Supporting service change in palliative care: A framework approach

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Abstract

Background

Palliative care services are increasingly identifying areas for improvement, then trying to create appropriate changes in response. Nurses in particular are often expected to take leading roles in Quality Improvement (QI) but are not necessarily trained or supported in these processes.

Methods

A framework approach to change was developed to guide services through a change cycle, and delivered via workshops by representatives of three national projects in Australia. Participants were predominantly nurses (80%) with the majority over the age of 50 (62.4%). The workshops and the framework were positively evaluated with participants feeling confident in a number of QI related activities following workshop training.

Discussion

Recognising and addressing problems in clinical practice and service delivery is an important way for nurses to ensure quality care for patients, however, they need support in developing the skills and knowledge that are essential to successful QI activities.

Keywords

Palliative care, quality improvement, change implementation, change framework

Introduction

As demands upon health services and systems grow, more focus is being directed to how services can improve their care practices and outcomes and utilise their resources most effectively (Wong et al 2012, Gordon et al 2014, Macdonald et al 2013). Health care services are increasingly being provided with, or are initiating activities which will result in, data and findings that highlight areas of need or areas for improvement within their organisation. Feedback from audits, complaints, self-reflection and annual reviews, or participation in more formal processes such as standards review and assessment, benchmarking or quality improvement (QI) cycles, can all highlight issues and areas for attention. In this way, it can become evident that changes are needed within a health service. However, difficulties can arise as the service considers how to move forward the need for change, with competing work priorities and issues such as time, staffing and lack of knowledge or confidence in change management processes all potentially impacting on their ability to proceed (Kerridge, 2012). Furthermore, services often function in isolation, working independently in trying to effect changes at the local level.

Despite these barriers, services are frequently expected to be involved in continuous quality improvement with nurses often expected to take leading roles in QI, or to be involved in change management processes. However, it is only fairly recently that quality improvement science has been introduced into undergraduate and postgraduate nursing curricula (Jones et al 2013, Smith et al 2013) and into continuing education (van Hoof and Meehan, 2013), so many nurses may have only a limited knowledge of QI or change management theory and methods.

These issues also affect palliative care service provision and care delivery with increasing interest in enhancing patient outcomes, supporting equity and access to palliative care and maximising the contribution of palliative care services to the health care sector (Lau et al 2013, Kamal et al 2011, Woo et al 2011, McMillan et al 2011, Dale et al 2009). The Agency

for Healthcare Research and Quality's review report, "Closing the Quality Gap: Revisiting the State of the Science", notes that despite high quality evidence in a number of areas, substantial gaps in care delivery remain. This review indicates that pain remains undertreated despite effective therapies, and highlights that many patients remain unaware of their prognosis, are uncertain of the risk and harms associated with treatment options, and along with their carers continue to experience unmet needs (Dy et al, 2012).

In Australia, Commonwealth government funding has supported a number of national palliative care projects designed to improve the quality of care being provided. Three of these national projects formalised a relationship through a memorandum of understanding which recognised their shared interest in improving palliative care by up-skilling palliative care services, facilitating quality improvement, and encouraging the use of evidence in practice. The three participating projects were:

- CareSearch (Flinders University): An online resource providing health professionals and patients, their carers and families with access to palliative care information, resources and evidence. It provides access to evidence about clinical and service issues as well as access to QI and change management evidence.

- National Standards Assessment Program (NSAP) (Palliative Care Australia): A national quality improvement approach that enables services to engage in a structured process of self-assessment against Palliative Care Australia's Standards for Providing Quality Palliative Care for All Australians (Palliative Care Australia, 2005). Services complete a self-assessment snapshot every 2 years against the standards and create and implement a quality improvement action plan, based on these results.

- Palliative Care Outcomes Collaboration (PCOC) (University of Wollongong): A voluntary quality program utilising standardised validated clinical assessment tools to measure patient outcomes and then benchmark these outcomes with similar

services' outcomes in palliative care. Participation in PCOC assists services to identify outcomes for improvement via a benchmarking report every 6 months and an annual benchmarking workshop.

However, even given the support offered by the three projects, services reported that they faced problems in trying to determine which needs to address, what to change to, and how to make changes that maximised the return for their efforts and which led to positive outcomes for staff, the health service and for patients and their families.

The aim of this study was to develop an aligned framework approach to change and to evaluate through a research study whether it would provide practical support to those involved in quality improvement activities in palliative care.

Methods

A working group with representatives from the three projects was established in March 2011 to identify common issues around change implementation being experienced by services and clinicians involved with the individual projects. A rapid literature review on QI, implementation processes and evidence based change was undertaken August 2011. From the literature, an increasing interest in the relationship between evidence based practice and QI and in how evidence can inform choices made and processes used in QI activities was evident (Bosch et al 2012, Glasziou et al 2011, Haley et al 2012). Research evidence can inform what knowledge can be included in the proposed quality improvement activities as well as the best methods and strategies to direct change and outcomes. Glasziou and colleagues (2011) have also highlighted the possibilities afforded by QI in enabling a mechanism for translating evidence for use in local contexts. Collaborations and data collection systems also provide an opportunity to support improvement and research (Clancy et al, 2013). Researchers and trainers have highlighted the importance of those involved in QI processes establishing functional goals, developing action plans, implementing specific

and measurable actions and monitoring progress when undertaking change activities (Cole 2009, Hughes 2008, Ovretveit and Klazinga 2012). The importance of education and training has also been recognised (Daugherty et al, 2013). There is an understanding that the evidence base for quality improvement science is still evolving and that there are still large gaps in a knowledge base to guide individual and system quality initiatives (McDonald et al, 2013).

The working group reviewed the findings from the literature overview in September 2011 and the group discussions were informed by issues documented in the individual project reports and studies (NSAP National Quality reports, PCOC reports, Tieman and Rawlings 2008). At this meeting, the planning group agreed to develop an aligned approach to facilitate change management, and the 'Working Together Change Framework' (WTCF) was developed, comprising six questions to guide planning and conduct of QI activities. The WTCF is described in Figure 1.

This procedure for quality improvement/change activity owed much to the approach suggested by van Bokenhoven and colleagues (2003) but was contextualised to the specific needs of the palliative care sector as experienced through the three projects. To introduce this framework to palliative care services, and evaluate its impact, a series of workshops were planned for delivery in 2012. The workshops were designed to support attendees to identify a problem, analyse the cause, source evidence and measures, create an implementation plan and review what happens. Ethics approval for the study was received through Flinders University (No. 5707).

Workshop recruitment
Attendance at workshops was voluntary and self-selected. As there was no direct funding for this project, to encourage attendance the WTCF workshops were scheduled to be held immediately prior to a ½ day NSAP update meeting which did fund travel and

accommodation costs for meeting attendance. Both the WTCF workshops and the NSAP update meeting were held adjacent to conferences relevant to palliative care, again to encourage attendance. Participation in the workshop was not dependent on the individual's willing to participate in the research. Hence, completion of the workshop evaluation form as indicated in the ethics approval was seen to provide implied consent to participate in the research study.

Invitations were sent to all specialist palliative care services in each State and Territory by NSAP for the WTCF workshops and the NSAP update meetings. The WTCF workshops were also advertised on the CareSearch, PCOC and NSAP websites, and via stakeholders

Workshop format

The workshops were facilitated by staff from each of the three projects, modelling collaborative working relationships and the connection between evidence, standards and outcomes. Each workshop started with an introduction to the research study, clarifying what was involved in participation. A presentation on the WTCF followed. Services were provided with information on the mock palliative care service, 'Butterfly Palliative Care Service', which drew upon hypothetical PCOC and NSAP reports. CareSearch staff provided an overview of the importance of evidence in the change process and specific evidence sources relevant to the identified change issues. The workshops focused on one of two topics – pain or carer support. These had been identified as high priority issues by both the NSAP and PCOC projects and were also reported in the literature of issues of importance in palliative care. Following the didactic presentations, each table was also provided with templates for problem analysis, details on the six questions sequence and sources of evidence, relevant to the topic. Participants then planned a QI approach with measures of change for the "Butterfly Palliative Care Service" before reviewing the proposed approaches as a group.

To prompt interest and to encourage QI action, all workshop participants who provided an email address were sent email updates with further information relevant to the carer or pain themes at 3 weeks and 6 weeks post workshop. It was a concern that once back in practice, with work pressures, the knowledge from the workshop could potentially be lost. If further information was supplied, then attendees may be encouraged to talk to colleagues about the WTCF and possibly look at areas to focus on. The workshop format and materials can be found on the CareSearch website:

(www.caresearch.com.au/caresearch/tabid/3003/Default.aspx)

Workshop Evaluation and Follow up Study

Workshop participants were invited to complete a workshop evaluation on the day, immediately after the workshop. Those who attended a workshop and who completed the post workshop evaluation were eligible to participate in a follow-up study. These participants were sent a further survey at eight weeks to ask if they had commenced any QI activity and to see if the workshop information had been used in practice.

Data Analysis

Reponses to the survey were received and managed by a research assistant, and were entered and analysed using SPSS, with none of the researchers aware of who had participated in the study. Content analysis of responses to the open questions in the surveys involved the extraction of the comments by question field to create a Comments Dataset. Emergent coding of the comments by one of the investigators [JT] resulted in the development of categories applied to all comments. The question field was treated as the unit of analysis. Therefore, each question field could have several codes applied (Graneheim and Lundman, 2004).

Results

Participation

Eighty one people attended and participated in one of five workshops conducted in Adelaide (South Australia), Melbourne (Victoria), Launceston (Tasmania), Perth (West Australia) and Dubbo (New South Wales). Fifty six participants completed a workshop evaluation. The Ethics Committee advised that those who had completed the workshop evaluation would be seen as having provided consent to participate in the research project. Of the fifty six who were therefore eligible to participate in the follow up survey at eight weeks, thirteen (23%) completed a survey for analysis. Twenty five workshop participants did not complete a workshop evaluation and hence received only the emails to prompt for future action and to provide further QI and content information. The number of participants involved at each stage of the study is outlined in Figure 2.

The demographics of the participants were collected, with the majority holding nursing roles within their organisation, with 45 (80%) identifying as nurses (three participants did not provide their role). The participant's roles are detailed in Table 1. The age of participants was also collected, and was provided by 55 participants, with 28.6% between the ages of 40 and 49, and 55.4% between the ages of 50 and 60. Seven percent (n=4) were over the age of 60 years as detailed in Table 2.

Workshop Evaluation

The responses from the workshop evaluation forms are summarised in Table 3. The data shows that overall 23.2% (13/56) were extremely satisfied and a further 53.6% (30/56) were satisfied with the workshop. Eighty nine percent agreed or strongly agreed that the content was relevant to their needs. Workshop survey responses showed that participants felt confident in a number of QI related activities following participation in the workshop (Table 3).

Many comments made by participants in a comment box associated with the Likert scale demonstrated positive sentiments.

I love the key message of "shrinking the thinking" in relation to thinking about breaking down the problem conceptually to smaller units/specifics. PW4013

Change management is difficult however this workshop provided basic tools to assist me PW4006

Thirty nine responses were provided to a free text question "What was the most useful thing you learnt today?" Several themes emerged. The first related to the value of a structured approach to support quality improvement activities.

Having the framework circle* to work through to formalise the process AW 1006

The 6 questions* and how to apply them in practice LW3016

Systematic approaches reinforced and write down each step down/document your planning. PW4007

*NB: respondents have used various terminologies to describe the WTCF

The second theme was around three services/projects working together.

Using NSAP, PCOC and CareSearch data to build a plan AW1013

Seeing the representatives of the three organisations together on the same podium DW5005

The third theme related to the value of the data already being captured and the evidence resources available.

> *Variabilities and aspects of service outcomes which can be extracted from PCOC and NSAP data DW 5010*

> *How national and state data can be used on the ground MW2013*

Twenty seven comments were received in relation to improving the content and format, and included: advertising (2), requests for rural specific content (7), requests for project specific information (4) and logistical or organisational suggestions (10). Twenty three comments were received in response to the question on 'how to encourage applying evidence to quality improvement activities among palliative care professionals?' This included comments relating directly to evidence (8), practical suggestions (9) and general feedback (6).

> *Support researchers, interest groups, educate people to understand why research/evidence can make a difference, online workshops, workshops at multi-sites PW4014*

> *Teach the basics – it is not something as practitioners we are necessarily have experience with MW2032*

> [Name removed]*'s comment about "If this was a group of emergency medicine clinicians…" Palliative care needs to move away from the "but we've always done it like this" and embrace outcome measures. DW5021*

Follow-Up Study

Thirteen follow up survey responses were received (table 4). It was hoped, but not assumed that respondents were going to follow up from the workshop and plan changes in the workplace. Some were not in a position to do so and so it was not applicable.

Respondents were also asked about barriers and facilitators to change in their workplace. Twelve respondents identified barriers. Time was highlighted as a key barrier but staff attitudes and lack of knowledge were also seen as issues.

Time, Lack of knowledge on how to change PW4013

Six responses proposed facilitators which included staff engagement and patient care.

Promote staff interest and enthusiasm. Clearly defined activities with outlined goals. Targeted data collection MW2002

Identification of issues that impact on patient care or staff workload. Fostering a team culture of continuing improvement. PW4013

Discussion

There is increasing interest in driving improvements to patient care and to organisational efficiency with many services needing to report on QI actions and initiatives. Many health professionals and palliative care services are taking on QI activities at the local level in response to needs that are being identified within the service or through data collection and self-assessment projects. However, those who are taking on these tasks within services are not necessarily being trained or supported in this work (Wilkinson et al 2011). Much of the research literature has focused on large scale interventions using particular methodologies which may have a limited applicability to local QI projects at the service level (Dilley, 2012).

Participation in, and evaluation of, the workshops suggests that the WTCF (and workshop methodology) were useful to assist individuals and services involved in QI activities. Participants appeared to recognise that successful QI interventions require skills and knowledge, and that they did not necessarily have the required competencies. The majority

of participants in the workshops were nurses, with many in more senior or advance practice roles, potentially with the expectation of initiating or leading QI activities within their organisation. The ages of the nurses in this research study correlate with current nursing workforce statistics (AIHW, 2013). As an older cohort (62.4% were over the age of 50), many may not have been exposed to theories and methods in formal education and training instead relying on experience and skills acquired in the workplace. It is only in more recent years that there has been an increasing focus on the importance of teaching EBP to nurses, the inclusion of QI theories and models in the curriculum and the development of EBP nursing competencies (Melnyk et al, 2014). It is worth noting that formal education, however, does not necessarily ensure preparedness and capacity to undertake QI work (Kovner et al, 2010).

Nearly ninety percent of participants saw that the content of the workshop was relevant to their needs. A number highlighted the benefit of having a framework that organised the work in discrete and manageable elements. For the majority of participants, and especially those with no formal training or little experience in QI, a framework consisting of a series of questions provides a roadmap to an end point as well as specific directions to particular points along the way. The explicit relationship to evidence within the WTCF reminds users to consider what research already exists relevant to their improvement areas as well as evidence about effective strategies and approaches that can be used in planning, implementing and measuring their QI activity. Indeed it is worth noting that 81.8% of those who completed workshop evaluations felt more confident in applying evidence-based solutions and of those who completed the follow up survey, 76.9% had discussed the role of evidence in change activities with service colleagues. Other emerging research is also highlighting the value of evidence reviews to support local QI initiatives (Danz et al, 2013).

Feedback about the value of the three projects working together highlights the benefit of cohesive and integrated networks and systems. Health professionals and services are time

poor with competing demands and multiple areas of responsibility. By aligning the approach, services have the opportunity to draw upon resources and information from the three projects to guide their QI planning, decision making, implementation and monitoring activities. There is also the opportunity to extend QI activities to be responsive to the issues raised through self-assessment in NSAP, such as collaborative workshops, and through clinical outcomes measurement. This area remains a significant direction for future work.

At the time of the follow up study, after eight weeks, 12.5% (7/56) of workshop participants had actually identified a problem that they wanted to change. Several of these participants had already commenced the process of identifying evidence to guide the QI activity and to assess whether it was effective. However, it is beyond the scope of this study to follow these participants to determine if the framework was successfully applied and supported QI activities.

It is worth noting that despite positive feedback on the WTCF and the workshops, it is unlikely that a single workshop, even with follow up emails, will provide the support needed by individual health professionals and health services to solve the issues associated with implementing change. This project represents a single step in building awareness about the need for a structured and planned approach to QI and the role and contribution of evidence in QI processes. Responses from the participants highlighted the need for training and support in QI activities and this remains a focus for the three projects. Around three quarters of workshop participants 43/56 would recommend the workshop or an online equivalent to colleagues. However, the ability to implement ongoing or future workshops is also limited by cost and staff availability. The framework and associated resources could potentially be delivered online, formatted for specific groups, allowing participants to complete it in their own time. Workshops via webinar are also an approach that could be considered.

Strengths and Limitations of Study Approach

This study benefited from workshop participation of those involved in QI activities in services across Australia. Co-location of the WTCF workshop with a funded NSAP update meeting would have facilitated participation by some attendees, particularly those from rural and remote areas. This study also sought to promote the use of evidence within QI and to concentrate on QI processes rather focusing on than a specific QI content activity such as introducing bereavement practices in palliative cares services.

Although a follow up survey was undertaken, it did not directly address whether the service or individual had commenced a QI project. The response rate for the follow up study was relatively low at 23.2% suggesting that many workshop participants may not have undertaken any further work. The workshop format did not directly introduce the issue of management buy-in although this is already negotiated in both the NSAP and PCOC projects.

Conclusion

Recognising and addressing problems in clinical practice and service delivery is an important part of ensuring quality care for patients. Staff and services need support in developing the skills and knowledge that are essential to successful quality improvement activities. The WTCF was developed to guide specialist palliative care services through a change cycle, and when delivered via workshops services were able to see how it could work in practice.

The results of this evaluation will add to a growing body of knowledge on the difficulties encountered by health professionals in using evidence to support their clinical practice and the difficulties faced in evidence based quality improvement in the workplace. It also adds to considerations around the amount of support required for services to understand QI, its implementation and evaluation. The information gained by study participants will in turn help to improve the direct care that is delivered within services and in the palliative care sector.

Conflict of Interest

The authors declare that there is no conflict of interest.

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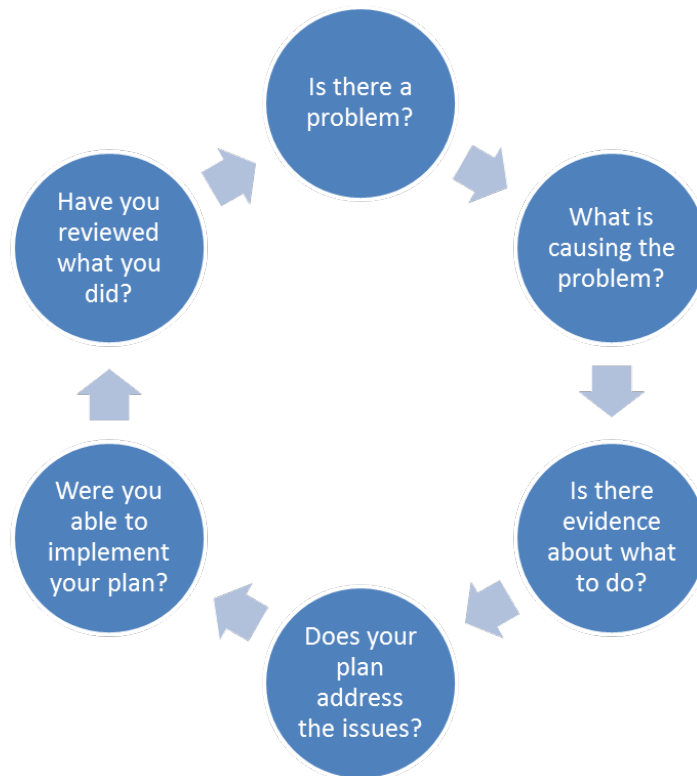Figure 1: The Working Together Change Framework model as developed by the project team

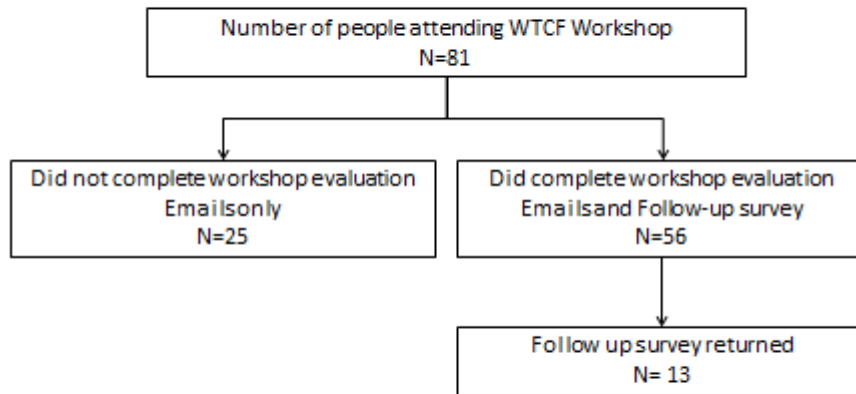Figure 2: Overview of participation numbers

Table 1: Overview of workshop participant's role within the organisation	
Allied Health	2
CEO	1
Clinical Nurse Consultant	3
Clinical Nurse specialist	16
Consortia Manager	1
Enrolled nurse	1
Nurse educator	0
Nurse Practitioner	1
Nurse Unit Manager/ Associate	7
Palliative Care Physician	2
Palliative Care Registrar	1
Project Nurse	0
Quality Manager	0
Regional Palliative Care Co-ordinator	2
Registered nurse	9
Researcher	1
Research nurse	0
Social Worker	2
Volunteer Carer	1
Other	3
TOTAL	**53**

Table 2: Age of workshop participants	
30 – 39 yrs	7.1%
40 – 49 yrs	28.6%
50 – 60 yrs	55.4%
60+ yrs	7.1%

Table 3: Responses to workshop evaluation questions	Strongly agree	Agree	Not sure	Disagree	Strongly Disagree
The content of the workshop was relevant to my needs	17 (30.4%)	33 (58.9%)	6 (10.7%)	0 (0%)	0 (0%)
After this workshop, I feel more confident in analysing the cause of problems that have been identified in my service	6 (10.9%)	38 (69.1%)	9 (16.4%)	2 (3.6%)	0 (0%)
After this workshop, I feel more confident in applying an evidence based approach to addressing these problems	7 (12.7%)	38 (69.1%)	8 (14.5%)	2 (3.6%)	0 (0%)
After this workshop I feel more confident in looking at processes involved in quality improvement	7 (12.5%)	36 (64.3%)	9 (16.1%)	4 (7.1%)	0 (0%)
After this workshop, I feel more confident in implementing change in my organisation	4 (7.3%)	35 (63.6%)	12 (21.8%)	4 (7.3%)	0 (0%)
After this workshop I feel more confident in reassessing and reviewing changes that have been implemented	2 (3.6%)	42 (76.4%)	8 (14.5%)	3 (5.5%)	0 (0%)
After this workshop I feel more confident in completing a PDSA cycle as part of quality improvement	7 (13.2%)	30 (56.6%)	13 (24.5%)	3 (5.7%)	0(0%)

	Extremely satisfied	Satisfied	Not sure	Dissatisfied	Extremely dissatisfied
The use of NSAP and PCOC scenarios and data made the workshop more relevant	13 (23.6%)	38 (69.1%)	3 (5.5%)	1 (1.8%)	0 (0%)
I would recommend this workshop (or its online equivalent) to my colleagues	9 (16.4%)	34 (61.8%)	7 (12.7%)	4 (7.3%)	1 (1.8%)
	Extremely satisfied	Satisfied	Not sure	Dissatisfied	Extremely dissatisfied
Overall satisfaction	13 (23.2%)	30 (53.6%)	6 (10.7%)	7 (12.5%)	0 (0%)

NB: PDSA cycle: Plan Do Study Act

Table 4: Responses to the follow up survey	Yes	No	Not applicable
Since attending the workshop, have you discussed the Working Together Change framework with any of your colleagues?	11 (84.6%)	2 (15.4%)	
Since attending the workshop, have you discussed the role of evidence in change activities with your colleagues?	10 (76.9%)	3 (23.1%)	
Following the workshop, do you feel more confident about undertaking QI and/or change activities in your service?	9 (69.2%)	4 (30.8%)	
Since attending the workshops, have you identified or thought of a problem that you want to change?	7 (53.9%)	6 (46.1%)	
Since attending the workshop have you identified any sources of evidence to support the need for a change activity?	6 (46.1%)	7 (53.9%)	
Since the workshop have you thought of, or developed, any appropriate strategies for implementation of the changes you have identified?	6 (46.1%)	4(30.8%)	3 (23.1%)
Since the workshop, have you identified any measures you could use to assess the success of your change activity?	4 (40%)	6 (60%)	
Have you seen any problems in implementing change within your workplace or organisation?	9 (69.2%)	4 (30.8%)	