and equipment, but also goodwill. This is vital to the long term health of the service.

**Efficiency and economy** Financial management should ensure correct assessment of services, consumables and staffing costs. Value for money is crucial to the long term health of palliative care services. Higginson (1993) pointed out that resources will not meet all requirements for the growing range of treatments available. Purchasers will compare services in relation to outcomes achieved for a given input in terms of money. The care team must be included in planning and maintaining effective cost management.

All staff must be aware of the high cost of services and of the price of the medical consumables they use. Costs should be kept to a minimum, while patient care is maintained at a consistently high level of quality. An effective skill mix must be achieved in order to improve the efficiency and overall economy of the team. Labour must be evenly and fairly distributed. Tasks such as training, equipment provision, duty rostering, finance and so forth, need to be assigned to all members of the team. This will lead to a greater awareness of the complexities of running a palliative care service and will also develop the skills of all staff.

**CONCLUSION**

The Maxwell model of quality is one of many methods of quality assurance available to nurses and can be used in a variety of settings. Its use can allow a more scientific approach to assessing and improving quality in health care. Nurses should examine others that are available to determine which is suitable for assessing their unit.

Strong leadership in nursing is the key to improving quality. The manager must employ a top-down approach to quality, sharing his or her vision of quality with the team and encouraging ownership in the service. The future of nursing may depend on improving the quality of the service.

Nurses, nurse teachers and managers must collaborate with all other members of the patient care team. They must become familiar with and start to use models of quality, and be ready to respond to the rapid changes in health and nursing today.

**REFERENCES**


