Measuring standards in end-of-life care to raise awareness of best practice across a trust

Developing an end-of-life benchmark in acute care

In this article...

- Essence of Care Benchmarking is a national tool designed to improve quality of care
- Nottingham University Hospitals developed its own end-of-life benchmark
- This provided a baseline of current practice and increased awareness of standards

Implementation

During the spring of 2008, Nottingham University Hospital relaunched Essence of Care to encourage staff ownership and involvement in quality improvement processes and raise standards in fundamental aspects of care.

The benchmarking process was reviewed and developed, based on feedback from staff and consultation with patients. The result is a robust and consistent approach with all clinical areas benchmarking at the same time in the same way (Haines and Warren, 2011).

A set of indicators of best practice was developed for each of 12 benchmarks. These indicators reflect the Essence of Care tools (Department of Health, 2010) but have been adapted to suit the needs of an acute trust. The indicators were developed through a systematic process of ongoing consultation with staff, patients, and other key stakeholders. The resulting tool is streamlined, easy to use, and relevant and meaningful to all clinical areas.

The trust has a mandatory rolling programme for scoring in all clinical areas. Clinical teams score each benchmark within a two-month period and achieve an overall score of gold, green, amber or red, depending on how many indicators of best practice are achieved.

Wherever possible, the benchmarks are aligned to other quality initiatives, for example the Eight High Impact Actions for Nursing and Midwifery (NHS Institute, 2009) and the Productive Ward initiative (NHS Institute, 2007). All indicators have been linked directly to the Care Quality Commission's regulatory standards. An Essence of Care steering group oversees the whole process.

Developing an end-of-life care benchmark

The End of Life Strategy (DH, 2008a) and the Quality Markers and Measures for End of Life Care (DH, 2009) emphasise that improving end-of-life care in the acute setting is paramount, given that half of all
The palliative care and nursing development team at the hospital put together the benchmark indicators working with stakeholders, including the bereavement team and patient partnership group. The indicators were then reviewed by representatives from all directorates. The resulting benchmark contains 15 indicators of best practice, encompassing issues important to staff and patients (Table 1).

### Challenges
One particular challenge was to develop a benchmark of best practice relevant to all clinical areas. In the initial stages, it became clear that a separate benchmark was needed for children’s areas, which was developed with specialist input from the paediatric practice development nurse and the specialist children’s palliative care nurse.

Also, scoring the end-of-life benchmark in critical care areas showed it did not meet the specialist needs of these areas and a separate benchmark is under development.

### Scoring
The end-of-life benchmark was scored in all adult inpatient areas, except for maternity; theatres, radiology, and short stay and critical care areas; day case areas were also excluded. All 60 eligible wards submitted scores. Areas were scored by at least two staff members and an independent scorer.

### Good practice
Nine wards achieved all 15 indicators with an overall gold score; 12 of the 15 indicators of best practice were achieved by at least 80% of the wards. In total, 98% of areas reported that nurses referred to the clinical guidelines found in the “last days of life pathway” and knew how to manage common symptoms in dying patients. Staff in 98% of areas could explain how they helped relatives and carers to remain with the dying patient.

#### End-of-life care in theatres
Although theatre areas were not formally required to score the benchmark, they did use the tool to review practice and ensure they were following guidelines and policy. The work was led by the dignity champions who had identified the need to raise awareness of care of the dying patient.

To support staff, a teaching package was put together and a practical session was given during a specialty development day. These updated theatre practitioners’ knowledge and practical skills. It also gave them opportunities to ask questions and dispel ritualistic practice and behaviour, as well as to discuss their fears and lack of experience.

It was also discovered that trainee operating department practitioners were not taught this aspect of care and these skills are learnt in practice as and when the opportunity arises.

The processes of delivering end-of-life care and continuing care of the patient after death has now improved with:

- Only staff who are actually needed are present in the area when providing end-of-life care;
- Equipment needed for last offices is kept together in an end-of-life box, preventing practitioners having to leave theatre or patients;
- When providing end-of-life care, staff work in teams of three. Two care for the patient and one liaises with relatives, ward staff and people in other significant departments;
- Theatre practitioners now have a greater understanding of the whole process and sources of support. For example, they know where to obtain information on the cultural and spiritual needs of patients and relatives;
- Good working relationships have developed with the bereavement centre;
- Charity funding and support has been secured to provide facilities for bereaved relatives;
- A room for relatives has been identified, where they can speak to the doctor and use a telephone in private;
- Patients who have received palliative surgery and are at the end of their life are “fast tracked” through recovery or relatives are included in their care in the department. Relatives have expressed their gratitude for the respect shown to them and patients;
- Staff are routinely supported after a death in a debriefing session;
- Theatre practitioners have been supported to perform the final act of care for their patients with dignity, respect and support. Relatives are provided with correct information and psychological support.

### Areas for improvement
As part of the benchmarking process, all areas develop local action plans to address points of concern. Where trust-wide issues are identified, actions are implemented on a trust-wide basis. Three such areas for development were identified.

First, not all areas had access to Liverpool care pathway leaflets to support relatives and carers.

The process has made staff more aware of these leaflets. All wards are required to have a supply and ensure that all staff are familiar with the content, and offer them to relatives and carers as appropriate. The hospital palliative care team continue to promote their use through a rolling programme of educational conferences and the launch of the new version of the Liverpool care pathway during 2011.

Not all staff were aware that, when discharging a patient at the end of life, they should use a specific discharge planner – a relatively new initiative that had been developed with health professionals from primary and acute care. The final version was only finalised in early November 2010 and some wards did not have access to it before scoring took place during that year. Scoring the benchmark helped raise awareness and the palliative care team have continued to roll it out across the trust.

Not all areas had a robust system of recording the number of patients who have died on the last days of life pathway every month. There is a need to document
the use of the pathway to meet CQUIN expectations (DH, 2008b) and this data will need to be recorded as part of the next National Care of the Dying Audit starting in April 2012. Before benchmarking, ward areas were prompted to phone the palliative care team when a patient was placed on the pathway but this practice has been inconsistent. To improve record keeping, an electronic form has been created.

**Conclusion**

The development and scoring of this benchmark has provided a baseline of existing practice. The scoring process raised awareness of standards of best practice for end-of-life care across the trust.

The palliative care team continues to provide specialist advice and a programme of educational conferences for the multi-professional team.

Continuing development of the benchmark tool will be necessary to raise the number of gold scores in all areas and will need to reflect the expected publication of the NICE end-of-life guidance this year. **NT**

**References**

- Department of Health (2006a) End of Life Care Strategy – Promoting High Quality Care for all Adults at the End of Life. tinyurl.com/endoflife-strategy
- Department of Health (2006b) Using the Commissioning for Quality and Innovation (CQUIN) Payment Framework tinyurl.com/cquin-paymentframework

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**TABLE 1: INDICATORS OF BEST PRACTICE FROM THE NUH END OF LIFE BENCHMARK**

<table>
<thead>
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<th>INDICATORS</th>
<th>YES</th>
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| Identify with shift coordinator if any patients in area are expected to die in the next 2-3 days. Then answer EITHER 1a or 1b:  
1a If there are identified patients dying, these patients are cared for on the trust’s last days of life (LDOL) pathway. |     |    |        |
| OR                                                                         |     |    |        |
| 1b If no patients are dying, staff are aware of the LDOL pathway and can locate document |     |    |        |
| Nurses know how to manage common symptoms (for example, pain, chest secretions) in dying patients and refer to guidelines in the LDOL pathway |     |    |        |
| Staff know how to access specialist palliative care advice (in and out of hours) |     |    |        |
| All areas have access to the Liverpool care pathway leaflets:  
Coping with dying  
Relative/carer information (information leaflet on the Liverpool care pathway) |     |    |        |
| Staff can explain how they can facilitate relatives/carers to remain with the dying patient, ie:  
• provision of food/drinks  
• access to hygiene facilities  
• place to sleep |     |    |        |
| Staff know how to access free car parking for relatives/carers of the dying patient |     |    |        |
| Staff are aware that when discharging an end-of-life-care patient who is in the last few weeks of life, they should use the trust approved Discharge Planner for End of Life Care Patients |     |    |        |
| Staff are aware of and can locate the Last Offices Guidance |     |    |        |
| Staff are aware of the correct labelling procedure required to identify the deceased patient |     |    |        |
| The Information for Those Who are Bereaved booklet is provided for relatives/carers |     |    |        |
| Staff are aware of the correct procedure for dealing with the deceased patient’s property |     |    |        |
| Staff are aware of the correct procedure to be taken for relatives/carers who wish to see the deceased patient after they have left the ward |     |    |        |
| Staff feel they have the appropriate skills to communicate with dying patients and their relative/carers |     |    |        |
| Medical staff are aware of the requirement to either issue a certificate or refer to the coroner within 24 hours of the death or on the next working day if death occurs at a weekend |     |    |        |

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<tr>
<th>INDICATOR</th>
<th>YES</th>
<th>NO</th>
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- **Commissioning for Quality and Innovation (CQUIN)**
- **Payment Framework** tinyurl.com/cquin-paymentframework
- **Department of Health (2009)** Quality Markers and Measures for End of Life Care. tinyurl.com/endoflife-qualitymarkers
- **Department of Health (2010)** Essence of Care. tinyurl.com/essenceofcare-guidance
- **NHS Institute for Innovation and Improvement (2007)** The Productive Ward: Releasing Time to Care: www.institute.nhs.uk/quality_end_value/productivity_series/productive_ward.html