UNIT 2 QUALITY ASSURANCE AND STANDARDS

Structure

2.0 OBJECTIVES

After studying this unit, you will be able to:

- define quality, quality assurance, standards;
- describe the concept and importance of quality assurance;
- explain the need and types of standards for nursing practice;
- describe the approaches and strategies for developing standards for nursing practice;
- explain the tools and techniques for assuring quality of nursing care – Nursing Audit;
- enumerate selected models for quality assurance; and
- describe the role and responsibilities of a nurse administrator in developing quality assurance system in the hospital.

2.1 INTRODUCTION

Concern for the quality of care is as old as health facilities itself. Individual practitioners from Hypocrites to Florence Nightingale have recorded their observations of poor quality care and made recommendations for improvement.

Throughout ages, the purpose of nursing, as a social institution, has been to give services that are beneficial to mankind – to nurture, to help and to heal. Over the years as nursing practice has become a profession, its primary purpose has been not only to provide care, but also to improve its standards of practice. Nursing is committed to professional excellence by providing highest quality of possible care. Quality care involves both technical aspects of providing care and human aspects, which arise from the personal contact between the supplier and receiver of care. A distinguished mark of any professional person is not only that individual brings disciplined thinking to the practice, but also considers that 'the best' is never good enough. In this, the individual is a person with both ideas and ideals.

Quality assurance in health care is the burning issue of the time. It is a system set up to measure the quality of care in nursing. In this unit you will learn about definition, concepts, stages and needs of quality assurance; standards of quality care and evaluation of care.

2.2 DEFINITIONS AND CONCEPTS OF QUALITY, QUALITY ASSURANCE AND STANDARDS

2.2.1 Definitions

You need to learn the definition of terms that you will be using in the subsequent sections and subsections of this unit.

Quality: Quality health care has been described as the extent to which the process of care increases the chance of desirable outcome and reduces the chances of undesirable one (Holtzemer, 1990).

In health care quality involves the interrelationships between numerous groups of professionals and lay people. A simplified view of this relationship is given below in Fig. 2.1.

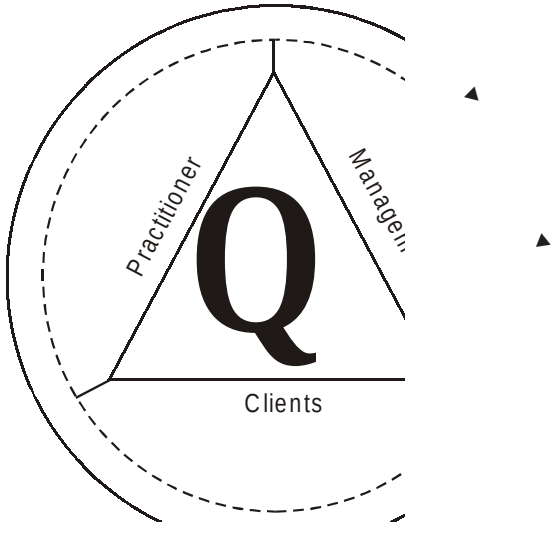

Fig. 2.1: The Quality Focus

Quality is shown as the central focus of attention for practitioners, managers and clients. Society at large influences the relationships between the groups.

Quality Assurance: Quality Assurance refers to: A system for monitoring outcomes of professional interventions and departmental activities, which are compared with established standards to evaluate and document appropriateness and effectiveness of practices.

Quality Assurance involves:

i) identifying standards for excellence;

ii) evaluating care against those standards;

iii) taking action to correct deficiencies and to reach these standards (Zimmer, 1974).

Standards: The Oxford Dictionary provides several key concepts for definition of standards. Firstly, it notes that standards are degree of excellence. Secondly, it notes that standards are a minimum with which a community may be reasonably content, and finally, that a standard is recognized as a *model for imitation.*

Standards are "professionally developed expressions of the range of acceptable variations from a norm or criterion" (Donabedian, 1985).

A standard is defined as "an acknowleged measure of comparison for quantitative or qualitative value criterion norm." Various definitions of standards are as under:

- A standard is a means of determining what something should be, in the case of nursing practice.
- Standards are the established criteria for the practice of nursing.
- Standards are statements that one widely recognises as describing nursing practice and are seen as having permanent value.
- Standard specifies what is necessary for high quality practice (ANA, 1973).

2.2.2 Concept of Quality Assurance

Quality assurance is an integral part of client care activities in all health care setting. Its objective is to improve the care provided to clients. Quality assurance is the effective execution of all the activities concerned with attaining quality.

Quality Assurance provides objective evidence that gives clients and society confidence that the quality of care within an institution satisfies stated requirements. This is the level of guarantee.

2.2.3 Process of Quality Assurance

At a basic level, quality assurance process incorporates the following stages/steps (Lang, 1984):

- Setting standards
- Apprising actual achievements
- Planning for improvement
- Taking action when required.

These basic steps are repeated in cyclincal nature as shown in Fig. 2.2. This is commonly referred to as the quality wheel.

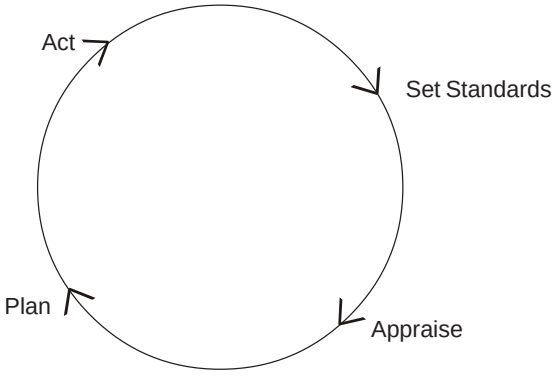

Fig. 2.2: Quality Wheel

i) *Setting standards:* Setting standards involve writing statements that describe achievable and desirable levels of quality of care. These are professional expectations of the service and statement of intent to clients.

ii) *Appraising actual achievement:* Appraising actual achievement involves comparing practice with the defined standards through measurement criteria.

iii) *Planning for improvement* is necessary when after appraisal any gap between provision and expectation is identified.

iv) *Taking action when required:* If quality of care is below the stated accepted levels, the action is taken to raise quality until standards are met.

2.2.4 Need for Quality Assurance in Health Care

There are many reasons why quality assurance programmes are needed in health care (Fig. 2.3).

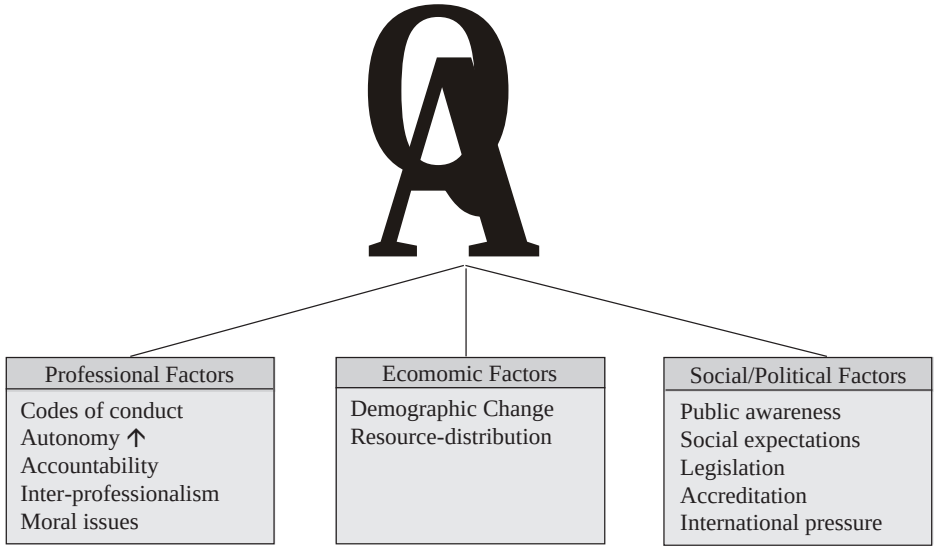

Fig. 2.3: The Incentives for quality assurance in health care

In this section, you have seen that there are many reasons for importance of quality assurance in health care. These include professional, economic and social/political factors.

Check Your Progress 1

1) Define the following terms:

   a) Quality Assurance

   .....

   .....

   b) Standards

   .....

   .....

2) List the steps of quality assurance.

   a) .....

   b) .....

   c) .....

   d) .....

2.3 STANDARDS

2.3.1 Standards as a Pre-requisite for Quality Care

Historical Background

Nursing has come a long way as a profession since the days when Florence Nightingale established basic standards for education of nurses. The standards she set emphasized the importance of nurses' understanding the rationale for their actions. She designed a curriculum that included classroom time and study as well as the practice. Her innovations clearly indicated that she believed in the value education for practicing nursing rather than in the mere repetition of certain behaviours, wihtout supervision.

In 1893, Lystra E. Gretter led a committee of nurses in the development of "The Florence Ninghtingale Pledge". This was an effort to identify a set of ethical behaviour by which nurses could be judged. One passage within it states, "I will do all within my power to maintain and elevate the standard of my profession." However, the standard for the profession was not defined at that time and a clear objective establishment of standards was not attempted until much later. It was not until 1960s and 1970s that the American Nurses Assocation began developing standards for nursing practice in general and for the various specialities.

Standard as Important Part of Quality Care

Standards reflect the actual situation and can be tailored to most specific situation. Standards for nursing practice help to fulfil the profession's obligations to provide quality nursing services to clients. They focus on nursing care needs of the patient and what the patient can expect from nursing services. They are essential to a professional nurse. Standards are the mechanisms that are used to describe and define the scope of nursing practice.

We need standards because these:

- provide guidelines and directions for organizing nursing structure and nursing performance;
- provide guidelines to enable a systematic and organized approach to nursing care regardless where and when it is practiced and assist in decisions on priorities in care, mixture of skills needed in nursing care;
- provide a baseline or criterion for evaluating quality of nursing care ranging from excellent care to unsafe care and take necessary corrective measures. This helps in improving quality nursing care, increase effectiveness and efficiency of care;
- ensure that the patient's right to consistent excellent nursing care is met;
- help in supervision and guide staff to improve their performance;
- help justify demands for resource allocation;
- help classify nurses area of accountability at different levels.

Nurses need to define and describe their practice because of their statutory, legal and social responsibility to give best possible care to patients and clients.

Purposes of Standards

The purposes of standards are to:

- assist the profession in evaluating the quality of practice in any setting.
- provide a common base for practitioners to coordinate and unify their efforts in the improvement of practice.
- identify the element of independent function of practice.
- provide a basis for planning and evaluating educational programmes for preparing practitioners.
- inform the society of our concern for the improvement of nursing practice.
- assist public in understanding what to expect from nursing practice.

- provide a means by which members of different health professions can coordinate their efforts in the improvement of health care.
- help the employers to understand what to expect from the practitioners.
- stimulate and encourage nursing personnel to promote and support education, studies and research which affect the care of patients, the practice of nursing or the welfare of nurses and nursing.

In general, nursing care standards are important to:

a) improve the quality of nursing care,

b) decrease the cost of nursing care, and

c) promote a basis for determining nursing negligence.

2.3.2 Types of Standards

The standards are stated according to a systematic approach to nursing practice: the assessment of client's status, the plan of nursing actions, the implementation of the plan and evaluation (Nursing process approach). The standards can be **normative standards** and **empirical standards**.

i) **Normative Standards:** These standards are description of practices which are considered ideal by authrotiy. These standards describe higher quality of practices, e.g. standards set by professional association.

ii) **Empirical Standards**: These standards are description of practices which are in actual practice in large number of setting and which are agreed upon and achievable, e.g., standard set by law enforcement bodies and regulatory bodies – like health departments and licensures bodies.

Standards can be established to appraise care according to may approaches. **The most common approaches are based on Structure, Process and Outcome.** The facilities and organization of an institution are usually evaluated according to structure standards; the activities or delivery of care are evaluated by process standards; and the patient's health status or recovery is evaluated by outcome standards. But all three types of standards are inter-related and can be used to evaluate various aspects in the area of nursing service.

> So structure standards apply to the things we use (human, financial and physical resources). Process standards apply to what we do (activities that constitute care, service or management). Outcome standards address the results (both clinical and non-clinical) of what we do with the things we have.

Structure Standards (Institution Oriented)

Structure standards are related to care providing system and resources that support for actual provision of care i.e. organization of nursing care department, e.g. the nursing staffing system establishes the standard for nursing personnel requirement relative to patient care needs, job-description – define the education, experience, credentials, and abilities required for placement of applicants in nursing positions. Utilization policies, determine patient sub-populations placed and cared for selected nursing units, e.g., ICU, CCU, OT, Equipment's supplies and medication standards define essential resources required to support patient care. Safety and infection control policies describe environmental considerations and controls essential to patient and personnel safety.

These standards are designed to identify what is necessary, but do not describe sufficient conditions for quality care. This implies that structure standards alone will not ensure quality care.

These standards provide necessary conditions under which it is likely that quality nursing will take place or in other words, will help in implementation of practice standards. So the structure standards are related to:

- Policies, goals, objectives.
- Staffing: number, type, training, qualification, job responsibilities.
- Recording system.

- Administrative set up — line of communication.
- Equipment and supplies.
- Budgeting.
- Physical facilities, building etc.

Process Standard

Process standard involves the activities concerned with delivering patient care, i.e. describe the manner in which nursing care is to be delivered and nursing activities to be carried out. These standards measure nursing actions, or lack of actions, involving patient care. These focus on nursing techniques and procedures i.e. planning, communication and recording. These standards take into consideration adequacy of care, appropriateness of care and quality of care, e.g. standard I of the ANA (American Nurses Assocation's) "Standards of nursing practice" which states, "The collection of data, about the health status of the client/patient, is systematic and continuous. The data are accessible, communicated and recorded".

Process standards are communicated through modalities such as standard care plan, nursing protocol, nursing procedures, performation appraisal. Prior to the initiation of any monitoring activities, process standards must be identified from these frameworks and stated clearly.

The process standard helps in assessing the degree of skills with which the techniques are performed, the degree of client involvement, the nature of communication and interaction between nurse and the client. Thus, it implies professional judgement in determining the quality of nursing care/skills.

The standards are stated in action verbs which are observable and measurable, e.g. nurse prepares appropriate written nursing care plan for the patient.

- Identifies personal needs, disease-related needs and therapy-related needs.
- Identifies nursing actions.
- Mobilizes resources.
- Implement actions.
- Evaluates the result.

Outcome Standards (Patient Centered/Client Centered)

Outcome measures the patient's change in health status, e.g. these standards are descriptive statements of results of patient care/client care and are stated in terms of change that occur in patient/client. The reference is both qualitative and quantitative. Outcome standards are drafted in terms of what the patient will do, know, express or experience and reflect nursing goals for physiological, emotional and mental wellbeing. These outcome standards may be conceptualized as long-term goal for patient's knowledge improvement or change in physical, social and emotional functioning, etc.

It is difficult to isolate outcome due to nursing because there are many interacting factors resulting to patient outcomes e.g. medicine, social sciences, nursing etc. Outcome standards are related to patient's health status, self care abilities, functional ability or disability, morbidity and mortality status, occurrence of complication and restoration of functions etc. Outcome standards are important in evaluating community health care service. These are often in terms of targets, such as lowering infant mortality, morbidity, etc.

The result of outcome standards may be positive or negative. When the outcome is satisfactory it matters little whether what structure or process standards are used. If one discovers that outcomes are not according to expectations then one needs to scrutinize the structure standards and process standards e.g. patients experiencing nosocomial infection in the ward or infant in developing malnutrition. Outcome standards reflect effectiveness and results, rather than the process of giving care. It is generally found that universal or generalized outcome standards that are applicable to all patients/clients are not feasible because individuals, their conditions and situations will vary and therefore, outcomes also vary. The solution to this problem is to have common standards for patient/clients with similar problem, disease or functional disabilities, e.g. in a newly post-operative colostomy

patient, a nursing outcome standard might be stated as: "patient will demonstrate self-irrigation using routine equipment that will be used at home".

As one of the three approaches is the evaluation of a standard is valid indicator of quality of care, but quality of care is possible only when structure, process and outcome are all involved.

2.3.3 Approaches/Strategies to Developing Standards

Standards may include all the three frame of references organised around nursing practices, nursing structure and nursing outcomes. The statements may be broad and applicable to varied work settings or may be very specific to serve specific purpose.

Basic Standards (The Input)

1) Philosophy of nursing practice: What we believe about the nature and character of nursing practice; what we believe about societal and clients need for nursing service; what we believe about nurse-patient/client relationship; what we believe about clients role and why do we believe.
2) Purpose of nursing practice: What is the ultimate purpose of nursing practice and how does it relate to the organization's purposes.
3) The objectives of nursing practice: What is that we would like to achieve through nursing services. The objectives are derived from the philosophy and purpose. It is better to state the objectives in terms of outcomes rather than process (methods) and structure organization. This will help in directing desirable practice and structure standards.

Steps of Standards Formation

1) Organize into a small group of nurses who work in the same field and meet periodically.
2) Decide on the area of nursing practice for which you want to work out standards.
3) Review, revise philosophy, purposes and objectives of patient care.
4) Review nursing theories/existing nursing care practices, nursing process and identify your client for nursing service; client's role, approaches and strategies for nursing care services.
5) Write the statements: Consider all the three dimensions (structure, process and outcome) giving the rational and criteria, i.e. assessment indicators. See that the standards are relevant, understandable, measurable and achievable.
6) Discuss them with the nursing service administrator to get their approval so that they are made feasible.
7) Devise a mechanism for determining the achievement of standards. It may include criteria checklist for making observation of care given, for examining records, self evaluation checklist, client opinion etc.
8) Determine the validity by giving to the expert.
9) Try out of the standard to determine the feasibility and validity.
10) The standards are not put into practice and quality care is audited.

Example of Structure, Process and Outcome Standards

Standard Statement:

The client or significant others will understand the colosomy care 24 hours prior to discharge.

Structure Standard

- One qualified nurse, competent in colostomy care on each shift.
- Colostomy care advice sheet.

- Irrigation set along with colostomy care set will be available in the ward.
- Out patient appointment card.

Process Standard

- The qualified nurse will assess the patient's capabilities from admission onwards and maintain appropriate records.
- The nurse will teach the client or significant others colostomy care, after the healing of the wound.
- The client or the significant others will demonstrate colostomy care, under supervision.
- Colostomy care and possible complications will be discussed with the client or significant others and advice sheet is given to patient.
- An outpatient appointment is made according to doctor's instructions.
- Information regarding colostomy rehabilitation associations given.

Outcome Standards

- The client or the significant others will be able to briefly explain management of colostomy and possible complications.
- The client or the significant others will be confident to carry out the colostomy irrigation and colostomy care 24 hours prior to discharge.
- The community health agency will be notified and carry out the nursing procedures as required.

2.3.4 Format of Writing

You have learnt about types of standards and process to setting standards in Sub-sections 2.3.2 and 2.3.3. In this section you will study in detail about appraising the standards, i.e. setting, agreeing and writing standards.

The steps used here in writing standards are derived from the work done by Lang (1989) and expanded upon in the Royal College of Nursing System Dysssy (1990) i.e. Dynamic Standard Setting System. We have chosen to follow this approach because of its clarity and its increasing popularity in nursing and other professions. The basic steps involve discussion and agreement on:

- Topic
- Sub-topic
- Care group
- Standard statement
- Criteria

Topic: A topic is an area of activity or aspect of care for which a quality assurance group wishes to write, e.g. "Basic Nursing" standard i.e. general set of clients under consideration.

Sub-topic: A sub topic is smaller/more specific area of the topic, e.g. "assisting patient with normal breathing"

Care Group: The care group is the set of clients for whose care the standard is to be written, e.g. All hospital patients.

Standard Statement: The standard statement is the hub (or base) on which the other elements of the standard revolve. It is an agreed level of performance appropriate to the care group and relevant to the selected sub-topic. It specifies a **desirable**, **acceptable** and **achievable** level of care, e.g. "All hospitalized patients are assisted for normal breathing by nurses in each shift".

A standard should:

- Be clearly written
- Address on agreed sub-topic

- Pertain to an agreed care group
- Be acceptable to relevant colleagues
- **Criteria:** Criteria specify clearly and precisely the level of performance which has to be achieved to satisfy the standard. Criteria can be based on the types of standards i.e. structure, process, outcome.

Quality assurance group have to choose the criteria which are both the best indicators of the achievement of standards and the easiest to use. One way to check criteria is to apply the 'AMOUR' principle as given below. The criteria are:

- **A**chievable
- **M**easurable
- **O**bservable
- **U**nderstandable
- **R**easonable

Two alternative forms of writing standards are presented as under:

The Standards written by Nurses at the Regional Cancer Centre, Trivandrum

Topic	:	Treating side effects of chemotherapy
Sub-topic	:	Control of vomiting
Care/client group	:	Patients receiving cytotoxic drugs
Standard statement	:	Patients receiving cytotoxic drugs receive nursing care support to reduce vomiting to an optimum level

Structure	Process	Outcome
a) Clean environment provided for each patient b) Qualified staff to give confirmation and advice	a) Encourage protein sources carly in the day b) Encourage small frequent meals as per likes and dislikes c) Avoid fried food and advice bland dict d) Frequent mouthwash e) Maintenance of proper intake and output chart f) Administration of intravenous fluids g) Give antiemetics if prescribed h) Educate the patients as well as family members about the cause of vomiting	a) Patient accepts that fact that vomiting is drug-induced b) Patent takes the food and drink provided c) Patient feels comfortable

Topic: Palliative care of patients with advanced cancer; sub-topic: palliative care of patients with oral cancer

Standard statement: The patient and the family receive the importance of oral hygiene and palliative care in oral cancer and thus improve the quality of life through physical, psychological and spiritual aspects.

Structure	Process	Outcome
Physical, psychological and spiritual care of the patient with the aim of improving morale and emotional status despite poor physical prognosis.	Physical, psychological spiritual needs of the patients will be identified and treated at appropriate time.	The patient will die with dignity and minimum distress in accordance with his/her wishes and beliefs.
Relief from pain and other distressing symptoms includes infections (thrush) in the oral cavity, foul smell, dryness of the mouth, drooling of saliva.	Regular analgesia is necessary, especially oral morphine. Fungal infections should be treated with anti-fungals. Encourage regular month care with soda bicarb, or saline.	

Structure	Process	Outcome
	Sucking chipped ice or pieces of pineapple may encourage the production of saliva.	
Fatalistic attitudes towards cancers of the patient should be alleviated.	Support systems from family, friends and care givers to help the patient to remain self-determining and to live as joyfully and actively as possible until death.	

Example

Standard

Topic : Receiving the patient to O.T.
Subtopic : Checking and identification of the patient.
Care Group : Operative patient.
Responsible : Staff Nurses.

Standard Statement

- Every operative patient is checked and identified before taking to operation theatre.

Structure

- Every nurse is taught how to receive the operative patient.
- Protocol to receive the patient is updated by every nurse and and it is checked by the senior staffs.

Process

- While receiving, the patient is greeted by the OT nurse who is receiving with patient's name and make him feel comfortable.
- Re-assure the patient and patient relatives.
- Check the patient's file with his name, age, I.D. number.
- All the necessary blood investigation reports have been checked and it is within normal limits.
- Checking the medication chart and pre-operative chart which is filled up with the patient's necessary data.
- Inform to the anaesthetist if patient is having any allergy before anaesthetising the patient.
- Check for the invasive or non-invasive diagnostic procedure report.
- Check for the ward theatre checklist and surgical identity bond.
- O.T. nurse is re-identifying the patient by the relative of the patient.
- Shift the patient from ward trolly to O.T. trolly.
- Explain to the patient's relatives about how much time will take for surgery and where to shift the patient after surgery etc. and sending the relatives to the ground floor.

Check Your Progress 2

1) List the types of standards.
   a) .....
   b) .....
2) List the approaches of standards.
   a) .....
   b) .....
   c) .....

3) State the basis of standards.

a) .....

b) .....

c) .....

2.4 EVALUATION OF CARE

Of all the services provided in a hospital nursing service is closest to the patients. Nursing services major goal is providing nursing care to all people within the available resources of personnel facilities, organization and money. Service is committed to maintain standard of care. This has to be achieved by the profession by evaluating its services periodically and taking necessary steps for its improvement. In fact, the present day product oriented society and professional accountability emphasize the need to have frequent evaluation of effectiveness. The process of evaluation is essentially the process of determining to what extent the organizational objectives are actually being realized.

Two major functions of evaluation of nursing service are:

i) To ascertain the nature and effects of nursing care.

ii) To decide whether or not the observed effects attain acceptable standards of nursing care.

Each hospital nursing service is unique. Each should begin its programme of improvement of nursing care with a thorough understanding of its own problems, determined very careful, thoughtful and deliberate analysis.

2.4.1 Principles of Evaluation

Principles of evaluation are:

i) **Relevance** : that what is assessed is relevant in terms of health care actions.

ii) **Comprehensiveness** : that the assessment is made of the totality of behaviour required.

iii) **Problem-solving** : the ability to adapt to different conditions and to select appropriate action.

iv) **Validity** : that the assessment measures what it purports to measure.

v) **Generalizability** : that the assessment provide prediction to other situation.

vi) **Appropriateness** : that the format or type of assessment is suitable for the type of practitioner.

vii) **Effectiveness** : that the pre-determined objectives of the plan for nursing care are actually achieved.

viii) **Efficient** : that is the cost effectiveness in nursing time as well as in materials and money.

As a result of the evaluation of nursing services, certain changes will be recommended and these will/can be taken into consideration during the new planning cycle. In each new planning cycle, the focus will become sharper until through approximations, the kind and quality of nursing care most appropriate for the hospital concerned will gradaully be developed.

2.4.2 Tools and Techniques used for Evaluating Nursing Care

We can classify the tools/techniques into two categories:

i) **Patient Care Centred Tools/Methods**

These consist of :

a) Observation.

b) By giving opinionnaire/questionnaire to patients' relatives and/or staff.

c) Interviewing patients and relatives.

d) Nursing rounds.

e) Use of standards for nursing practice.

f) Indices for hospital utilisation, e.g. quick turn-over of patients, high bed occupancy rate.

g) Indirect criteria which may indicate that good nursing care is being provided, e.g.

- Number of errors and incidents of neglect resorted which indicate care negligibility.
- Few requests are made for private duty nurses.
- Few complaints are received from doctors, patients and/or families about the quality of care and care provided is frequently praised.
- Few patients return after discharge because of inadequate teaching.

We shall now focus on the nursing audit process including the development and use of this tool that provides a systematic framework for evaluating care provided to patients. Even if nursing audit has not been introduced into your hospital, it will certainly become an established part of the quality assurance process in the future. Therefore, it is important that you become familiar with the process.

ii) **Nursing Audit**

Quality of nursing is different to measure both qualitatively and quantitatively but is possible. Nursing Audit makes an important component of medical audit. Increase in the public awareness of their rights of safety and high cost of medical treatment necessitates that the nurses should become more and more accountable for care they deliver. This is the reason that the nursing process has become a legal document in many countries.

The word “audit” comes from the Latin word “auditus”, a hearing. It originally meant the hearing of facts and arguments about a situation to determine the truth. As the English language evolved the word in tune lost its original broader meaning and became specifically concerned with the checking and endorsing of financial accounts. Phaneof defined nursing audit as the nurse’s formal, systematic written appraisal of the quality of nursing services indicated in the care records of discharged patients. Today we think of audit in the terms listed below:

- *Structure Audit:* Concerned with the setting in which care is given (e.g., physical facilities, equipment and supplies, the personnel).
- *Process Audit:* Focused on the order in which events occur, i.e. procedure of giving car.
- *Outcome Audit:* Looks at the status of the patient as a result of care provided.

The audit can be External Audit, i.e. done by outside agency and Internal Audit, i.e. it can be done by health agency staff itself.

How to Do Nursing Audit?

1) Formulation of nursing audit committee consisting of Chairman (e.g. senior nurse) and 3-4 members (supervisors/head nurses).

2) Committee should meet once a month to audit records of patients discharged during that time.

3) Chariman would assign the number of charts each member will audit. Steps outline for evaluating auditing are:

   — visit the unit to complete the evaluation form

   — compile the score for each patient

   — meet the committee to discuss the finding.

4) Members should be very honest and impartial in their judgement. A confidential note should be sent to the individual if something very outstanding has been recorded.

5) Review of audit is done by the members of the committee, compiled and submitted to the authorities with recommendations for future action.

Uses/Advantages of Nursing Audit

1) Nursing audit gives a biographical index of quality of nursing each patient has achieved.
2) Patient is assured of good services.
3) It will give valuable and pertinent information for the staff; improvement in quality of nursing as well as strengths and weaknesses in nursing service are revealed.
4) It will lead to better cooperation and communication among the nurses and health team members as a result of improved quality of nursing notes.
5) It will help each professional nurse for her self-evaluation.
6) Nursing audit helps the administration – better planning can be done through nursing audit. It enables the nurse administrator to uncover the inefficient service and point the ways to elevation of standards.
7) It will reduce the incidence of medico-legal complications arising out of incomplete or inaccurate records maintained by nurses, because nursing audit serves to persue excellence and to contribute to nurses' moral and legal accountability for the service she renders.
8) It will broaden and strengthen nursing service in the hospital. It may provide data needed to effect required changes in the health care system.

Disadvantages

1) It is considered as a source of punishment by the professional group.
2) Medico-legal important – they feel that these will be used in court of law as any document can be called for in court of law for clear, adequate and efficient evidences.

Using Results of Nursing Audit

For Nursing Care Service

Results of the nursing audit can be used in a number of ways:

1) Modifying nursing care plans and the nursing care process, including discharge planning, for selected patient population.
2) Implementing a programme for improving documentation of nursing care through improved charting policies methodologies and forms.
3) Focusing supervisory attention upon areas of weakness identified, such as one particular nursing unit or specific employee.
4) Focusing of nursing rounds and term conferences.
5) Designing responsible orientation and in-service education programmes.
6) Gaining administrative support for making changes in resources, including personnel.
7) Using the evaluation based on nursing audit criteria to focus staff attention on individual patient outcome.

For Nursing Administrators

The measurements:

1) Provide evaluations of particular programme, such as orientation of personnel or establishment of a patient teaching programme.
2) Support requests for accreditation or for financing for a particular programme.
3) Serve as basis for planning new programmes or programme changes.
4) Serve to identify areas of strength and weakness in the total nursing programmes, in specific areas of the programme, and in various settings in which a programme exists,
5) Determine the influence of varied staffing patterns.
6) May be used as data in cost-effectiveness status. For example, studies comparing the quality of care received by patients in varied situations in which costs of staffing vary.

For Supervisors and Head Nurses

The measurements:

1) Identify areas of needed patient care improvement,
2) Provide basis for in planning inservice education programme,
3) Identify teaching/supervision needs of staff members who give direct care to patients.

For Staff Nurses

The measurements:

1) Provide a self-examination of care in their specific nursing unit or setting,
2) Identify particular types of care in which practice may be improved merely by increased attention and conscientiousness,
3) Identify types of care in which improvement will depend on the staff's acquiring additional knowledge and skill.

One requirement for an effective audit is a strong commitment of staff to reflect accurately nursing practice in nursing documentation. Clear, adequate and efficient charting and recording is very essential to start a nursing audit in a hospital. There should be:

- promptness
- accuracy
- proper itemization
- legibility
- neatness
- conciseness

As the audit is neither inclusive nor exclusive, it should be used in conjunction with other quality assurance mechanisms, and in collaboration with other disciplines. Commitment at all levels – consumer, provider, administrator – is essential for success.

Examples of Nursing Audit

Example 1

Audit Objective: Are all hospitalised patients assisted for normal breathing by nurses in each shift?

Target	Method	Code	Audit Criteria
Nurse	Ask	S1	Do the nurses have required level of knowledge to assess breathing?
Nurse	Ask & Observe	S2	Do the nurses have the skill to assess breathing?
Nurse	Observe	S3	Are adequate devices available?
Ward	Observe & Ask	S4	Is a respiratory manual available?
Nurse	Ask & Observe	P1	Do nurses assess patients respiration in each shift?
Nurse	Ask & Observe	P2	Do nurses identify/prioritise breathing needs of patient?
Nurse	Observe	P3	Do nurses intervene using measures appropriately?
Nurse	Check records	P4	Do nurses record all observations regarding breathing?
	Observe & check	P5	Do nurses report abnormalities?
	records Ask & observe	O1	Does the patient state that s/he can breathe comfortably?
	Observe	O2	Does the patient appear to breathe normally/comfortably?

Example 2

Audit Objective : To establish what percentage of parties were assisted to maintain normal breathing and ascertain reasons for inability.

Sample : Adult patients admitted in medical ward, random 20% of sample of nurses notes, total population of 100, patients – 100.

Time Frame : Two weeks.

Auditor(s) : Mrs. A. and Mrs. B.

Date : February 10, 1999.

Audit Summary

Audit Objective : To establish what percentage of patients were assisted to maintain normal breathing and ascertain reasons for inability.

Sample : Adult patients admitted in medical ward, random 20% of sample of nurses notes, total population of 100, patients–100.

Time Frame : Two weeks.

Auditor (s) : Mrs. A. and Mrs. B.

Date : February 10, 1999.

Activity	Findings	Conclusions
Compliance	Eighty per cent of the clients were assisted by nurses to maintain normal breathing. Twenty per cent could not be assisted due to sudden deterioration of patient's condition.	Need to reinforce. The need for early detection of any deviations in normal breathing.
Staff Training	Hundred per cent of staff possess general basic nursing training.	Need to organise a short-term training course on respiratory are.

Example 3

Activity	Findings	Conclusions
Compliance	Eighty percent of the clients were assisted by nurses to maintain normal breathing. Twenty percent could not be assisted due to sudden deterioration of patient's condition.	The need for early detection of any deviations in normal breathing.
Staff Training	Hundred percent of staff possess general basic nursing training.	Need to organise a short-term training course on respiratory care.

Example 4

Action Plan

Audit Statement : All hospitalized patients are assisted to maintain normal breathing.

Audit Objective : Are all hospitalized patients assisted to maintain normal breathing?

Identified Problem	Suggested Action	Member of Staff Responsible	Time Period
Staff lacks special training in respiratory care.	Organise short-term course on "respiratory care".	Department of Continuing Education/In-service Education Incharge/Nurse Administrator of the Unit.	One week

Check Your Progress 3

1) Match the statements given in Column B with the terms given in Column A.

Column 'A'	Column 'B'
a) Relevant	i) the assessment measures what it purports to measure
b) Comprehensiveness	ii) the assessment provides predictions to other situations.
c) Validity	iii) what is assessed is relevant in terms of nursing care actions.

d) Generalizability

e) Appropriateness

iv) the format of assessment is suitable for the types of practitioners.

v) the predetermined objectives of the plan for nursing care are actually achieved.

vi) the assessment is made of totality of behaviour required.

2) Define Nusring Audit.

.....

.....

.....

.....

.....

.....

2.5 STEPS IN DEVELOPING QUALITY ASSURANCE IN HOSPITALS

Quality assurance is a cyclic process of setting standards of care; measuring care according to these standards, evaluating data from chart review, observations, and interview and making recommendations for improvement.

2.5.1 Quality Assurance Task Force

Considerable deliberation and planning are needed by all nurse managers in a health facility in order to institute a quality assurance programme. The most successful nursing quality assurance programme are simple, inexpensive and non-threatening to staff members. A long range plan with intermediate target dates for completion of each element of the programme should be established. The following steps are to be followed in quality assurance programme.

a) Approval of the programme.

b) Task force or committee to be appointed.

c) Orientation programme to be arranged for the committee member to familiarize with the purpose, principles, methods etc.

d) Examine their belief and behaviour concerning quality control through workshop.

e) Explore the difference in nursing value through open confrontation.

f) Identify institutional supports and constraints to be dealt with in measuring and improving nursing quality. Steps and principles of QAP are summarised in Fig. 2.4.

2.5.2 Approaches to Quality Assurance

A quality assurance programme consists of different methodologies which focus on:

a) Planning of action to be developed.

b) Communicating these standards to those who will use them.

c) Developing indicators and thresholds to continuously monitor these standards.

d) Problem-solving and process improvement.

All quality assurance approaches share one common theme, i.e. the measurement of actual performance and its comparison with either the changes in the delivery of health services or consequently with clients' health status.

Two major categories of approaches exist in quality assurance. These are:

1) *General Approach:* It examines the ability of the agency to meet criteria or standards.

2) *Specific Approaches*: These are methods used to evaluate provider and client interaction.

General Approach: The mechanism often used in the health care system is credentiality which is defined as the formal recognition of a person as professional with technical

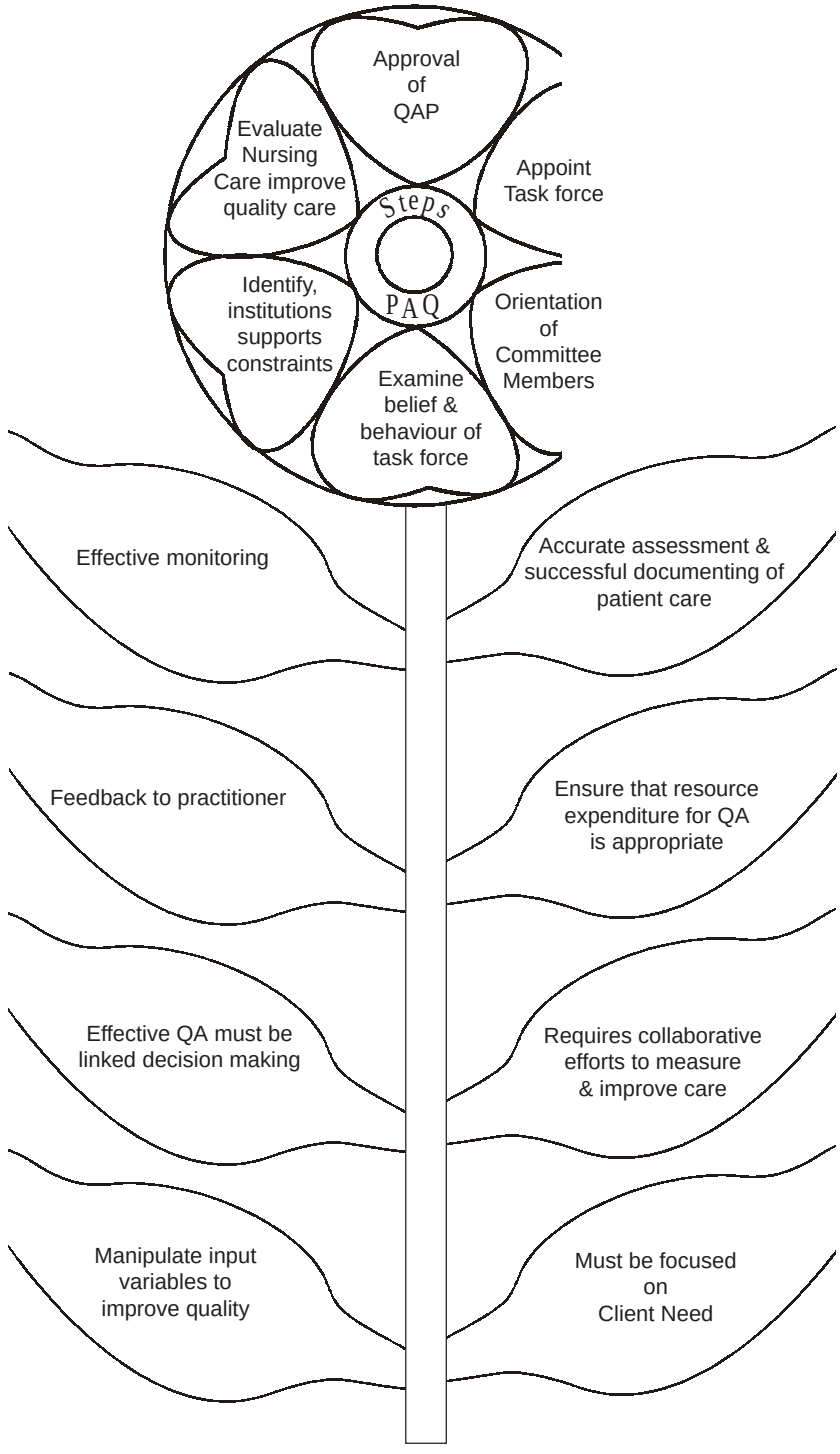

Fig. 2.4: Steps and QAP (Quality Assurance Principles)

competence or of an agency that has met minimum standards of performance. These mechanisms are used to evaluate the agency structure through which care is provided and the outcomes of care given.

The goal of credentiating process are:

a) To produce a quality product.

b) To confer an unique identity e.g. registered nurse.

c) To protect the provider and the public.

d) To control the profession.

Examples of credentiality are – licensing, certification and accreditation. The other general approaches include – recognition and education (academic degree).

Specific Approaches: The goals are:

a) To identify problems between provider and client.

b) To intervene in problem cases.

c) To provide feedback regarding interaction between client and provider.

d) To provide documentation of interactions between provider and client.

These specific approaches often are implemented voluntarily by agencies and provider groups interested in the quality of interactions in their settings.

Examples of specific approaches to quality control are agency:

a) Staff Review Committee:

   1) Concurrent audit

   2) Retrospective audit

b) Utilisation Review:

   1) Prospective

   2) Concurrent

   3) Retrospective

c) Evaluation Studies: Three major methods are introduced in this model for evaluating the quality. The first method is *structure* – evaluating the setting and instruments used to provide care e.g. facilities, equipment, characteristics of the administrative organisation, qualifications of care provider. The second method is *process* – evaluating activities as they relate to standards and expectations of health provider in the management of client care. The third method is *outcome* – the net change that occurs as a result of health care. To get an overall picutre of quality of care they (i.e. these methods) should be used together.

d) Client Satisfaction

e) Malpractice Litigation

Beneficiaries of Quality Assurance Programme

1) The recipients of care who receive safe effective satisfying services.

2) The care providers because evaluation offers opportunity to promote personal and professional growth.

3) The agencies – which obtain data for planning, cost containment and legal protection.

4) The profession – quality assurance programme promotes development of standards and protocol and generations of new knowledge.

Factors Affecting Quality Assurance

There are some factors which are affecting quality assurance in nursing care. They are as follows:

1) Lack of Resources – Infrastructure, equipment.

2) Personnel Problems – Lack of trained, skilled and motivated employee, staff indisciplines etc.

3) Improper Maintenance – The buildings, especially spot of leakage of roofs, cleaning of bathrooms, laterines.

4) Absence of well informed populace – To improve quality nursing care it is necessary that the people become knowledgeable to quality care.

5) Absence of Accreditation laws:

   - Inspect hospitals and ensure that basic requirements are met.
   - Enquire into major incidents of negligence.
   - Take action against health professionals involved in malpractices.

6) Lack of good hospital information system:
   - Workload, statistics, admission, bed occupancy, procedures, length of stay.
   - Activity, audit scheduling of procedure.
7) Absence of conducting patient satisfaction survey:
   - Delay in attendance by doctors, nurses.
   - Discourtesy shown to patient during the course of hospitalization.
   - Lack of amenities.
   - Incident of incorrect treatment.
8) Lack of nursing care records:
   - Detail of patient's condition.
   - Document all significant interaction between patient and the nursing personnel.
9) Miscellaneous factors:
   - Lack of good supervision.
   - Absence of knowledge about philosophy of nursing care.
   - Lack of policy and administrative manuals.
   - Lack of procedure manuals.
   - Substandard education and training.
   - Inadequate quality and inadequate number of professionals.
   - Lack of coordination between and within department.
   - Lack of evaluation technique.
   - Lack of written job description and job specification.
   - Lack of inservice and continuing educational programme.
10) Indian publications on nursing are very few. Though we have many resource persons hardly few publications are available.
11) Lack of adequate nurse administrator is one reason for poor initiation of any innovative project in nursing profession.

2.6 ROLE AND RESPONSIBILITIES OF A NURSE ADMINISTRATOR IN DEVELOPING QUALITY ASSURANCE SYSTEM

With present day focus on productivity, it is necessary that although appropriate and full utilization of personnel is important, it is equally important that a high quality nursing care is provided in our hospitals. Through development of quality assurance programme, the nursing profession assumes the responsibility of self-evaluation and self-regulation. Such professional accountability can only lead to improvement inpatient care and validation of nursing contributions within the institution. Nursing is not an isolated work for the patient and/or family. It is the activities rendered in cooperation and coordination with other health team members. So organisation climate is essential for this. Nurse administrator plays a very vital role in developing a quality assurance programme in her hospital (Fig. 2.5).

She participates in the following steps as suggested for ensuring quality of nursing care.

1) Deciding upon the philosophy.
2) Make certain that you as well as your nurses know what you wish to evaluate and why.
3) Formulate objectives.
4) Set standards.
5) Enlist expert guidance.
6) Plan carefully and select the evaluation tools suitable to the unit.
7) Work cooperatively.
8) Publish the report of the results of evaluation of care.

Fig. 2.5: Nurses role in quality assurance

2.6.1 Quality Assurance Group

A quality assurance group committee is a team of people who meet together to undertake quality assurance activities. Each agency/hospital needs a quality assurance committee to establish criteria and a process for quality assurance and to evaluate care, make recommendations, and do follow-up work. A chairperson with enthusiasm and attention to details helps ensure a successful programme. Members also need to be interested in quality assurance and knowledgeable about channels of communication, hospital resources, patient population and nursing needs. Representation of staff nurses, head nurses, and inservice instructors from various nursing units help to develop and implement a quality assurance programme effectively.

Sound evaluation tools alone will not be sufficient to improve the quality. To attain the goal of providing optimum quality care nurses themselves should make them ready by critical thinking and by developing and implementing a quality assurance programme in their hospital so as to provide a scientific care which is combined with humanitarian approach.

Check Your Progress 4

1) Place 'T' against those in the following statements which you consider as True and 'F' against those which you consider as False:

   a) Quality assurance is a cyclic process of measuring care according to established standards of nursing practice. (T/F)

   b) Quality assurance programme promotes personal and professional development of nursing personnel but do not ensure safe and satisfying services to the clients. (T/F)

   c) Lack of appropriate and accurate nursing care records can hinder a quality assurance programme. (T/F)

   d) Quality assurance programmes do not ensure accountability of nurse practitioners. (T/F)

2) Enumerate the components of the model on steps of Quality Assurance Principles (QAP).

   a) .....

   b) .....

   c) .....

   d) .....

   e) .....

   f) .....

2.7 LET US SUM UP

In this unit, we have discussed about the concept of quality assurance and defined various terms used in relation to quality assurance i.e. quality, standards essential for you to learn. Before we went to discuss about the approaches for developing standards for nursing practice which are the pre-requisite for quality assurance, you were acqainted with various types of standards – structure, process and outcome. We also discussed about various tools used for observing standards. In section on Evaluation of Care we discussed the principles of
evaluation and described the tools and techniquies utilized for evaluation of nursing care with special reference to nursing audit. Nursing audit is a systematic method of evaluating nursing care, is a newer concept and needs to be introduced in our hospitals in order to ensure quality care.

There are certain basic steps we should follow in developing quality assurance programme in a hospital and have been discussed in detail. Role of a nurse administrator has been highlighted in the last section of this unit. We trust you have had a gainful learning through this unit as well as other units of this block.

2.8 KEY WORDS

Accountability : The state of being answerable for one's decisions and actions.

Accreditation : The process by which an agency or organization evaluates and recognizes an institution as meeting predetermined standards.

Appraisal : The formulating, achieving agreement upon and monitoring of standards.

Audit : A methodical review or investigation of resources and activities.

Cost-effective : Able to achieve the intended objective(s) with the optimum use of resources.

Criteria : Professionally developed statements optimal health care structure, process or outcome.

Quality : Degree or standard of excellence.

Quality Assurance : A process in which achievable and desirable levels of quality are described, the extent to which these levels are achieved.

Standard : A statement which defines agreed level of excellence and describes the skills, resources or results required to achieve the level of achievement excellence in terms which can be used to measure ...

2.9 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) a) Quality assurance refers to a system for monitoring outcomes of professional interventions and departmental activities which are compared with established standards to evaluate and document appropriateness and effectiveness of practices.

   b) Standard is defined as an acknowledged measure of comparison for quantitative or qualitative value criterion, norn.

2) a) Setting standards.

   b) Appraising actual achievements.

   c) Planning for improvement.

   d) Taking action when required.

Check Your Progress 2

1) a) Normative.
   b) Emperical.
2) a) Structure Standard
   b) Process Standard
   c) Outcome Standard
3) a) Philosophy of nursing practice.
   b) Purpose of nursing practice.
   c) Objective of nursing practice.

Check Your Progress 3

1) Match the statement:
   a) iii
   b) vi
   c) i
   d) ii
   e) iv
2) Nursing audit is defined as the nurses formal, systematic written appraisal of the quality of nursing services indicated in the care records of discharged patients.

Check Your Progress 4

1) a) True
   b) False
   c) True
   d) False
2) a) Appoint Task Force
   b) Orientation of committee members
   c) Examine belief and behaviour of
   d) Identify institutions support and constraints
   e) Evaluate nursing care — Improve quality of care
   f) Approval of QAP

2.10 FURTHER READINGS

American Nurses' Association (1975), *A Plan for Implementation of the Standards of Nursing Practice*.

Aun Mrriner & Tomey (1992), *Guide to Nursing Management*, Fourth Edution, St. Louis: Mosby Year Book Inc.

Christine C. Wright and Dorothy Wittington (1992), *Quality Assurance : An Introduction for Health Care Professionals*, London: Churchill Livingston.

E.G. Heidemann (1993), *The Contemporary Use of Standards in Health Care*, WHO.

Irwin, P. & Fordhan, J. (1995), *Evaluating the Quality of Care*, London: Churchill Livingston.

Khan, Yasmeen, 'Factors Affecting Quality Assurance in Nursing', *Nursing Journal of India*, 90 (8); 173-175.

Perrodin, C. (1980), *Supervision of Nursing Personnel*, New York: The Macmillan Company.

Sridhar, S.S. (1998), 'Quality Assurance in Nursing', *Indian Journal of Nursing and Midwifery*, 1 (2), 5.7.

Swatzby, J.E. et al. (1994), 'Challenges to Achieve Quality Care, Efficiency, Effectiveness and Beneficence', *International Nursing Review*, 41 (1); 27-31.