

Exploring the Intersection between QI and Evidence

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Introduction

The 2018 National Palliative Care Strategy released by the Australian Government clearly states that ensuring care is high-quality and evidence-based is a guiding principle to ensuring all people experience the palliative care they need.

Evidence matters, it informs decision-making by providing reliable information beyond individual experience on what is the right thing to do for most people. Information that where practical is obtained through research studies designed to eliminate any potential sources of bias so that the relationship between action (intervention) and effect can be established.

This has led to the application of an evidence hierarchy with study designs that minimise bias placed at the top. Doing the right thing when providing care is also important and is the focus of quality improvement (QI), addressing recurrent problems at the systems level of care.

Optimally QI will generate change leading to improved outcomes and high-quality care, although this can be subject to many influences such as individual behaviour that may be difficult to control. QI initiatives are common across the Australian health and care system, including globally recognised examples in palliative care.

As CareSearch announces inclusion of QI reports from PCOC and other Australian initiatives in the Grey Literature database we share our findings of a literature review to better understand the intersect between evidence and QI.

What is evidence?

Evidence is information that comes closest to the facts. It informs our choice of appropriate treatment and services by highlighting potential benefits and harms of what we do. It informs us about the **right thing to do** based on the most likely outcomes.

Research provides evidence on health care interventions by posing questions that can be tested through rigorous study. Pooling results from independent but comparable studies leads us to evidence that can be generalised beyond the local context.

What is quality improvement?

Quality improvement (QI) programs seek to improve local care outcomes in the health system including in palliative care. By focusing on **'doing things right'**, QI uses local data to show where there are gaps between what we do and what we should do. Ongoing collection of data then shows whether any implemented changes lead to improvement and whether this is sustained.

Where do they intersect?

QI is often embedded within a PDSA cycle (Plan, Do, Study, Act). In the original QI cycles that gave rise to the commonly used PDSA model, evidence and QI intersected at the point of determining what changes should be implemented. Only changes likely to improve practice were chosen to be adapted to local contexts. In this way resources are not wasted on changes unlikely to lead to improvement.

Ongoing collection and analysis of data related to the changes and expected outcomes enables assessment of impact and monitoring of sustainability. This might be viewed as 'local evidence' informing us of those changes bringing the greatest benefits in our local context. Variation between and within settings prevents generalisation of this data to other contexts but it is an essential part of all QI.

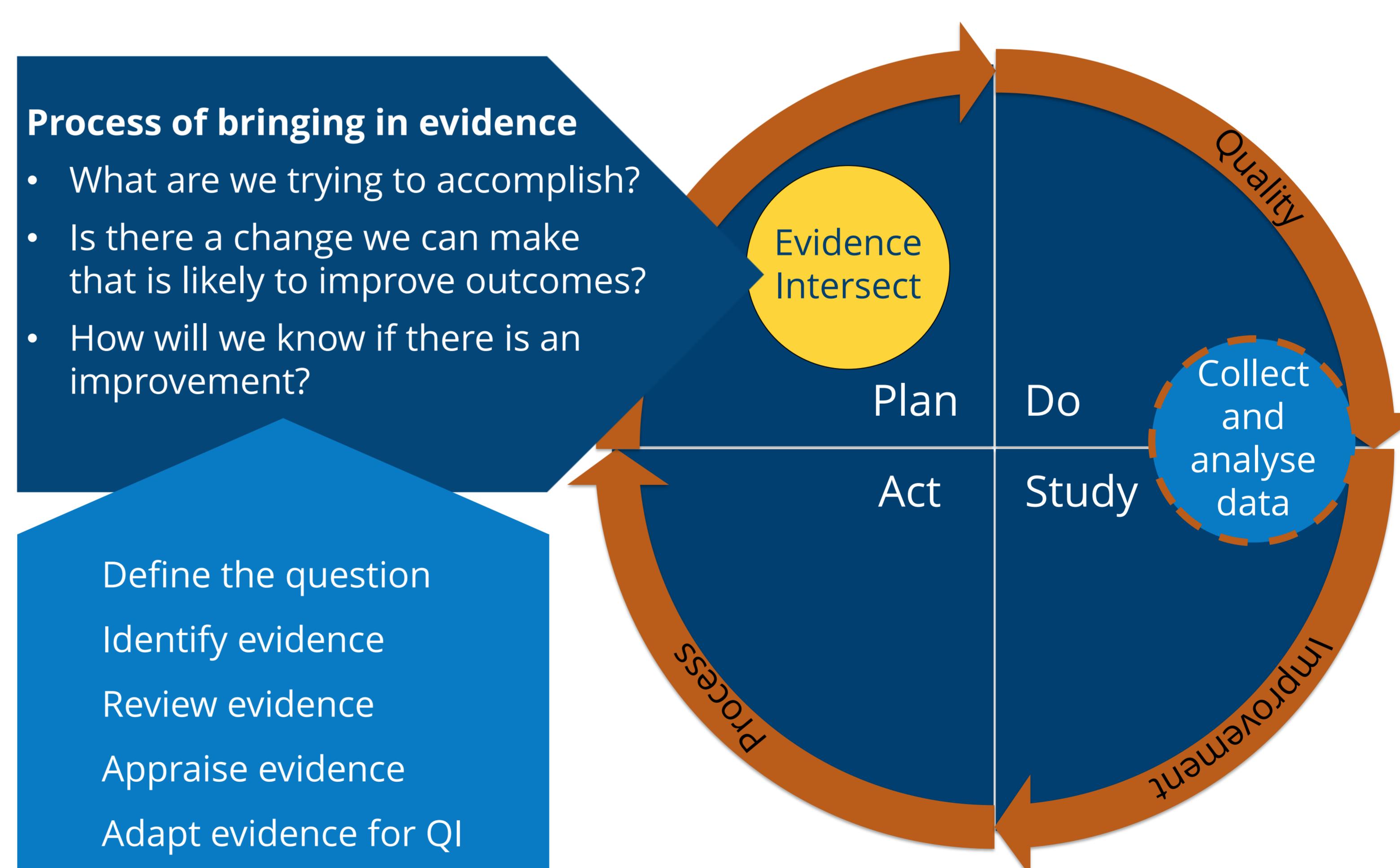


Figure 1. Intersection between evidence and PDSA

Conclusions

Initial consideration of the available evidence, either to identify useful changes or to assess a proposed change, is seen as important for effective QI. With increasing demands being placed on available resources in health care greater use of evidence in QI would seem sensible. Access to QI reports from others may provide a starting point for new projects, and together with a review of best available evidence is likely to assist future improvements in palliative care.

Finding out more

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