Measuring Quality in Community Nursing

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What is quality in community nursing

- What does it mean to clinicians?
- What does it mean to patients, their families, and the wider public?
- What does it mean to commissioners of care?

Measuring quality

1. Healthcare efficiency (getting the most from staff expertise or effort)
2. Patient safety / risk reduction
3. Patient satisfaction
4. Patient outcomes

(adapted from Emslie and Hancock, 2008)

Healthcare efficiency

- Productivity – cost and time efficient use of resources.
- Primarily financially driven incentives – i.e. service level agreements on numbers of patient contacts / CQUINS
- Measuring productivity and what else we do in our working day is important in a world of limited resources.

Healthcare efficiency

- Example: rationalising the dressing store room.
- Workload measurement tools enable better use of resources and skill mixes to meet patients needs.
- Targets and efficiency measures taken alone do not equate to quality.

Patient safety measures

- Focuses attention on key areas for improvement.
- Incident report patterns.
- The NHS Safety thermometer (NST) reinforces the notion to all of "harm free care".
- Safety data offers safe guards and transparency.

Patent safety measures

- Safety measurements work well alongside other measurements of quality – to avoid the risks of "gaming"
- Need to focus on clinical issues within the control of nursing staff to prevent.
- NST offers a starting point in developing suitable community patient safety indicators.

Patient outcome measures

- Did the person achieve the best outcome possible given their situation?
- Moving away from measuring processes of care (i.e. offered smoking advice)
- Many patients live at home with multiple complex health and social conditions
- Limited consensus or evidence currently

Patient outcome measures

- **Example: Supporting people to die in the place of their choice** – 2 GP surgeries:
- Regular 8 weekly GSF meetings, 24 hours care, Advanced care planning, Just in Case Drugs, Effective timely care input, Good MDT communication and team working, Focus on improving care.
- **50 people: 93% died in the place of their choice.** 44% (N 22) of people were able to die at home verses wider local figures of 27%.
- The change in practice was limited by not measuring relative's experiences.

Patient experience

- Care in vulnerable people's own homes can otherwise go unobserved.
- QNI report (2011) showed wide inconsistencies in peoples experiences of community care.
- Range of local led measurements around patient dignity and active involvement in care decisions
- Do the questions we ask help us to really measure experiences of care and make suitable changes?

Conclusion

- Quality underpins everything we do as community practitioners
- We need to effectively measure quality - and use this information to improve care.
- The metrics in use today in the community are in their infancy - we need to refine and adapt them.