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Title: Measuring a good death - Validation of a tool for retrospectively measuring quality of death
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Introduction:
Quality of dying is difficult to measure. As the usual gold standard of asking the patient does not apply, different approaches are required. In a hospital setting death can be complex; there are many people involved in care at end of life (EOL) and it is not always anticipated. In 2015/2016 an audit tool evaluating quality of death was developed in Canterbury District Health Board (CDHB). This audit tool retrospectively captured the physical, spiritual, cultural and emotional aspects of dying for the patient and their family. This audit highlighted areas that are being done well and areas that need improvement. However, the tool still needed to be validated and compared to opinions of staff involved in the care of a patient.

Aim:
To validate a previously created quality of dying audit tool to evaluate its robustness, repeatability and accuracy and to measure the likely resource required to implement the tool throughout Christchurch Hospital.

Impact:
The ultimate goal is to apply this tool to all deaths within the CDHB (including community settings), aiming to improve quality of death by championing areas of excellence and identifying areas for improvement.

Method:
Tool and survey refinement: An online prototype of the quality of death audit tool (QoD) was set up to audit deaths in the oncology department, Christchurch Hospital. A staff survey was also set up to gather feedback from staff involved in the EOL care of individual patients. This anonymous staff survey invited staff to comment on their perceptions of quality of death and provide feedback on aspects done well, aspects to be improved and overall family needs. The QoD items were refined and more demographic data was added for use in other departments. During the course of the project, the staff survey was rolled out to other departments throughout the hospital.

Staff survey qualitative analysis: Thematic analysis was started on the staff survey to identify themes considered to be important in EOL care, highlighting aspects that are done well and those that need improvement.
Variability measurement: Intra- and inter-observer reliability was validated from five observers of six cases.
Comparison of QoD to staff survey: Although measuring different aspects surrounding EOL care, the staff survey and QoD were informally compared.
Measurement of timing and resource required: Resource required for the QoD was temporarily added and was measured by timing each case audit.

Results:
Staff survey analysis: Comments from the staff survey were analysed using thematic analysis. Each comment was analysed in its initial grouping (aspects done well, aspects that could be improved and family needs). Categories arising from each comment were recorded and then grouped into themes for later comparison. Interesting outcomes from this study have been the cathartic nature of the staff responses. The anonymity of the survey allowed for personal reflection and there is the opportunity for departmental and quality improvement. The staff survey also highlights the different

opinions and staff involved at various times during the patients EOL care, for example one patient may have several staff not in agreement about symptom management.

Inter- and intra-observer reliability: Initial analysis of the intra- and inter-observer reliability of the QoD appears to have good agreement between observers.

Comparison of QoD to staff survey: Expanding to other departments meant that different types of death were captured. Unexpected deaths usually score lower than expected deaths on the QoD (higher score equals better death). Comparison of the QoD and staff survey identified discrepancies, indicating that a good death was often achieved, even though the score was relatively low. This suggested that some elements within the QoD should not be evaluated in patients who died unexpectedly. As the tool was initially set up for expected deaths, some adjustments were required in order to make it a more representative tool for use in unexpected deaths.

Resource required and rollout to rest of hospital: An initial limit of 30 minutes per case was placed on the QoD. Refinement was required so that questions could still be completed within the timeframe. Deciding on category of death was found to be the main time constraint and so it was decided that in future use, someone with clinical experience (ideally from the treating team) would be better placed to do this categorisation leading to a faster audit. It is hoped that both the QoD and staff survey will be rolled out within the CDHB.

Conclusion:

Two products have been developed; an audit tool and a staff survey. The audit tool measures documentation of aspects important to the provision of EOL care and the staff survey evaluates staff perceptions of the quality of care. The information gained from both of these can be used hospital wide (or within individual departments/services) to evaluate and improve quality of care so that all patients who die in Christchurch hospital can have the highest standard of EOL care.