District nurses need to demonstrate the effectiveness of their care by using quality indicators, but meeting targets should not override clinical discretion.

**Quality indicators to measure end-of-life care**

### In this article...

- Why district nurses need to measure quality
- How to identify quality indicators in end-of-life care

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This article gives examples of how to use quality indicators to demonstrate and improve effectiveness in supporting people with their end-of-life care needs.

District nurses deliver a range of nursing care to adults in their own homes. However, practitioners have not effectively demonstrated the value of this care to primary care commissioners (Queen’s Nursing Institute, 2009). As a result, district nursing numbers continue to decline at a time when there is increasing demand from an ageing population for more care to be provided at home (Royal College of Nursing, 2012). If district nursing services are to receive the resources they need, practitioners must measure and communicate the impact of their care through “quality indicators” agreed with commissioners.

### The drive for change

The drive for transforming community services (DH, 2009a) and local commissioning quality, innovation, productivity and prevention (QIPP) schemes have stressed the need to measure quality of care.

Measuring the impact of district nursing input becomes problematic as patients often do not have a clearly defined care outcome that can be measured through easily agreed indicators (Horrocks et al, 2012). The chronic nature of older people’s needs often means district nurses need to concentrate on supporting their “care” rather than “cure” (Davies et al, 2011). The complexity of community care also often results in several services having input into patients’ care.

This creates a dilemma for district nursing services, as practitioners and their patients may perceive they are providing quality care (QNI, 2009). This is often subjective and does not necessarily demonstrate clinical effectiveness or value for money to commissioners. Indeed, a survey showed many patients felt their district nurses were too rushed, uninterested or lacked skills to meet their needs (QNI, 2011).

### Measuring quality

Community services have started to demonstrate quality to commissioners through agreed patient safety indicators and patient satisfaction questionnaires.

Two examples are reducing the percentage of people who develop a pressure ulcer or a catheter-associated infection. By focusing on these issues, practitioners have become aware of how to apply good practice to prevent adverse incidents. However, reducing the frequency of adverse events does not directly measure whether patients received the right care to achieve optimum outcomes (Jull and Griffiths, 2010).

Patient satisfaction is a vital measure of quality. Current questionnaires tend to ask patients whether they are happy with practitioners’ mannerisms and care. These are important in identifying whether people have been treated with respect, dignity and felt involved in decisions. However, generic questionnaires often do not identify whether nurses have supported what matters most to patients receiving care at home.

There is certainly more work to be done in agreeing quality indicators that have value to commissioners, patients and practitioners. There are common features that help when looking for indicators.

### Identifying quality indicators

Donabedian (1988) said health quality indicators consisted of three interrelated components: structure; process; and outcomes. These types of measurement have different strengths and each has an effect on the next (Raleigh and Foot, 2010).

The QNI (2011) found the public want district nurses to be caring, kind and skilled to coordinate and meet their care needs. Commissioners want care to be clinically effective and measurable, cost-effective and meaningful for patients. While practitioners understand the need for greater efficiency, they want to deliver effective care focused on meeting patients’ holistic needs (Davies et al, 2011). Quality indicators can encompass these shared values when they are jointly devised by clinicians, patient representatives and commissioners (Raleigh and Foot, 2010).

### Key points

1. It is crucial to evidence the quality of nursing care
2. Measuring district nursing input is problematic due to the nature of care provided
3. Selecting quality indicators requires careful thought
4. Health quality indicators consist of three interrelated components: structure, process and outcomes
5. Quality indicators need to relate directly to district nurses’ work

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within their control to influence. To enable this, indicators tend to consist of agreed outcomes to measure the ultimate aim of care, and process indicators to identify appropriate practices to get there (Box 1). Although structure indicators are vital in delivering quality end-of-life care, these are often out of the scope of influence for practitioners working in clinical practice.

Quality outcome indicators

Dying in the preferred place of care is recognised as a defining outcome indicator of meaningful end-of-life care. However, the reasons people do not die in their preferred place include lack of discussions about their wishes, ineffective symptom control, and patients or carers feeling unable to cope at home (O’Brien and Jack, 2010).

Measuring the percentage of people supported to die in their preferred place, be it at home or any other setting, offers insight into the effectiveness of district nurses in identifying and meeting people’s needs. However, measuring this indicator alone is flawed as factors beyond district nurses’ control influence patient outcomes.

Quality process indicators

To meet people’s end-of-life needs, district nurses also require process indicators that they can influence directly to enable more people to die in the place of their choice.

Box 1 gives examples of processes to help identify patients’ and carers’ needs and coordinate services to meet their wishes. Evidence suggests that addressing each of these processes relates to improvements in outcomes (Horrocks et al, 2012).

Just which process indicators are most crucial is subject to debate. Certainly, supporting people and their families to make advance care planning decisions enables them to be realistic about what help they need. This can be seen in the clinical effectiveness of care when GPs, palliative care specialist nurses and district nurses work together with patients in identifying their concerns, and likely symptoms, and ensuring anticipatory drugs are available at home (Bowers et al, 2010).

Some patients and families do not want professional input until the terminal stages. In these situations, completing some process indicators can be counterproductive to building therapeutic relationships and results in “tick box” exercises. Clinical discretion and a realistic multidisciplinary team approach are needed.

Measuring quality in practice

If district nurses already use established end-of-life pathways, such as the Gold Standards Framework, measuring the percentage of patients who die in their preferred place of care is a relatively quick exercise. Keeping an up-to-date register of patients and what support structures have been put in place is already considered good practice in multidisciplinary GSF meetings.

However, transparently providing evidence on other process indicators, such as demonstrating good symptom control, is more challenging. Such indicators are subjective measurements and family members may have different views from health professionals. While carer questionnaires can be used after patients have died, research shows that feedback can be influenced by feelings of grief, regrets and past experiences unrelated to end-of-life care support (Moss et al, 2008). When identifying process indicators, serious thought has to be given to how they can be measured.

In practice, patient records may not state whether process indicators have been achieved. Information can be spread over several sets of records and reading through these to check that process indicators have been achieved is time consuming. Horrocks et al (2012) found this requires extensive time and can be inconclusive.

Organisations need to allocate resources to quality indicator data collection, which will become easier with mobile electronic notes. With foresight, systems can be put in place to capture data automatically that shows quality indicators have been achieved.

Limitations of quality indicators

Consensus on what constitutes evidence-based best clinical practice for many conditions supported by district nurses remains vague (Horrocks et al, 2012).

“Gaming” can be a risk when selecting quality indicators (Raleigh and Foot, 2010). If the quality of a district nursing service is measured by the percentage of pressure ulcers developed while receiving care and the percentage of people on end-of-life care pathways who die in their preferred place, then it becomes tempting to focus resources on these issues. People with other health problems may be inadvertently neglected if their needs are not considered an equal priority.

Selecting quality indicators requires careful thought to ensure they represent the needs of the local population.

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