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Many Hands Make Light Work:

NSAP Improvement lessons from the frontline

Brisbane – 27th August 2010

This project is funded by the Australian Government Department of Health and Ageing under the National Palliative Care Program

National Standards Assessment Program (NSAP)

- National, standardised program to self-assess against the 13 national palliative care standards
- Continuous Quality Improvement (CQI) program
- **NOT** an accreditation/certification program, - contributes/ provides evidence towards services' accreditation process
- Tool to support palliative care services to move towards best practice (all patients/all the time)

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Project Status

- National roll out commenced July 2009
- 142 services registered nationally
- Various stages of completion
- 69 reports received as at 30/6
- Peer Mentor Program has commenced
- Phase 2 funding from DoHA.

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What have we learnt so far about care and improvement through participation in NSAP?

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What services do really well

9/88

More than 90% services rated QE 'often' or 'always'

QE		%
10.1	**Service supports/promotes continuity of care**	95.4
4.5	**Discharge plans discussed with pt. & family**	93.2
10.10	**Accommodation of language, dietary and ritual practices**	93.2
2.2	**Treatment and care are individualised**	90.9
6.1	**Pt concerns, hopes, fears are addressed openly and appropriately**	90.9
6.2	**Care plan is revised for terminal phase**	90.9

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Where can we improve?

27/88

More than 30% services rated QE less than ‘sometimes’

QE		%
1.5	**Patient determines the involvement of family in decision-making**	34.1
7.5	**National standards included in education**	47.7
8.1	**Policies and procedures to guide bereavement**	38.6
8.3	**Families clinically assessed to determine risk of complicated bereavement**	40.1
8.5	**Families need to support is reassessed on ongoing basis, including after death**	34.1
10.4	**Community profile compared with service profile**	42.8
11.2	**Regular, routine and reported QI activities**	31.2

Where can we improve?

27/88

More than 30% services rated QE ‘sometimes’ or less

QE		%
4.2	**Formal agreement with service providers**	52.3
10.4	**Regular assessment of unmet need**	50.0
11.5	**Clinical audit program**	47.7
1.2	**Patient priorities are discussed and ACP documented**	45.4
2.5	**Validated clinical assessment tools are used**	40.9
5.1	**As assessment of carer needs, desired involvement and ability**	34.1
8.6	**Culturally appropriate resources on loss & grief**	34.1

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Knowing – Doing Gap

Pseudo-action deceptions

- Thinking that knowing is sufficient for success
- Thinking that talking (meetings, committees, reports etc) is action
- Thinking that measuring things is action or contributes to performance
- Thinking that making a decision is the same as taking action
- Thinking that planning is the same as action

(Pfeffer- Sutton (2000))

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Top 10 priority improvement action areas

Ranking	Improvement Area	% services
1	**Implementing Research /Quality Improvement**	71%
2	**Supporting Carers and families**	68%
3	**Care planning**	67%
4	**Patient assessment**	65%
5	**Staff education**	64%
6	**Bereavement**	64%
7	**Patient & family Feedback**	52%
8	**Supporting staff**	51%
9	**Coordinating care**	42%
10	**Referral**	41%

Priority 1: Quality Improvement and Research

Ranking	Specific Improvement Actions	T=89
1	**Clinical Audit**	25%
2	**Building a Quality Culture**	17%
3	**Developing & Collecting clinical indicators**	9%
4	**Improving PCOC data collection**	9%
5	**Death review / M&M**	8%
6	**Benchmarking**	8%
7	**Evidence/Research translation**	6%
8	**Patient/Family reported outcomes**	3%
9	**Participating in research**	3%
10	**Other**	3%

Priority 2: Supporting Carers

Ranking	Specific Improvement Actions	T=89
1	**Information for carers/family**	46%
2	**Assessing the needs of the carer**	20%
3	**Educating carers**	8%
4	**Identifying carer support resources**	4%
5	**Providing after hours support**	4%
6	**Documenting family meetings**	4%
7	**Documenting carer preferences/wishes**	2%
8	**Educate MDT re carer support resources**	2%
9	**Other**	5%

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Many hands make light work – finding opportunities to work together

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Collaboratives

Participants

- learn improvement techniques,
- exchange insights and advice
- generate enthusiasm
- Generate a shared sense of commitment to achieving common improvement goals and outcomes.

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Establishing a collaborative

Steps:

- Choose a problem – common priority areas
- Provide modest funding for 2–3 experts to be present at a meeting
- Publicly involve others, especially services with common improvement motivations
- Exclude no-one
- Develop a tool to address the problem

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A word on tools vs. guidelines

- Guidelines tolerate outdated habits and idiosyncratic practices
- Tools should have a quadruple purpose:
  - Outline what should be done
  - Record that tasks have to be done
  - Facilitate audit
  - Promote dissemination, stickiness and use of these principles

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Benefits of working together

- Change **of** a system rather than **in** a system
- Patients benefit from improved outcomes
- Clinicians benefit from intrinsic rewards from participation
- Clinicians almost universally report enjoying the experience of interacting with colleagues on focused clinical issues

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Early opportunities

- Carer and family information
- Care planning
- Clinical assessment tools
- Clinical audit
- Education
- Bereavement

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A final word of warning!

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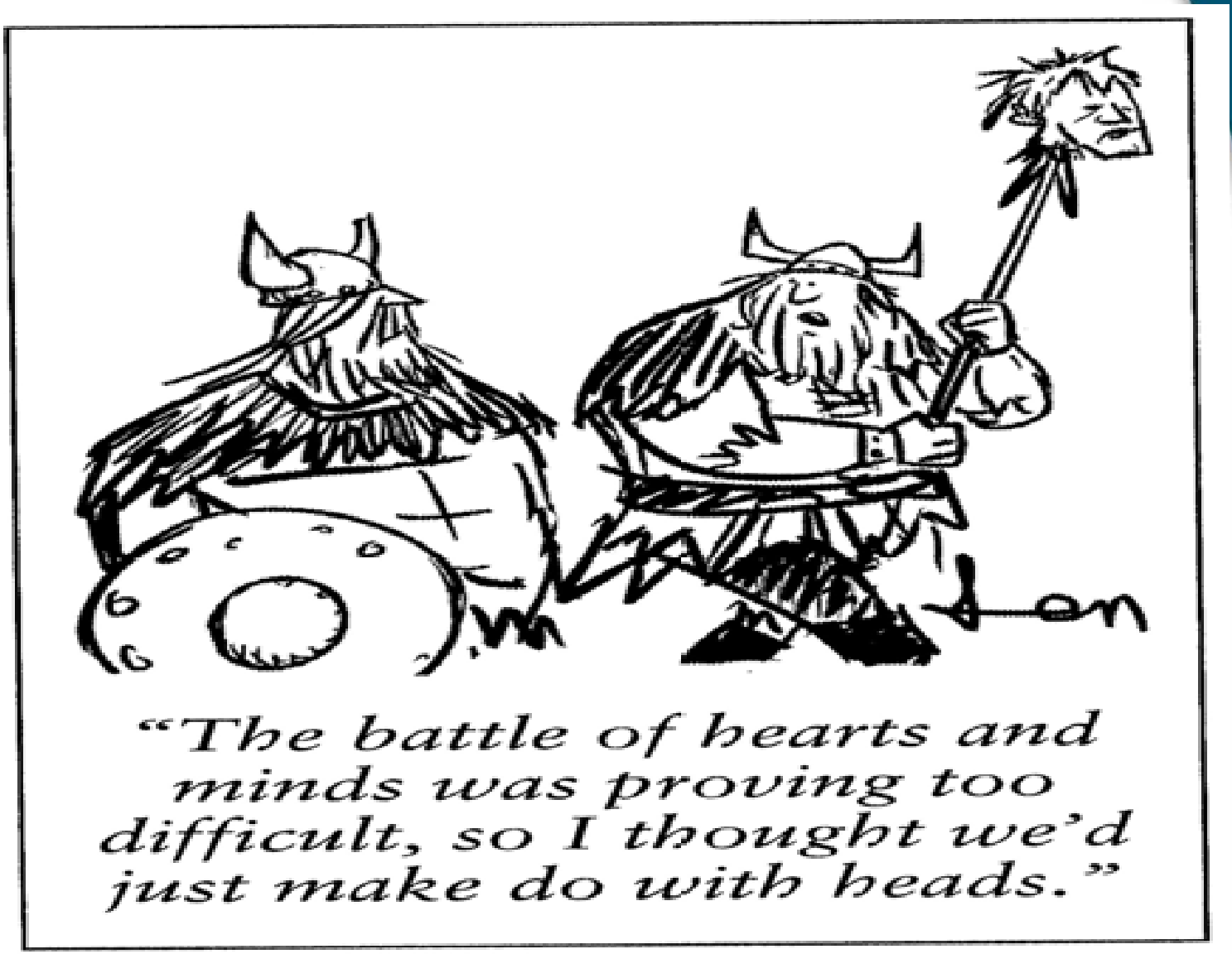

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More information?

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