

**A health system should seek to make improvements in six areas or dimensions of quality, which are listed below.**

These dimensions require that health care is:

- **Effective** – delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need.
- **Efficient** – delivering health care in a manner which maximizes resource use and avoids waste.
- **Accessible** – delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need.
- **Acceptable/patient-centred** – delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities.
- **Equitable** – delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.
- **Safe** – delivering health care which minimizes risks and harm to service users.<sup>107</sup>

Most paediatric palliative care services and hospices are involved in quality improvement (QI) activities. This involves changes in practice or care that lead to better care and outcomes for patients and families. Implementing evidence based practice into routine day to day care is a key objective of quality improvement. Health services require a strong culture of quality, and also a willingness to collaborate with other services within this context. “The Standards for Providing Palliative Care for all Australians” has been established to define the standard of care that will best meet the needs of dying patients and their caregivers (see appendix 5).

These standards incorporate the unique needs of dying children and their families.

Activities that can assist with quality and service improvement include:

- Clinical governance.
- Development of policy, procedures and guidelines related to care.
- Audits of practice and documentation.
- Analysis of clinical and critical incidents
- Routine review of the care of patients after they die (i.e. death reviews, mortality and morbidity meetings).
- Incorporating child and parent feedback into how a service operates (both families currently caring for a child with a life limiting condition, and also bereaved parents and families).
- Monitoring clinical indicators (see appendix 6).
- Self-assessment programs (e.g. National Standards Assessment Program/NSAP).
- Peer review and mentorship (e.g. NSAP).
- Collaborative projects (e.g. through the Australian and New Zealand Paediatric Palliative Care Reference Group and NSAP).

The ‘plan, do, study, act’ (PDSA) cycle<sup>108</sup> uses simple measurements to monitor the effects of change over time. Changes and improvements do not need to be large and can be implemented over small time frames (weeks to months). Larger improvements occur through successive cycles which become linked cumulatively to each other and across organisations. Reflective practice and building on prior learning and experience also assist this process. Such change can be based on existing ideas and research, or through practical ideas that have been proven to work elsewhere.<sup>109</sup>

Within the paediatric context, family centred care is also important in the context of patient or child centred care. Family centred care can be achieved by:

- Better communication with parents and carers.
- Treating all family members with dignity and respect.
- Embracing the family as part of our team of carers.
- Providing prompt feedback.
- Accepting a joint decision-making process
- Enabling carers with the skills to provide ongoing care.
- Improving overnight carer accommodation.<sup>110</sup>

**FIGURE 10** PDSA Cycle <sup>108</sup>

