

# How to ensure good quality palliative care: a Spanish model

In the first of a two-part series, **Xavier Gómez-Batiste, Frank Ferris, Josep Maria Picaza, Silvia Paz, Jose Espinosa, Josep Porta-Sales** and **Joaquim Esperalba** describe a model for the evaluation and improvement of the quality of care for patients with terminal illness

**A** cornerstone of progress in any healthcare service – in addition to education, training and research – is the evaluation and improvement of its quality. It is essential, therefore, that this is set out in a strategic plan that defines the values, vision, objectives and actions for the short, medium and long term.

Several systems exist to evaluate and improve the quality of healthcare services and, more specifically, of specialist palliative care services or other services that deal with large numbers of patients with advanced terminal illness. Evaluation can include quantitative and qualitative aspects, or a combination of both.

This article presents a pragmatic approach based on a comprehensive model of care that includes all the areas of need of patients and their families. We present a systematic evaluation tool that can be used by the healthcare team. It includes quantitative and



The Institute of Oncology (ICO) in Barcelona, Spain, at which the authors' approach to evaluating quality of care has been tested

## Key points

- This article describes a system for evaluating and improving the quality of specialist and conventional healthcare services for patients with advanced terminal illness and their families.
- The system is based on something known as the 'square of care' model combined with an adapted version of a model used for organisational management systems.
- The model has been used for four years at the Catalan Institute of Oncology (ICO) in Barcelona, Spain, but is suitable for any healthcare service that deals with patients with advanced terminal illness and their families.
- Its use should result in a systematic plan of improvement, including a list of specific measures for change relating to the clinical and organisational aspects of the service.

qualitative aspects. It involves drawing up and prioritising objectives and actions, and identifying specific indicators for monitoring.

This approach has been tested successfully in the palliative care service at the Catalan Institute of Oncology (ICO) in Barcelona, Spain, and in training activities. It will also be tested in several different settings to ensure it is reliable, feasible and useful.

## Improving specialist healthcare

The aim of this article is to describe a system for evaluating and improving the quality of specialist and conventional healthcare services for patients with advanced terminal illness and their families. The proposed approach is based on the 'square of care' model (explained below) and on an adapted version of the EFQM model of evaluation and improvement

of quality. The EFQM model is a framework for organisational management systems promoted by the European Foundation for Quality Management (EFQM) and is designed to help organisations to become more competitive. Our model, the ICO/SECPAL (Catalan Institute of Oncology/Spanish Association of Palliative Care) model, has been used for four years at the ICO in Barcelona and tested in several workshops in Spain.<sup>1,2</sup>

## Principles of evaluation and improvement

We can define a specialist palliative care service as a healthcare service with a highly competent, trained, multidisciplinary team that looks after patients with advanced terminal illness and their families, and is identified by patients and other services as a specific service or resource.<sup>3,4</sup>

The quality of a healthcare service can be defined by the degree to which it achieves its aims and how it is perceived by patients and families, healthcare professionals, administrators and financial experts. Obviously, this is also linked to expectations.

A strategic quality assessment plan must be tailored to the needs and demands of patients and their families, and based on a well-defined model of care. It should be gradual, pragmatic and measurable. It should include quantitative and qualitative analysis and be participative. There should be appropriate leadership, supported by those in charge of the institution. The plan should become part of the culture and values of the organisation.<sup>5</sup>

Like any service in any national healthcare system, palliative care services need to draw up strategic plans and include formal plans for quality assessment and improvement.<sup>6</sup> The driving force towards progress is a combination of systematic evaluation of results, education and training, research and quality improvement – all of which should be included in the plan.

The description of a healthcare service should include its context (needs, location, institution), its tasks, aims and values, its objectives, its structure (including the number of professionals involved and their training background), the number, type and characteristics of its patients, the type and complexity of interventions, its outputs (basic quantitative results, such as length of intervention and stay) and its outcomes (clinical, efficiency, satisfaction) or results.

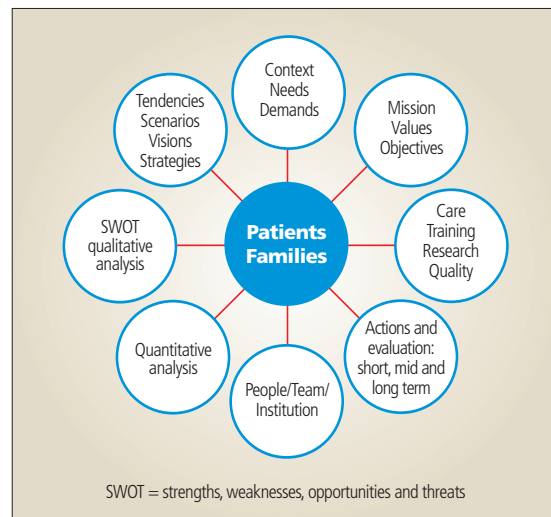


Figure 1. The elements of a strategic plan

The goals of a strategic plan are to plan in advance the development required to adjust to needs and demand, and to give a long-term vision. The elements of a strategic plan are shown in Figure 1.

## A systematic approach to quality improvement

The conventional factors that contribute to the overall quality of a healthcare service are listed in Box 1.<sup>7</sup> Evaluation and improvement of quality must be part of the essential elements of the palliative care service. These essential elements are listed in Box 2.

As well as a strategic global plan, a systematic approach to quality improvement is needed to evaluate and monitor the quality of the service, identify areas for improvement and implement measures in a constant, day-to-day way.

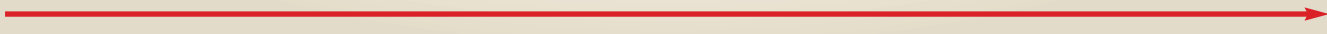
### Box 1. Factors that influence the quality of a health service

- |                      |                   |                 |
|----------------------|-------------------|-----------------|
| ■ Commitment         | ■ Appropriateness | ■ Participation |
| ■ Efficacy           | ■ Continuity      | ■ Satisfaction  |
| ■ Effectiveness      | ■ Accessibility   |                 |
| ■ Efficiency         | ■ Opportunity     |                 |
| ■ Cost-effectiveness | ■ Privacy         |                 |
| ■ Cost-efficiency    | ■ Safety          |                 |
- Adapted from the JCAH (Joint Commission on Accreditation of Healthcare Organizations)<sup>7</sup>

### Box 2. Essential elements of the palliative care service

- |   |   |
|---|---|
| ■ Patient care                                    | ■ Links with society                    |
| ■ Family care                                     | ■ Evaluation and monitoring of results  |
| ■ Teamwork  | ■ Training                              |
| ■ Decision-making                                 | ■ Research                              |
| ■ Case management, continuing care, co-ordination | ■ Evaluation and improvement of quality |

Needs of patients and their families	1. Assessment	2. Sharing information	3. Decision-making	4. Care planning	5. Care delivery	6. Confirmation	7. Measure results	8. Indicators and standards
Disease management								
Physical								
Emotional								
Social								
Spiritual								
Practical								
End of life								
Bereavement and loss								



**Figure 2. The 'square of care' model**

Implementation of quality palliative care within an organisation involves careful strategic planning, followed by the systematic development of guidelines, outcome measures, indicators, standards, and general and specific short-, medium- and long-term aims.<sup>8</sup>

The quality approach requires a specific culture and vision within the organisation, as well as the implementation of strategies in the everyday running of the service. Those strategies have to be agreed on by healthcare professionals and recognised by patients and their families, by other related services and by stakeholders such as managers and planners.

The quality of healthcare services can also be expressed through:

- Their structure – what do they have at their disposal in terms of human resources, units, beds, documentation, and so on
- Their process – what do they do, as shown by their activity (number of patients, number of visits, and so on) and their outputs (length of interventions, length of stay, mortality)

- Their outcomes – what do they achieve in terms of clinical care, outputs, finance and key or main results.

### The 'square of care' model

In any healthcare service, but especially in those that care for a high proportion of patients with advanced terminal illness and their families, the basis for quality of care must be a systematic approach. The clinical aspects of palliative care can be represented in the 'square of care' model shown in Figure 2.<sup>9</sup> On the left-hand side are listed common issues faced by patients and their families. Across the top are listed issues related to the provision of care. All the aspects of care can apply to the issues faced by patients. This allows us to take a systematic approach to the care of patients.

For example, in managing pain, we:

1. Make a careful assessment
2. Share that information through effective communication with the patient and the patient's family
3. Give the patient treatment options, enabling them to make decisions
4. Draw up a care plan
5. Deliver the care as agreed with the patient and family
6. Confirm that the patient has understood what has been suggested and is happy with the care
7. Measure the results of the care provided
8. Look at the indicators and standards of care.<sup>9</sup>

In addition to the 'square of care' model, the Spanish Association of Palliative Care (SECPAL) has drawn up detailed criteria regarding quality of care, which are the result of professional consensus and can serve as references. The SECPAL has identified 104 criteria, 34 indicators and standards and 12 core indicators that can be checked (see Box 3).<sup>10</sup>

#### Box 3. The 12 core indicators identified by the SECPAL (Spanish Association of Palliative Care)

- Initial needs assessment
- Care plan
- Monitoring
- Symptom-control monitoring
- Definition and care of the primary carer
- Therapeutic plan
- Access and continuity
- Confidentiality
- Monitoring of quality indicators
- Multidisciplinary meetings
- Multidisciplinary documentation
- Co-ordination with other resources

Several other good examples of quality indicators and standards exist.<sup>11-13</sup>

The criteria, indicators and standards shown here are general references and teams can adapt them when drawing up their own plans and indicators according to their specific needs. The quality of a healthcare service for patients with advanced terminal illness will depend on following these principles.

**Practical tools for self-evaluation**

Once a model of care has been formally decided upon and shared with the team, and adequate leadership agreed on, care can be systematically evaluated. Recommendations for the process of self-evaluation and improvement of services are listed in Box 4.

The two key questions are ‘How are we answering the needs of patients and families, and of our organisation?’, and ‘What can we do to improve the service?’. These questions and methodology can be applied to any healthcare service, either specialist or conventional, that cares for a high proportion of patients with advanced terminal illness and their families.

It is recommended that a specific ‘quality improvement group’ is created and that the

framework used is based on the square of evaluation and improvement for services (see Figure 3), with two or three formal meetings to work on it. Figure 3 also shows three examples of self-evaluation performed at the ICO on specific aspects of patient care (what to do if patients do not respond to treatment with first-choice opioid), teamwork (how to improve weekly multidisciplinary sessions) and co-ordination (how to improve co-ordination with other palliative care services in the district).

For each aspect of service, we can establish guiding principles, a quantitative evaluation,

**Box 4. Recommendations for the process of evaluation and improvement of services**

1. Consider the evaluation process as part of the culture of the service and involve the service leader
2. Promote participation and empowerment
3. Systematise
4. Include quantitative measurement: the amount of things we do and the results (outputs, outcomes)
5. Include qualitative measurement: the quality of what we do as perceived by patients, families, team members and stakeholders
6. Make the process easy and digestible
7. Register, measure and evaluate

Aspects of service	Principles	Quantitative evaluation	Strong points	Weak points	Areas for improvement	Objectives	Actions	Indicators	Team member responsible for process
Patient care	Need for a policy when there is no response to treatment with first-choice opioid	30% of patients with non-responsive pain	- Commitment - Knowledge of opioids - Opioids available - Pharmacy service available	- Lack of ability to predict treatment response - Length of decision to change treatment - Lack of knowledge of alternative opioids	- Identification of patients at risk - Time it takes to change treatment - Use and dosage of alternative opioids	- Early detection and assessment - Rapid treatment change - Use of alternative opioids	- Use Edmonton Symptom Assessment System during the first visit - Three specific sessions devoted to opioid rotation	- % of patients with Edmonton staging done - Written protocol for opioid rotation (OR) - Three sessions (on OR) realised	
Family care									
Teamwork	Multidisciplinary sessions are a key activity for the team	There should be at least one per week	- Commitment - More than 70% of sessions done	- Late start - No order of interventions - Lack of registration	- Time-keeping - Order-keeping - Register decisions and evaluations	Order and regulation of the multidisciplinary team sessions	- Use moderator - Use session protocols - Start on time - Register decisions	- Moderator - Protocol done >90% of sessions done in time - >80% of clinical charts having written actions	
Decision-making									
Evaluation, monitoring, documentation									
Co-ordination, liaison	Palliative care services must be co-ordinated within the district	50% of patients are ‘shared’ with home care support teams and other units	- Informal daily phone liaison - Individual patients referred - Good personal relationships	- No formal interventions criteria - No formal links or meetings	- Criteria for interventions - Formal and established links	- Networking - Interventions based on established criteria - Formal liaison	- Written document on criteria for interventions of services - Set up monthly formal meetings	- Document done - Nine meetings held	
Accessibility, continuity									
Training, research, other									

Figure 3. Square of evaluation and improvement for services (with three examples of self-evaluation performed at the ICO)



# National viewpoint

Needs of patients and families	Principles	Quantitative evaluation	Strong points (3–5)	Weak points (3–5)	Areas for improvement (3–5)	Objectives (3)	Actions 3 x short, medium, long term	Indicators (1 for every action)	Team member responsible for process
Disease management									
Physical									
Emotional, information, communication									
Continuity of care									
Social									
Spiritual									
Practical									
End of life									
Bereavement									

Figure 4. Square of evaluation and improvement for patient care

a qualitative evaluation (strong and weak points), areas for improvement, objectives, actions and indicators.<sup>14</sup>

If we apply this methodology to all aspects of care, we end up with a list of several selected areas for improvement. This list can be used to draw up objectives and actions to be implemented over the following year, or in the medium to long term.

Frequent mistakes in the use of this methodology include being too generic or too vague, embracing too many aspects of care, and lacking specific, tangible actions. It is essential that identified persons are in charge of and lead the process. It is also essential that the process is participative.

Key recommendations are to concentrate on specific areas of care, as well as to select areas of improvement according to relevance, prevalence, feasibility, the capacity for improvement and the ability to measure it.

It is also necessary to check whether additional resources will be required. It is recommended to draw a list of measures that can be implemented without additional resources. This is an efficient way to improve quality and promote organisational adjustments. It also shows commitment, which provides you with a good position from which to negotiate the actions that do require additional resources and need to be discussed with the healthcare institution.

Finally, it is necessary to select indicators that will enable you to measure and monitor the evolution of the quality of the service. Indicators must be specific, simple, sensible, efficient and easy to measure. The source of information and the frequency at which it is

## Box 5. Process of qualitative evaluation and improvement

1. Set up principles and core indicators
2. Define dimensions
3. For every dimension:
  - Define principles or statements
  - Conduct quantitative analysis
  - Conduct SWOT qualitative analysis\* and identify areas for improvement
  - Set up objectives and priorities according to the areas for improvement
  - Propose actions (short-, mid- and long-term) indicators and person(s) responsible for process

\* SWOT qualitative analysis: strengths, weaknesses, opportunities and threats qualitative analysis

recorded must be clear. It is crucial to establish who will be responsible for carrying out any actions that could be required.

### What is an indicator?

An indicator is a quantitative way to measure a dimension or aspect of care. Indicators are normally the result of a fraction (xxx/yyy) and can be of *structure* (having a protocol, in which the evaluation is 'yes' or 'no'), *process* (an activity, normally a number or a percentage), and *other types* ('indicator of alarm', detection of a harmful situation – such as the overuse of emergencies by patients – or a long time from demand to intervention of a support team or admission of patients).

Each indicator should include the name, type, definition of terms, justification, target population, fraction elements, source of information, frequency of data collection and the member of the team responsible for it.

## Evaluating patient care

The same methodology used to evaluate the quality of a service can be used to evaluate the quality of patient care. The process is similar except that, here, the different dimensions will be different aspects of patient care (see Figure 4, page 146, square of evaluation and improvement for patient care). Again, the process involves establishing, for each aspect of care, the guiding principles, a quantitative evaluation, a qualitative analysis (strong and weak points), areas for improvement, objectives and actions in the short, medium and long term.

The frequent mistakes and key recommendations are very similar to those mentioned above. The same process can in turn be applied to the care of families, specifically developing the dimensions related to their needs and demands.

The general process of qualitative evaluation and improvement is summarised in Box 5 (page 146). It can be applied to every area or type of service – palliative care inpatient unit, outpatient clinic, day unit or home care support teams – and should be participative and empowered. This process can be carried out in any healthcare service that deals with patients with advanced terminal illness and their families. The difference between conventional and specialist services will be the intensity of care, and the outcomes acceptable for each situation.

The main outcome of the process will be a systematic plan of improvement based on systematic self-evaluation, as well as a list of measures of improvement relating to the different clinical and organisational aspects of the service. If the process has been participative and if it has had appropriate leadership, those involved will take ownership of the plan and ensure that it is implemented.

## A pragmatic tool

Palliative care services, whether specialist or conventional, must regularly evaluate and improve their quality. A plan to evaluate and improve quality should be included in every healthcare organisation's strategic plan. It can be redesigned and implemented annually, with the aim of identifying areas of improvement, drawing up objectives, proposing actions and defining the indicators that will allow monitoring of progress.

We have described a pragmatic approach oriented to the needs of patients and their families and based on the EFQM quality model

as well as on the principles of the 'square of care' model. This approach is currently being tested in several services, and we will present the results once these are available. There are several aspects that need to be improved; for example, the involvement of patients and their relatives – and the involvement of other services – in the evaluation and improvement process. However, the ICO/SECPAL model could become a pragmatic tool for the evaluation of healthcare services.

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